A FOLLOW-UP STUDY OF CHILD GUIDANCE CLINIC SERVICE TO CHILDREN RATED IN THE 1951 BATTLE CREEK SCHOOL SURVEY

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CHAPTER I

INTRODUCTION

This study was suggested by the Battle Creek director's concern with an apparent tendency of the schools to neglect to refer to the Clinic other than the most seriously maladjusted children. It was felt that Clinic services should be focused more on less seriously maladjusted children with whom there would be a better prognosis for clinic treatment. An opportunity to investigate the relative seriousness of mental health problems referred by the schools was presented when the State Department of Mental Health loaned to the writer research data collected during a 1951 Survey of the Battle Creek school population. It was hoped that through a study of teachers' evaluations of some of their pupils and the subsequent referrals of children to the Clinic, some understanding might be gained of the teachers' view of the Clinic as a service to help disturbed children.

In addition to the ordinary need for continuing re-evaluation of agency role in the community, most child guidance clinics have to operate under pressure of long intake and treatment waiting lists. During the last six months of 1956 the Battle Creek Clinic's pending application list averaged 137 cases waiting for service at the end of each month. Although the waiting client learns to get along with his problem somehow, a basic complaint of mental health authorities is that the patient does not u-

sually become available for treatment until his problem is too deep seated for much direct preventive work to be done. While requests for service must be held on the waiting list, time is lost in the developmental years of children and their conflicts may be resolved in unhealthy fashion.

The necessary solution is a system of case selection which makes optimum use of clinic staff time. Some questions involved in the development of such a system are; what are the relative needs of individuals for psychiatric help or treatment; which individuals in need are able to use any kind of professional help; and which individuals in need of and most able to use professional help can be helped through clinic treatment? These questions involve many other broad questions such as; who is in need of help; who is mentally ill; who is able to use professional help; what kind of help is given in clinic treatment; and, what accomplishments can be expected through clinic treatment?

This study is generally limited to the problem of how to discover which persons from an average population are in need of professional psychiatric help. Relating this to a community setting and a child guidance clinic in that community, the question becomes; which children are in need of clinic treatment? Since the school provides a relatively controlled and objective setting in which almost all of the community's children may be, and are, ob-

served, the school becomes a logical place for the making of a community level evaluation of the children's mental health treatment needs.

Can such a rough preliminary evaluation of children's treatment needs be made by the schools with any reasonable accuracy? This depends upon (I) whether those expressions of a person's psychological identity which reveal mental health status are observable in the school setting, and (2) whether the school personnel with their individual diagnostic skills ("the average teacher") might be relied upon to select out of a total population those children who are in need of clinic treatment.

The 1951 "Survey of the Mental Health Status of Battle Creek School Children"[I] was carried out by the Battle Creek Schools and the Research Section of the Michigan Department of Mental Health. In that survey a ten percent sample of the approximately eighty-five hundred pupils was selected proportionately from the first, third, fifth, seventh, ninth and eleventh grades. Random numbers were used to select the sample of children to be rated, and each rating teacher rated six children, three boys and three girls, by completing a Rating Scale for Pupil Adjustment schedule for each child. The Research Section of the Department had tested this schedule for reliability in use by teachers,

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I. Gwen Andrew, "A Report on a Survey of the Mental Health Status of Battle Creek School Children", Michigan Department of Mental Health, 1951.

and for validity as a determinant of the relative mental health status of the children rated and much confidence was expressed in its reliability.[2] The teachers were not responsible for the final evaluations which were extracted out of the rating schedules by the professional research staff.

Some general findings of the survey were that 19 percent of the school population were "poorly adjusted", including two percent "severely maladjusted", and the remaining 81 percent were "well adjusted". The survey report suggested that the "severely maladjusted" were seriously in need of clinical help and that the total in the "poorly adjusted" range might benefit from some help which the school might offer as a part of a mental hygiene program.

Of significance to this study is the history of the Battle Creek Guidance Clinic which was founded after the 1951 Survey. No information was obtained concerning the use of the Survey findings in the promotion of this new agency in Battle Creek.

Prior to February, 1952 the two counties, Calhoun and Branch, were serviced by the Kalamazoo Child Guidance Clinic. In the mid-1940's when the needs of these two counties for clinic service became more than the Kalamazoo Clinic could handle along with the needs of seven other

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2. Ibid., pp. 31-32.

counties, efforts were begun to establish a separate Battle Creek Clinic. The new clinic opened in February, I952 with a staff of two psychologists, one being the director, one psychiatric social worker, and the consultative service of the Kalamazoo Clinic psychiatrist.[3] This staff composition remained constant until the summer-fall of I954 when the psychiatric consultant, the social worker, and the psychologist-director left. The current director-social worker began service November, I954, and the staff size continued at no more than three workers until late summer of I955 when two additional social workers were employed. Further additions have built up staff to a March, I957 peak size, including the director-social worker, a psychiatrist one day each week, one psychologist, four full-time social workers and one part-time social worker. Financing has come from the Michigan Department of Mental Health, the Boards of Supervisors of Calhoun and Branch counties and, from I955 through I958, a grant from the Kellogg foundation. No Community Chest funds have been involved.

Calhoun and Branch counties which are served by this clinic contain over one hundred fifty thousand persons, about one third of whom live in Battle Creek. Projecting the I95I Survey results upon the total population gives a

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3. The Battle Creek Child Guidance Clinic Annual Report, I953.

rough estimate of about five hundred "severely maladjusted" children included in about forty-eight hundred "poorly adjusted" children in the two counties. A total of 824 new case openings was made between February, 1952 and November, 1956. How many of these would have been rated by the 1951 Survey as "severely maladjusted", how many in the less seriously maladjusted group and how many "well adjusted"? Also, to what extent and with what types of children has the school been promoting referrals to the clinic?

To explore these questions a review was made of the closed-case file of the Battle Creek Clinic to find the names of those children who had been rated in the 1951 Survey and had subsequently come to the clinic for service. A similar review was made of the record of Kalamazoo Clinic service to the two counties prior to 1952. By comparing and contrasting the clinic findings and activities with the Survey evaluations of these same children, it was hoped that some answers might be found within the limits of a small sample size, changes in clinic staff and policy through the period studied and the necessary subjectivity of case analysis.

CHAPTER II

HISTORICAL BACKGROUND AND CURRENT OPINION

There have been several reports on studies and programs related to the question of teacher understanding of pupils' emotional adjustment. Three of those reviewed below deal with teachers' evaluations of students, two with the relationship between teachers' evaluations and clinical service and two with the improvement of teachers' evaluative abilities.

In 1927 E. D. Wickman made a study comparing teachers' evaluation of a list of behavior symptons in degree of seriousness and clinicians' evaluations of the same symptoms, which seemed to have been one of the earliest studies done in this area.[1] He found a negative correlation between these evaluations, but in a follow-up study conducted in 1940-41 he found that,

> unless the data from teachers' ratings in 1940-41 were influenced by the fact that different directions were given to teachers in 1940-41 from those in 1927, these data show that mental hygienists and teachers are much closer together in their thinking about many of the behavior problems of children than they were in 1927. 2

Although differences about the seriousness of some symptoms still existed Wickman found an extremely high reliability among the teachers' ratings themselves.

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1. E. D. Wickman, Childrens Behavior and Teachers Attitudes, N. Y., 1928

2. E. D. Wickman, "A Study of Teachers' and Mental Hygienists' Ratings of Certain Behavior Problems in Children", Journal of Educational Research, XXXVI (1942) p. 306.

In I94I Carl Rogers conducted a survey in three Columbus, Ohio elementary schools using ten weighted indexes, ranging from age of the child relative to the median of his class, to teachers' and observers' ratings of the children.[3] If a child was selected not by one or two but by several of these indexes, then he was designated maladjusted. Rogers felt his system of "fallible indexes" actually discovered the maladjusted children in the population studied. According to his standards I2 percent were seriously maladjusted and an additional 30 percent were poorly adjusted.[4]

For a study made during I950-5I a Childrens' Clinic in Maryland developed a multi-factor child adjustment rating system which included: (I) teachers' general adjustment estimates; (2) an adjustment score on a specially constructed Forced-Choice Test filled in by teachers; (3) tests on the pupils themselves; and (4) sociometric ratings by classmates.[5] The general conclusion of this study was that,

> ratings by others appear to be better predictors of the response by society to acted-out behavior, and self descriptive data appears to be better

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3. Carl Rogers, "The Criteria Used in a Study of Mental Health Problems," Educational Research Bulletin, Vol. 2I (I942), pp 29-40.

4. Carl Rogers, "Mental Health Findings in Three Elementary Schools," Educational Research Bulletin, Vol. 2I (I942) pp 69-79

5. C. E. Ullman, "Identification of Maladjusted Children," Public Health Monograph No. 7, (Washington; Federal Security Agency, I952).

> predictors of that aspect of adjustment which has to do with feelings, attitudes, inner tensions, and what the individual himself will choose to do.[6]

A phase of this study involved a comparison of clinicians' rating of statements on a five point scale of significance for mental health, and teachers' weighted application of these descriptive statements in their evaluation of maladjusted and well adjusted children. "The correlation between the discriminative power of each statement, as observed from the clinicians and the discriminative power, as obtained from the teachers, was 0.86. Teachers and clinicians were in closer agreement on favorable than unfavorable statements."[7] Although they agreed on the significance of most items as indicators of adjustment, they differed on the meaning of politeness and obedience. Teachers felt these characterized good adjustment, while clinicians felt it was equivocal.

Two experiences with the relationship between teachers' attitudes toward children's behavior and the actual operation of a clinic are reviewed below.

In a report of experience in establishing a new children's clinic within a school setting, Lester Peddy concluded that,

Over the years we have seen an increasing var-

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6. Ibid p. I223

7. Ibid p. I221

> iety in the reasons for referral (from teachers). There seems to be an absolute reduction in the number of overt behavior referrals and we now see more youngsters referred for such reasons as (examples which involve little disturbance to the rest of the class). Included within this group is a fair proportion of children whose classwork is passing and whose general behavior in school is well within the limits of acceptable development. This suggests not only a rapprochment of clinical and educational thinking in these schools, but, more important, it suggests the capacity, interest and willingness of teachers to broaden their point of view in assaying a child's needs. 8

A relatively thorough evaluation of child guidance service was reported by Martens and Russ of Berkeley, California.[9] Over a two year period of time I09 treated problem children, 50 non-treated problem children, and I09 non-problem children were rated on overt behavior by teachers at the end of each school term. By the end of the second year the treated problem children had shown a significant rise in rating, the non-treated problem children remained about the same, and the non-problem children fell in rating. General conclusions of this report were,

> all children are problem children in that they may or do have overt behavior difficulties and should receive some type of attention; multiple causation demands careful observation in order to detect the initial symptoms of maladjustment; and prolonged intensive study and clinical attention by a group of psychiatric, psychological, medical and social

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8. Lester Peddy, "Clinicians in the School," Journal of Social Work, Vol. I, No. 3, (July, I956), pp. 83-84

9. Elise H. Martens and Helen Russ, "Adjustment of Behavior Problems of School Children; a Description and Evaluation of the Clinical Program in Berkeley, California," United States Office of Education, Bulletin No. I8 of I932.

> specialists has a direct positive relationship to a progressive change for the better in the overt problem behavior of children. IO

"It is well accepted that the school should play a major role in the discovery and identification of children with emotional problems."[II] "In evaluating behavior, teachers and other professional people must be constantly on the alert not to label behavior abnormal merely because it offends personally, or disturbs personally, or does not fit in with an individual code of behavior."[I2] In a recent study, a group of teachers listed behavioral symptoms in an order of seriousness which indicates a tendency to consider as the most serious those items which suggested a violation of middle class standards and morals. This points to the need to be objective in evaluating behavior.

Current opinion that teachers should be more fully prepared in the area of mental health is reflected in projects which have recently been undertaken to increase teacher preparedness. Farmer and Rossman have reported on a specifically designed mental health school program intended to develop group processes in a school through which teachers and students could participate in becoming

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IO. Ibid., p. 68

II. John R. Altmyer, "Public School Service for the Child with Emotional Problems," Journal of Social Work, Vol. I, No. 2 (April, I956), p. 96

I2. Ibid., p. 99

aware of mental health theory and generally adopt good mental health practices.[I3] Although some teachers felt personally threatened when exposed to psychiatric theory, there seemed to be a general improvement in teacher capacity to apply theoretical awareness to their practices in the classroom. The Michigan Society for Mental Health has reported on the pilot first year of their three year project to involve teachers in programs of mental health orientation, training and practices which may contribute to improvement of mental health in the schools.[I4] Groups of teachers have engaged in special evening classes, and lecture and discussion meetings with authorities in the field of mental health. The reviewers of this project seemed convinced that real progress can be made in promoting mental health through special programs.

The efforts of those working in this area seem to be inspired by a realization that almost universal child contact and exposure in the schools provides a great opportunity for improving community health, both in dealing with poor mental health and in promoting better mental health for all. The findings of the above reviewed reports indicate that teachers have something to learn in the area

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I3. Hess Farmer and William B. Rossman,M. D., "Helping Teachers Appreciate Emotional Problems in Children," American Journal of Psychiatry, Vol. I08, Pt. I (Nov., I95I), pp. 374-380.

I4. Interim Report- First Year, School Mental Health Project, Michigan Society for Mental Health, I956.

of mental health and that special group training programs contribute much to their proficiency in this area.

No report was found of any prior study which followed up a teacher rating survey with an evaluation of clinic use for the children rated, with no intervening use of the teachers' ratings to select children for clinic service.

CHAPTER III

METHODS OF STUDY

The original rating schedules completed by teachers in the I95I Survey were loaned to the writer for this study by the Research Division of the Michigan Department of Mental Health. Case register inspection was the procedure used to discover which of the 788 children rated in the Survey were given clinic service between the date of the Survey, March, I95I, and the date this study began, November, I956. Since the Kalamazoo Clinic gave service to the Battle Creek area prior to I952 a separate comparison was made between the 788 rating schedules and a chronogical case opening register of Kalamazoo Clinic service to Calhoun and Branch Counties. Two rated cases were found to have been opened between March, I95I and February, I952. The Battle Creek Clinic card file of closed cases was then compared with the 788 rating schedules and I6 rated cases were found. This made a total of I8 clinic cases appropriate to this study.

The only cases used were those which had been officially opened (at least one face to face interview) and subsequently closed. The purpose was to work only with those cases in which the clinic service given could be considered a completed unit, something impossible when service is continuing on the original opening. In none of the eighteen cases was service being given currently and none of the records indicated pending plans for fur-

ther clinic service.

A schedule for case analysis was constructed and then modified during its employment.[1] General areas of information sought were; timing of referral and source of referral; the problem from the perspectives of history, current appearance and future development; and activity on the case following this evaluation of the problem.

Some face sheet information was taken as given, but most schedule entries were quotations or summaries extracted from the body of the record. In a few instances case histories lacked any discernible record of items such as diagnosis, prognosis, or a plan of service. For the most part it seemed unnecessary and impractical to attempt to classify the entries according to any standardized concepts such as the six official presenting problem types.[2] Although some of the material contained in the Kalamazoo Clinic records dealt with service given prior to 1951, an effort was made to extract data solely from the record of clinic service following the date of the Survey.

A problem encountered during the analysis of case records was how to summarize into a phrase conflicting or unrelated diagnostic or prognostic statements made by different clinicians about the same case. The tendency in

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1. See Appendix.

2. Department of Mental Health, Child Guidance Statistical Manual, 1954.

this study was to accept the most direct concise statement, particularly when there was a choice between standard psychiatric terminology and a more lengthy descriptive statement. There was considerable difference among the I8 cases as to conciseness of such material in the records.

Although the precision of this study was limited by the use of subjective judgement in the evaluation of case history material, this study was able to consider a greater variety of case differences than is often possible in studies dealing with larger numbers of cases.

Following reading and analysis of the clinic records, a master work table was constructed which brought together data from both the I95I Survey rating schedules and the case analysis schedules. All final tables were evolved from data presented in the master work table.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

The data taken from the I8 records are presented according to the chronological sequence of the processes examined; rating of the children; referral of the children; clinic service to the children; and disposition of the children following clinic service. A preliminary section deals with the question of the number of rated cases found for use in this study.

Number of Cases

The I8 rated cases were found out of a total of 887 names of children given clinic service during the five and one-half year period under study. Because the population of Battle Creek comprises about one-third of the total population served, one might have predicted that about one-thirtieth of the total children served would be found to have been rated in the I95I Survey.

Why were only I8 found rather than about thirty? Turnover in clinic-served population would seem to account for some of the difference. Two causes of turnover in clinic-served population would have been the aging of the I95I school population which eliminated some of those children from the clinic-served age range, and the probable movement of some children's families from the city, in keeping with the high urban mobility rate in this country. Also, in combination with the aging of the I95I school population, the lesser accessibility of clinic

services during the earlier years of the period under study probably deprived some of the I95I clinic-served population from services which were provided to similar children during the later years of the period under study. Another factor may have been the continued treatment of some rated children while this study was being conducted so that they would not have been reported on the closed case file which was used to discover rated clinic cases.

Survey Rating Distribution

Of the I8 cases found, ten had been rated poorly adjusted in the I95I Survey. Their distribution within the poorly adjusted classification ranged from the severely maladjusted level, the lowest possible rating, to just below the dividing line between poorly adjusted and well adjusted. Only one was rated severely maladjusted and no distinction was made between that one and the rest of the cases in the poorly adjusted class in this study.

The remaining eight children had been rated well adjusted. Comparing this group with the total Survey sample shows that less than half of those given clinic service were rated well adjusted while 8I percent of the Survey sample was rated in this category. Further, only three of the well adjusted were included in an upper well adjusted range which included nearly 60 percent of the Survey sample.

This suggests that the ratings may have an ability

to predict which children out of an average population might come to receive clinic service.

Timing of First Referral

Relative to date of Survey, -

It seemed possible that the involvement of the schools in this Survey and the later publication of the Survey Report would have inspired the Battle Creek community with increased concern for the mental health of its children. One result of such an inspiration might have been a rush to refer problem children for clinic service.

Of the I8 rated children studied here, three had been served at the Kalamazoo Clinic prior to March, I95I when the Survey was made. Of the other I3 only five had been referred by the end of the second year following the Survey. Although clinic availability was minimal during I95I and still limited during the first year of the Battle Creek Clinic in I952, the above findings suggests that the Survey did not inspire this community to make prompt referrals to a clinic.

Of the I3 children with no prior service seven were well adjusted and eight poorly adjusted. Of the five children with no prior service who were referred during the first two years following the Survey, four were well adjusted and only one poorly adjusted. This suggests that the order of referral from the I95I school popula-

tion was not determined by degree of maladjustment on Survey criteria.

Relative to age of child. -

The ages of the I8 children at first referral ranged from 7 to I6. Excluding the three children who had clinic service prior to I95I, the ages ranged from II to I6. The age distribution within the poorly adjusted group did not differ from the age distribution within the well adjusted group. This suggests that the age at which a child would be referred could not be predicted from their degree of maladjustment according to Survey criteria.

Although the Survey found many poorly adjusted children in the first and third grades[I] whose ages in I95I probably ranged from about six to ten years, five-sixths of the Survey sample children who had been given clinic service by I956 were over II years old at referral. This suggests that clinic services were not often requested for younger children during this period of years in Battle Creek, regardless of degree of maladjustment.

Relative to sex of child. -

All four children aged I4 or older at referral were girls, and the one other girl in the rated case group was I3 years old at referral. Three of these girls were in the well adjusted group and two in the poorly adjusted group. Therefore, timing of referral for girls seems e-

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I. First grade, II percent; third grade, 22 percent.

ven more dependent upon relative age than in the case of boys.

Referral Source

One of the primary questions of this study was, to what extent and with what types of children has the school been promoting referrals to the clinic?

Table I shows that the school made seven first referrals out of a total of 18, four being in the poorly adjusted group and three in the well adjusted group. The school also made one re-referral of a well adjusted child who had received service on a prior referral from a different source. The court made four first referrals, three in the poorly adjusted group and one in the well adjusted group. The court also made four re-referrals of children previously served on a referral from a different source, two in the poorly adjusted and two in the well adjusted groups. Therefore, both the school and the court made referrals on eight different cases.

Including both first referrals and different re-referrals there seems to be no important difference between the two adjustment groups as to distribution of sources of referral. Any conjecture that the schools tend to refer more children classified poorly adjusted than well adjusted on survey criteria is not supported by these data.

The fact that the court made four out of five re-referrals suggests that the court, more than any other re-

ferral source, tends to make use of clinic service following completion of service on a referral from a different source. However, not much confidence can be expressed for this finding due to the very small number of re-referrals found in this study.

Table I

Source of First Referral by Adjustment Classification

Source	Total	Well Adjusted	Poorly Adjusted
Total	I8	8	I0
School	7	3	4
Court	4	I	3
Police	2	I	I
Health Department	2	I	I
Parent	I	0	I
Family Service Agency	I	I	0
Self referral	I	I	0

Presenting Problem

The data about the presenting problem were gained from face sheet entries and other records of referral contacts. Although all clinic cases are at some time classified into one of the official presenting problem types, it seemed appropriate to this study to review the specific types of problems as described at referral.

In Table 2 the specific presenting problems are classified in an order of degree of personal threat which the type of behavior suggests. Multiple presenting problems were reported for several cases. Each case was classified in Table 2 according to the most threatening behavior form mentioned in the referral information.

Table 2

Behavior Symptoms Given as Presenting Problems by Adjustment Classification

Behavior Symptoms	Total	Well Adjusted	Poorly Adjusted
Total	I8	8	I0
Physical aggression toward others	3	0	3
Verbal aggression toward others	2	I	I
Stealing	3	0	3
Destruction of property	I	I	0
Truancy (from school and home)	4	2	2
Severe non-social	2	I	I
Light non-social	3	3	0

The following is an explanation of the classifications; physical aggressiveness toward others includes fighting and sexual advances; verbal aggressiveness includes teasing and authority challenging; stealing, de-

struction of property, and truancy are self explanatory; severe non-social symptoms include stuttering and poor muscle control; light non-social symptoms include thumb sucking, nail biting, and apparent anxiety. This classification system was developed during the process of this study.

The distribution of well adjusted and poorly adjusted children in Table 2 according to the most threatening behavior form suggests that the poorly adjusted group tends to be more threatening to persons than the well adjusted group. This is most strongly suggested at the ends of the scale. Three poorly adjusted but no well adjusted children were reported for physical aggression against others. The most threatening behavior reported for three of the well adjusted was light non-social, while all of the poorly adjusted presented more threatening behavior than the latter classification.

Relating these classifications to source of referral shows that all five children rated aggressive toward others were referred by the school. All four referred with stealing or destruction of property as their most threatening behavior were referred by the court. Of the four in the truancy classification, three were referred by the court and one by the police. Both of those classified severe non-social were referred by the school. Of the three classified light non-social, two were referred by

the school and one was a self referral. Although the relationships between source of referral and type of problem behavior seem suspiciously direct, it appears that children who might disturb a class by direct aggression against other persons or by distracting forms of non-social problem behavior would tend to be referred by the school, and children whose greatest difficulty came in extra-classroom behavior tend to be referred by the courts and other sources.

Diagnosis

The following is a listing of clinicians' diagnostic evaluations of the I8 rated children. In order to facilitate comparison of the clinicians' findings with the Survey evaluations, the diagnoses are divided into two groups on the basis of the Survey evaluations of the same children. Those in quotations are specific statements taken from the case narratives or evaluative summaries. Other entries were taken from face sheets, and some are condensations of evaluations which were too long to be quoted directly.

Rated Poorly Adjusted in the School Survey

"Incipient psychosis"
"Disturbed girl . . . ."
"Might well be a seriously conflicted child"
Neurotic
"Primary behavior disorder conduct type with many psychopathic elements"
"Has some pretty involved psychological problems"
Psychopathic personality

Character disorder
"Essentially healthy"
No diagnosis

Rated Well Adjuated in the School Survey

"Chronic anxiety of moderate degree"
"Anxiety present, moderate to severe in degree"
Personality disorder
Secondary emotional problem
"Not conflicted girl"
Not considered neurotic
"No severe depression in a delinquency situation"
No diagnosis

In general, the poorly adjusted group seems to present a higher frequency and a greater severity of psychological problems than does the well adjusted group. In the poorly adjusted group only one of the nine children for whom some type of diagnosis was made was not identified as having a psychological problem. In the well adjusted group denial of a type of psychological problem was made in three cases of the seven diagnosed, and in one other case the emotional factor was considered secondary to the other factors contributing to the child's difficulties. Only three of the well adjusted were positively identified as having psychological problems. This suggests that the Survey ratings would have some ability to predict which children out of an average population would be evaluated by clinicians as having more serious psychological problems.

Prognosis, Treatability and Treatment

An attempt was made to extract from the I8 clinic

case records some idea of the clinicians' general psychiatric prognosis regarding each child. Very few records contained such prognoses. The following are the most nearly prognostic statements found: "could quite easily become chronically mentally ill"; "does not seem motivated to change". Other prognostic statements were related more specifically to how, or whether, the child could be treated. Some case records contained nothing which could be considered a prognosis. An attempt was also made to discover prognostic opinions of clinicians at the close of clinic service but this type of entry was found even less frequently than the preliminary prognosis.

The following is a listing of treatability estimates for cases in the poorly adjusted group, arranged in descending order of the degree to which each estimate suggests that the child would be amenable to clinic treatment. The treatment disposition and reason for termination for each case is added after the treatability estimate.

Rated Poorly Adjusted in the School Survey

Treatability Estimate	Treatment	Reason for Termination
Excellent treatment candidate	None	Mother declined
Felt could be treated	None	Mother declined
Short term all necessary	Mother, 3 months	Mother terminated
Proposed group therapy	None	Court removed from locale
Unsure of motivation	None	Court felt new home sufficient

Question motivation	Child, IO months	Clinic transferred to court worker
Not considered, diagnostic only	None	No treatment requested by court
No evaluation	Mother and child, I month	Clients withdrew
Would not respond quickly to any therapist	Child, I month	Court withdrew child
Not suitable for outpatient psychiatric treatment	None	Clinic declined to treat

Most of the estimates of treatability in the poorly adjusted group were either vague or negative. Only the four most positive estimates suggest that clinic treatment was proposed with any confidence for success. When compared with the treatment dispositions the estimates of treatability do not seem to be the primary criteria for commencement of treatment in this group. In the four cases given the most optimistic treatability estimates, no treatment was given to the child. In three the mother terminated and in the other the court terminated. The clinic made the overt decision to terminate service in only two of the ten poorly adjusted cases. The parent or the child effected termination in four cases and the court effected termination in the remaining four cases.

The following is a listing of treatability estimates for the well adjusted group, also arranged in descending order of the degree to which each estimate suggests that the child would be amenable to clinic treatment. Treatment dispositions and reason for termination for each case

are added after the treatability estimate.

Rated Poorly Adjusted in the School Survey

Treatability Estimate	Treatment	Reason for Termination
Probably would respond well to treatment	Child, 6 months	Clinic closed case
Felt would be responsive to treatment	Child, 4 months	Clinic closed case
Possibly insufficient motivation	Child, 2 months	Child withdrew
No evaluation	None	Further service not considered by Clinic
No evaluation	None	Clinic felt other service more appropriate
No evaluation	None	Clinic felt no further service necessary
No evaluation	None	Child withdrew after one interview
Neither in-patient nor out-patient treatment would help	None	Parent failed to follow up

As was the case in the poorly adjusted group, the estimates of treatability in the well adjusted group were mostly vague, nonexistent or negative. However, there seems to have been a distinct difference between the two groups in the relationship of estimate of treatability to treatment disposition. Whereas in the poorly adjusted group the most treatable children were not treated, in the well adjusted group treatment was given to the only two children who were positively recommended for treatment. Therefore, the decision of whether to treat or not to treat seemed based more on the clinic evaluation of treatability with the well adjusted group than it was with the poorly adjusted group.

A sharp difference between these two groups appears

in an evaluation of reasons for termination. In the well adjusted group the clinic made the overt decision to terminate in five out of eight cases, while in the poorly adjusted group the clinic made this decision in only two out of ten cases. It is possible that the clinicians felt under less pressure to treat the well adjusted group because of their own estimate of the children's needs or because less pressure was felt from the school, the court or the parents to consider these children a problem.

Disposition Following Clinic Service

No attempt was made to evaluate the possible effects of clinic service on the lives of the I8 children. However, as a final test of the validity of the Survey ratings an evaluation was made of information available on the disposition of these children following clinic service. The information listed below was gained from closing statements and records of incidental contacts following closing. No attempt was made to follow up the cases. It is believed that the clinic records gave a fairly good idea of what happened to the children immediately following clinic service.

Rated Poorly Adjusted in the School Survey

One in process of commitment to a state hospital
One sent to Boys Vocational School
One probably sent to Boys Vocational School
One in boarding care under court supervision

Three probably under court supervision in their homes

One assigned to a new school counselor

One receiving new special interest by the school

One reported doing well and in need of no special service

Rated Well Adjusted in the School Survey

One definitely under court supervision

Two probably under court supervision

One in process of referral to a private training institution

One receiving special service in the school

One receiving private remedial reading help

One quit school and may have gone to work

One on which there was no report.

The above listing shows that following clinic service seven out of the ten poorly adjusted children were under court jurisdiction and three of these were to come under care in public institutions. The remaining three poorly adjusted children were not being given what might be termed intensive community service. Only three of the eight well adjusted children were under court jurisdiction and none of the eight was to come under care in public institutions. Of the remaining five well adjusted children only one was to be given what might be considered intensive community service.

This suggests that the Survey ratings have some power of predicting which children might become the greatest

burden upon community services, particularly court services. The poorly adjusted group seems to present a much heavier burden than the well adjusted group. However, it seems appropriate to emphasize that the data presented in this section are incomplete and a careful follow-up study would have to be made before a great deal of confidence might be placed in such a conclusion as that presented above. Such a follow-up study was beyond the scope of this study.

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

The broad objective of this study has been to investigate the validity of a school evaluation of children's emotional adjustment, with a particular emphasis on the relative needs of children for clinical treatment. Also, an effort has been made to evaluate the schools' use of the clinic as a service for helping children with different degrees of problems.

The Survey seemed to have some validity in differentiating: (I) which children will most tend to behave in a manner threatening to other persons; (2) which children out of an average population might come to receive clinic service; (3) which children would be evaluated by clinicians as having the most serious psychological problems; and (4) which children might become the greatest burden on community services.

However, the ratings did not seem to have the ability to differentiate; (I) which children out of a school-age population might be referred earlier for clinic service; (2) which children might be referred for clinic service at an early age; or (3) which children might be referred by the school.

Specifically in relation to clinic service, the ratings seemed to have some ability to predict with which

children the clinic would have less discretionary power to control the amount of and type of service to be given. This finding has many implications relative to parent-community-clinic relationships which would be difficult to assess without intensive study.

Conclusions

The findings of this study support the findings of studies done by Carl Rogers[1] and Charles Ullman[2] in suggesting that some refinement of a child adjustment rating system used in, and by, the school would have considerable validity as a tool for evaluating the relative needs of children for clinical service. However, this study further suggests that, without some relatively objective system of evaluation in use at the community-school level, children most in need of clinic service will not tend to get to the clinic any more quickly than children less in need. There is also an indication that after the clinic provides some amount of service to a group of children, those most in need of help with psychological problems become less available to the clinic than those less in need.

Recommendations

Recommendations arising out of this study are: (I) that the schools adopt some relatively objective system which can be used in evaluating the emotional adjustment

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1. Rogers, Op. cit.

2. Ullman, Op. cit.

of entire school populations; (2) that the selection of children for referral to clinics be made from this framework of relatively objective evaluation; and (3) that in the use of such a system emphasis be placed on referral of problem children at an early age.

Further study seems called for on the question of why, after the clinic provides some amount of service to a group of children, those most in need of help with psychological problems become less available to the clinic than those less in need.

Another indicated study would be a follow-up on all of the children rated poorly adjusted in the 1951 Survey to see what life experiences might be predicted of children so rated.

Finally, an historical study of the effect of the 1951 Survey on school programing and mental health services might reveal to what extent the Survey served its intended purpose.

APPENDIX

SCHEDULE FOR CASE ANALYSIS

November 1957

I Referral

A. Child's name _____

B. Clinic:

	referred	opened	closed	re-opened	closed
Kalamazoo					
Battle Creek					
(Time since March 1951					

C. Given referral source _____

1. If parents, other referral source involved _____

2. Indication of referral having been suggested prior to current referral _____

3. If court, how was school involved in causing court action _____

(A) Other source involved in court action _____

4. Any other indications of school involvement in reaction of child problem _____

II Problem

A. Presenting problem classification

B. Diagnosis from intake _____

C. Prognosis from intake

I. General psychiatric prognosis _____

2. Treatability in child guidance clinic

a.____ Long term

b.____ Short term

____ All necessary

____ All practicable

c. None

I. Child condition _____

2. Parent condition _____

3. Other reason _____

III Treatment

A. Treatment undertaken with _____

B. Length of treatment _____

C. Reason treatment terminated _____

D. Prognosis (psychiatric) at close of treatment__

E. Following end of service on first referral any further service on case _____

F. Other agency pick up, as result of clinic closing?_____

G. Other agency become involved for other reason?

_____

H. If re-opened following service termination, reason?

_____

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