# A CHILD GUIDANCE CLINIC AS A SOCIAL RESOURCE IN A SMALL METROPOLITAN COMMUNITY

by

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# A CHILD GUIDANCE CLINIC AS A SOCIAL RESOURCE IN A SMALL METROPOLITAN COMMUNITY

Study made at the Lansing Children's Center, Inc.

by

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A PROJECT REPORT

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The Three Hundred Rules of Ceremony could not control men's natures. The Three Thousand Rules of Punishment were not sufficient to put a stop to their treacherous villainies. But he who knows how to cleanse the current of a stream begins by clearing out its source. And he who would straighten the end of a process, must commence with making its beginning correct.

---Taoist Inscription

This study was undertaken as part of the graduate Social Service Curriculum at Michigan State College. The writer is particularly interested in doing work with children and completed three hundred hours of supervised field work at the Lansing Children's Center in June of 1947. Immediately following this, work on the study was begun and was completed in December of 1947.

Thanks are due to both the professional and secretarial staffs of the Center, who were very cooperative in helping to carry on this study.

Marcella J. Gast

This research study is an exploratory attempt to discover what the role of a child guidance clinic is in the community; what type of service is most frequently sought; what problems it endeavors to treat and its success in dealing with these problems; and thus to provide a background of knowledge on which to build an educational program for the community. Through comparison of two studies on treatment cases made three years apart at the Lansing Children's Center, trends and differences will be presented. Data related to the above will be utilized in a final discussion on how the present child guidance services of Lansing are meeting the need of this community and its surrounding areas.

The child guidance field is a relatively new one. In 1896, Witmer established the first psychological clinic at the University of Pennsylvania which was concerned with practical investigation of the problems of school children. Healy's behavior clinic started in 1909, is more often pointed to as the beginning of child guidance work. This clinic was connected with the Cook County Juvenile Court in Chicago, which is now known as the Illinois Institute for Juvenile Research.

Between 1925 and 1929 five experimental child guidance clinics were established by the National Committee for Mental Hygiene, with funds from the Commonwealth Fund. Since the child guidance movement was begun, it has been operated under essentially psychiatric auspices. There has been constant growth up to the present time and clinics are now located all over the country.

The child guidance clinic was the first agency to study the child as a whole. The teamwork of the various professional members of its staff carry out a fourfold plan---examining the physical condition of the child, his intelligence, the home and its influences, and the emotional attitude of the child toward himself, his problems and his friends.

The Lansing Children's Center, Inc. was originated in the spring of 1938 by the Child Guidance Committee of the Ingham County Council of Social Welfare. A survey had been conducted by the National Probation Association in connection with the prevention of delinquency, previous to the establishment of the Center.

The philosophy under which such a clinic as this operates, is that it is possible for the child having difficulty to make a satisfactory readjustment to his environment, through the understanding of the nature of the difficulty. Hence, the function of the Lansing Children's Center is the diagnosis and treatment of behavior and personality disorders of children. To carry on a preventive and educational program is also part of their function.

The Lansing Children's Center is part of the State Department of Mental Health's program to offer child guidance services in the community and surrounding areas. It is financed in part by the State Civil Service Commission which provides the salaries of the psychiatrist-director, the psychologist, and one psychiatric social worker. Local sources support the actual operation of the clinic and salaries for additional professional workers. Funds are obtained from the Greater Lansing Community Chest, the Board of Education, etc. There is a local advisory board, made up of prominent citizens, which acts as a liason body between the community and the Center.

The staff is comprised of members from several professions. The psychiatrist, and most generally the director of the clinic, is a doctor of medicine and has had special training in adult and child psychiatry. At present, the Center is without a full time psychiatrist. Dr. C.V. Morrison left at the end of the summer to organize a child guidance clinic in Portland, Oregon. Dr. Samuel Hartwell has been at the Center part-time until a qualified person is found for the position.

The two psychiatric social workers have training and experience in social casework treatment with emphasis on children's problems. There are also two student social workers on a part-time basis. The psychologist has special training and experience in psychological testing of children to determine their intelligence, special abilities and disabilities. As of this week, the clinic now has a part-time physician to do physical examinations.

There are three main types of service offered by the clinic. These are Diagnostic: The child is studied to determine his feelings in regard to his unique situation and is usually tested to discover his mental capacity. The parents are interviewed in regard to the home life and relationships and information from other persons in the community having had contact with the situation is gathered. From all this, the Center makes recommendations either to the parents, the referral agency, or both.

Treatment: After a diagnostic study, children who are thought to be able to respond to individual treatment are seen regularly. Depending on the individuals problem and his particular feelings about the situation, the length of treatment varies. Parents are also seen periodically to help them to understand the child's behavior and their part in the treatment plans. Other community agencies may help in working out plans for the child.

Consultation: The Center staff may be called upon in an advisory capacity by other agencies when they are dealing with problems involving children. This is usually done by conferences but may be just a written report from the Center's records on the case.

The clinic's services are free to everyone. However, gifts to the Center financial or otherwise, are accepted. Anyone can make a referral with the parents permission and older children may seek help on their own initiative. The staff confers when planning treatment, for each child referred to the Center.

Some background information for undertaking a study to this nature was obtained from Healy and Bronner's study of juvenile delinquents and one made at the Michigan Children's Institute in Ann Arbor by Hewitt and Jenkins. The latter brought forth a group of behavioral items which are sufficiently alike in their meaningful implications to be considered as symptoms of the same fundamental pattern of maladjustive reactions. This did not pertain directly to the study done at the Lansing Children's Center in its objective, but the general methods used were helpful. Other references will be referred to when the points they discussed have some bearing on the data for this study.

The actual source of all material for this paper were obtained from the Center's records and reports. The names of all children referred to the clinic between Januaryl and July 1, 1946 were taken from the regular and emergency waiting lists. Monthly reports for the State Department of Mental Hygiene provided the source of referral and the counties served. Descriptive information about the 1943 cases was derived from data sheets filled out on each case accepted for treatment.*

The one hundred and fifty cases referred to the Center in January 1 to July 1 of 1946 were abstracted to discoverethe necessary points for comparison. The face sheet information* was helpful in obtaining factual data but often the number of interviews held and the length and results of treatment were rather difficult to determine. The agency's methods of recording are not set up for research purposes but rather to help in the treatment process, to assist the new worker being transferred to the case and for supervisory purposes. This was discussed in Johnson and Reid's article, "Hope for 3 out of 4".

Case load records were also looked into to discover the actual case load of the clinic for each month of the period from January to July of 1946.

* see appendix

After gathering the data and classifying it by means of schedules and charts*, comparisons were made between the entire number of children referred to the clinic from January 1 to July 1, 1946 and those accepted on a treatment basis. Objects of the comparison were to find out what type of service is requested most frequently of the clinic and to see if there is a difference in the age range of the boys and girls carried on a treatment basis as against those given consultation or diagnostic help.

Emphasis was placed primarily on another comparison. The children referred between January and July of 1946 and accepted for treatment were then compared with the treatment cases derived form a previous study made at the Center in January to July of 1943. Comparison was made on the following points: total number of cases, number of boys and number of girls, age range and the average age, reason for referral, referral sources, counties served, length and results of treatment.

Detailed information on the 1946 treatment cases will also be cited as pertains to the delay in offering service, the number and kind of interviews held, the number of psychological tests and other services performed by the clinic.

Data on total referrals January 1 to July 1, 1946

A total of 148 referrals were taken between these dates. Two more were actually referred, but these did not receive service of any kind. The reason for this being, they were on the waiting list for over a year and when service was finally offered to them, they no longer desired help. Of these 148 children referred, 107 were boys and 41 were girls. Ages ranged from 1yr. 3mo. to 18yr. 2mo., the average age was about ten. As will be shown later this was approximately the same as the average age for all treatment referrals.

* see appendix

Distribution in the counties served and referral sources can best be shown by listing.

| Counties served | |
|---|---|
| Ingham | 107 |
| Eaton | 14 |
| Jackson | 7 |
| Shiawassee | 7 |
| Clinton | 5 |
| Livingston | 4 |
| Hillsdale | 3 |
| total | 148 |

| Source of referrals | |
|---|---|
| Social Agencies | 64 |
| Schools | 44 |
| Courts | 8 |
| Private Physicians | 18 |
| Friends, self, parents | 9 |
| Others | 5 |
| total | 148 |

From these figures, it may be seen that the most numerous referrals come from Social Agencies whether it is for consultation on one of their own cases or perhaps because they are more aware of the services offered by the Center and do not hesitate in calling upon it for help.

The school referrals are mainly through the visiting teachers. It is encouraging to see so many school referrals because this is the first real group contact the child makes, and if he is not able to adjust here, it is a good place to begin in helping the child to make a normal adjustment . An emphasis has been placed on education of the school personnel along child guidance work too and this might be fruits of the efforts put forth.

The court referrals are not too plentiful and this may be because the court personnel feels it is able to handle many of the problems they are confronted with. On the other hand, the clinic deals mainly with pre-delinquent children on a preventive basis rather than readjusting the delinquent.

Private physicians often refer when their is doubt about the child's mental ability as promotes his infantile behavior or when the basis of the child's illness is emotional rather than physical.

Referrals which come from the child himself or his parents usually request treatment. Here, they already have some awareness of the problem and are desirous of help themselves.

"Others" include nurseries and ministers in this particular study.

In percentage terms, types of services given appeared to be divided as -- 40% treatment, 40% diagnostic, and 20% consultation. Treatment cases are usually given diagnostic service first, and in consultation service, diagnostic measures may also be included. Hence there is a great deal of overlapping when cases are to be put into one of these categories.

Treatment Referrals January to July 1943
January to July 1946

The first study at the Lansing Children's Center took place in the summer of 1943 and included 1) referrals prior to July 1, 1943 back to the time of the opening of the clinic, 2) those cases accepted for treatment, and 3) by treatment is meant cases where there has been at least one interview beyond the intake interview. From this entire study, the investigator chose to use only the cases from January to July 1943 in order to have the length of time equivalent to that considered in the 1946 study.

The data gathered in the 1943 study has never been used in its entirety, so perhaps the reliability of the summarizing material in this paper will be somewhat subjective.

In comparing the 1943 treatment cases with those referred in 1946, the following discoveries were made. The total number of treatment referrals in 1946 was larger, 59 as compared to 45 in 1943. However, the boys and girls distributed themselves in the same percentages--25% girls and 75% boys. The age range was slightly wider in the 1946 cases because of younger children being referred. The average age of referral was about ten in 1946 and was slightly older, ten years and nine months in 1943.

The majority of referrals were from Ingham county in both studies. This is probably due to the fact the center is more accessible to the people in Ingham county and it also has a larger population. The Eaton County Health

Department has made a fairly large number of referrals.*

The two noticeable differences in the source of referrals were in the social agencies and schools. Both of these have increased since 1943. It is possible there is greater cooperation among the social agencies of Lansing in referring and consulation. The expansion of the visiting teacher program plus a trend toward individuation in the schools might account for the increase in referrals from that source.*

The same classification of reasons for referral was used for the 1946 cases as had been used in the 1943 study. The eight categories listed were habit disorders, neurotic disorders, personality and behavior disorders, delinquency, neurotic delinquent, psychoses, and educational ability. The eighth category "others" was omitted in the 1946 classification. Over 40% of the reasons for referrals in both studies were for personality and behavior problems, which is really a very broad term. Educational difficulties showed a marked increase in the 1946 study, although there often were combinations of problems presented in the referral. The most frequent combination was personality and behavior disorders and educational disability. There was a slight increase in habit and neurotic disorder, the same number of delinquents and a slight decrease in neurotic delinquents and psychoses in the 1946 study.*

Treatment range was over a longer period of time in several cases of the 1946 study. The length varied from two weeks to seventeen months. Average length of treatment likewise was slightly longer ~~a~~five months as compared to an average of four months plus in 1943. The 1943 treatment range was from less than a month to thirteen months.

Results of treatment were classified a little differently .

| 1943 Results of treatment | | 1946 Results of treatment | |
|---|---|---|---|
| Improved | 29 | Improved | 26 |
| Unimproved | 10 | Unimproved | 11 |
| Unknown | 0 | Unknown | 10 |
| Satisfactory | 6 | Still active | 12 |
| total | 45 | total | 59 |

* see appendix

Although there is a very small decrease in the number of improved cases, there is descrepancy because twelve of the cases are still active. Of these twelve, at least half have improved somewhat but they are not to terminate contacts. The results of treatment of a case are unknown when the family moves out of town or when after several interviews they simply feel as though they no longer want to come in, even when the problem has not been cleared up, let alone the causes behind it alleviated. These individuals are too threatened by such contacts.

Upon more detailed analysis of the 1946 treatment cases* it was found that the delay in offering service varies from a day, on emergent situations, to over a year and three months. The average delay is about three months. There are just too many referrals for the staff to dispose of efficiently and keep up to date on. A re-evaluation is made from time to time of the waiting list. If the referral has been on the waiting list for a year, a pre-intake is offered in hopes that this will prevent the person from getting too discouraged and to offer some help within that interview. If in the meantime the situation becomes critical, special considerations may be made and the case taken on for regular treatment if at all possible.

Psychological testing was done in one-third of the cases carried on a treatment basis. Likewise contacts with other agencies were evidenced in approximately one-third of the cases. Examples of agencies contacted are schools, Michigan Children's Aid Society, Michigan Children's Institute, the court, Children's Division, Lincoln Community Center ( colored children) and the State Health Department. These contacts are often in the form of conferences. The Center may send reports to other agencies, obtained from their record of the case and vica-versa.

* see appendix

The psychiatrist saw about forty of the treatment cases, either the patient, parents, or both. He usually aids planning by the diagnostic impression he obtains from one to four interviews with the patient or the parents. Although it is not the usual practice, the psychiatrist may accept a few cases and see them regularly when the situation involves some extremely disturbed persons. This procedure is generally over a short period of time.

Social worker interviews with patients average approximately four to a case. These interviews held with children under 12 or 14 years old, are referred to as "play interviews". Along with complete acceptance of the child by the worker, the child is encouraged to talk and act as he really feels while he plays. Play is merely the medium through which a relationship is established with the patient by the worker and therapy is carried on. It is often the case that the referred child is not seen by the clinic at all. Work is done entirely with the parents, as they are the most important factors in the child's home environment. Then again, a child may be seen almost weekly for over a year's time. It depends on who is most likely to benefit from contacts with the clinic.

One social worker has play interviews with the patient while another social worker interviews the parents, if both are seen at the clinic. This is to avoid feelings of competition between child and parents for the worker's feelings toward them. It also seems to decrease the child's and parents' fears of their statements told in confidence being betrayed. It is also convenient to see both patient and parents in one trip to the clinic. The average number of interviews held with parents and other persons about the patient is higher then the number spent with the patient himself, about six per case.

This appears to support the fact more work is done with the parents than with the child himself in a child guidance clinic. This trend may stem from the concept that the basis of causation of emotional instability of children brought to the attention of a clinic, seems to lie in the disturbances of interpersonal relationships within the family group. Hence, it is necessary to develop increasing insight into what constitutes a normal emotional development, and increasing skill in helping the child assimilate traumatic experiences and achieve substitute satisfactions.

Even though there was only a three year interval between this study from the 1946 treatment referrals and that undertaken in 1943 at the Lansing Children's Center, an increase in the total treatment cases is shown. The number is not overwhelming--fourteen to be exact--but is significant, over such a short period of time. Then too, the Center has only been in operation less than ten years.

Surmising from the delay in the acceptance of cases for treatment, the present staff is not large enough to meet the requests for service. It is a deplorable fact that in some instances referrals are on the waiting lists for over a year. In 1943, there wasn't a waiting list at all. Having to wait so long for help , the problems may increase in number and intensity and readjustment will take longer and be more difficult. This could be avoided if referrals were accepted for treatment soon after their original referral date. Parents who have children with problems may not refer them at all, knowing what a long wait is in store for them.

The case load of the clinic per month from January to July of 1946 was

| | |
|---|---|
| January | 372 |
| February | 395 |
| March | 406 |
| April | 419 |
| May | 397 |
| June | 389 |
| total | 2378 |

or approximately 400 per month

It is true that some of these cases are ready to be closed and may only need a closing summary attached. But all in all, the case load is still too heavy to consider taking on more cases. It is logical that when a member of the staff is overburdened he is not able to give as effective help as is expected of him. So it may be concluded that on the basis of this study, the staff of the Lansing Children's Center would be more able to meet the demand for services if it were increased by additional members.

It is of the utmost importance to have professionally trained workers to carry on child guidance work. An interest in children is fundamental but not nearly enough to do work in a specialized field such as this is. Standards and requirements for positions on a clinical staff should become more rigid, rather than digress. Haphazard assistance by persons unqualified for child guidance positions would do more harm than good, even if more cases were taken care of.

Child guidance is often a long-time process. One cannot expect feelings, attitudes, problems and difficulties which have been evidenced and more so over a number of years, to disappear overnight or after a couple of trips to the clinic. Logically it would take as long if not longer to wipe out the difficulty as the time taken to build it up. Behavior problems can be compared to physical ailments in the sense that the longer they are allowed to go on without treatment, the more serious they become and a longer period is spent in treating them.

It is a subjective process to analyze the results of treatment. Professionally trained workers must exercise the same responsibility as a physician when called upon. Other workers may check on the evaluation of a case sometimes. Heckman and Stone discussed this in their article on "Forging New Tools".

Four hundred and thirty children were studied at the Ryther Children's Center in Seattle, Washington ( 1935-1945 ) by Johnson and Reid. Their write-up of that study was in the article "Hope for 3 out of 4" in the October Survey Midmonthly. They found 74.1% success in the cases studied. This was some higher than the improved cases in the Lansing Children's Center study. Johnson and Reid defined success as" being able to get along in school and at home and accept the codes and mores of the community". In all success cases, the basic pathology and maladjustment will not completely be alleviated but the patient will have made sufficient gains to warrant a "success" result. The percentage of successful cases should increase as diagnosis and treatment become more effective.

Economic status was not determined in the study done at the Lansing Children's Center. But from other studies of a similar nature, it has been stated that children from families of widely varying economic status present many of the same patterns of problem behavior.

Racial and minority groups are often too small to correlate, as was the evidenced in the study made at the Lansing clinic. The largest group of this type was made up of eight negro children.

In Hewitt and Jenkins study at Ann Arbor, percentage of boys and girls ran very similar to the percentage found in the Lansing study, namely 78% boys and 22% girls. The average age of the Ann Arbor group was about a year older--eleven years plus. It would appear cultural norms still protect girls in that they are not referred nearly as often as boys are and yet certainly they must have nearly as many problems as boys do. In the follow-up of the Ann Arbor study, best results were found in school rather than at home, with the overinhibited child, and when the cooperation of the parents is obtained. Hewitt and Jenkins also concluded written case histories may contain admitted shortcomings and present numerous difficulties in statistical treatment, but they are still a fruitful source of data.

Services offered by a child guidance clinic cannot be duplicated easily in the community. Its concentration of purpose to help children and their problems meets a special need. Cooperation with other resources in the community through referrals and consultation is essential. Like wise in the organization and presentation of an educational program , cooperation is necessary. The Social Service Exchange provides clearing of all cases, so that there will not be duplication of service. The writer of the paper would suggest this same type of cooperation in planning for an educational program on the various agencies' services to benefit both the agencies and the lay public. Lectures, discussion groups and special activities make the community as a who more aware of problems and how to handle them, if not by individuals taking care of their own difficulties, then by impressing upon them the available resources in the community giving just that type of service.

The role of the child guidance clinic has been defined as agency whose function is the diagnosis and treatment of behavior and personality disorders of children. The specific types of problems referred include: daydreaming, difficulty in concentration, quarreling, destructiveness,, unsatisfactory work in school due to limited intelligence or because of worries and unhappiness. Behavior problems seen in children referred are: truancy, cruelty, enuresis, masturbation, thumbsucking, lying, sex delinquency, stealing, temper tantrums, bullying, disobedience, etc.

The services are diagnostic, on a treatment basis, or consultation. The first two are about equal in frequency, approximately 40% of total intake. Consultation makes up the remaining 20% of services and this is usually with other social agencies, not upon direct referral of a case to the clinic. It is impossible to draw a sharp dividing line between the above services.

The Lansing Children's Center is filling a definite need in the community and the surrounding areas, but not completely. The waiting list as of December 1, 1947 has a total of eighty two referrals on it. This is evidence of needs which are not being met at the present time. The requests for service are greater than that which the clinic staff is able to give. The findings of this study then, would suggest an increase in staff membership to take care of the lag in accepting referrals for service.

As a closing thought, Dr. Milton Kirkpatrick once said in an article, "Childhood is the golden era of mental hygiene, and this is the time when personality problems, which will eventually lead to maladjustment and unhappiness, inefficiency and failure, should be attacked". The individual as a unique person recently has been emphasized and this is one concept which must be firmly implanted in the minds of men if child guidance work is to progress.

# APPENDIX

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# Face Sheet of Case Record
## Lansing Children's Center

Case No.

E ..... Telephone .....
Last Given Middle

RESS .....
Street No. City County

re of Address .....

date ..... Sex ..... Color ..... Religion .....

lace—Patient ..... Father ..... Mother .....

ol ..... Grade ..... Teacher .....

e { Father ..... / Stepfather ..... } Name of { Mother ..... / Stepmother ..... }

ress { Father ..... / Stepfather ..... } Address of { Mother ..... / Stepmother ..... }

t living with parent, with whom? .....

tionship .....

| | Age | Nationality | Education | Occupation | Remarks |
|---|---|---|---|---|---|
| THER | | | | | |
| THER | | | | | |
| LINGS | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

e of referral ..... Accepted ..... Date ..... Type of Service .....

cy Referring Child .....

e of Agency Worker .....

ly Physician ..... Address .....

trations .....

.....

.....

.....

n for Referral .....

.....

.....

.....

# THE LANSING CHILDREN'S CENTER, INC.

NAME

| Last | Given | Middle | Clinic | Year | Case No. |
|---|---|---|---|---|---|

ADDRESS

TELEPHONE

REFERRAL SOURCE

| INTELLIGENCE | AVERAGE OR ABOVE | BELOW |
|---|---|---|
| | | |

MONTHS UNDER TREATMENT

| TREATMENT RESULT | | UNIMPROVED | IMPROVED | SATISFACTORY | UNKNOWN |
|---|---|---|---|---|---|
| DIAGNOSIS | HABIT DISORDERS | | | | |
| | NEUROTIC DISORDERS | | | | |
| | PERSONALITY AND BEHAVIOR DISORDERS | | | | |
| | DELINQUENCY | | | | |
| | NEUROTIC DELINQUENT | | | | |
| | PSYCHOSES | | | | |
| | EDUCATIONAL DISABILITY | | | | |
| | OTHER DISORDERS | | | | |

REMARKS

Schedule used in recording data in study made in 1943

7-44—1M

SCHEDULES FOR RECORDING DATA

Lansing Children's Center
Total Referrals
Januaryl to July 1, 1946

| Date | Name | Sex | Age | County | Source of Referral | Kind of Service |
|---|---|---|---|---|---|---|
| | | | | | | |

Lansing Children's Center
Treatment Referrals
Januaryl to July 1, 1946

| Case # | Delay in Acceptance | Referral Reason | Interviews with pt. | Interviews about pt. | Interviews psychiatrist | Outcome Imp. | Outcome Unimp. | Outcome Unkn. | Outcome Active | Length of Treat. | Testing |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | | | | | | | | | | | |

Lansing Children's Center
Treatment Cases
January 1 to July 1 , 1943

| Case # | Sex | Age | Diagnosis | Source of Referral | County | Treatment Length | Results |
|---|---|---|---|---|---|---|---|
| | | | | | | | |

CHARTS

Lansing Children's Center
Treatment Referrals
January-July 1943 & 1946

| Counties Served | 1943 | 1946 |
|---|---|---|
| Ingham | 43 | 44 |
| Jackson | 1 | 2 |
| Eaton | 1 | 7 |
| Shiawassee | - | 1 |
| Livingston | - | 4 |
| Hillsdale | - | - |
| Clinton | - | 1 |
| Total | 45 | 59 |

Lansing Children's Center
Treatment Referrals
January-July of 1943 & 1946

| Source of Referrals | 1943 | 1946 |
|---|---|---|
| Social Agencies | 7 | 17 |
| Schools | 10 | 21 |
| Courts | 7 | 1 |
| Private Physicians | 9 | 9 |
| Friends, Self, Relatives | 10 | 9 |
| Others | 4 | 2 |
| Total | 47 | 59 |

CHARTS, continued

Lansing Children's Center
Treatment Referrals
January-July 1943 & 1946

| Diagnosis of Problem | 1943 | 1946 |
|---|---|---|
| Habit Disorders | 3 | 8 |
| Neurotic Disorcers | 2 | 6 |
| Personality & Behavior Disorders | 21 | 29 |
| Delinquency | 5 | 5 |
| Neurotic Delinquency | 6 | 4 |
| Psychoses | 4 | 2 |
| Educational Disability | 17 | 38 |
| Others | 2 | - |
| Total | 60 | 92 |