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Birmingham Child Guidance Clinic

A Review of Two Years' Work

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This article is based on the report of two years work at the Child Guidance Clinic in Birmingham, which is conducted under the Education Department of the City. It is meant to survey the ground already covered, and to point out some practical conclusions which may be drawn from an experiment of this sort.

Birmingham has a school population of 140,000, and as only three sessions weekly were alloted to the Director and Psychologist (the rest of their time being occupied by work in connection with the Special Schools) the danger was that the Clinic might be overwhelmed by applications, so it was decided to restrict the area which the Clinic should serve to the North sector of the City, which gave a school population of 37,000, and included all types of schools.

The head teachers of these schools were circularised with a description of the Clinic's aims and methods, including a warning that the Clinic was not meant to deal with mentally defective children, although backward and borderline cases would be considered.

A meeting for these head teachers was also held, and it became evident that hopes were entertained by some that we might and should be of special assistance to the slum cases, whose problems arose from sheer poverty and a lack of the amenities of life. These are the cases which they quite rightly feel most sympathy for, and it is not an easy task to explain why it is that one can do less for these than for others, since they are in need of social rather than psychological assistance. The question of the bearing of economic conditions upon Child Guidance work is touched upon in another part of the article.

At first we were somewhat swamped by cases, and a waiting list persisted for some months. The question of the number of personnel and number of working hours in relation to the number of cases to be dealt with, is always an important one for Clinics which are just starting. In the American Review of C.G. Clinics recently published[1], it is estimated that to deal with 300 cases yearly, it takes a personnel of full time Psychiatrist, and Psychologist, with two or three social workers. In our case we have dealt with a total of 353 cases referred for the two years, of which 212 received full treatment; the balance between the two being made up by diagnostic, unsuitable, or uncooperative cases. This number was felt, at first at any rate, to involve too rapid a turn-over, and one had the feeling of seeing endless new cases, and not being able to deal adequately with them. Too much selection is unwise, especially at first, otherwise those who refer cases and are informed more than once that they are unsuitable, begin to wonder what we are for. Something has to be done for nearly all cases, if only a brief examination and report, or a recommendation to the country holiday society. This again is in keeping with American experience, for we are told: " increasingly the clinics tend to limit flat rejections to a negligible minimum, and to find some way of serving nearly everyone who comes to them, even if practical considerations restrict this service to a single interview."

Gradually one adapts one's methods to the number and type of cases, and is content with less intensive treatment. The social worker finds that her reports assume less voluminous proportions, and that cases have to be selected for home visits, while in others the interviews take place at the clinic.

Another interesting point emerges: many children, especially among the younger ones, show improvement when nothing much more is done for them than attendance in the play room. We have not been able to find consistent help in the matter of playroom helpers, though some have come and gone, so that the work of organising and attending to this has also largely fallen upon the social worker; with plenty of material however, and some help and encouragement, much is achieved by the children and an ever growing pile of drawings, patterns, and pictures bears witness to the interest shown in this type of activity. Water and sand trays are also essential adjuncts.

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(1) " Child Guidance Clinics—A Quarter Century of Development," published by the Commonwealth Fund, 1934.

Now with regard to the type of cases referred, the figures are as follows:

1. Nervousness, fears, seclusiveness, and other personality traits 63
2. Nervous habits, e.g. enuresis, stammering, habit spasms, etc. 68
3. Backwardness 74
4. Delinquency 71
5. Behaviour problems 120

It is of course obvious that such a classification only refers to the symptoms for which cases are referred, and that many cases fall into more than one category, yet such figures are always interesting to compare with those of other clinics, and also as an index of the type of problems which are considered by the community to require treatment by child guidance methods.

The comparatively small number of cases referred primarily for faults of personality accords with the results of two recent investigations into this question[1].

Miss Macfie found a surprisingly large number of children in the London schools which she visited, who showed problems of one type or another, the figure being 46%. Of these no less than 50% were personality traits. Comparing these figures with the cases for one year at the Guy's Hospital clinic, she found that personality problems only accounted for 19% of the total number referred to the clinic, while behaviour problems accounted for 42%.

The inference is that parents and teachers are, naturally enough, more interested in problems of behaviour, especially when these involve some revolt against authority, while psychiatrists tend to look at deviations of personality as having a greater importance for mental health.

The second group which includes the various types of nervous symptoms is the least homogeneous, as these symptoms hide such a protean variety of problems—physiological as well as psychiatric. The largest number of these —22—were referred for restlessness or tics; among them are many who appear to be temperamentally so constituted that they require considerable and suitable outlets for their energy, and are helped by supplying this in congenial forms, such as dancing.

Cases of stammering are sent from the speech training classes, when a fuller psychological investigation and treatment seem to be indicated; among these are to be found some of the most difficult cases with which one has to deal.

The third group, of backward cases, brings in the psychologist's side of the picture. Of the 212 cases tested:—

18 or 10% had I.Q. of 70 or below.
83 or 46% had I.Q. of 71-90.
74 or 41% had I.Q. of 91-110.
5 or 37% had I.Q. of 111-125.

This means that just about half the cases were *below* normal intelligence as measured by Burt's revision: an unduly large proportion, showing a lower

(1) See Brit. Journ. Educ. Psych., Feb., 1934.

average I.Q. than, for example, the London Child Guidance Clinic. This might mean a lower average among the population from which cases are drawn, or might depend upon a greater number referred for retardation; both factors may be operative here, as the number referred specifically for backwardness (74) was not unduly high. In later months fewer cases of such low I.Q. as the 10% have been referred, as greater discrimination in the choice of cases is increasingly found, and the average I.Q. may be expected to rise.

The striking feature is the large number in the " dull and backward " group; and this is not all, for a considerable percentage of the " normal " group are unduly retarded in school attainments in relation to their I.Q. (The psychologist, Miss Dove, reports that in 58 cases out of 180, the Reading Age was definitely below the Mental Age). This bears out the figures recently given by Miss Fildes to the Conference of Mental Welfare. She stated that out of the total number of cases she had tested at the London Child Guidance Clinic, 40% were more than two years retarded in reading and arithmetic, while the figures were even more striking in the case of delinquents; she concluded that special treatment for this group of children, as well as for the whole " dull and backward " group in schools, was an essential part of the prevention of problems in childhood; this without begging the question of whether backwardness is to be counted as cause or effect of the emotional problem.

The group of delinquents, numbering 71, is almost entirely concerned with stealing. Of this number only 32 came from the juvenile court, either directly from the magistrates or through the probation officers. The small number may be accounted for partly by the difficulty experienced by the court in deciding which are suitable cases, or by other factors which cannot be discussed here.

When we consider the rest of the group referred through other sources, some interesting facts emerge: the average age was 9 years, while that of court cases was 11½; of the former 60% were considered satisfactory results compared to only 30% of the latter. This suggests the importance of getting cases before they can be considered officially as delinquents. The American review[1] makes a special point of this, and also refers to the general tendency for C.G. clinics to be less closely associated with the Courts than was the case at the beginning of the movement, except in cases where they are officially attached.

Regarding the group of behaviour problems, there is not much that can be said in a short space. Half of these were described as " unmanageable " and it is found that not all these are psyschological problems in the sense of being reactions to emotional situations, but merely due to lack of home life, interests, or parental care: their only training ground has been the street.

The difficulty of doing anything in the psychological sphere for those cases which come from homes below a certain economic status has been referred to. It is not merely a question of poverty but rather of destitution; the parents from such homes are of poor intellectual capacity and character,

(1) Loc. cit., page 24.

and are unable to provide their children with the elementary needs of civilised existence. Apart from cases which are definitely unsuitable or unco-operative from this cause, there are many where economic anxiety and unemployment have had their effects on the character of the parents and the harmony of the home, with consequent effects on the children. To deal with such cases is disheartening and depressing, and one cannot help insisting on the truism that the cure for a great deal of delinquency and neurosis in these days lies in the provision of decent living conditions for all.

It is perhaps worth quoting the table giving a rough classification of our cases according to economic status:—

Poor slum	14
Slum	40
Poor working class	46
Good working class	75
New housing estates	16
Suburban	15

On this point the social worker, Miss V. Lilwall, writes as follows:—

"It will be noticed that most of the cases *accepted* for treatment come from 'good working class' families, where the father is a skilled worker, in regular employment, the home economic conditions are fairly stable, and both parents have time and energy to devote to their children and are willing to co-operate with the Clinic and its methods. The next largest group come from 'poor working class' families where the father is a seasonal worker, or in and out of work; quite often the mother is called upon to supplement the father's wages, the children if old enough are left to fend for themselves, or else passed on to neighbours or relatives during the day, which may in itself create a further problem; and the lack of consistent co-operation from such parents makes treatment lengthy."

The question of cases from "slum" and "poor slum" areas has already been mentioned above, so that if we include the "poor working class" status, we get a total of 100 out of 212 where material conditions themselves are hampering whatever treatment may be considered necessary from the psychological point of view.

The question of treatment need not be gone into here, as it is on much the same lines as in any other Child Guidance Clinic, with a greater stress perhaps on the value of social group play and artistic activity. Individual play-technique has been used very little owing to limitation of time. Owing to the close connection with other departments of the Educational system it is possible to supplement the treatment by sending children to the day open-air schools where they are not only marvellously strengthened, but are kept for longer hours, including all meals in the school, and can receive more individual attention, and less pressure of work, if necessary. In addition there are two open-air residential schools where cases can go when sufficiently improved in behaviour or social adaptation; this proviso is made because it has been found

that if children go there with their problems still upon them, and their conflicts quite unsolved, it is neither good for the child nor for the school. Valuable as this after-treatment is for many cases, it only enhances the need for a small specially staffed observation and treatment home, as an adjunct to the Child Guidance Clinic.

Since such a large proportion of our cases are referred from schools either directly by the head teacher, or through the Assistant School Medical Officer —actually 213 out of 353—it is obvious that close co-operation with the school should be maintained. This is done either by personal visits from the staff, chiefly the psychologist, by case-conferences at the Clinic (which have not been found satisfactory for this purpose), or by reports. Actually it is not as easy as one might suppose, to work in to any great extent with the schools in the treatment of a case. This is partly due to lack of time, but also from the fact that the investigation into home circumstances is a private one which cannot concern the school (most problems at school are reflections of the family situation); also that the school has generally done all it can with the child before it is reported to the Clinic, and therefore the Clinic takes on treatment of the child where the school leaves off. It is of the greatest importance, of course, to establish the friendliest relations with the teachers so that they may understand the nature of our work, and realise too why it is that we cannot help them very much with *ad hoc* advice about the case. Personal contact can do more than many lectures or case conferences to bring this about, and confidence in the Clinic methods can only be built up by results. If a teacher can see improvement manifesting itself in the child, the effect is certain; the only trouble is that of three cases which a teacher may have referred, only one may show it to any marked extent, and then the effect is weaker; or again the first case referred may be a failure and then there is, naturally, less incentive to refer another! We were perfectly aware that it would take time to win the confidence of many teachers, and if we have succeeded, it is the best tribute to our work.

Apart from cases referred through the schools, there were only 43 in the first two years referred from other sources, including 16 from parents themselves, but this number will certainly increase when it becomes known that anyone may refer a case. We are particularly pleased to have had a few interesting cases from the Children's Hospital and from other hospitals as well.

The actual number of children who can be treated annually is, of course, a very small one out of the child population, but the educational work which the clinic can do in spreading knowledge as to the mental hygiene of childhood is just as important. "The Clinic teaches by serving some children and, by teaching, serves all children."[1]

It has been said above that this information is spread most effectively by personal discussion over cases, but the giving of lectures and the holding of study circles is also indispensable in order to reach a larger audience. So far

(1) Loc. cit., page 54.

about 30 lectures or study-group discussions have been held at the Clinic, and an equal number of lectures given in Birmingham or in other towns, including Burnley and Warwick; quite a satisfactory number in two years. Mention may also be made of two annual courses organised by the Home and School Council, consisting of weekly lectures and study-groups.

Finally a word as to results. The facts and estimates are very difficult to translate into figures, for there can be no fixed standard. The only criterion is perhaps whether the child is sufficiently adjusted to cease attending the clinic, but after this the environment changes, the child grows older, and relapses may occur; not only this, for after a lapse of time other influences come into play, so that the picture is ever changing. However the figures, for what they are worth, are as follows:—

Adjusted	110
Partially adjusted	31
Unadjusted	16
Relapsed	3
Still attending	52
Total ...	212

This means that about three-quarters have certainly improved as a result of attending the clinic, which I believe is approximately the same kind of result as reported from other clinics.

This brief description of two years work has given as truthful a picture as possible of conditions, difficulties, and advantages, of Child Guidance work within the educational organisation of a large city.

There is one question of interest concerning the future: the relation of C.G. Clinics to other community organisations; are they to be in association with schools, or hospitals, or are they to exist independently of any close connection with any particular agency?

American experience seems to point to closer association with medical schools or hospitals than anything else, but it is also probable that they will assume a variety of forms, possibly with greater variety also in organisation and technique, to suit different fields of activity.

Our own experience as a unit of the Education Department is convincing as to the value of this association for the clinic, and the decision to continue the clinic at the end of the experimental period seems to show that it has a certain value too in the eyes of the City.