CHILD GUIDANCE CLINIC AT ABRAHAM LINCOLN CENTRE

Elizabeth Baker

In February, 1939, the child guidance clinic of Abraham Lincoln Centre was established under the direction of Dr. Rudolf Dreikurs, Adlerian psychiatrist. In the beginning it took the form of individual interviews, but very shortly the group method was instituted, and this practice has been continued successfully. The parents sit in a circle facing the psychiatrist, who addresses each parent concerning the problems he is experiencing with his children. As this individual interview progresses in the presence of the group, other parents recite how they have handled similar problems with their own children. From time to time during the interview the psychiatrist asks the other parents how they understand the particular behavior of the child, or what they would do under similar circumstances. He also discusses these issues from time to time with the social worker.

Thus the parents help each other by realizing that it is not they alone who have problems and make mistakes in managing their children. They are also frequently better able to accept an explanation or suggestion given to another parent than when it is given to them directly. After the interview with the individual parent in the presence of the group, the parent leaves the room and his children are brought in from the playroom for an interview. They usually sit on a bench together and address themselves to the psychiatrist. In this interview the other parents are only onlookers. During the ensuing discussion with the children, the psychiatrist gives them an interpretation of their behavior and frequently discusses it with the social worker.

At the conclusion of this interview the children return to the playroom and their parent returns to the clinic room. The psychiatrist explains the meaning of the children's behavior and attitudes to him and discusses with him some specific educational approaches on which to concentrate in the interim before the next appointment.

Sometimes very young children insist upon remaining with their parents in the clinic room. There is no objection to this as long as the discussion can be maintained without undue interruption. Many times this has resulted in quickening constructive results with the child, since he frequently grasps the psychological import of the discussion better than the adults, because he has fewer inhibitions than his elders. Generally these periods of remaining with the parent in the clinic room are of short duration and thereafter the child is content to remain in the playroom with the other children. The only reason all the children are not kept in the clinic room throughout the clinic session is that as a group they have proved too disturbing to the clinic procedure.

The social worker is used in the clinic as a third person to assist in interpretation by objectifying the discussion. Also, she usually knows the parents and children well and can contribute to a discussion of incidents and interpretation from this resource as well as act as the known factor to the parents and children. From time to time the nursery school supervisor acts in this capacity instead of the social worker. On referred cases from other agencies their social worker on the case frequently supplants the clinic social worker in this regard. From time to time there are visitors, such as social workers, teachers, or students, interested not in any particular case but in observing the methods employed. These persons also enter into the discussion, although not as much as do the parents. Recording of the interviews in the clinic is generally done by a student interested in further understanding of the methods of Individual Psychology.

The playroom is under the supervision

of a volunteer, usually a student in sociology or group work. Materials such as modeling clay, jigsaw puzzles, pencils, paper of different colors, crayons, story and picture books, and toys are used to occupy the children. Sometimes the playroom supervisor tells stories to the whole group or plays games with them, although on the whole they are so individualistic and disorganized that group conduct is relatively impossible.

The social worker introduces families into the clinic by several methods. The most desirable situation is that in which the parents perceive that something is wrong in the adjustment of their children and, seeking assistance in a solution, ask for an appointment to come to the clinic. These parents are the most likely to succeed in changing their own behavior and that of their children toward a more social adjustment, since it is their wish to effect a change. The social worker then elicits from them in an interview social history information, some details of the complaint, the relationship of the various members of the family, and their methods and success in pursuing their separate goals. Subsequently she makes a clinic appointment for the family and, as the treatment continues, makes appointments for future clinic attendance in consultation with the psychiatrist. Frequently parents apply for admission to the clinic after they have attended the parents' group discussions on child behavior which are held monthly.

Another method of introducing families into the clinic is used when some difficulty is perceived in the behavior of the child in the group, such as the group work department or the nursery school. Then the social worker proposes to the parent attendance at the clinic. This method is likely to be less successful than the first, since the idea comes from the social worker and not the parent, so that the parent frequently feels that clinic attendance is unnecessary and superimposed. However, occasionally the parent has been suffering from the behavior of his children and gladly accepts an offer of assistance.

The third method of recruiting for the clinic presents difficulties similar to those of the second. It consists of referrals to the clinic by other agencies. These also are frequently cases where the idea for treatment originates with the social worker rather than with the client. In such referrals the clinic social worker receives from the referring agency a social history before the family is admitted to the clinic, and in turn reports to the referring agency the recommendations of the psychiatrist from time to time during treatment and his conclusions at the end of treatment. It is invariably helpful to the other agency to have the social worker on the case attend the clinic in order to cooperate in interpretation to the client and assist in the manipulation of environmental factors where indicated.

A fourth source of referrals involves no social agency connection. Such persons may have seen the announcement of the clinic on the bulletin board, may have been told about the clinic by some former patient, or may have had it recommended to them by a private practicing psychologist. These cases offer fairly good promise of success, since the persons make application for the most part on their own volition.

The majority of parents attending the clinic are mothers, partly because some of the fathers work during clinic hours and partly because the fathers frequently feel that the job of rearing the children rightly rests with the mothers. The cooperation of the fathers, however, is very important, for although they may hold the maternal responsibility theory, usually it does not deter them from interfering in the management of the children, particularly if they are in conflict with the mothers, when they may try to win the children to themselves. Several of the fathers have participated regularly in the clinic. In other cases it has been possible to arrange an interview with the psychiatrist for the father at a time when he is not at

work. In some instances the social worker has interpreted to the father the recommendations of the psychiatrist outside of clinic hours in the office or in the family's home.

Frequently the social worker has known the family for a considerable length of time through the Centre, because of the children's attendance in the group work department or at camp. In such instances the pre-clinic interview is mainly preparation for the clinic rather than obtaining social history information; because of the information already gathered, the social worker is able to prepare a summary of the situation for the psychiatrist without an extended interview for that purpose.

Social treatment is facilitated by the Centre social worker by manipulation of the Centre program, alteration in the placement of the child in the group, consultation with the school, and making available to the client other resources, especially those of the Centre such as particular activities, special groups, and camp. From time to time therapeutic or special groups have been conducted by the social worker under consultation with the psychiatrist. These groups frequently include children who are attending the clinic as well as those who present maladjustments in the group work program. The psychiatrist has met monthly with the case-group seminar, composed of staff workers, for interpretation of child behavior problems, including those of the clinic children. This furthers the possibility of uniform understanding and approach to children in groups by the group worker, thus facilitating the work of the clinic. The psychiatrist has likewise worked with the camp staff at intervals, with a similar purpose and effect. He has also conducted weekly evening seminars for case workers, group workers, teachers, and others interested in Individual Psychology. Members of the Centre staff have attended these seminars for a further insight into its technique.

At the time of this summary, the clinic has functioned 22 months, from February, 1939, to January, 1942, except during vacation periods from June through September. Clinic periods have comprised one 2½-hour session each week, augmented by the other services already indicated. During those 22 months, 40 different families including 50 parents and 87 children were served by the clinic. The children ranged in ages from small babies to seventeen-year-olds. These 137 persons made 743 visits to the clinic. Of the 40 families, 17 were white and 23 were Negroes; 26 were Centre clients; 10 were other social agency referrals; and four were private families with no agency connections. During 1940 six of the families from the 1939 sessions continued to come to the clinic with the same number continuing in 1941 from 1940. Ten new cases were admitted to the clinic during 1941; 12 during 1940. All were admitted to the clinic free of charge except for two of the private families, who paid a small fee scaled according to income.

As has been indicated, the greatest measure of success in treatment may be anticipated from those cases in which the parents seek assistance with their problems. This is aided by whatever environmental factors may be manipulated advantageously by the social worker. Some of the families made rather spectacular gains, although probably none could be called "cured," inasmuch as no treatment can be described as ultimately successful in all respects. The following cases represent perhaps some of the most interesting situations:

The C family consisted of a father, mother, and six children of whom the fourth, named H, presented marked problems. The C family was a foreign-speaking group and the father the dominating figure. H, aged five, presented the appearance of a feeble-minded child. There is no doubt that he was retarded, but the parents, particularly the father, had accepted this too literally and the child had received almost no training. He refused to eat unless coaxed and fed with much attention. Otherwise he

would throw the dishes across the room. He urinated and defecated without control in his clothes and in the bed. He seemed frightened by the toilet and did not respond to that stimulus for evacuation. He was extremely fearful of people, of noise, and of fast-moving objects such as trains, street cars, and automobiles. He spoke only one or two words. He was easily excited, would cry and storm, and had a tremor of the hands and arms. He could be quieted temporarily by bright colors and soft, harmonious sounds.

After winning the cooperation of the mother, it was possible to change the training habits fundamentally. First, the unnecessary ado about eating was stopped, and the boy started to eat normally. He also responded quickly to toilet training. Then the parents were advised not to give so much undue attention to him. He was encouraged to do things for himself.

During treatment over a period of 27 visits, H improved remarkably. He began to talk in both languages, to eat by himself, and would even go through the first motions of preparing his food when hungry. He was trained to go to the toilet with only very occasional lapses. He played with other children, learned to ride a tricycle, obeyed his mother, and lost almost completely his tremors, his sensitivity, and his fears. He gradually developed in the natural habits of childhood. There were periods of regression, but improvement continued in greater measure. H attended camp for two weeks and play school quite regularly. His behavior presented difficulties to workers, but his development in the group was marked.

The M family consisted of mother and four children. Mrs. M was oversolicitous of the children and they had made a slave of her with their various attention-getting mechanisms. B, aged ten, was very slow, refused to do things for her own benefit, and was regarded as a "bad" girl by the other children. MJ, the second child, an eight-year-old girl, succeeded in getting attention both at home and at school by ridiculing and mimicking adults. J, the third child, a seven-year-old boy, habitually refused to comply and used to pound his fists on the desk at school shouting, "I won't learn to write!" R, the fourth child, a five-year-old boy, was envied by the other three as the baby who got the advantage of everything. R was capable of getting almost anything he wanted in the dime store by going into a tantrum. At home, after mother had finished cleaning the house, R would follow her about pulling tablecloths and bedspreads onto the floor. Mrs. M stated that she frequently gave in to him at home because she feared the noise of his tantrums would bring complaints from the neighbors. R also consistently slept with his mother. Although she frequently put him back into bed with J late at night, in the morning she would find him again in bed with her.

The main difficulty was to stop mother from overindulging. She made herself the slave of everyone and at the same time impressed each of her children that she cared more for the others. Especially B received the most attention although in a discouraging and antagonizing way. The mother learned to understand why each of the children behaved as they did and tried to counteract more successfully their intentions.

During the treatment of nine visits the two boys improved much more markedly than did the two girls, although the latter also showed some improvement. J became the responsible member of the family. He would get up in the morning before anyone else, start breakfast, and run errands for his mother. He became quite solicitous of his mother and would often ask if there were something he could do for her. R discontinued most of his babyish behavior and after one discussion ceased sleeping in his mother's bed. MJ became more constructive in her approach. B showed the least improvement, probably because Mrs. M seemed firmly convinced that B was bound to be "bad" and would not recover. B did gain considerable self-confidence during treatment but left much to be de-

sired. Mrs. M discontinued coming to the clinic partly because of her hospitalization but later also apparently because of her conviction of B's incurability.

The W family consisted of mother and three children, of whom the middle child, A, aged seven, presented the major problem. The mother had good insight, cooperated well, and was anxious to change her attitudes for the welfare of her children. The oldest child, aged 15, was substantial, reliable, and independent. The youngest, L, aged four, was babyish in his behavior. A would usually do the opposite of whatever her mother indicated.

As treatment progressed the mother was able to relate herself more to the middle child, who then gave up most of her antagonisms. As A improved L regressed. One day Mrs. W asked in the clinic if a child could become deafened by street noises. L never seemed to hear her when she called him. With an explanation of this behavior, intended to get attention which L was fearful of losing since A had improved, and with recommendations for treatment, Mrs. W handled the situation successfully. She stopped coming to the clinic after seven visits because her children were progressing as they should and because she had come to understand how to treat little difficulties as they arose and forestall greater hazards.

In summary, it may be said that the settlement provides an excellent base for the establishment of a child guidance clinic. People are more apt to go for assistance to an agency with which they are already acquainted and which they know is interested in the welfare of their children and themselves. The known factors help to dispel the difficulties of the unknown. It is a fairly tangible and quite fruitful method of parent education. The combination of these services offers a marked aid to the coordination of case work and group work for the greater service to individual and group. This particular type of psychiatric work, especially the group treatment in the clinic, is uncommon in this country and therefore offers a rich field for experimental procedure.

IN MEMORIAM

Five years ago, on the morning of the 28th day of May as he was walking down a busy street in Edinburgh, Scotland, Dr. Adler was suddenly striken. That day he was to have completed a series of lectures for the University of Edinburgh. But his work was cut short. The news of his death was quickly carried by radio to his thousands of friends and followers in all parts of the world. With the shock of the news, there also came the sober realization that the continuation of his work had now become the responsibility of those left behind, who were in any way equipped to carry it forward. That responsibility was part of the heritage from him.

Therefore, in spite of our sadness, the Chicago Association went on with the lecture and discussion which previously had been scheduled for that day. It was believed that our greatest mark of gratitude would be our efforts to share with others the understandings which we had come to through him and his work.

It is in that spirit of doing our best--under whatever difficulties--to extend the work which he began that the Bulletin is issued. Its pages record the work of many who attempt to plant and spread the scientific understanding that human nature is characteristically social, and that each of us is an individual-in community.

In a world now giving agonizing evidence of the need for greater "sense of community," among both individuals and nations, every effort toward that end--no matter how small, nor from what direction--is a help. Let none of us be disheartened by the size of the task. Each, in his own way and place must assist however possible. In that direction lies the most sincere tribute we can pay to Dr. Alfred Adler, our loved and understanding friend, and to his great work. --Edyth B. Menser