The Child Guidance Clinic of Abraham Lincoln Centre

History, Purposes, Techniques, and Results

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The Child Guidance Clinic at Abraham Lincoln Centre is unique in several ways: First in its form of group therapy, through which parents learn from each other as well as from the psychiatrist; second, in the technique used; third, in its growth and organization; and fourth, in the economic, inter-racial and cultural cross section of the persons in its clientele.

The clinic has been in existence for five years, having been organized in February, 1939, by Dr. Rudolf Dreikurs, psychiatrist, the present director. Dr. Dreikurs had previously conducted similar clinics in Vienna, as an associate of Dr. Alfred Adler. In Chicago he met the problem of accustoming people of this country to a clinic of this type, and to the idea of group therapy. Dr. Curtiss W. Reese, Dean of Abraham Lincoln Centre, realized the importance of group therapy in working with parents and children and opened the Centre for such an experiment. The gradual acceptance of the method has resulted in requests from many parents, who in one way or another came into contact with successful results, for admittance of their children into the clinic, so that now many more ask admittance than can possibly be cared for. There is also an increase in requests from various social agencies to accept their referrals.

Many forms of social service are possible in a community center such as Abraham Lincoln Centre, but emphasis on certain ones is determined by the function of the agency, the changing needs of the community, and advances in the field of social work. Thus the kinds of social service change from year to year. Complete care of such needs is limited by the number of social workers, their qualifications, both personal and professional, and the time element.

At Abraham Lincoln Centre much emphasis is placed on the cultural arts program, the War Nursery, and the out-of-school care unit. During the summer a camp is conducted for children of the community. It is inevitable that children's behavior problems and strained family relationships will show up in such programs, and these are referred to the Child Guidance Clinic. However, this clinic does not attempt to deal with psychotic cases nor with very severe behavior problems, but refers them to special clinics set up to deal with such cases.

The specific purpose of the clinic is to help children adjust with some degree of satisfaction to home, school and playmates; at the same time learning to conform to community demands and to develop their own

talents to the best of their ability within the social framework. This cannot be done satisfactorily without the full cooperation of the parents, especially the mother. Other members of the family, as well as the child's teacher, can do a good deal to bring about this adjustment through understanding cooperation.

When the clinic was first organized, most of the children who came in, were rather annoying behavior problems, who found their way into the Clinic because they were so uncomfortable to live with that their parents and teachers could no longer tolerate them. With such children, remedial measures were clearly indicated, along with help in present adjustment of social situations.[1] At the present writing the picture has changed somewhat, many parents bringing their children into the clinic in anticipation of the more or less normal crises through which all children pass in the growth process, so that the clinic now has a threefold function:

1. Prevention, and planning for the future.
2. Present and immediate assistance in adjustment to the social situation.
3. Remedial measures.

Assistance is, of course, given on all three levels in each instance, the difference lying in the degree to which help is needed in each.

Parents are seldom aware of what the *difficulty* is, but they are very much aware of the *symptoms,* which are always uncomfortable for the parents, and also to the child. Among the most common of such symptoms are: Enuresis; fighting and quarreling to an unwarranted degree; disobedience; slowness in dressing, eating or in performing duties; overinterest in sex; sleep difficulties; food problems; fears of various kinds; withdrawal from companionship; failure in school, and so on.

Parents are at first interested only in getting rid of such symptoms and are a little surprised to learn that these are indications of a child's unhappiness—usually caused by situations that can be remedied, but which, if understood by the child, can be tolerable.

The most serious problem of all is often unrecognized by the parent (unless it is extreme), and that is the withdrawal of the child from social participation because he is so utterly discouraged. Too often such children are "no trouble," and much too conforming, but their degree of discouragement is likely to be more serious than that of the more aggressive child who fights an unfriendly world.

All persons, be they adults or children, crave a place in the sun and want to feel at home in the world—that is, they need to feel useful and important, and they want to feel comfortable with other people. It is when they are frustrated in this, in the growth processes, that children rebel and are "naughty," or retreat from the world. This frustration may occur because of unwise handling by parents or teachers, because of a child's view of his place in the family constellation, or because of some physical defect.

The oldest child in the family is almost always jealous of the second child. The new baby robs him of his mother's exclusive care and attention, and he doesn't like it. He may resort to infantile behavior, such as crying or enuresis—or any mechanism that he has found through experience will get his mother's care and attention.

The middle child often feels "squeezed" between the oldest child and the youngest. The oldest child gets privileges and attention by virtue of being the oldest; the youngest likewise gets certain privileges and attentions because he is the youngest. All this is resented by the middle child, who may retreat in discouragement to his ivory tower, or may use various attention-getting devices, or may even compete for the oldest child's position—and get it, like Esau and Jacob—in which case symptoms of unhappiness and discouragement appear in the oldest child. It takes a parent of unusual skill and discernment to handle such situations without the help of expert advice. The only and the youngest children present special problems as they are the smallest in the family.*

Other causes of children's discouragement and frustration are perfectionistic parents who set impossibly high standards—who care too much what the neighbors think; a rejecting parent who for some reason doesn't sincerely love the child; tensions caused by other persons living in the family; a teacher who doesn't understand children; teasing by schoolmates; need for status in some group; imitation of poor attitudes of previous generation; organ inferiorities— to mention only a few of those most commonly encountered.

Referrals to the clinic come from other units in the Centre, principally the War Nursery, the Out-of-School Care unit, and the Cultural Arts Program. Others are referred from outside agencies, such as the public school and community agencies. And as has been stated, more and more children are being brought in by parents who want advice in handling a very young child; who want to know how to prevent food problems, temper tantrums, enuresis, etc.

Before entering the clinic and seeing the psychiatrist, the parent must make an appointment to see the social worker in her office, where

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*Of 57 children who were during the last two years brought to the clinic by their parents as causing the most difficulties, 13 were "only" children, 23 were first-born, 10 were second (5 of whom were youngest and 4 so-called middle children), 7 were third children (4 of them youngest), 4 were fourth, and 2 were youngest of a larger group. Therefore, if we include the second and third children, 11 altogether were the youngest in the families.

Without making any far-reaching conclusions from these more or less incidental figures, it seems to be noteworthy that almost two-thirds (36) of all the children who presented problems were either "only" children or those who as first-born were "only" children during the first years of their life.

rapport is established, the general nature of the parent's conception of the problem obtained, and a case history secured.* An appointment is made for appearance in the clinic, and a summary of the case prepared for the psychiatrist. The number of families seen in one afternoon is limited to four to six, though other clients may be present, learning a great deal from listening to discussions with other parents—drawing a good deal of hope and courage from the fact that others have similar difficulties and have been in some measure able to overcome them.

The clinic is set up so that the psychiatrist and social worker, seated at a table, can face the assembled mothers who are seated in a companionable semi-circle. A piano bench is placed at an angle so that children who are called for interviews can sit on it, facing the psychiatrist, yet not be too aware of those present. An open square of long tables surrounds the mothers, and outside the tables are seated the observers,—parents who have no appointment for this day, ten to a dozen medical students from the Chicago Medical School, social service students, teachers and social workers. Non-professional people are not allowed to observe except by special invitation of the psychiatrist.

Adjoining the clinic is the playroom were the children are cared for and observed by a student from George Williams College, a group-work institution, and a 'teen age assistant. The group-worker lets the children choose toys, and after some observation writes a very brief report on what they choose, how they play with that choice and how each child adjusts to the group.

In the Clinic the psychiatrist, with a summary before him, talks with the mother and gets her picture of what she conceives to be the difficulty. After this conference the mother is sent out of the room and her child (or children) brought in from the playroom. The manner in which children enter and seat themselves on the bench is often indicative of the child's place in the family. The protectiveness of one child for another, the antagonisms evidenced by pushing or ignoring one child, and the way they seat themselves on the bench, are all indications of the relationship between them.

The psychiatrist greets them and converses in friendly manner. The children are almost always quite at ease and much absorbed in what is happening, but occasionally one is frightened or shy and has to be reassured. A few questions on what they like to do, on school, on how they

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*As might be expected, a great deal of intimate information is given. This is known to the social worker and the psychiatrist only, and is never brought out in the clinic under any circumstances. Even though the mother may sometimes show an inclination to bring her own personal affairs into the clinic picture, this is avoided by the psychiatrist. It is desirable that it be known, but it has no place outside the privacy of the social worker's office.

help mother, perhaps a direct question on the core of the difficulty—put at the right time—gives the psychiatrist the other side of the picture. A few explaining remarks are most always understood by the child, who generally remembers and repeats them at home. After a few minutes of this the child (or children) is sent back to the playroom and the mother returns.

The psychiatrist is then ready to discuss the real problem with the mother and to talk over with her ways and means of coping with the situation. In this discussion other mothers present often take part. Not too much is told the mother the first time, but there is some attempt to make her see what the pressures on the child are, and to get her suggestions as to how they may be relieved, as well as giving her one or two concrete techniques for making the child feel more comfortable in the home. In later sessions this preliminary exploration and suggestions are followed up in a more positive fashion.

New mothers are prepared for what they may expect in the clinic by the social worker in the initial interview, and arrangements are made so that each new mother may watch at least one family through the clinic before her turn comes. Some new mothers are at first inclined to be a little shy and reticent—however it is interesting to watch the remarkable psychological transformation they undergo as they realize that the clinic is a friendly place; that their problems are quite likely common to all; and that everyone present is reaching forth a helping hand. Not only do children change perceptibly in this atmosphere, but mothers thaw out, relax, become hopeful, and so happier in appearance.

Occasionally both father and mother come in together, so the entire family is present; sometimes even a grandmother or two come along, but usually only the mother is present with her children. Sometimes a teacher comes with a child.

The basic concepts of treatment arise from recognition of the three tasks of life imposed by our culture:

1. Love (family relationships and all they imply).
2. Work (the need to achieve; to do something worthwhile; to earn a living for self and loved ones).
3. Friends (community interests, friends, participation in groups —school, church, political affiliation).

As has been pointed out, a problem child is usually a discouraged child. In general the attempts of children to compensate for discouragement and unhappiness may be classified in four general categories, or combinations of any two:

1. Active methods
2. Passive methods
3. Constructive methods
4. Destructive methods

Methods of gaining satisfaction have been classified by Dr. Dreikurs as:

1. Attention-getting devices.
1. Superiority attitudes (child who tries to prove his strength and power).
3. Vindictiveness (child who tries to punish elders, teachers or friends for not being liked).
4. Complete discouragement and apathy (withdrawal).

When a child's need and method of satisfying it is understood, an attempt is made to interpret them to the parent, without arousing too much feeling of failure. Not only is the aid of the parents enlisted, but that of siblings and others in the family. For this reason all members of the household are invited to the clinic. A bit over-simplified as presented here, suggestions to parents may be as follows:

1. Learn to enjoy your children—play with them, take them on excursions, let them share in both work and play as a family unit. The parent-child relationship is a fact that can never be undone—certainly it is wise to learn really to enjoy one another.
2. Punishment of all kinds—spanking, nagging—is discouraged. Instead, let the child suffer natural consequences of his act. Sometimes this means considerable thought and discipline on the part of the parent, but the psychiatrist patiently teaches him.
3. Make available to children experiences that will help them develop their possibilities to whatever extent they are capable of developing them. (Referral to classes in the Cultural Arts Program is often found helpful.)
4. Show children affection—don't make them take it for granted that you love them—they won't. But don't be insincere and overdo it.
5. A child must learn why certain routine is necessary for cooperative living. Lateness and slowness contribute to confusion.
6. Praise a child whenever he merits it. Put the emphasis on the worthwhile things he does and say as little as possible about the undesirable things.

Both parents and children are encouraged to act in such a way that the three basic tasks of each will be met, and both are aware of the suggestion made to each. Sometimes change is slow, because of deep-lying needs in parents to continue to treat their children in a certain way; usually an understanding of why they do so kindles insight and improvement begins. If the root of the difficulty lies in a severe and deep neurosis that requires more intensive, deeper treatment, the parent is referred to an agency where he can get such treatment, or he is advised to undergo

psychotherapy. If there has been no other contact, referrals are made to the clinic of Dr. Dreikurs at the Chicago Medical School. Children, who need psychometric tests, are also referred to the out patient department of the C. M. S.

Not all children who come into the clinic can be helped to an immediate appreciable degree. Sometimes the change in a family is dramatically sudden; sometimes there seems to be no change, and one wonders if perhaps a seed has fallen where at a later time it may germinate and bear fruit as the child or the parent or both gradually realize the full import of what went on in the Child Guidance Clinic.

James H., 9, had been in the adjustment room in the public school for more than two years and was making no progress whatever. His mother heard of the Clinic from a friend and made an appointment with the social worker for an interview. She was a tense, rigid, highly perfectionistic and protective mother. She said James, the oldest child, always played alone—she had kept him from playing with other children all his life to keep him from getting into mischief. He refused to play with his two sisters, Patricia and Carmen, and his baby brother Robert, preferring to shut himself in his room and amuse himself with fantastic games no one else understood. He disliked meeting new persons and avoided new experiences. He would read at home for his mother, but never at school. In fact, scarcely anyone outside his home ever heard him say a word, and he said little there.

When he first came to the clinic he refused to go into the playroom, but sat with his mother. He refused to utter a word, refused even to leave his chair to talk to the psychiatrist. Finally, to get him out of the room, the psychiatrist and the social worker gently lifted him bodily, chair and all, out into the hallway.

It was learned that the mother punished him a great deal—that he got severe spankings when he was slow and got to school late. It was suggested to the mother that she not spank any of the children for a week, to see what happened. Also it would be interesting to see what the results would be if she let them alone in the morning—let them get to school late and take the consequences, but under no circumstances let the child stay home. (The attitude is taken that a child who can't go to school, is sick, and he is gently but firmly put to bed in a darkened room and fed uninteresting invalid's food. He gets *no toys* and none but absolutely necessary attention. He is usually ready to go to school the next day.) The psychiatrist also suggested that the mother play with the children—not only with James, but with all of them together, something she had never done before.

The next week when James came to the clinic again, he was quite willing to move from one seat to another upon request; he still refused to talk, and once or twice he smiled, and once or twice he nodded his head in answer to questions. He still refused to go into the playroom. The

third time he actually answered a few questions—very briefly, it is true—and he stayed in the playroom. While there, he drew several pictures, particularly violent in color and action.

The mother cooperated full-heartedly and showed excellent judgement in her interpretation of the psychiatrist's suggestions. It was suggested that James enroll in the Cultural Arts Program, especially in the art class. The director of CAP was made acquainted with James' history and informed the teachers who were to work with him of his difficulty. In art class he showed real aptitude; his pictures continued to be lurid scenes of great fires, fire engines and firemen; or scenes of violent battle, showing soldiers wounded, dead, pierced with bayonets or swords, and with great oceans of brilliant red blood flowing from them. Too shy and repressed to get rid of his aggressions normally, he found an outlet in art.

He even enrolled in dancing class and did fairly well. He especially enjoyed his percussion instrument in the rhythm band. One day his teacher came to report with considerable elation that he had reached out and tapped the girl ahead of him with his instrument! He finally began taking piano lessons.

Six months after entering the clinic James was taken to the summer camp where he personally expanded like a flower in the sun, despite a severe attack of asthma. He never did talk a great deal, but he did respond readily, and he learned to enjoy playing group games keenly.

The mother gradually became more relaxed and one day suddenly said that she had never known her family could be so much fun—she was actually enjoying them for the first time in her life.

But while James was coming out of his retirement and adjusting happily to life, things were happening to Patricia, his younger sister. She, too, had been of a retiring nature, but when James began to expand and respond, Patricia began to retreat deeper and deeper into her personal world, until she was more silent and withdrawn than James had been. We generally expect such repercussions from the improvement of one child and discussed with the mother ways of helping both her children, not only one. Patricia, too, was enrolled in the CAP, but the season was almost over, and in the short time left she did not respond as well as James. She did go to a camp and while there adjusted quite well and enjoyed herself greatly. The family is still coming to the clinic—the therapy is not yet complete, but everyone is far happier than a year ago, and James is a changed person.

Frankie G., 4 years old, an oldest child in a family of three, was a "tough guy"—a superman. He fought and tore about, tried to climb a huge brick pillar—tried to knock the building down, Samson-fashion. He "beat-up" on his little three-year-old sister and chased his mother with a butcher knife. He was the terror of the nursery school. His mother, an intelligent rather well-educated woman, was in despair about Frankie. He had been jealous of Muriel ever since she was born and resented her mightily.

The mother much disliked housework and had a strong antipathy for any sort of routine and organization in any area. She was small—the father was large and masculine. There was in Frankie not only a strong resentment toward Muriel, but a mighty desire to be like daddy—or even "better" than daddy—like Superman in the comic strips.

This family came to the clinic with considerable regularity over a period of two years, with little appreciable results as far as the mother was concerned. She was not ready to accept any suggestions. Frankie was referred to CAP and did quite well in art. He went to camp and enjoyed it all tremendously, losing much of his aggressiveness while at camp. Frankie did quiet down and become more serious, but almost too much so. His aggressive assaults on a disordered life seemed fruitless, so he seemed about to decide to retreat from it all. Then the mother began to work, and since she was unable to come to the clinic, due to working hours, Frankie came alone. He is showing now an amazing maturity and steadiness of purpose. It begins to look as though in the not too distant future Frankie will be taking care of mother. He is now 6 years old.

The growth of the clinic as far as client count is concerned, follows in Table I.

Table I

Feb. 1939 — May 1939	111
Oct. 1939 — May 1940	216
Oct. 1940 — May 1941	249
Oct. 1941 — May 1942	449
Oct. 1942 — May 1943	363
Oct. 1943 — May 1944	469

This count includes both parents and children seen in the clinic. By family count, the picture is like Table II.

Table II

Feb. 1939 — May 19, 1939	16 families
Oct. 1939 — May 19, 1940	18 families
Oct. 1940 — May 19, 1941	14 families
Oct. 1941 — May 19, 1942	17 families
Oct. 1942 — May 19, 1943	27 families
Oct. 1943 — May 19, 1944	40 families

During 1942-43, 1943-44, and in the present year, 1944-45, professional visitors and students in medicine and social work have been permitted to observe, making the clinic into a demonstration clinic for those who wish to study management of children. Total attendance for the present year cannot, of course, yet be given, but for the two previous years it is as follows:

1942 — 43 696
1943 — 44 708

In 1942-43 there was an attendance of 152 medical students and internes from Chicago Medical School, and 105 professional social work-

ers. In the 1943-44 season the attendance of medical students was 93, and that of social workers was 89. Several principals of the neighboring schools and a number of teachers from the district visited the clinic and maintained contact with the social worker.

There are thirty meetings of the clinic each year, which means the clinic has an average of 25 present at each meeting.

The attendance record shows a fairly even division between white and colored persons, about fifty per cent being white and fifty per cent colored; but further analysis shows that by actual count only 33 1/3 per cent of the families is white, and 66 2/3 per cent colored. The white families come oftener and over a longer period of time, thus raising white attendance to a higher level.

During 1942-43, 15 parents came less than 3 times and 12 came 3 to 25 times. In 1943-44, 21 parents came less than 3 times and 19 came 3 to 16 times.

Children coming into the clinic are usually accompanied by their mothers, though occasionally both parents come in, and in some instances only the father. Usually the mother's absence is due to the fact she is working, ill or deceased.

During the year of 1942-1943 the clinic became too large and unwieldy, and 1943-44 a definite attempt was made to cut down the number of children seen. It would be desirable, perhaps, to have a larger number of observing client-parents present, and to see personally fewer familes in each clinic, but this is one of the details not yet worked out.

By and large the results of the work of the Child Guidance Clinic have been highly satisfactory. While no child or parent has ever reached anything approximating perfection as a result of clinical experience, yet in each case there has been improvement to some degree. The exact degree will never be known, nor will the time at which the clinic experience becomes most effective be known—it may be weeks or months afterward —but it is certain, on the observation of staff members and on testimony of parents and teachers, that gains have been made. Such evidence has been sufficient to warrant continuance of this method of group therapy and to suggest that more clinics of a similar type would do much to relieve the difficulties of more parents and teachers, to say nothing of increasing the happiness of more children.

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[1]Elizabeth Baker, "Child Guidance Clinic at Abraham Lincoln Centre." **Individual Psychology Bulletin,** Vol. II, No. 3, 1942. Dr. Rudolf Dreikurs, "Our Child Guidance Clinics in Chicago." **Individual Psychology Bulletin,** Vol. III, No. 1, 1943.