CHILD GUIDANCE CLINICS IN SMALL COMMUNITIES OF OREGON

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[Reprint from COMMONWEALTH REVIEW, vol. XXI, no. 1, May 1939]

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MANY students of sociology today contend that, insofar as society may be said to create the individual, it should create individuals with "traits" or "dispositions" essential to the general welfare. Social control, they believe, should be so directed as to guide, to social ends, the bundle of instincts and propensities inherent in the newborn infant. A child's "disposition," it is held, should be molded toward activities yielding the highest possible correlation between individual satisfaction and social service. The essential virtues, according to one author, should consist of attributes such as: "reliability, control of animalism, steadiness of endeavor and the social spirit or sense of social justice."[1]

Today, as yesterday, men everywhere and of all professions, are taking thought of how they may improve society. Despite current ideas on the subject, not a few of these are physicians practicing medicine in the various communities of the United States. Physicians specializing in the so-called "behavior field" of medicine are particularly concerned with this problem. These doctors, usually known as specialists in psychiatry, are concerned with attempts to adjust specific individuals to "the conditions of life." They attempt to apply the findings of social science as well as natural science to specific situations requiring personality guidance.

The ordinary practitioner may act to reduce bodily suffering without particular reference to sociality. The modern psychiatrist, however, is concerned with a much larger field. He is interested in relieving bodily suffering and also in adjusting the patient to society. This was not always the case, of course. It was only after years of experience that psychiatrists were led to believe that individuals who were not in step with social requirements were most likely to continue their mental sufferings. Suffering might be due to conflicts within one's mind or to the repressive action which society often imposes upon an unadjusted individual. But, unless the sufferer could be aided to strike some sort of a balance between his individual promptings and their satisfaction in the social milieu, the state of "unadustment" would persist.

Modern psychiatrists have contributed to social science and to

[1] Edward C. Hayes, *Introduction to the Study of Sociology*, D. Appleton, New York and London (1921), p. 588.

medicine the concept that "socio-individual" balance is manifest by emotional health, the desired psychiatric attainment. "Undersocialized" patients are the ones who become the subject of incarceration or other repressive social disposition, and "oversocialized" patients are the unhappy victims of "conscience," individuals in whom this society-born aspect of mental anatomy has virtually throttled the animalistic component of the personality equation.

Child Guidance Clinics

There is no doubt that the joining of medical and sociological thinking has netted society a distinct gain, especially in the expression of their ideology in formal social machinery such as the child guidance clinic system. In the child clinic organization, specialists in applied education and psychology, as well as psychiatry and sociology, are mobilized to join forces in a systematic approach to the study and treatment of specific instances of personality unadjustment.

The child guidance clinic idea had its beginnings in 1909; since that time it has been the subject of much experimentation. It is usually considered, today, that the working unit for a properly organized clinic consists of the following specialists: a psychiatrist as director, a pediatrician, an educational psychologist, a remedial teacher, a case-work supervisor, and two or three case workers.

The clinic staff, in teamwork fashion, handles the cases in more or less uniform sequence. After the case has been accepted the case worker prepares the patient's social-history study, the psychologist prepares psychometric studies, etc., and the pediatrician prepares the medical study. On the day of the clinic session all reports on the studies are made available to the psychiatrist. The psychiatrist then sees the child, his parents, and possibly others interested, and is responsible for making the diagnosis and instituting treatment.

Following the psychiatrist's contact, a case conference is held, attended by the case worker, case-work supervisor, and other members of the staff. In the conference, the responsibility for treatment is assigned. The plan usually involves psychotherapeutic efforts directed toward the child and his parents, and what might be termed efforts to manipulate the child's environment and provide constructive satisfactions for him. Usually the psychiatrist, case worker, and remedial teacher will agree on carrying out parts of the plan. (In traveling clinics the more inexperienced workers are usually assigned to make "needed arrangements." The psychiatrist does the formal "interview work" at succeeding clinics.) The goal of treatment is

the elimination of the behavior problem and the return of the child to good emotional health.

The child guidance clinic idea grew out of the American urban situation, not only because the cities presented acute problems to be met, but because specialists were at hand to meet them. Chicago, which had developed the juvenile court, also developed the first clinic in 1909; in succeeding years most other large cities followed Chicago's example.

Child Guidance in Oregon

The University of Oregon Medical School founded the Child Guidance Clinic in Portland in 1932. The same year a department of psychiatric instruction for students of the Medical School was established.[2] The director of the Portland clinic is the professor of psychiatry at the Medical School. The case-work staff is mobilized from the staffs of community agencies, especially the Portland Public Schools visiting teacher staff and the Court of Domestic Relations staff. The case-work supervisor is the head of the visiting teachers. Clinic sessions take place twice weekly, in the morning.

In 1937 a program of child guidance extension was inaugurated in the state under the direction of the Medical School. According to an experienced worker in the field of clinic promotion, Dr. George Stevenson, the development of clinic extension service during the next decade is calculated "to rank in importance with the rapid spread of larger clinics between 1920 and 1930." Oregon's traveling clinic experiment has received nation-wide attention. Leaders in the clinic field feel that a successful project in Oregon would demonstrate the even greater practicability of similar projects in more densely populated states. It is recognized that clinic extension in Oregon presents peculiarly difficult problems, because of the large rural area, as large as four of the New England states, the relatively small secondary cities, and the comparatively small total population of less than a million inhabitants.

Very little literature on the child guidance extension existed when the Oregon program was started. The Medical School in 1937 had to rely almost exclusively upon such literature as: Porter Lee and Marion Kenworthy, *Mental Hygiene and Social Work* (New York: Commonwealth Fund, 1931); Mary Augusta Clark, *Recording and Reporting for Child Guidance Clinics* (New York: Commonwealth Fund, 1930); Norman Fenton, *The Organization and Purposes of the Visiting Child Guidance Clinics of the State Department of Institutions* (California Bureau of Juvenile Research); and George S. Stevenson and Geddes Smith, *Child Guidance Clinics—A Quarter Century of Development* (New York: Commonwealth Fund, 1934). The first two deal with urban clinic organization. The third is more nearly applicable to the Oregon situation, but concerns a financially much more ambitious program than would be possible in Oregon. Under the California program described, the state staff performs a greater amount of local work than we do in Oregon. The fourth is useful mainly through providing an orientation in nation-wide practices in urban areas; it is not a handbook for contemplated rural projects. The statement is made that "the Division on community clinics has studied state services and its findings contain a wealth of suggestive fact." If this data was ever prepared for distribution, it did not find its way to Oregon. There are, however, excellent though brief statements that bear on Oregon problems, such as the following:

> It seems clear that in small cities, towns and rural counties progress in mental hygiene service depends on state leadership. In the states where the program is most advanced, clinic teams working out of state hospitals or state bureaus of mental hygiene or welfare visit town and rural centers at stipulated times and do as complete a job of diagnosis as conditions permit, sometimes returning to the same point often enough so that a methodical series of treatment contacts with individual cases can be arranged. More generally treatment must be left in the hands of the local agency which brings the case to the clinic. In Massachusetts and California public health nurses have been experimentally used for fact finding or follow-up or both. Elsewhere a similar service is performed by the staffs of children's agencies, local welfare bureaus, schools, and the like. Because of the sharply limited time which such a clinic team can give to any community, it must focus its efforts on direct clinical work leaving the task of education and interpretation to others, and these services therefore lack the balance and direct impact on the community which larger child guidance agencies consider essential. State mental hygiene societies have occasionally, as in Massachusetts and Pennsylvania, taken up the task of public education. Where this has not occurred, the clinic teams must rely on the general educational effect of the child guidance movements as a whole to open the way for them and secure a sympathetic reception.
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> Such programs are necessarily of a much simpler order than child guidance as the larger cities know it. The diagnosis of mental defect and of gross behavior deviations occupies most of the available time. There is scant opportunity for study of the marginal cases of personality disorder which escape the notice of the usual school teacher or welfare worker. It is important to remember, however, that small communities in which mental hygiene service is at this level are recapitulating the development of the movement as a whole, and that just such simple beginnings have led to the great refinements of urban service.
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> It seems evident that a very modest nucleus of social or educational organization is sufficient to justify the introduction of some mental hygiene care in a given community. A county agent, a rural visiting teacher, a well staffed nursing organization, may provide the peg on which to hang such efforts. The particular shape which the program takes in a given community will depend largely upon what peg the clinic program finds. Some nucleus there must be, for the effect of an itinerant clinic for which there is no local preparation and

[2] While there had been some instruction in psychiatry at the Medical School, prior to 1932, it was not until that year that a professor of psychiatry, Dr. H. H. Dixon, was appointed.

no local follow-up will naturally be negligible. Unless one trained worker is continuously available the prospect for useful accomplishment is slight.

Certain difficulties are usually present in such projects. The inadequate training and limited social outlook of the persons responsible for public education and the care of dependents, and the almost complete lack of organized social facilities, are a grave handicap. Where individuals capable of giving the clinic effective cooperation exist, there are no ready means of finding them, and the contact of the clinic with the community is often a leap in the dark. Rivalry and jealousy between the few social agencies which have a local footing is a common hazard: the clinic may sterilize its work by becoming identified with a single agency, or with the wrong one. In some instances the medical profession, oversensitized to "state-medicine," has offered organized opposition. Without strong and unified local leadership, continuity of effort and cumulative returns become almost impossible.[3]

The Legislative Act for Extension Clinics

The Oregon Mental Hygiene Society is principally responsible for the creation of the extension program in Oregon. Long and patient efforts on the part of the directors of this group culminated in legislative success at the session of 1937.[4]

The Child Guidance Extension Act appropriated $24,000 to last during a biennium for the extension of the child guidance service to counties in the state "outside of Multnomah County." An important provision delegated administrative duties to the University of Oregon Medical School. Never before had the administration of the Medical School officially, and in the name of the school, underwritten an activity to extend so far beyond the confines of the campus. The act added to the manifold activities of this institution a new and decidedly unprecedented function. The reactions of the administration and faculty of the school were mixed in the beginning. They felt the challenge of public service and the possibility of meeting vital community needs. On the other hand, however, they knew that the project was experimental and possibly somewhat visionary. There was a possibility that the service might be somewhat "ahead of the times" and might therefore fail. This possibility was distasteful in view of the unbroken record of Medical School achievements.

[3] *Child Guidance Clinics,* pp. 142-144.

[4] The directors of the Oregon Mental Hygiene Society in 1936 were the following: David L. Davies, president; Dr. Laurence Selling, first vice-president; Burt Brown Barker, second vice-president; Mrs. S. Mason Ehrman, third vice-president; Mrs. Ray Matson, secretary; William L. Brewster, Jr., treasurer; Dr. Elam J. Anderson, Dr. David W. E. Baird, J. Hudson Ballard, Dr. R. D. Byrd, Mrs. Harry P. Cramer, Ralf Couch, Dr. Richard B. Dillehunt, Dr. Henry H. Dixon, Mrs. Sadie Orr-Dunbar, Mrs. Malcolm L. Gilbert, William Griffith, Dr. Wendall Hutchens, Dr. Lyle B. Kingery, Mrs. William Kletzer, Judge Clarence H. Gilbert, Dr. Lewis O. Martin, Dr. Wilson D. McNary, Dr. Frank R. Mount, Charles A. Howard, Linn Sabin, Dr. Frederick D. Stricker, Dr. Charles O. Sturdevant, Miss Elnora Thomson; Allan East, executive secretary.

The Organization Plan

When the time came for positive action, the Medical School created a State Extension Administrative Committee, to be headed by the assistant dean, with assistance from the executive secretary of the school, the professor of psychiatry, and any others necessary.[5]

Medical School officials had been aware for several years that it would probably be called upon to assume responsibility for an extension program. They had already reviewed the available literature, and had taken every occasion to confer with Dr. Stevenson during his yearly field trips to the Northwest. The organization policies adopted evolved more from these conferences than from the little literature available. But, while out-of-state leadership had much to contribute, the plan was also influenced by the personal experiences of the individual committee members. The dean and assistant dean, for example, had acquired a working knowledge of community arrangements in the various urban centers of Oregon in connection with the state intake policies of the Outpatient Clinic and Shrine and Doernbecher hospitals, located in Portland. The administrative secretary had had much experience in developing medical service procedures and in matters of administration generally. The professor of psychiatry had for several years attended invitational child behavior clinics at the request of health-unit directors and school heads throughout the state. He had opportunity to note what persons had come forward in these cities to offer case assistance, and he had noticed a growing desire for a properly arranged organizational approach. Since the program proposed outside medical service for communities, many of which had an excess of practioners per capita, the committee had a knowledge of the needed technique for introducing the service on the basis of friendly cooperation rather than competition with local doctors.

All of these considerations are reflected in the organization plan: The state was divided into districts along the lines of physical accessibility and probable number of children needing assistance, with certain urban areas designated as district centers.[6] Each prospective center was to receive information concerning the services and, if interested, was to make formal petition to the Medical School for assist-

[5] The composition of the State Extension Administrative Committee was originally: Dr. D. W. E. Baird, chairman; Dr. Henry H. Dixon, Ralf Couch, and Dr. Richard B. Dillehunt (ex-officio).

[6] The designated centers were: Eastern Oregon: Baker, La Grande, Pendleton, The Dalles. Central Oregon: Bend, Klamath Falls. Willamette Valley: Salem, McMinnville, Albany, Corvallis, Eugene. Southern Oregon: Roseburg, Grants Pass, Medford. Coast: Astoria, Tillamook, Marshfield.

ance. An official of the local medical society was required to petition in behalf of the entire medical group in the center. The superintendent of schools was required to sign with the approval of his board. The superintendent's signature was vital, since school cooperation often entailed new expenditures in a tax-burdened community. The program required a teacher in the district-center school system who was trained in remedial techniques for any prospective patient in the schools needing skilled tutoring. If the schools had a case worker this person was also needed. Other desired signers were health physicians, juvenile court judges, and chief officers of any local groups interested in children and public health. In every community these latter groups ranged from women's clubs to men's service clubs.

The State Administrative Committee soon enlarged itself by including members of a recently appointed state staff, which had been selected to execute committee plans. Two practicing psychiatrists were selected from the Portland Child Guidance Clinic for part-time duties, a full-time clerical secretary was employed and installed in an office at the Doernbecher Hospital, and the executive secretary of the Oregon Mental Hygiene Society was recruited to act as full-time field representative and supervisor of psychiatric social work. Some time later a medically trained speech specialist was engaged on a part-time basis. It is obvious, from the size of the staff, that the extension program could not be managed solely through the activities of the state staff. It was determined that in each center the needed psychological, medical, and case-work services were to be mobilized locally and integrated with the state staff activities. The committee decided that any aid to the more remote rural area outside of the center would need to emanate from the center staff. Service would be rendered, provided the needed study and follow-up could be made available.

At this point, the state committee would have welcomed the assistance of an expert from the National Mental Hygiene Committee; but this was not possible because of the limited staff of that organization.[7] Consequently the committee decided to act as follows upon receipt of an application for service:

The Field Representative was to call in the locality to make a survey of needs based upon:

a. Estimated number of children needing care in district center.
b. Estimated number of children in district outside of center needing assistance.

[7] The state committee had been cognizant, of course, that nation-wide organizations, such as the National Probation Association, had specialists and field representatives who were available for local survey and organization work.

c. Check of local services to be established.
   1. Facilities for physical examinations and treatment.
   2. Facilities for case work assistance.
   3. Facilities for psychometric testing.
   4. Facilities for remedial teaching instruction.
   5. Place for holding clinics.
d. Willingness of the signators of the community application to form into a district administrative committee, coordinating local agencies in the child guidance field, planning community-wide education and support and providing an entity, apart from the local staff, for contacts with the State Administrative Committee.

Decision as to establishing a Unit—State Administrative Committee.[8]

The Plan in Execution

A number of districts responded immediately with completed applications, but the majority wanted verbal as well as written explanations of the service.[9] Some of the communities requested a survey to determine whether there were sufficient mental-hygiene problems to warrant a district program before they applied. Hence survey, application, and organization often merged so completely as to be almost indistinguishable as parts of a process. It early became the policy for the field representative to accompany one of the psychiatrists to the city applying, and, at a general meeting of interested persons, to attempt to interpret the program. The psychiatrist usually explained child guidance concepts and spoke from experience concerning results of the clinic system in Portland or elsewhere. Types of service to be rendered were stated as "diagnostic and treatment service," "diagnostic service alone" and "agency consultation service." The field representative usually confined his remarks to the contemplated survey or organization. Usually both men had an opportunity to meet potential staff members or to suggest where outside persons could be obtained. Public health physicians, school superintendents, and county welfare administrators usually came forward to offer nurses, remedial teachers, or welfare workers as part-time case workers. Frequently the school superintendent had a school psychologist in mind, and the medical representative, without notable exception, committed the local physicians to a policy of cooperation. Few local doctors could see how their domain was to be invaded when they learned that the physical study and medical treatment arising from clinic recommendations was to be done locally.

As a general rule, the survey took a very short time. In the rela-

[8] *Child Guidance in Oregon* (University of Oregon Medical School, 1937), pp. 6-7.

[9] *Child Guidance in Oregon,* containing a large amount of pertinent information, was made available in each community.

tively small and compact centers one or more key individuals possessed most of the needed facts. It was very difficult, however, to establish the exact extent of child guidance need, since the community so obviously needed education in the recognition of incipient problems. Usually the gross behavior problems were enumerated; but it was necessary to read between the lines concerning other difficulties. Each community had its accumulation of cases over the years, and there was generally plenty of "grist for the mill" in sight for a two-year program. Before many months had elapsed there were nine prospective centers applying for units, and it was clear that available staff time would give each community not more than three clinic sessions in any school year. All of the prospective centers found it possible to finance such a modest program. The organization of a district committee became a matter of routine after one or two of the earlier attempts. The following record of a hypothetical meeting, based on actual minutes, will show the typical procedure:

In response to an application made to the Medical School for the organization of a Child Guidance Unit in District No. 10, consisting of Orange and Black Counties, there were assembled the individuals who had signed the application.

Those present were: Dr. Byron L. Brown, representing the District Medical Society. Mr. Marion Wilson, representing the Center School System (in Orange County). Dr. L. E. Williams, representing the Orange County Health Department. Judge John L. Cole, representing the Orange County Juvenile Court. Mrs. L. L. Waite, representing the District Parent Teachers Association. Mr. John A. Temple, chairman of the Center School Board. Mrs. John Rogers, representing the District Public Health Association. Mr. James Dunthorpe, representing the District Boy Scouts. Mr. Larry Smith, representing the District Service Clubs. Mrs. George Gilbertson, representing the Orange County American Red Cross. Mrs. Mary Johansen, Chairman of the Child Care Committee of the American Legion Auxiliary.

Present from Portland were: Dr. John Henry, a Psychiatrist, and Mr. John Doe, the Field Representative and Supervisor of Psychiatric Social Work, representing the state staff of the Medical School.

Mr. Doe presented Dr. Henry, and stated that the doctor had previously spoken to some of those present and to the school board concerning the Child Guidance Program. It was stated that since the survey had revealed local need and that there was a possibility of establishing service, at least on an experimental basis, the state administrative committee was willing to make scheduled visits to the community to conduct Child Guidance sessions.

Discussion followed as to the plan of the Medical School as it would apply to the county of Orange and there was discussion of concepts which were not made clear by the written pamphlet "Child Guidance in Oregon" or previous data which had found its way to the district.

Those present seemed to be highly desirous of participating in the program. Therefore, working toward proper organization of the committee, Mr. Doe appointed Dr. Williams and Mr. Temple as a committee of two to nominate officers. The committee adjourned for several minutes and brought back the following names: Mr. Wilson for Chairman, Dr. Brown for Vice-Chairman, and Mrs. Rogers for Secretary. These individuals were unanimously elected upon motion of Dr. Brown, seconded by Mrs. Waite.

Following a discussion of the qualifications involved, the naming of a "District Clinic Director and Custodian of District Records" was the next item of business. Dr. Brown moved and Mr. Temple seconded a motion to the effect that the present physician in charge of the Orange County Health Unit should act as local Clinic Director. It was pointed out that Dr. Williams, a young man, would be an excellent leader of the local staff. Though a health physician, he had had a psychiatric service during his internship. The motion was carried unanimously.

Concerning the locale of the clinic sessions, which would be three in number during the coming school year, it was decided in a motion made by Dr. Brown, seconded by Mrs. Waite, that the present Public Health Unit quarters be used, since the space was seen to conform to standards of the state committee. The committee and the medical school then certified Mr. Wilson as Psychologist and Educational Advisor for any clinic work done in Orange County.

Those certified as case workers for any clinic work done in Orange County were as follows: Mrs. Edith Johnson and Miss Elsie Gilstrap both of whom are Public Health Nurses and Miss Gladys Norton, case worker of the Orange County Public Welfare Committee. Mr. Wilson stated that he was in the process of obtaining a qualified teacher to act as remedial teacher for the Center City School System. He stated that Miss Joan Gardner and a Miss Wade were at the moment applying for the position. He stated that he would interview these individuals to obtain an idea of their personalities and to learn in detail facts concerning their professional background.

Concerning stenographic help for the clinic, in the matter of typing the necessary records and taking dictation from the psychiatrists, there was offered by Dr. Williams, his secretary Miss Ethel Jones, and Miss Justice or some qualified substitute was offered by Mr. Wilson.

The Medical School announced the exact dates for the clinic as follows: 9-18-38, 12-12-38, 4-1-39.

The meeting was adjourned until the evening following the first clinic session.

Throughout the preceding account, the reader has probably been aware of the existence of a definite plan of organization procedure. Very early in the life of the project, all concerned had been convinced that the realization of clinic ideas was dependent upon proper arrangements and adequate administration.

A "procedure" manual was prepared, with directions on such matters as "Application for Service," "Types of Service Rendered," "Local Studies," "Clinic Session," "Follow-up," "Case Recording," "Case Closing," "Clinic Quarters," "Custody of Records," and "Committee Management." This manual indicates how it was proposed to establish a yearly, state-wide schedule; how state and district record keeping was to be accomplished; and in what manner the clinic worker was to make application, and to study and treat cases.

The procedures of urban clinics were adapted to meet the situation existing in the state. The adaptation also reflected the limited time and funds available to the state staff.

The First Biennium

Excerpts of the writer's 1939 report to the state committee following the first biennium of experience with the traveling project are quoted here. In perusing this report, the reader should recall Dr.

George Stevenson's statement that traveling clinic programs are necessarily much simpler than child guidance programs in large cities.

Without exception, the various part-time clinic directors are fine persons who are chosen by the Child Guidance Committee in each district, with part if not all of the needed qualifications, the chief problem presented being their preoccupation with their regular paid positions. The director has the following duties, as outlined in the "Procedure." He is expected to supply leadership and advice to case workers between clinic sessions and to supervise local clinic records. He passes upon all applications to the central unit and sees to it that the necessary studies: psychological, social and medical, are prepared prior to the clinic session in the case of all newly accepted applications for service. For the cases under treatment it is the director's role to see that the recommended follow-up is completed and recorded in the case record. For the clinic sessions, he must have prepared the agenda and the quarters. To date, the committees have selected for the director's role recognized local persons; a public health physician or a social or educational expert.

That the majority of clinic directors would not be able to carry out their total clinic duties was not altogether anticipated. Because of two replacements, the worker has attempted, to date, to work with 14 persons in the director's role. Until this year, especially, the worker when in the community has sometimes had to assume a director's functions, catching up on matters for him often up to within a few days of the clinic sessions. This year, however, the worker has sometimes asked the overburdened director to delegate a case aide to perform some or all of his functions, depending upon the degree of his preoccupation with other community matters. Where this has been done the needed training has been given this other person. In such cases, the director is director in name only, for the sale of using his position to retain community prestige for the clinic.

In the worker's opinion the success of a traveling clinic hinges very largely upon the quality of performance of case workers in the district units, since unlike urban clinics, the psychiatrists or the social work supervisor are not constantly present in the communities to assist in case handling.

Under the present "Procedure" these case workers are selected jointly by the local clinic director, the district committee and representatives of the medical school. Without notable exceptiton the district officials have recommended the most suited individuals to be obtained, locally; usually individuals who have in years past won a positive community role associated with ministrations to the sick or unadjusted child. Invariably the persons recommended have been employed full time as public health nurses, relief and probation workers. Some centers seem to have created but one of the agencies employing these persons, over the years, while some have created all three. In a very few centers the specifically experienced child welfare workers of the state public welfare commission have recently been introduced.

When the local selections of staffs were first announced, the state Public Health Nursing and State Child Welfare departments reacted immediately to the use of nurses and federal child welfare workers for case work connected with the clinic. The first reaction of the staff of the health nursing department was to divide evenly for and against the use of nurses. [The objection was on the ground that] . . . the nurses were over-burdened with the ordinary public health program and were not properly experienced in mental hygiene work. It is known that most of the questioning was inspired by a clear realization of the implications of using inexperienced workers in child guidance, and some by fear of neglecting essential parts of the present program for the new. The later reactions of the state nursing office came after experience with the project, and led, in the second year, to efforts of cooperation. At present many clinic referrals are seen to have their origin through the state nursing field supervisors.

In his article, "Child Guidance Clinics—The First Year" appearing in the May 1938 number of the COMMONWEALTH REVIEW, Ralf Couch expresses for the entire State Extension Administrative Committee a lament that there was not, in the beginning, a sufficiently detailed discussion of the proposed state organization with the state public health officials. Certain administrative problems encountered, he writes, arose from the lack of knowledge on the part of the committee of the organization and operation of this and other state agencies. That the program went along as well as it did is due to the grounding, accomplished in the other ways, in each center. Quoting again from the writer's report:

. . . . A potent force in the direction of nurse usage in child guidance was the fact that the local committees looked upon the use of nurses as desirable and this naturally had its effect on the policy of the state health nursing office since its historic aim had been to cooperate in the promotion of positive community desires.[2]

[2] It is a fact that some of the state's veteran public health nurses were largely responsible for the community application for Child Guidance Service in their centers. These nurses had contended that the public health program in the schools, especially, required psychiatric assistance. Where nurses were not the instigators, the local public health doctor was usually instrumental in requesting service and requiring that his nurses take on child guidance duties. In his school health examination program the average health officer in Oregon often feels very inadequate where emotional cases are encountered. In these instances he desires clinical assistance. (See Erickson, Dr. H. M., "The Relationship of the Child Guidance Clinic to the County Health Unit," COMMONWEALTH REVIEW, May 1938).

As an example of nurse initiation of child guidance service there is the known history of the inception of service in Salem, Eugene and Medford prior to the legislative action of 1937 creating the present state aided system. In these towns the nurses and health associations arranged to have the professor of psychiatry of the medical school see children in clinic sessions arranged by them. Lacking proper pre-clinic data and follow-up organization, it was up to the psychiatrist to do his best without proper supporting organization.

In Pendleton in 1935, a present member of the state public health nursing staff arranged for local child guidance service through the psychiatrists of the Eastern Oregon State Hospital.

So that the reader may properly understand social organization in Oregon, it is well to mention that public health services have been firmly established in this state for a great many years. One of the most potent social action groups in the state is the "Public Health Association," with local units in almost every county of Oregon. These lay groups are usually very strong and have been responsible to a large extent for the creation of the governmental "County Health Units." State leaders in this movement during pioneer days, were Sadie Orr-Dunbar, Elnora Thomson and Philip A. Parsons, the latter two emphasizing nursing and case work training through the University of Oregon.

To further the direction of nurse usage, as just described, a policy of cooperation between the state health department and the central staff was effected. A University of Oregon Extension Course for nurses in the field was instituted, using central staff members for the instruction. This effort, and what the worker and the psychiatrists are able to accomplish by supervision of nurses, carrying actual child guidance cases, constitutes the present liaison between the central staff and the Health Office.

A useful but more remote benefit also accrues from the mental hygiene courses obtained by student public health nurses in training at the medical school, some of whom eventually take positions in Oregon areas served by the clinic system. After two years it can be said that many of the nurses have made appreciable progress in their child guidance activities, demonstrating mature judgment and understanding approach. Many have excellent community following.

When the use of federal child welfare workers was announced locally, as previously stated, the Child Welfare Division of the State Public Welfare Commission obtained a definite understanding regarding referral policies and

the very limited quota of time available in the beginning of that program, for cooperation with the child guidance program.[3]

[3] The child welfare service in Oregon has a psychologist operating over the entire state and it is frequently the welfare worker's custom to handle a case locally in the following way: to clear the behavior symptom with a local physician for any possible organic basis, to obtain the psychological findings from the state psychologist and then upon the basis of the worker's own social findings formulate the diagnosis and institute treatment. Sometimes the child welfare worker does not feel that the clinic is the needed resource for his own case. Then, too, the sessions do not always come at opportune times.

Here again, as Mr. Couch points out, the central committee was delinquent in its opportunities, making it necessary for the Child Welfare Division to instigate the conversations on coordinative functions.

. . . . The child welfare service expands only as fast as local counties realize need and cooperate in proper introduction and maintenance of the workers. For this reason in two years about one per cent of the cases handled have been carried by child welfare workers. Thus far but three of the twelve centers have had such service for any period of time and these workers are greatly burdened, in the beginning of their program, with responsibility for underprivileged children in families requiring public assistance. Several additional centers may obtain child welfare service, however, and it is to be hoped that a good coordination can be established through increased case handling and in assistance of the less experienced workers by these persons. Since the medical school is committed to a reasonable quota of cases, yearly, this latter sort of activity by the busy welfare worker, as well as case handling, might well become one of the important future activities of the child welfare worker in the centers.[4]

[4] It has been seen in Oregon, that the more successful child welfare worker is exceedingly tactful in his community contacts. He has a liking for case handling and mingles on a free give and take basis with the other local workers.

There are only a few school attendance officers and probation workers who are affiliated with the clinic program. Usually they merely hold themselves ready for a specific aid to a case worker. Frequently underpaid, overburdened and without adequate experience (according to the standards of the National Probation Association) they sometimes even retard action on clinic recommendations.[5]

[5] One case comes to mind where the probation worker delayed one year taking responsibility for a court order of dependency, specifically requested by two different psychiatrists. During the year the youngster ran away from his inadequate home and continued his stealing. Until the advent of the clinic the historic treatment policy of this court had been little but the inevitable procedure of arrest, warning, probation of a sort, rearrest, and finally incarceration in an institution.

In a few instances recently, a school administration has made available a "school case worker," who may or may not have additional duties such as psychological testing or teaching activities. The combination of duties are usually necessitated by case load and financial outlay considerations. These few workers have given a good account of their services to the community and may stimulate a demand on the part of other school administrators for similar service.

Earlier in this article Dr. Stevenson was quoted as saying that "unless one trained worker is continuously available, the prospect for useful accomplishment is slight." If this statement means that each local center must have an experienced worker on the scene continuously, the Medical School has been working far afield. However, if the child welfare worker could be introduced into more centers and could carry clinic cases and direct other workers as part of his duties,

Dr. Stevenson's recommendations might in time become literally true. At present the state staff has only one social worker, and his duties include clinic administration and community organization as well as case-work supervision in all of the twelve centers. Mr. Couch, in his article, mentions the inadequacy of the original plan in this respect, and suggests that the state staff must provide, in some way, more adequate service in psychiatric social work than it has to date. (The attempts of the Medical School to secure additional social workers for the state staff met with no success, however, at the last meeting of the Legislature.) He intimates that the original plan was too restricted. Therapy was to be limited principally to remedial teaching and what could be done in the school routine. He points out that the problems handled during the two-year period showed a need for a vast amount of social case work outside of school and not necessarily available through existing school personnel. The "community clinic" point of view requires clinic workers working in the home, in the neighborhood, and in industry, as well as in the school.

The writer's report continues:

In centers in which the remedial teachers do not perform the role of psychometrician, the studies are made by additional persons who are professors of psychology in colleges and normal schools in Oregon, or supervisors of grade school teachers. The worker has recently devised a report form for psychological findings on the basis of collaboration with these individuals. As a feature in educational testing, in giving the Stanford Binet test, for example, the form requires that the examiner record his general observation of the subject in some detail, in addition to recording the chronological age, mental age, and intelligence quotient.

Beside the Binet the psychologists have been giving group tests, special aptitude tests and diagnostic and achievement tests of one kind or another. All seem to recognize that their findings are not infallible and when requested to repeat a study do so willingly. They all seem to believe that the intelligence quotient finding is but one way of establishing facts in arriving at a diagnosis, and they are fully aware of the present crudities of the psychological test.

In many yet unserviced Oregon towns it is found that if a psychologist is an educational advisor, and does not have case workers and psychiatrists to assist him, he himself goes ahead, analyzing problems and instituting some sort of treatment, even if it be only in the sphere of school curriculum and course of study. This is found, also, to be the case, when child welfare workers operate single-handed in Oregon. Until traveling clinic service is available, the community is often observed to be interested enough to go ahead if someone feels able to take constructive steps. Few communities remain idle even though some do not appreciate the inadequacy of a service wherein a psychologist or case worker acts singly, without help.[6]

[6] An instance comes to mind in which during the days before establishment of clinic service in one of the present centers, a certain capable, yet somewhat unoriented psychologist operated single-handed in the study, diagnosis and treatment of school behavior problems. Even today this person is heard to say that he should play a psychiatric role as well. Needless to say, others aware of his limitations have undertaken to hold him within his legitimate sphere of activity.

In the beginning there was talk of employing a psychologist and educational supervisor, on the central staff, to travel about the state. While there would be undoubted benefit from such a person, the use of local psychologists

has been very satisfactory and has aided in making the program solid in each center. There would be no objection to having someone in the State Department of Education coordinate and supervise the activities of these various local persons, who now look almost exclusively to the traveling staff for collaboration.

The feature of extending the clinic team of psychiatrist, case worker, and psychologist to include a "clinic teacher," seems to be somewhat unique. Usually this person is not also a case worker. She enters the picture after the clinic session, when the plan of the new case calls for remedial teaching service or "educational treatment" as it is sometimes called. At times the child may not need tutoring in subjects, as such, but a period of emotional calm at the hands of an understanding teacher.

Where this teacher is in charge of a room containing clinic patients she is not expected to have a large pupil load, and the group is as homogeneous as possible. Her role is to give each patient a great deal of individual attention so as to determine how he learns best and then to apply the needed "remedial techniques." Her goal is to bring the patient up to his maximum learning level so that he can reenter his regular class and compete successfully with his fellows. The effect of discouragement in school children is well understood and hence it has seemed worthwhile to the superintendents in the centers to individualize the school approach in this way. Where the teacher travels about from room to room seeing clinic patients in that manner, her goal is the same.[7]

[7] The many children in school who symptomize maladjustment have prompted additional changes in the Oregon educational system to date. There seems to be a growing desire in Oregon to prepare children for life without necessarily subjecting them to a rigid curriculum.

Attempts to tie class teaching in with clinic procedure seems exceedingly worthwhile. If the teacher is capable and respected by other classroom teachers she acts somewhat like a human yeast, leavening the entire faculty with mental hygiene thinking.

Present standards of the various superintendents require that teachers, wishing clinic positions, have a certificate for teaching elementary subjects, possess experience in such teaching, and have verifiable evidence of a definite interest in atypical child problems; also to have taken specific courses in remedial teaching techniques. As an aid to the equipment of such qualified individuals the medical school in the past provided for some instruction in psychiatric concepts during summer sessions. The individuals accepted for summer instruction were recommended by school officials in their home town. They were not supposed to be over thirty-five years of age. The application for instruction was passed upon after personal interview by the psychiatrists and others, the idea being that the accepted teacher possess general personality balance and have requisite aptitude. The courses given were the joint efforts of the psychiatrists and the director of child study and special education of the Portland Public Schools, consisting in lectures, case-handling illustrations, practice teaching experience and required reading. Since there were usually more students than positions, some selection of teachers for clinic positions was made possible.

The fifteen practicing clinic teachers, on the whole, have been fine individuals, ambitious, hard working and proud of their connections with the clinic. There is considerable dynamic in being a member of a clinic team.[8] Those with college degrees have usually had normal school training and have worked for college degrees during many summer periods.

[8] In one case, in which a teacher with a college degree failed in her performance as a clinic teacher, she had not had elementary school teaching experience. She had felt different from others on the grade school faculty, tended to remain aloof, and failed to gain for herself the needed status and prestige.

An interesting fact based upon two years experience, is that parents usually do not resist special teaching assignment since they recognize that the remedial or "clinic" teacher is an arm of the clinic and because the psychiatrist sells the parent upon this course of action. In the cases in which the teacher is resourceful, having teaching aids, such as activity program equipment, she can be amazingly versatile in therapy. The undersocialized child may receive his first lessons in group participation, without trauma, and a suppressed child may glory in self-written articles in the class-room newspaper. The aggressive and ego-centric child may be helped to change his tactics through praise for cooperative and unselfish actions. In cases in which the parents are more or less "inaccessible" to treatment and the community lacking in treatment resources, it may be that the clinic teacher offers one of the only available positive aids in therapy. The intimate tie-up with the school system effected by the presence of this teacher gets away from situations in which parents are amenable to case work plans, but school policies are rigid, and unchangeable, hampering needed cooperation. Much depends upon skillful teaching, of course, and the child must not be stigmatized through the specific method of handling.

The management of the local committees by a medical school representative is usually necessary. The committee members must be kept interested and informed. Disinterested persons (dead committee timber) have to be replaced so as to keep the group functioning and active. The choices for committee officers have been excellent. Usually the committee meets only when state staff members are present since the agenda is usually a product of state and district thinking combined.

Since the first meeting to organize, the committees have been active in such matters as the following: public interpretations of the work, press and publicity policies, and actions to create treatment resources. It is noticeable that staff members get inspiration for more effort, knowing the enthusiastic interest of the committee members who are influential in the community.

The various committees have acted as host to innumerable persons and organizations wishing to obtain a knowledge of child guidance, through committee sponsored mental hygiene lectures and round table discussions.

In small communities where there is little or no organized approach to child behavior problems, the social value inherent in the clinic process is great. Courts, schools, and health groups have been troubled for years by the rise of personality disorganization. The clinic organization has given these agencies much help in specific case handling. In the March 1939 issue of the COMMONWEALTH REVIEW Dr. H. H. Dixon, chief psychiatrist of the clinic project, states that the results were comparable to those in urban clinics, and attributes this fact largely to the unusual coordination of agency efforts possible in the smaller communities.