4-587

Historical Data CS4

Child Guidance

Jean Walker McCarthur

Olga Bridgman

1924

pre school behavior help

Langley Porter

Dean 1925-36 40

McKim Merritt 1940 got 36 but died

F.S. Smyth

1925 - Dept Prof

Dean - 44 - 54

Alva Henry 1927 - 56

Louise Morrow Chem Inst
41 - 45

Bergmann 33 - 58

Scholer 1940

78

24

54 th

References:

1. Report. The task force on pediatric education. The future of pediatric education, Evanston, Illinois, 1978.

INTRODUCTION

INTRODUCTION

Historical Information

As mentioned, this volume represents the description of a clinical approach which has been developing over the past thirty years within the Child Study Unit. A brief history of the development of that unit within the Department of Pediatrics at the University of California, San Francisco, will help the reader to glimpse the setting which has nurtured and helped to develop our ideas.

Thirty years ago the unit began with two staff members and one trainee. It was established by the late Dr. George Schade, a pediatrician at the University of California, San Francisco; he was one of four pediatricians selected throughout the country in the 1930's to receive two years of training with Dr. Frederick Allen and Jessie

Taft at the Philadelphia Child Guidance Clinic. Training for the four pediatricians, directed towards increasing their knowledge in the management of pediatric emotional and behavior problems, was supported by the Commonwealth Foundation. The organization hoped through this project to improve the training of many more pediatricians in the management of common emotional and behavior problems in children. For it was explicitly expected that the four pediatricians, following training, would return to their respective pediatric departments, all in university teaching hospitals, and subsequently establish teaching programs devoted to this aspect of pediatrics. Following World War II, Dr. Schade, with the aid of a small grant from the Commonwealth Foundation and subsequent support from the University of California and the Department of Pediatrics there, fulfilled this expectation by formally opening the Pediatric Mental Health Unit in 1948. The staff consisted of himself, a psychiatric social worker, and his first pediatric fellow, Dr. Helen Gofman.

From the beginning, the purpose of this unit was to provide opportunities for pediatricians "to become better pediatricians". Pediatric house officers were helped to understand and manage the behavior problems commonly seen in pediatric practice. ~~There was particular emphasis on the understanding of normal development and of developmental differences in children~~. There was particular emphasis on the understanding of normal development and of developmental differences in children. Frederick Allen's view had been that a child's behavior was often a manifestation of his own "growth towards independence". This view, one of the early attempts to understand children utilizing

a "growth" model, rather than a "pathology" model, was incorporated into teaching efforts with pediatric trainees in the unit. Clinical approaches as taught by the staff, again largely due to the influence of Allen, were concerned most often with the present, rather than with the past, and with an emphasis on practical interventions and strategies, the last especially appealing to pediatricians. The early work of the unit was greatly aided by the contributions of the late Dr. Olga Bridgman, a psychologist and psychiatrist who had been long associated with the Department of Pediatrics and also with the Department of Psychology at the University of California, Berkeley. Her main interest was in the developmental assessment and management of children with visual handicaps, hearing deficits, cerebral palsy and/or mental retardation. It was through her efforts that pediatric

psychologists with expertise in the developmental assessment of children were added early to the staff of the Pediatric Mental Health Unit, their number growing from one to, now, five in the unit.

Two years after its inception, Mrs. Wilma Buckman joined the Pediatric Mental Health Unit in 1950 as a psychiatric social worker. Aside from her background in social work, she had also had experience as an elementary and nursery school teacher and director; she had received a Masters Degree in child growth and development and had operated several day care nursery schools for working mothers during World War II. She thus also stressed the unit's clinical emphasis on the developmental aspects of child growth and behavior. Mrs. Buckman and Dr. Gofman in the 1950's began working steadily on the development of a practical teaching program for pediatric house officers in interviewing and pediatric counselling.

In 1961, following the sudden death of Dr. Schade, Dr. Gofman assumed the directorship and began to concentrate her energies on another area of training: the evaluation of children with learning problems. As a result of this interest, she was able to gradually increase the size and diversity of the unit staff, adding a neurologist and educational consultant to the roster and forming a close alliance with the Department of Otolaryngology, Speech and Audiology. As more and more children were referred to the unit for learning and developmental problems, in addition to those referred for behavioral complaints, a change in name seemed indicated; and the title, Child Study Unit, was adopted in 1966.

By this time financial support had been obtained, first from the U.S. Children's Bureau and then from the Department of Health, Education, and Welfare, Division of Maternal and Child Health. The support allowed the addition of a psychiatrist and a second pediatrician to the staff. And a third pediatrician, Dr. Bayard Allmond, joined the unit in 1969. It was during this period also, in the middle and late 1960's, that the members of the unit became quite interested in the newly developing field of family therapy and in possible application of family therapy approaches to pediatrics and to pediatric interviewing. As a result both Mrs. Buckman and the unit's consulting psychiatrist, Dr. Alan Leveton, sought and received training directly from both Virginia Satir in family therapy and from Frederick Perls in Gestalt Therapy. Returning to share their training experiences with the remainder of the Child Study Unit staff, these two individuals became largely responsible for the incorporation of family therapy and Gestalt therapy principles into the ongoing training program for pediatric residents. These new dimensions in interviewing, the subject of this book, were firmly established in the unit's pediatric training endeavors by the early 1970's, altering significantly the previously existing program in interviewing which had been offered to pediatricians-in-training.

The mid 1970's saw the addition of still another pediatrician to the staff; and a pediatric nurse practitioner has also joined the staff ranks. Thus from two individuals, the staff has grown now to fifteen professionals: four pediatricians, five pediatric psychologists, one psychiatrist, one neurologist, one pediatric nurse practitioner, one educational specialist, and two secretaries.

Just as the staff has grown and diversified over the years, so have the trainees. In the early years, training was somewhat irregular, directed towards whoever was willing to be taught and/or "unlucky" enough to have been assigned a patient with a behavior problem requiring assistance. But training became more formalized - and apparently quite successful - with time. By the early ~~1960~~ 1950's a pediatric resident could elect a specific three month rotation through the Pediatric Mental Health Unit. The rotation was always filled, and in 1969 the pediatric house officers themselves requested that the (now called) Child Study Unit be a required, rather than elective, rotation for all pediatric residents. That situation has been the case ever since. Every PL-II trainee at the University of California San Francisco spends two months in the Child Study Unit.

In addition to pediatric residents, the Child Study Unit has been training post-graduate pediatric fellows (two per year) in a one or two year fellowship of behavioral pediatrics since 1965. This aspect of the training has received continuing support from the Division of Maternal and Child Health, Department of Health, Education and Welfare.

And finally the Child Study Unit is considered core curriculum for medical students at the University of California, San Francisco. Consequently the majority, if not all, medical students in either their third or fourth year, spend time with the staff of the Child Study Unit.

Other trainees have participated in Child Study Unit programs regarding behavioral pediatrics depending on their specific interests and time. These individuals have included: nurses, physicians in primary care residencies, and genetics counsellors. While the unit,

its staff, and its trainees have grown and changed over the years, still the main purpose of the unit remains: the training of pediatricians in children's behavior and development. And it is to this end that the work continues today. The setting described above and the main purpose just stated form the basic professional underpinnings for the authors and for the written work which follows.

Format

Case illustrations using specific dialogue are used heavily throughout this book. We are aware that this style of writing has both advantages and disadvantages. On the negative side, accounts of a verbal dialogue tend to lose something once they are written. Many of the nuances of non-verbal behavior, of setting, and of mood are unavailable to the reader; and he must either imagine those aspects of the conversation or do without them. In any case the juices and flavor of the dialogue may suffer, rendering the interchange somewhat flat and one-dimensional. This limitation of the written word to describe events which are both visual and auditory is regrettable but unavoidable; we concede that such a limitation exists. An additional disadvantage, one may find lengthy sections of dialogue cumbersome reading, requiring a different set from that to which the reader is accustomed...in much the same way that reading drama differs from reading prose and necessitates a different approach by the reader. We have attempted to minimize the reader's possible struggle over dialogue by deleting obviously clumsy grammatical and syntactical constructions which are so much a part of literal verbal language (the hems and haws, repetitions, grunts and groans, etc.), when doing so would not change the flavor of the

dialogue itself. Thus in many of the situations presented, the dialogue has been "neatened up" to allow for less effort and difficulty in the reading process. The conversations themselves are actual, and beyond the editorial deletions to which we have just referred, the gist of a person's speech has not been changed. To insure the privacy of patients and of their families we have, however, freely changed names, sometimes sexes, geographic locations, ages, and occupations.

In spite of the drawbacks attendant upon the use of written dialogue for clinical illustration, we have obviously chosen to use it, and to use it considerably, for very particular reasons. This book is concerned with demonstrating clinical approaches which are practical and specific. We have felt that our illustrations must share in that same practicality and specificity. And nothing could be more practical and specific than to share with the reader very particular situations in which practical skills are being utilized, i.e., clinical interviews with specific dialogues between physicians and families.

The book is also concerned very much with "how" questions, i.e., how does a certain family member react to a given comment, how does a doctor handle this certain situation, how does one tell a mother this particular news, and so forth. Examples of clinical dialogue can effectively answer such "how" questions, perhaps more succinctly than any other written device, in a way which is often unlabored, direct, and to the point.

There is a third reason for our inclusion of so much clinical illustrative dialogue. We have long maintained that to be an effective teacher in this field of behavioral pediatrics, one must be willing to

risk exposing one's own interviewing style and clinical techniques with patients - for better or worse, through the successes and through the failures as well. Some of the cases to follow, particularly those in the first part of the book, upon our own re-reading, sound very neat, easy, almost too successful. While we do not feel constrained to apologize for these successes - they did in fact occur - we have attempted to present also a few of our clinical failures and partial failures, in order to balance the scale and to gently encourage others to risk themselves in like situations. We hope, with our own risk-taking demonstrated in the pages to follow, to invite that of the reader in his or her own clinical work with children and families. For it is risk-taking, as we all know, which ultimately separates the successful learner from the non-successful.

Most often an interviewer in the examples presented throughout this book is referred to as "the pediatrician" or "the doctor" or "the physician". These terms when so used, are actually meant to be generic and broad, standing for any health care worker who may be involved in the medical and psychological care of children - be that individual a family physician, pediatrician, nurse, social worker, psychologist, ~~surgeon~~, psychiatrist, or family therapist. Each of these professionals may indeed conduct family interviews, and the substance of this book is directed to them all. It would, however, have been awkward to list everyone of those terms in the text whenever an interviewer were described or mentioned. We trust that readers - especially those who are not pediatricians nor perhaps physicians, but for whom our approach seems useful - will understand that it was

a desire for simplicity in writing style rather than professional chauvinism which motivated our choice of terms.

The book is divided into two major parts. The first section, Principles, presents in four chapters the work of four theorists and clinicians who have strongly influenced not only the character of our own clinical work with children and families, but also our teaching approaches with pediatric trainees as well. Our granting each of these individuals a separate, extensive section and/or chapter may be misleading for some readers. One could assume from this format that we see our own clinical work simplistically limited to a literal application of the ideas developed by each or all of the four theorists. Such is not the case. A clinical approach so developed we would find constricting, unimaginative, and too artificially compartmentalized. We are indeed grateful for the ideas of Satir, Minuchin, Haley, and Perls, the four individuals reviewed in Part I. And their work is often at the heart of what we do clinically with families and with trainees. But we are also mindful of the writings of Sigmund Freud, Erick Erickson, Milton Erickson, Carl Jung, Frederick Allen, Murray Bowen, and many, many others.

With all of these innovators in the field of psychological thought, we have seen fit to add elements of our own choosing, our own style, our own creativity. And it is this mix of 1) Satir, Minuchin, Haley, and Perls, 2) legendary others in the field, and 3) our own individuality - distilling into a clinical approach - which we have attempted to present through case illustrations in the second section of nine chapters titled, Clinical Application.

Some readers may even prefer to begin with this second section of the book, learning something first of our specific clinical approaches and style, proceeding thereafter to Part I and our discussion of many of the principles which underly our work. Since we suspect that many busy pediatricians will probably do this anyway, we would like to sanction such an approach to the reading of this book. Part II may indeed be read first, depending on the reader's preference.

And we insert one final balancing statement. This book is rather enthusiastic in its view that family therapy principles can be applied to pediatric practice for both the diagnosis and management of pediatric problems, particularly those in the behavioral and psychological realms. Our enthusiasm stems from the fact that we have found a family systems approach to be practical, effective, exciting, congruent with our own ideas about children and their families -- and thus comfortable for us to use. However, in sharing our approaches with the reader we are not suggesting the arrival of Truth, nor in our enthusiasm do we seek to nullify other theoretical hypotheses and alternate clinical approaches to the same human problems as those which we have encountered. Rather our work in this volume is intended to introduce a method, a model, an approach which has worked well for us.

COPY

ANNUAL SOCIAL SERVICE REPORT

CHILDRENS PSYCHIATRY CLINIC

(1948-49)

For a report of my first year as a social worker with Dr.Schade in Childrens Psychiatry Clinic, I feel that a fairly detailed and descriptive analysis of the case load would serve to demonstrate and perhaps clarify our specific services. With our particular treatment service added to the other functions of Childrens Psychiatry, I also feel that our particular proceedures of operations and the functions of our clinic team members might be restated and re-defined at this time. This report will cover the period 5/1/48 to 7/1/49.

I. PERSONNEL

In May, 1948, I was assigned as social worker to work with Dr. George Schade, Mental Hygiene Consultant for Childrens Psychiatry Clinic, on cases referred to us by the pediatricians in Childrens Clinic. In September, 1948, Dr. Helen Gofman, a Fellow in Pediatrics, was added to the clinic for specialized training in the treatment of emotional problems of parent-child relationships, and Dr. Kent Zimmerman, Pediatrician and Mental Hygiene Consultant, joined the staff on a part time basis. The services of a full time psychologist, Mrs. Barbara Ise, have been available within the clinic for psychological testing. Dr. Olga Bridgman of the clinic has also offered consultation services on specific cases.

II. FUNCTION

The main function of our service has been on teaching the emotional factors in child growth and development rather than on giving wide service to a large number of patients. This teaching function has been carried out through conferences and consultation with pediatricians, through recorded material in the medical charts, and through case demonstrations in seminar meetings. The demonstration, or teaching emphasis, has been on the integrated biological and emotional factors of child growth and development and the dynamic relationship between parent and child in this growth process.

As the social worker in this setting, my main functions have been to complete application interviews, or give consultation services, on new referrals made by the junior clinicians and the house staff of Childrens Clinic; to make adequate disposition on all cases referred either by treatment in our clinic or appropriate referrals elsewhere for services; to carry demonstration treatment cases on a team basis with the three doctors in our clinic; and to participate in case demonstrations to the house staff in pediatric seminars.

III. PROCEEDURES

The diagnostic process begins in General Childrens Clinic with a complete medical work-up of the child, and a joint evaluation of the child's

problem by the pediatrician and the mother. The pediatrician then discusses the problem with the social worker in Childrens Psychiatry before making an appointment for an application interview. This is followed by the application interview, contact with schools or other agencies interested in the child, if such is indicated, consultation with the mental hygiene consultant (this may include a combined conference with the psychologist and the referring pediatrician), and whatever projective techniques in the way of psychological testing as are applicable and helpful in the individual case.

Cases are accepted for application interviews only upon referral from clinicians in the Pediatric Service. By a joint discussion of the case between the referring pediatrician and the social worker in Childrens Psychiatry, the purpose and function of the clinic and the appropriateness of case selections can be mutually evaluated and understood. The mother's willingness and desire for psychiatric help and her ability to participate in a treatment plan have been stressed as important considerations in the referring doctor's evaluation. In general, the pediatrician has discussed the findings of the medical work-up with the mother before consulting with Childrens Psychiatry.

Following the discussion with the referring pediatrician, an hour interview with the mother is scheduled by the social worker or the Fellow-in-training for a discussion of the child's problem. The mother is given an opportunity to discuss the problem as she sees and feels it, and no attempt is made to direct her discussion or to take a static social history of any kind. The focus, therefore, has been on the present parent-child problem or dilemma which motivated the mother to seek help. The function and service of the clinic are explained to the mother, if the case seems appropriate, and she is given the opportunity to discuss her feelings about the kind of service offered and the freedom to choose it or reject it. She understands that final acceptance for treatment is contingent upon consultation with the mental hygiene consultant.

A copy of the application interview is typed and filed in the back of the medical chart, showing the impression and plan resulting from the study completed in Childrens Psychiatry. A brief written notation is also made in the chronological medical history in the chart with brief follow-up statements of progress or significant information. Full recording of treatment interviews are kept in a separate file in Childrens Psychiatry, but are available to the pediatricians upon their request. At the time that the parent and child terminate treatment, a typed summary and evaluation of total treatment is completed and filed in the medical chart for the use of the medical staff.

IV. ANALYSIS OF 150 REFERRALS

During the first twelve months, approximately 150 cases were referred to us for service. Most of these were direct referrals from pediatricians in the Childrens Clinic, but a few were consultation services with outside agencies or mothers who called directly to me. Of this total, 85 cases were accepted for application interviews. Consultation service only (without contact with the patient or mother) was indicated on the others. Disposition on the latter group was handled primarily by the pediatrician. Some of these mothers did not want psychiatric service; others were referred to the pediatric medical social worker at the point where the pediatrician discussed the situation with me; others to special clinics such as the Convulsive Clinic

where guidance to mother and child is given by the doctor along with medical care; others to appropriate community agencies. Of the 85 children studied, 55 were boys and 30 were girls. Average age of the boys was 8.2 and the girls, 9.6 years. The age range for the 85 children was from 8 days to 17 years.

PRESENTING PROBLEMS

In considering the types of problems presented in the 85 referrals accepted for application interviews, 41% were children who presented behavorial difficulties, usually mild in degree, and predominately boys; 34% were children without behavior difficulties but with inadequate personality development, or emotional and personality problems involved in illness and physical defect with nervous symptoms, (equal as to sex distribution); 16% were children with problems primarily related to mental defect or dull normal intelligence; 9% were miscellaneous problems such as sudden school failures or preventive work with parents of infants under 2 yrs. of age. Only one child, a 14-year-old adolescent girl, presented symptoms suggestive of psychotic reaction.

Behavior problems

Of the 35 children with behavior problems, 12 had no accompanying illnesses or particularly significant physical or nervous symptomatology. With one exception, this group was entirely boys. The age range was from 2 to 12 years and the average age was 7.8 years. The other 23 children of this group had illnesses and significant physical and nervous symptoms as well as behavior problems. Boys predominated this group, representing 70% of it. The age range was from 3 to 15 years, and the average age was 8.4 years. Asthma and allergic rhinitis were the most frequent illnesses in this group and enuresis and bowel disorders were the main physical and nervous symptoms. Other symptoms included unexplained dizziness, nausea, vomiting, overeating, nail biting, and vague somatic complaints.

Non-Behavior problems

In the other major groups, the non-behavior problems, 18 were children who had physical and nervous symptoms of unknown etiology or relationship to illness, disease, physical or mental defect, or infection. There were twice as many girls as boys in this group, and the average age was 9.4 years (a little older than the children presenting behavior problems). Eleven of this group were in the adolescent age group from 10 to 15 years, and these were predominately girls. Physical and nervous symptoms which predominated were unexplained bladder and bowel disorders, unexplained vomiting, general nervousness and self-consciousness. Less frequent were fainting spells, overeating and obesity, vague abdominal pains, rashes, labile hypertension, night terrors, nail biting, and general irritability.

The other 11 children without behavior problems who were in this group presented mainly personality difficulties seemingly related to or involved in a specific physical illness or defect. This group of children were all marked by moodiness, irritability, nervousness, and timidity. They were often quite dependent on their mothers and therefore somewhat immature for their ages. This was the oldest age group, averaging 10.2 years. The age

range was from 5 to 17 years, and 8 of the 11 children were boys. Asthma occurred in 6 of these children (all of whom were boys); post-encephalitis and meningitis in 2; diabetes, spina bifida and physical anomaly each occurred once. Only 2 of these children were bed wetters; 1 had fainting spells; 1 had possible convulsive susceptibility, and 1 had a severe speech defect.

DISPOSITIONS

Disposition on those 85 cases accepted for study could often be made at the end of the application interview. This was true in 33 cases, and the largest number (13) were referred back to the pediatrician for handling. Ten were referred to other services or to community agencies where the need could best be met. This might be due to the nature of the problem itself, the distance of the home from the hospital, parental attitudes, etc. Nine were closed without referral primarily because the mother did not want psychiatric help. This seemed to be true particularly when the referring pediatrician was the first to see the child's problem as an emotional one and to recommend treatment in Childrens Psychiatry without allowing the mother an opportunity to express her feelings freely about the referral. These mothers often said that they came to us because the doctor told them to, but they did not see the need for it or want it. Disposition on 10 other cases was reached prior to the application appointment, but in only four of these, did the mothers actual cancel the appointments. This seems to reflect care and thought on the part of the referring pediatricians in evaluating cases and completing referrals.

Case Examples

(1) Bradford, age 3½, and his mother were referred to us from both Dermatology and Pediatric Clinics. There was no significant medical problem, but the mother described the boy as a behavior problem. One of his symptoms was pulling his hair out and eating it. In my application interview with the mother, I found that the real problem was a marital one, with both parents taking out their feelings on the children, particularly this child. With the focus of the problem being on marital maladjustment rather than faulty parent-child relationship, the mother was referred to adult psychiatry for help.

(2) Rena, age 9, and her mother were referred to us as the pediatrician felt the child was a behavior problem. In reviewing the medical chart, including the psychometric testing and the social data in the letter from the private doctor, we found that Rena's problem was related to mental defect rather than to emotional maladjustment. Since an adequate interpretation of the child's mental handicap had never been given to the mother she was referred back to the physician for this purpose following our conference discussion with him.

(3) Jacqualine, age 10, known to Pediatrics with a diagnosis of constitutional dwarfism, was referred to us through the public health nurse at the school. The nurse felt that the girl demonstrated poor social

adjustment at school mainly because of her relative small stature. The mother, instead of asking first to discuss her problem with a pediatrician, came directly into my office. She was upset and had been drinking. It was quite obvious that she did not want psychiatric guidance at this point, but had forced herself to come in because of pressure being put upon her. When given the opportunity to express her feelings and to make an independent choice, she chose to work the thing out without outside help. She understood she could come back if she desired to do so later.

The above cases illustrate situations which do not call for our particular service. In a second group of cases, totaling 25 of the application interviews, counseling service to the mother (and occasionally with the child) for a short period of time was indicated. Interviews on these cases ranged from two to eight and averaged between three and four interviews per case. In general, in these cases the parent-child relationship was not too disturbed, and it was not necessary for the child to come in for treatment. In some instances the total family situation was complex and the focus of the problem unclear. Sometimes the diagnostic process required several interviews, which were partly counseling in nature. Half of these cases were referred eventually to other social and health agencies or services, either because it was more convenient in terms of location, or because the function of the other service was more appropriate to the specific need. Brief counseling only on the rest of the group was needed, after which the mothers felt able to cope with the situations themselves without further help. In some of these instances the mother's lack of knowledge and information, or worry and concern based on "ignorance", was an important factor rather than any serious emotional problem in parent-child relationship. This could sometimes be detected in the initial intake interview.

Case example of diagnostic study and counseling

Dale, age 2½, and his mother were referred to us from Childrens Clinic for an evaluation of a possible psychological component in the child's retarded emotional and social development. At the age of 2½, Dale made no attempt to feed himself, would not eat solid food or talk, could not be toilet trained and showed negativistic behavior. Medical examination was essentially negative. Psychometric examination brought out a mental age of 1½ years, but the psychologist felt that the child was capable of achieving at a higher level. Although he appeared alert and observant during the testing, he was unusually timid and negativistic. In consultation with Dr. Bridgman, she felt that much of the material suggested mental deficiency, but a definite diagnosis was deferred for six months or a year, with the recommendation that the child then be re-tested.

During this period of diagnostic study, I had about five interviews with the mother, a divorced woman with three children. Her husband had been an immature person who drank excessively. Their entire married life

had been unhappy and tense. Dale was conceived during a very trying period when the parents were contemplating separation; the separation and subsequent divorce took place shortly after Dale's birth. The mother when I saw her was obviously nervous and functioning under considerable emotional and financial strain. Our study of Dale suggested that his problem, in part at least, might be an emotional one as well as mental retardation. It was difficult for this mother to face the possibility of the latter and not know definitely one way or another. At the conclusion of our study of the child and my counseling interview with the mother, I referred the case to the East Bay, where the family lives, to the Child Development Center of Childrens Hospital. At this center, the mother could continue to receive counseling help nearer her home while Dale's problem was further studied and explored.

The third group, 18 of the 85 application cases, were accepted in our clinic as demonstration treatment cases. In thesecases the mother has been seen weekly by one of the staff while the child has been seen by another staff member. The mother-child relationships in these cases was usually tense and uncomfortable, resulting in a struggle ofopposing forces. Often the child's illness or physical symptoms seemed to be involved in the complexity of the relationship. These cases were chosen to demonstrate the physical and emotional factors inherent in the growth and development process and the interplay of family and social forces on the child in this process. In accepting these cases, both child and mother assumed responsibility for coming and participating in treatment. The parent was asked to prepare the child for the experience and to explain the reasons for their coming. The focus of treatment was kept clearly on the mother-child relationship, and subsequent interviews with the mother centered on her "role as a mother" and her concomitant problems.

These demonstration cases were almost equally divided between behavior problems and non-behavior problems. The average age for this group under treatment was 8 years and the range was from 4 years to 13 years. Eleven boys were under treatment and 7 girls. Asthma and allergies appeared in 6 of these children, diabetes in 1, labile hypertension (unexplained) in 1, post-meningitis in 1, and spina bifida in 1. Bladder and bowel incontinence was reported in 9 of these children and was the predominant symptom. Occurring in 4 other children were overeating and unexplained nausea and vomiting. Behavior problems presented were, in general, mild in degree. All of these children were tested by the psychologist as to mental capacity and some for achievement levels. All of the children under treatment fell in the range of normal intelligence. A few were in the dull normal level and a few in the superior level. The problem of poor school adjustment often complicated the picture in those children with dull normal intelligence. An adjustment in school situations, or parental attitudes toward achievement, was considered in our total handling of these cases.

Half of these 18 cases were still under treatment as of May,1949. The other 9 cases terminated after an average of 9 interviews with the mother and 7 with the child. The cases still under treatment have involved many more interviews over a much longer period of time. The factors involved in the length of time patients come to us for service have not at

at this point been evaluated. Ending of treatment is a decision left up to the parent and child, though sensitivity to their feelings on the part of the interviewer often helps them to reach their own decision to end and feel free enough to discuss it. In as much as we have presented examples of treatment cases in Pediatric seminars, I am not including one in this report.

Before presenting the total statistics for the year's activity, I also want to mention that we were fortunate in obtaining a $1000. grant from the funds of the National Mental Health Act which we are using to purchase a dictaphone, to set up a psychiatric library forChildrens Psychiatry, and to purchase more toys for our use in working with the children referred to us for service.

ANNUAL STATISTICS OF CASE LOAD ACTIVITY

(Includes my contacts only and not those of other clinic members)

	May & June 1948	July 1948 to July 1949
Total number of cases active	19	89
Consultation cases active	3	71
Total	22	160
Total interviews and contacts		
With patients	9	100
With patient groups	52	469
With doctors	41	809
With clinic and hosp. groups	17	168
With agencies	16	105
Total	135	1651

Average case load per month (Including consultation cases)---------- 32

Average number new referrals per month (Including consultation cases)---------- 12

Average number interviews and contacts per month---- 138

Virginia McIntosh
Social Worker
Childrens Psychiatry Clinic
University of California Hospital.

To: W.C.Deamer,M.D.
Cc: F.S.Smyth, M.D., Dean
G.H.Schade,M.D.
O.Bridgman,M.D.
Miss Addie Thomas

COPY