MCGILL UNIVERSITY

THE SOCIAL ADJUSTMENT OF VERY SUPERIOR CHILDREN: A STUDY OF TWENTY-FIVE CHILDREN REFERRED TO THE MENTAL HYGIENE INSTITUTE DURING 1948 AND 1949

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CHAPTER I

INTRODUCTION

Many years of experimental research were required before the French Psychologist, Alfred Binet was able to produce an intelligence scale, whereby the relative intellectual capacities of children could be measured. The formulation of these tests in 1905[1] revolutionized the psychological field and paved the way to a fuller understanding of the mental powers of people. His concept of intelligence emphasizes three characteristics of the thought process.

> "Its tendency to take and maintain a definite direction; the capacity to make adaptations for the purpose of attaining a desired end; and the power of auto-criticism."[2]

In the early part of this century Lewis Terman, an American Psychologist revised the Binet scale, reducing it to a workable unit which he termed the Intelligence Quotient, setting the basal figure at 100. On this revised Stanford Binet Scale 68 per cent of the population have I.Q.'s ranging from 90-110, which is regarded as normal intelligence. People with an I.Q. scoring above 110 are exceptional by reason of their superior ability, and have been divided into three groups according to the I.Q. range: superior being between 110 and 120; very superior between 120 and 130; and genius over 130.[3] As a result of his investigation

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(1) G. Murphy, A Briefer General Psychology, New York, 1935, p. 364.

(2) L.M. Terman, The Measurement of Intelligence, New York, 1916, p. 362.

(3) R.B. Cattell, Your Mind and Mine, 1939, p. 88.

Terman became interested in exceptional children as a group with special problems, and since 1920 has done a great deal of research regarding them, publishing his findings in several volumes.(1) In his follow-up study of gifted children he found that they

> "are less inclined to boast or to overstate their knowledge; they are more trustworthy when under temptation to cheat; their reading preferences, character preferences, and social attitudes are more wholesome and they score higher in emotional stability. On total score of the character tests, the typical gifted child of nine years tests as high as the average child of twelve."(2)

Individual examples of social maladjustment, behaviour problems, and almost every type of personality defect were found in the group studied, however. He was convinced that children of superior intelligence constitute a problem with many ramifications, and that the total personality must be considered if a genius is to be helped to make his optimal contribution to society.

Leta Hollingworth also found that "Children of superior intelligence are typically superior in other qualities also, in emotional stability and control", but that they are faced "with problems which arise from a combination of immaturity and superiority".(3)

In other parts of the world psychologists have recognized the wisdom of assisting gifted children to develop their capacities. Dr. Jose

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(1) L.M. Terman, Genetic Studies of Genius, 3 Volumes, California, 1923.

(2) L. Terman and P. Oden, The Gifted Child Grows Up, California, 1948, p. 56.

(3) L. Hollingworth, "The Child of Very Superior Intelligence as a Special Problem in Social Adjustment", First International Congress on Mental Hygiene, p. 48.

Germain tested one thousand superior children in the schools of Spain and reported that the superior child's ability should be discovered early enough to help him find a place where he can use it and be able to fulfil his purpose in life. This must be one of the aims of mental hygiene, along with vocational guidance at the time when needed most.(1) Dr. Salkind also reported on work done in Russia, emphasizing the need to keep in mind that the mental ability is only one aspect of the total personality. He maintained that a fertile environment is necessary for the most fruitful development of gifted children.(2)

Whereas Terman's investigation of superior children was mainly concerned with the effect of physical and mental development on the social adjustment, Phyllis Blanchard has approached her study of children who were referred to the Philadelphia Child Guidance Clinic prior to 1930, with greater emphasis on the emotional aspects of the personality. She concluded that

> "While it is of the utmost importance, as Dr. Hollingworth has so well stated, that we recognize the special problems that confront the gifted child, by virtue of the somewhat isolated position created by his very superiority, we must not lose sight of the fact that he may also be subject to the same maladjustments as the child of lesser intellectual endowment. His superiority is no protection against the subtle affronts of emotional conditionings and emotional conflicts if he chances to be exposed to environmental situations that produce them."(3)

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(1) J. Germain, Proceedings of First International Congress on Mental Hygiene, p. 61.

(2) A.B. Salkind, Proceedings of First International Congress on Mental Hygiene, p. 61.

(3) P. Blanchard, Proceedings of the First International Congress on Mental Hygiene, p. 62.

The writer's interest in the subject of superior children was first awakened during a course in abnormal psychology, when the term "abnormal" was defined as including all those who did not fall within the range of the normal, the mentally superior as well as the inferior. Further curiosity regarding the difficulties of such people was aroused by the phrase "the loneliness of genius", and although the book in which it appeared and the author's name are now forgotten, the interest remains. It is not surprising that a period of training in a mental health clinic would revive that interest and awaken a desire to study the problems and ways in which a social worker may help gifted children.

The psychologists have studied superior children from an intellectual viewpoint, in terms of their mental, physical and personality development, and achievement. In so doing they have located the existence of problems, and Blanchard was able to detect the emotional basis for many of them. Social workers are interested in helping people to make the best use of their endowments so that they may be socially well adjusted and personally happy. Because the demands upon society of mentally retarded or deficient children are heavy, social workers have devoted a great deal of attention to their problems, but relatively little has been done by way of research on the problems of superior children. The most popular way of including them in a research project is by way of comparing them with groups of average or dull children.

One comparison of bright and dull negro children indicated that, although the behaviour of dull children was much more likely to be extroverted and aggressive, and that of the bright children more introverted and self-destructive, there was a degree of parental rejection in most of the cases studied. Conflicts with the parents, struggles against

vocational limitations and sensitivity to racial discrimination were felt to be the factors most influential in creating problems for bright children.(1) These findings are similar to those of Virginia Boston of the Pittsburgh Child Guidance Centre who compared a group of superior children who showed signs of fear with a group of average children with fear symptoms.(2)

One study was undertaken in which a group of superior children who were successful in all subjects at school was compared with a group of children of similar intelligence in the same school who were failing in more than one subject. As this was done before 1930 and prior to the time when the psychiatric concepts had been incorporated into social work practice as they are today, the factors considered were such things as the economic condition of the family, the family constellation, early feeding habits and training methods, religious influence and interest. Very little attention was given to the feelings of the children and their reactions to different emotional situations in the home, at school and elsewhere. Parental attitudes and teacher-pupil relationships were not considered as important as they are now. It was then found that there was almost as marked a prevalence of broken home conditions in the successful group as in the group of failures. Enuresis remained a problem for more of the successful children than it did for the failures, but temper tantrum behaviour had been overcome in twice as many cases among the former.

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(1) L.G. Stradford, "Problems of Bright and Dull Negro Children", Smith College Studies in Social Work, 1943, p. 241.

(2) M.V. Boston, "Some Factors Related to the Expression of Fear in a Group of Average and Superior Children", Smith College Studies in Social Work, 1939-40, p. 107.

While there were a few cases in the group of failures, in which fears had persisted for a number of years, there was none in the successful group. The author felt that there were other factors exerting a strong influence on the lives of these children to account for the difference in school performance, as there was nothing conclusive found in that study.(1)

Now that psychiatric concepts have penetrated social work thinking, case workers are more concerned with the feelings and anxieties which trouble their clients and make social adjustment difficult. The aims of this study are first, to explore the problems very superior children have in adjusting to their environment, and to discover what factors in their social relationships have a bearing on the way they relate to other people, and secondly, what can the social worker in a mental hygiene clinic do to help them with these problems. For purposes of this study "very superior" includes children with an I.Q. of 120 or over.

The first main question divides itself into various parts. As the child's behaviour in the home and his reactions to various family members are the earliest indications of his social development, his home adjustment is of first concern. An attempt is then made to find out the way these superior children get along in the classroom and with their schoolmates; what their attitudes are towards school, its discipline and demands, and if there is any relationship between the behaviour at home and that at school. To round out the information about social activities, information has been obtained about other interests or group participation wherever possible.

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(1) A.M. Conklin, "Families of Intellectually Gifted Students", The Family, June, 1930, pp. 99-106.

The second main question deals with the following aspects of the social worker's role. Some distinction has been made between the role of the worker in a social agency which uses the clinic services for consultation and direction, and that of the psychiatric social worker who is a member of the clinic team. Such questions as the following have been asked: How can the Institute best help the agencies left with the responsibility for carrying on social treatment of very superior children? How much responsibility should be carried by the psychiatric social worker, and how much left to the workers in other agencies? What is the most effective method of cooperation between psychologist, psychiatrist and social worker in planning and carrying out the treatment of very superior children within the clinic setting? As this study group is comprised of children who required help from the Mental Hygiene Institute, a brief description of its function and operating methods will be helpful.

The Mental Hygiene Institute in the City of Montreal is a community mental health organization operating for "the prevention and treatment of nervous and mental disorders, personality maladjustment, anti-social behaviour and delinquency".(1). Clinical services are directed mainly towards the diagnosis and treatment of mental and emotional disturbances in children and adolescents, but include similar services to a small number of adults who are having difficulty adapting themselves to work situation, family relationships and community life. A broad programme of mental health education for parents, teachers and the general public is a very important part of the Institute's activities. The Institute came into

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(1) Minutes of the Annual Report of M.H.I. for 1947, published in June, 1948, p. 1.

being a little over a quarter of a century ago as a result of the efforts of the Canadian National Committee for Mental Hygiene and a gift from the Rockefeller Institute. It now receives financial support from the Montreal Welfare Federation, the Federation of Catholic Charities, and a grant from the Federal Government given in accordance with the recent plan to improve health and welfare by means of annual grants to the provinces amounting to $30,000,000.(1)

Psychiatrists, psychologists, and social workers work together in the clinic setting to diagnose the child's problem and to plan a course of treatment. Not all problem children are referred to the Social Service Department, and very few cases in which the service requested is Mental Health Study or Vocational Guidance.(2) If the referring agency has prepared an adequate social history(3) the social worker may be called upon only to report back to that agency the findings of the psychological test and psychiatric examination. Sometimes this, too, is done by the psychiatrist. If further treatment has been decided upon, those cases which are not already known to the Social Service Department may be referred by the psychiatrist with a request for further social study and co-operation in working out an appropriate treatment plan. In a few cases the social worker has been asked to carry on therapy with the child under close supervision of the psychiatrist. Since the addition of two social workers to the clinic's Social Service Department in the fall of 1949 more ex-

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(1) Ibid, p. 8.

(2) See Chapter II for a description of these services.

(3) See Appendix B for sample of the Outline used in preparation of psychiatric social history.

tensive use has been made of the social services within the clinic.

One of the most important of these services is that rendered in the initial interview with the child's mother.[1] At this time, the agency function and policy is explained so that the mother may decide if the service of the Institute is that required. Information is obtained about the circumstances surrounding the pregnancy and birth of the child, subsequent development and growth, personality patterns and signs of emotional disturbances, and also about the meaning of the problem to the mother and to other members of the family. As the social worker is likely to continue to work with the mother while the child is being treated by the psychiatrist, the establishment of good rapport between the social worker and the mother is of primary importance. Several interviews with the mother may be necessary before the child is ready for examination.

Preparation of the child for psychological testing and for psychiatric examination is essential in order that he may approach these situations with as little apprehension as possible. It is the social worker's responsibility to help the mother assume responsibility for preparing her child for his first clinical experiences. When a good relationship has been established, the mother may discuss problems of her own as they relate to her feelings about the child and her handling of him. Thus the way is paved for a fuller understanding of both parent and child and the possibility of helping the mother in her relationship with the child.

Casework services to the parent must be geared to her ability to

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(1) In some cases a person other than the mother will bring the child to the clinic, but for ease of reference, "mother" has been used to indicate such a person.

use it. Treatment of the child is closely tied in with the parents' willingness to participate. The intelligence factor is important in both parent and child. For the gifted child the possibilities are great. This gives an added incentive to study the problems of very superior children and the ways in which social workers can best help them.

The initial plan of this study was to include all children between the ages of 2 years, 6 months, and 16 years, 9 months with an I.Q. of 120 or over, who were seen at the Mental Hygiene Institute during 1949. Only four per cent of the general population have an I.Q. as high as that.(1) As might be expected, therefore, the total number of cases who had been referred during 1949 did not include enough superior children to show any definite trends or insure validity of conclusions. The period had to be extended to include children seen during 1948 also. The group studied consists of very superior children(2) within the age limits mentioned above who were seen at Mental Hygiene Institute during 1948 and 1949. The lower age limit has been chosen as it is the approximate level at which a child begins to become socialized,(3) and the upper age level because people over sixteen are not normally given an intelligence test or accepted for treatment at the Institute.(4) Children referred for adoption study purposes were not included because of the special problems involved.

With such a large age range, differences in growth are marked.

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(1) Cattell, op. cit. p. 88.

(2) As defined above.

(3) Benjamin Spock, Baby and Child Care, p. 269.

(4) Minutes of the M.H.I. Annual Report for 1947, p. 1.

There are problems in the life of a child peculiar to the particular phase of his development which must be considered in a study of children's problems. The emotional development can be divided into three main stages, corresponding roughly with certain years of life.

It is during the period from birth to five or six years of age that the foundations of a personality structure are laid.(1) It is most important that the instinctual drives be modified, and that a healthy balance between the id, the superego and the ego be established.

By the age of six, the child has learned a good deal of self-control. He can postpone gratification of his needs, and he can find things to keep him interested for longer periods. It is during this latency period that positive identification with the parent of the same sex occurs.(2)

Puberty and adolescence are periods of reactivation of many instinctual drives which were quiescent during the latency phase. The physical changes which accompany this period of maturation in a child's life cause emotional disturbances which often result in conflicting feelings. Desires to cut loose from parental ties cause a great deal of difficulty, since our modern civilization prevents the adolescent from supporting himself and a family at the time he is physically ready to do so.(3)

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(1) English and Pearson, Common Neuroses of Children and Adults, p. 46.

(2) G. Hamilton, Psychotherapy in Child Guidance, New York, 1947, p. 211, 215.

(3) L. Hollingworth, The Psychology of the Adolescent, New York, 1928, p. 117.

Where possible these age differences have been taken into consideration in dealing with the problems of very superior children and their social adjustment.

Most of the material for the study has been collected from the records of the Mental Hygiene Institute. Records of the referring agencies have yielded valuable data to help fill in the gaps found in the Institute's own records. The agencies thus contributing are: The Family Welfare Association, The Children's Aid Society, The Protestant Foster Home Centre, The Juvenile Court, The Boys' Bureau of the Catholic Federation of Charities, The Girls' Counselling Centre, and the Social Service Department of the Royal Victoria Hospital. Supplementary information has been obtained by personal interviews with school principals, teachers, and social workers. Selection of the material has been guided by its relevance to the child's relationship with people at home, at school, and in other groups, and to the services rendered by the various agencies concerned.

The case-study method has been used to analyze the data collected, with tables being used to illustrate quantitative facts. The material has been organized into four main parts dealing with various aspects of the study.

The first section, Chapter II, is a presentation of the problems presented according to the age and sex distribution of the children.

The second section, Chapters III to V, inclusive, discusses the social adjustment of these children. Because the home is the first environment with which the child is acquainted, his relationship with various family members and his behaviour in the home has been discussed first. The

school is the next important addition to his daily routine, and the child's adjustment there has been considered next. Attention is given to the child's relationship with schoolmates, his behaviour in the classroom, and his academic achievement. Information about his outside activities and interests rounds out the picture of his social adjustment.

Chapter VI deals with the findings of the clinical team as related to the problems presented, the recommendations made, and how these were used. Some consideration is given to the role of the social worker in helping these children and their parents to a more satisfactory adjustment. In the final chapter the salient points presented earlier are drawn together in the form of findings and conclusions. A few recommendations have emerged from these.

CHAPTER II

THE PROBLEMS PRESENTED BY VERY SUPERIOR CHILDREN

The services of the Mental Hygiene Institute are not confined to those connected with personality maladjustment. They include such services as mental health study and vocational guidance. These will be discussed before the more serious personality problems which were apparent in behaviour disorders, neurotic symptoms and psychosomatic complaints.

Before we look at the problems presented by the very superior children seen at the Mental Hygiene Institute, a brief review of the psychoanalytic theory of the development of personality will help to show why social adjustment may be difficult for them.

A. The Development of Personality

Intelligence is but a part of personality, which includes all the inherited and acquired capacities of an individual. The emotional structure, of which anger, fear, rage, love and hate are component parts, also influences personality. A strong association between a dangerous experience of the past and some particular situation of the present might cause a child to feel afraid of a new experience. Intellectual understanding of the absurdity of the fear does not necessarily remove it. Intelligence has already been discussed.(1) The emotional level of personality is more dependent on experience than intelligence, and is part of the growth process.

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(1) See Chapter I.

During the pre-natal period the fetus has all its wants supplied without any effort on its part, and without much delay after the need becomes apparent. After birth, the infant is faced with a new situation. He is now a separate individual who has to depend on another person to supply his wants. That person is his mother, who remains very closely identified with him for the first year of life; so much so, that any discomfort which he feels will be attributed to her. His needs are not only physiological but psychological. He requires love and affection to nurture his emotional life just as much as he requires food to produce proper bodily growth.

The instinctual drives, which together provide a dynamic force within the individual are known as the id. In infancy the id is unorganized, undisciplined and uncontrolled. As the child grows, however, these instincts must be organized and controlled to conform with the social demands of the environment. While still dependent on others for gratification of all his needs, the young child has to learn to check these impulses, or be faced with the possibility of losing the source of supply from which he gains satisfaction of his needs, including his mother's love. This conflict between a desire to satisfy instinctual drives and a wish to be loved is present in every individual. The child who is loved and accepted suffers less from the conflict than the one who is insecure. The latter never has his wish for love gratified.

It is the task of every growing child to learn to control the id so that only those instincts which are pleasing to the mother may be expressed in reality. Either out of fear of the mother, or out of love for her, activities which displease her, such as soiling and masturbation, are controlled gradually. The screening process whereby certain instincts are

allowed expression, while others are forbidden, is at first carried on by the parents. Later these duties are taken over by the child himself through his superego, the censor of the id.

The superego is formed with help from the parents. The young child gradually incorporates the prohibitions which have been repeatedly made by his parents. As he develops, he can rely more and more on his own superego to prohibit expressions of the id which would not meet with the approval of society. If the id is too severely or too abruptly checked, however, the tension aroused by the instinctual drives is not sufficiently relieved, and may seek an outlet in other ways; in symptoms which are acceptable. When his need for protection and love is greater than his desire to satisfy his tension, the child will strive for the former and relinquish his attempts to gratify his libidinal needs. If the love and protection are not given, however, he may eventually give up striving for them, and devote all his attention to the satisfaction of other needs.

The sexual instinct also receives gratification through contact with the mother in the first few months of life. It is not until the age of two and a half or three that the child becomes aware of his father as another human being to be reckoned with; a competitor for the mother's love. The little boy realizes he is at a disadvantage because his father is much bigger and stronger, than he is, has body hair and a larger penis. Because he knows that his mother goes to bed with his father, he feels very inadequate and begins to wish his father out of the way. If he expresses these death wishes openly he will be in danger of losing his mother's love. In addition to this, he has found out that all children do not have a penis as he has, and he fears that if his death wishes

against the father become known he may be punished by losing this organ which he so greatly prizes. A similar conflict arises in the girl, who has to compete with her mother for the father's love, thus setting up death wishes against the mother. However, she cannot afford to let these be known, as she is also dependent on the mother.

Because the child loves as well as hates the parent of the opposite sex, the Oedipal conflict is normally worked through successfully by the time the psycho-sexual development reaches the latent period at the age of six or seven.(1) Understanding and loving parents, secure in their own relationships, are necessary to the satisfactory development of the personality through these early years.

The solution of the Oedipal conflict produces marked changes in the intra-psychic structure. The aggression, which was originally manifested as hatred of the parent, is redirected against the outside world where it is used to overcome physical discomforts, to master vocational and sexual rivals and to conquer objects which are harmful to life itself. As a safeguard against the aggression being again directed toward the parent, the restrictions, prohibitions and commands of the parent are incorporated into the superego.

Anything which interferes with this normal development tends to create unusual difficulty for the child. It may be the absence of a parent, which is most damaging when it reactivates earlier unsolved conflicts. This is illustrated in the case of D.R.

Born ten years after his parents marriage, D.R. spent

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(1) English and Pearson, op. cit. p. 44.

> most of his first two years with his mother, seeing very little of his father, who worked nights. The father then enlisted and was overseas for the next four or five years. During this time, the mother sought gratification of her own needs in the boy, letting him sleep with her, and being a constant companion to him. She took him to church and sunday school, watched for him returning from school, and was completely wrapped up in him. After the father's return, the boy had difficulty relating to him because the father drank quite heavily, and at such times, he was abusive of the boy and of his mother. Within a few months of his return, the mother died very suddenly on the street, at which time the boy showed no signs of emotional disturbance.
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> When he was sent to a foster home he was enuretic, very solemn and quiet, but otherwise well behaved. After the father re-married, the child was brought to live with the stepmother and her three year old daughter who was born after her mother's divorce. She was very guilty about the illegitimate pregnancy, and a very immature and insecure person herself. The stepmother found the boy's enuresis and encopresis very disgusting, and complained of his behaviour constantly. He developed habits of stealing, and on one occasion, the mother reported that she found him engaged in activities suggestive of sex play with her little girl.

The emotional trauma of the sudden loss of his over-protecting mother resulted in regression to earlier infantile days, when he was happy in his state of complete dependency which carried with it no responsibility for keeping clean. There had been no opportunity for a satisfactory solution of the oedipus complex because of the father's absence, and the conflict was renewed with the added emotional strain. There are other factors operating in this situation to hamper satisfactory personality development and adequate social adjustment, which will be discussed later.

Over-stimulation of the sex instinct can also interfere with the normal psycho-sexual development.

> A.S., a boy of 15 years, referred for Mental Health Study, reported that he had had heterosexual relations with different girls. He said he could not keep a girl friend because they would get fed up with him when he became too fresh with them, and drop him. His father had believed

> that he and his sister should bathe and dress together, which was the custom until the boy was seven years old. The father used to dress and undress in the presence of his children, and at the time of referral, he was having extra-marital relations with various women. Both children had been adopted, although the boy was not aware of the fact that his sister was an adopted child.

Attitudes of the parents, such as rejection, overprotection, or indulgence will also have an adverse effect on normal development, and these will be discussed more fully in Chapter III.

That superior children have problems of adjustment, as do average children, is apparent from a study of Tables I and II. Of the 898 new cases referred to Mental Hygiene Institute during 1948 and 1949,(1) twenty-five satisfied the requirements for this study, that is, in terms of age, superiority, and referral for other than adoption purposes. Almost half of them came for Mental Health Study and Vocational Guidance, but only four children did not have a symptom of a personality problem which became evident during the course of contact. The average number of problems per child in the first two age groups is almost double the average per child in the third age group, which seems to bear out the theory that superior children are better able to work out their problems in time.(2)

From an examination of Table I it will be seen that there was an equal number of boys and girls under six referred during this period, but over six, there were many more boys than girls attending the clinic. Why

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(1) Mental Hygiene Institute Annual Report for 1949, p. 4 and 5.

(2) Thom and Newell, "Hazards of the High I.Q." Mental Hygiene, January, 1945, p. 62.

TABLE I

REASONS FOR REFERRAL OF CHILDREN OF VERY SUPERIOR INTELLIGENCE (a)

ACCORDING TO AGE AND SEX DISTRIBUTION

Reasons for Referral	Total	Age in years at time of referral					
		2½-5		6-11		12-16	
		M	F	M	F	M	F
Total	25	4	4	9	2	4	2
Mental Health Study	6	2		2	1	1	
Vocational Guidance	5					3	2
Behaviour	4		2	2			
Poor Social Adjustment	1			1			
School Difficulty	1			1			
Enuresis	3		1	1	1		
Nervousness	1		1				
Physical Symptoms	2			2			
Speech	1	1					
Tics	1	1					

(a) Children with an I.Q. of 120 or over seen at Mental Hygiene Institute, Montreal, during 1948 and 1949.

Note: The first two categories of referrals do not imply personality problems.

The next three categories indicate aggressive behaviour.

The remaining four categories indicate neurotic symptoms of personality maladjustment.

this should be so is not evident from the material presented in this study, but raises certain questions which need further exploration. Do we need to be more alert to symptoms in girls which may be less noticeable because of their feminine characteristics? Is the difference peculiar to children of this study group, where more fathers than mothers were absent from the homes at the time of referral?

Table II indicates that superior children have difficulties of adjustment which are evident in many symptoms; behaviour, social maladjustment, and enuresis being the most frequent. School difficulties, stealing and lying also occur several times. Temper outbursts, fears, sleeping and eating difficulties are more common among the younger children.

B. Non-psychiatric Service Requested

As almost half the children came for Mental Health Study or Vocational Guidance, a brief summary of what is included in these services will be given before the different types of problems are discussed.

1. Mental Health Study. - Mental Health Study includes a psychological examination by the psychologist, and a psychiatric interview with the doctor, but not usually the services of a psychiatric social worker. In cases referred by another agency social histories are prepared according to the outline,[1] in which information is provided about early development and training of the child, later physical and emotional development, as well as social relationships and school progress. Self-referrals do not always have adequate social histories, as very often the informant is the mother, who cannot be truly objective without some help, because of

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(1) Appendix B.

TABLE II

DISTRIBUTION OF ALL PROBLEMS OF VERY SUPERIOR CHILDREN (a)

ACCORDING TO AGE AND SEX

Problem	Total	Age in years					
		2½ - 5		6 - 11		12 - 16	
		M	F	M	F	M	F
All Problems	65	11	12	23	4	7	8
M. H. S.	6	2		2	1	1	
Vocational Guidance	5					3	2
Behaviour	7	1	2	3	1		
Eating Difficulty	2		1	1			
Encopresis	2			2			
Jealousy	3		1	2			
Lying	3	1			1		1
Poor Social Adjustment	7			5		1	1
School Difficulty	5	1		3		1	
Stealing	4	1		1		1	1
Temper	3	1	2				
Truanting	2						2
Enuresis	6	1	1	2	1		1
Fears	2		2				
Nervousness	1		1				
Physical Complaints	2			2			
Sleeping Difficulty	3	1	2				
Speech	1	1					
Tics	1	1					

(a) Problems mentioned during the course of contact of twenty-five very superior children seen at the Mental Hygiene Institute, Montreal during 1948 and 1949.

her own involvement in the situation. Kriegman points out that the environment is a very important factor affecting the intelligence rating, and consists of physical, economic, and psychological components.(1) Unless all the factors are known, the intelligence rating cannot fulfil its function of helping adults to guide the child's activities along appropriate channels. The social worker can perform a very useful service in this respect, and should be used whenever possible to take the information for the social history, preparatory to the psychological test. The social history can then become a dynamic tool in the clinic process, instead of de-vitalized information, as was the case in one instance where the mother prepared the history in writing. Given an opportunity to talk with an understanding, helpful person, this mother might have gained considerable understanding of the importance of social relationships in a child's life, of the effect of her attitudes towards discipline and training, which would have promoted greater acceptance and ease.

When the mother complained to the psychiatrist that this child of 2.8 years enjoyed playing with children four years old or older, he interpreted this as the natural outcome of his superiority, and possibly did help to ease the mother's anxiety. However, further discussion of how his behaviour affected her or the other members of the family would probably have made better relationships in the family possible. The child's sullenness in approaching the test situation was an indication that case work services might have been very useful.

The fact that more than half the children referred for Mental

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(1) Kriegman and Hilgard, "Intelligence Level and Psychotherapy with Problem Children", American Journal of Orthopsychiatry, April, 1944, p. 257.

Health Study displayed symptoms of personality or social maladjustment is an indication of the need for a more intensive study of cases thus referred.

2. Vocational Guidance. - Vocational Guidance is another category in which the services of the psychiatric social worker are not usually employed. The tests given include intelligence tests, aptitude and special interests tests, and these are complemented by a psychiatric interview. In all the cases studied reports of the findings were sent back to the referring agencies, but the responsibility for helping these children to use the test results to best advantage was left with those agencies, with the exception of one case, in which a referral to the Social Service Department of the Institute was made. Grumer considers that the special skill needed to give vocational guidance requires specialization in a school of social work, or at least, that all counsellors be given a course in case work. This conviction arose from his definition of vocational guidance which implied that the individual must gain understanding of his own attitudes and abilities and emotional needs, as well as aptitudes, before he is able to plan adequately for the future.

In the case referred to the Social Service Department, the case work service given was found to be very useful in helping the mother clarify her own feelings regarding this boy, and in forming definite plans for her own, as well as her son's future. Given the opportunity of talking over the problem with the psychiatric social worker, this mother found relief from anxiety, whereupon she was in a better position to handle her problems and assist the boy in making a decision about further education. A brief account of her way of presenting her son's problems

will illustrate what may lie behind a request for Vocational Guidance or Mental Health Study.

> C.T., a boy of 15 years 8 months, was faced with the problem of deciding about going to work to help support his widowed mother, recently bereaved of her husband and means of support. The family had formerly been well-to-do, had travelled extensively, but had lost a great deal in the few years prior to the father's death. He had been a lawyer, but gave up his profession when he enlisted in the Air Force. The mother found herself left with no income, and saddled with a child who had ambitions to become a minister. The R.C.A.F. Benevolent Fund was making an effort to raise some money to help this boy, but it would be totally inadequate to carry him through college. Through the interview with the mother, the psychiatric social worker got a picture of the strained relationship between mother and son. The mother had been very depressed after the death of her husband, with suicidal ideas which had finally been overcome. The boy had worked part time to help out financially for the previous two years, while the family were in straightened circumstances. A shy, quiet lad of 6 feet 5 inches, he had few friends, preferred the company of older people, and did not engage in conversation freely. The mother complained that their conversation at home was like an old worn-out gramophone record, so that neither was much of a companion for the other.

The boy also talked with the social worker, who helped him to face his situation on a reality basis. He spoke casually of becoming a minister, but was astonished to learn in the interview with the psychologist that several years at college were required in preparation. The social worker was able to help him see the possibilities, but also face the obstacles to be overcome. The knowledge that there was someone to whom she could talk about her difficulties was enough support for the mother, who proceeded with plans which would enable them to live together and support themselves while the boy was receiving his education.

A further study of Tables I and II will indicate that although Mental Health Study and Vocational Guidance were given as the reason for referral of almost half the children in this study group, they represent only 17 per cent of the total number of problems, and that most

of the children so referred had signs of peronality maladjustment. To examine the various symptoms presented by these superior children, we shall first study the aggressive behaviour disorders and then look at the neurotic symptoms, and psychosomatic disorders.

C. The Problems Presented by Very Superior Children

1. Behaviour Disorders. - Kriegman and Hilgard maintain that there are two types of behaviour disorders; one where the child is "building up considerable repressed feelings", and the other where the child is "provocative, destructive, undisciplined, acting out hostilities in the form of delinquent behaviour".(1) These classifications have been observed by other authorities. Gordon Hamilton makes the distinction between the aggressive child whose behaviour is an expression of the hostility he feels because he has been deprived of love, and the child whose hostility is turned against himself, showing in symptom formation.(2) Children who are disagreeable, rebellious, defiant, quarrelsome and destructive at home are chronically aggressive in a different way than those who steal, commit anti-social acts, destroy property and commit truancy.(3) Inhibition of social activities and reduced capacity to use intellectual powers are indications of a personality maladjustment which may be just as disturbing to the child himself, though less troublesome to other people than the behaviour problem. The child with habit disorders has a greater need to punish himself than the child who acts in a manner which is more disturbing to others.

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(1) Ibid, p. 257.

(2) Hamilton, op. cit., p. 214.

(3) English and Pearson, op. cit., p. 139.

because of these things.

> His parents had recently been separated by the eviction of the father from the home; a court decision which resulted from the mother's reports of how the children were suffering because the father was continually quarrelling with them and was not interested in their welfare. The mother was a very domineering person, the masculine type whose demands for high performance were backed up by severe punishment in the face of failure to meet her standards. Because she identified this boy completely with her husband, even telling him he was just like his father, she unconsciously rejected him. She eased her guilty feelings by being over-protective of him at times. She wouldn't trust him to go to school alone lest he get run over by a car while crossing one of the busy streets.
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> When she brought the child to the clinic the mother reported that he was unmanageable, teased his younger brother, and fought with all the boys in the neighbourhood. He would not eat his dinner in the twenty minutes she allowed, and did not attend to his school work. He would day-dream rather than do his homework unless she stood over him. She knew he could do better, and he knew it also. She felt that he was naturally stubborn, defiant, and rebellious.

Another boy referred because of his behaviour had similar difficulties in his parent relationships, although caused by a different set of circumstances. He had been over-protected by his mother since he was one year old, when his father died. At the age of five she enrolled him in an educational institution, an act which was a great threat to a child who had had no father-figure to whom he could relate.

> At the time of referral P.F.'s mother was working as a stenographer in a distant city, where she had moved because she thought it might help her boy to get away from Montreal. No matter what she did to please him, everything was wrong and her fault, according to the boy's remarks. Gifts he had requested were deliberately thrown out when the mother brought them home. He would not get dressed in the mornings, and on these days, his mother would find him still in his pyjamas when she returned from work at noon. During the day he was enuretic and soiled himself, but this was controlled at night. When he did go to school he did the work all right, but was very unhappy with the other children. He had skipped one grade the previous time, as he had been forming lazy habits because the work was too easy for him. Since that time he had improved in his work, but he was not accepted by the other boys who bullied and teased him.

With over-indulgence and inconsistent handling this boy had not developed an adequate superego. The oedipal conflict had not been resolved, and identification with a father was impossible during latency. When puberty development aroused latent sexual instincts, he was ill equipped to handle his feelings. His hostility towards his mother was expressed openly, and at the same time, he regressed to infancy stage, being completely dependent on his mother.

b) Stealing. - English and Pearson believe that stealing can be regarded as aggressive behaviour which has been displaced.(1) The child who has been deprived of something he needs will take money, a symbol of love to satisfy his desire for affection. In this action he expressed his anger at being rejected or deprived by hurting the one who has been responsible. D.R., mentioned earlier,(2) was guilty of stealing from stores in the neighbourhood, but could not explain why he took the articles which were of little use to him. In all the cases of stealing reported in this group there was difficulty in the parent-child relationship, usually with the father.

> Although C.W., a lad of 16 years, had had a very happy childhood, his father had enlisted in the army and spent several years overseas while this boy was in the latency period. He had been a music teacher in the schools, and while he was away the mother had attempted to keep kind thoughts and ideals of their father uppermost in the minds of her children. Upon his return, however, the father did not want to live with his family, was drinking heavily, and was interested in another woman. The boy's parents later divorced, after a very unhappy, quarrelsome period of life together.
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> At sixteen years of age this boy had joined forces with a gang who became notorious for their stealing episodes. Although he

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(1) English and Pearson, op. cit. p. 150.

(2) Supra, p. 17 and 18.

himself had not been responsible, he was implicated in the shooting of a police officer. There seemed to be nothing in the very early life of this child to cause him to develop a delinquent personality. He had done very well in school, was active in many groups outside of school, and keenly interested in sports.

The probation officer who referred him for consultation and vocational guidance was impressed with the way he could reason things out, and the interest he showed in family life--a very direct expression of the true feelings of deprivation which were bothering this boy.

c) Truancy. - Truancy is a symptom of a desire to run away from an unpleasant experience, rather than an attack upon it. There may be factors in the school situation itself which are very unpleasant for the child, or the cause of truancy may be in the home. This is a healthier reaction to the conflicts than remaining in school preoccupied with day-dreaming and fantasy. In the group studied there were only two girls who truanted from school, both of whom were over twelve years of age, and had unhappy home situations. In each case, there was difficulty with relationships at home, and one of the girls had a great feeling of inferiority at school.

H.S, felt that the other girls did not like her because she was not Jewish as they were. Although she liked her teacher, she was having difficulty with her school work, and used to come late to class very often. On such occasions she felt that all the other children laughed at her when she came into the room, and she often preferred not to go at all. She would then attend a nearby show.

Her life had not been pleasant. The mother was of German descent, and the marriage had been a forced one, although the elder brother had died. The family lived with the father's mother and sister until a short time prior to referral, where there was a great deal of quarrelling and drinking.

The girl was still suffering from enuresis--a habit disorder which limited her activities and had made her camping experiences very unpleasant. She was a very close companion to her mother, but had few friends of her own age. She was referred for Vocational Guidance by the Girls' Counselling Centre, as she had expressed a desire to become a teacher, and the financial circumstances were not good.

The other girl was much better adjusted socially, as she had been quite popular at school until the year prior to referral, when her friends began to drop her because of her uncleanliness. She was working as a mother's help for her room and board, and was very unhappy at not being at home with her family.

d) Jealousy. - Jealousy is a natural outcome of a threat of loss of love when other children in the family receive a great deal of attention from the parents. It is especially noticeable at the time of the arrival of a new baby. Wise parents realize that a child cannot easily share his parents' love, and are careful to show their affection, particularly at a time when the new baby demands so much attention. If the child is loved, he does not need to repress the feelings of rivalry. Confident that he is loved, he does not need to fear what will happen if his hatred for the baby becomes known.

2. Neurotic Symptoms. - Gordon Hamilton distinguishes between the child with a behaviour problem, who acts out his aggression, and the neurotic child whose aggression is secondary to his fear of loss of love. She says:

> "The behaviour problem classically is more deprived than the neurotic child. Wary of love, because he has had so little of it, he fears relationship with anyone because it limits his aggressiveness--The behaviour problem boasts "I don't care if my mother does not love me", knowing that she does not--The psychoneurotic says, "I know my mother loves me, at least, I am sure she does, at least, I hope so". The behaviour problem says "no" to other people; the anxious child is forever saying "no" or "don't" to himself".(1)

a) Fears. - Besides the fear of loss of love or desertion by his parents, the anxious child may also fear mutilation or death. His anxiety

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(1) Hamilton, op. cit. p. 76.

appears when he feels increasing tension because some instinctual drive remains unrelieved, and at the same time, he fears that he may not have the opportunity of gratifying this instinct, or if he does, something terrible will happen to him.

Fears in young children usually represent conflict over parental relationships. A desire for love and a fear of losing the love because of the desires of the id are mingled together in the child's consciousness. Phobias related to animals, the dark, or insignificant things such as a piece of fluff, are prevalent in young children of three, four or five. These fears are more likely to be exaggerated and troublesome in a sensitive child who has become tense over feeding and training difficulties.(1) They may result from the psycho-sexual development of the oedipal phase as mentioned earlier.(2) It is common to find eating and sleeping disturbances in children who are afraid, for they fear that the undesirable thoughts and wishes which have been controlled during wakeful periods, may gain expression during the night when they are asleep and off guard. Such tensions cause adverse physiological changes in the muscles of the stomach, which then fail to function normally and prevent stomach contractions which produce hunger pangs.

> Although E.G., a little girl of 2 years, 8 months, was referred because of her behaviour, she had many signs of anxiety. She reacted to frustration by having temper tantrums, but much of her behaviour which was so annoying to the parents was the result of her fear of loss of love, and also fear of her death wishes for her mother. In this case, the mother did not understand why the girl should be so fond of her father, and increased the dangers of the oedipus complex by expressing her desire to have her husband to herself at least eight hours of

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(1) Spock, op. cit. p. 283.

(2) Supra, p. 17.

the day.

> The mother said that although the child would eventually fall asleep with great difficulty, she seemed to be waiting for the father's return, for as soon as he entered the door, she was awake and calling for him. She would waken many times during the night, and insisted that her father go to her. The parents were both worn out because of lack of sleep.
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> The child was afraid of the dark, of loud noises, of a flushing toilet, and would not eat unless fed by her mother. She had colic from birth, and from the start had refused to take more than one ounce of milk at each feeding, so the mother stopped breast feeding as soon as she was discharged from the hospital.

The mother's rejection was closely related to her own childhood, as she had felt jealous of her sister, and unappreciated by her parents who were very strict. Unpleasant experiences at birth also made acceptance of the child difficult for the mother. Prior to her marriage, the mother had been a school teacher for fifteen years, and recounted that she had always relied on strict authority to maintain discipline, whereas other teachers didn't have to do so. Previous to the patient's birth, the mother had had a miscarriage, and at the time of her pregnancy with this child, she had been very ill for four months. Birth had been difficult and painful.

b) Nervousness. - Nervousness is a term used by lay people to denote the presence of a personality maladjustment. It has little meaning of itself. The symptoms vary, and must be analyzed before a diagnosis can be made. There was only one girl referred because of her nerves, and her behaviour was very much like the other children of her age who had been referred as behaviour problems. The additional complaints of eczema and asthma, as well as a difference in the basic attitudes of the parents might account for the difference in classification by the mothers.

> It was felt that J.T.'s trouble was due to projection of the mother's own conflicts onto the little girl. The mother who

had married a Canadian soldier during his service overseas, had preceded him to Canada in the sixth month of her pregnancy. Unwelcomed by her in-laws, who had had their narcissistic ambitions for their son thwarted by his marriage, this mother was very unhappy living with them. The difference in religion and cultural backgrounds also made life difficult for her. The father was also very unhappy at the time of referral because of his work. When he obtained a more congenial position, and the mother understood how her own feelings were reflected in the child's behaviour, she modified her attitude, and the child's symptoms began to disappear.

c) Feeding difficulties. - A child under tension does not have a normal appetite. The tension may be caused by several things, any of the ones already mentioned. In infancy the child's identification with the mother causes him to feel tense and upset when the mother does. If this occurs during feeding, the feeding experience will not be as pleasant as it should be. Sucking needs are also gratified during feeding, and if there is interference with this process, the baby may express his dissatisfaction by biting, which only serves to increase the tension and arouse the mother's anger. Even if early feeding has been successful, children will later use this method of punishing their parents for things which prevent gratification of the id instincts. If the mother makes an issue of what the child eats, and how long he takes, there will be increased tension with resultant loss of appetite. Older children often revert to this form of behaviour as a method of punishing their parents when they feel rejected or deprived. They are starving for emotional satisfaction, and may either over-indulge and become greedy for food, especially sweets, or they may be unable to accept the food which is supplied by the one who denies the more important emotional sustenance, love.

d) Enuresis. -

Spock says the "commonest cause for enuresis seems to be the tenseness of various sorts in a child's feelings. This

apparently keeps his bladder small and irritable so that it will not hold much urine".(1)

A change of surroundings may make him feel somewhat homesick, causing his bladder to become tense. This seemed to be the case with the girl of 5 years, 11 months, who was an illegitimate child whose mother had just placed her in a foster home after she had been with relatives. Children who become overly excited with such experiences as birthday parties are apt to wet, but such lapses of control are not pathological. Regression to infantile habits is often noted in enuresis.(2) Weiss and English point out that frequency of urination may be used to punish oneself in that it leads to great inconvenience and the necessity of curtailing social life. Children and adults often capitalize in an aggressive way upon a necessity which cannot be refused.(3)

The problems of enuresis in children of this study were most indicative of personality maladjustment in the cases already cited.(4) Although K.G., a girl of 10 years, 7 months, was referred because of enuresis, this problem did not trouble either parent. The father was unconcerned, and the mother just laughed at it. The habit seemed to persist because of lack of sufficient training. The patient was reported to be happy, well adjusted in the home, and to have many friends.

3. Psychosomatic Symptoms. - All of the very superior children whose

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(1) Spock, op. cit. p. 408.

(2) Supra, p. 18.

(3) Weiss and English, Psychosomatic Medicine, Philadelphia, 1943, p. 360.

(4) Supra, p. 18, 26, and 28.

anxiety was expressed in psychosomatic disorders were boys, who had previously been examined by a physician who could find nothing wrong organically. One boy who had a severe case of dermatitis seemed to have a need to punish himself. His mother assumed an attitude of helplessness because of her belief that her son was very brilliant. She had, therefore, ceased to restrict or inhibit him. Weiss and English believe that

> "Skin conditions often express a great deal of repressed hostility in addition to having a sexual component, and the lesions may serve as a punishment for the hatred which they hold toward a parent".(1)

> This boy, M.K. 11 years old, had limited his social and recreational activities because he was very sensitive to the fact that other children avoided him because they believed the condition to be infectious. He refused to enter into gymnasium activities and sports where his arms and legs would be bare. He had started going to kindergarten at the age of three years, which might have given rise to feelings of rejection.

Another boy was referred because of his hoarse voice. He had not started school until the age of 7 years 3 months as his mother felt she needed to protect him because of his weak, physical condition. She unconsciously rejected him because her first-born child had been a stillborn baby. He was reported to be greedy at school parties, unkind to his sister, and very unhappy. The eating process may be used for gratification of pleasure cravings which should be satisfied in other ways.(2)

One very superior child of 5 years, 8 months of age, had been refusing to speak for several months prior to referral. He had been hospitalized at an early age because of trouble in the respiratory passage, and had had a convulsion prior to admission to the hospital. The child

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(1) Weiss and English, op. cit. p. 494.

(2) Ibid, p. 339.

had been through several unfortunate experiences which troubled the mother greatly. The mother was described as a neurotic person, overly concerned with her own health and that of the other children. The father had spent some time in a mental hospital. Although the mother said she welcomed pregnancy, she spoke of a very difficult time at childbirth. The child was also having severe night terrors and body twitching when he was asleep. Both this child and the boy with dermatitis had a parent who was epileptic, and the attacks were frightening to the children.

Allen believes that a tic serves as a shield against any true feelings of relationship.(1) The child with this symptom was the brother of D.K. mentioned earlier as a severe behaviour problem. Although the mother accepted this boy, he was continually fearful about losing that love, since his mother had put his father out of the home, and rejected his brother quite openly. As if to convince himself, he remarked in the clinic that his mother and everybody preferred him to his brother. He, too, had been hospitalized at a very early age, one and a half years, when an adenoidectomy was performed. He had to return for another operation on his adenoids and tonsils at the age of two, because he was having such great difficulty in breathing.

D. Summary

From the foregoing it appears that the largest number of children with personality problems is in the group between the ages of six and twelve years, and that most of them are boys. There is an equal number of boys and girls in the group of children under six, but no attempt has been

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(1) F.H. Allan, Psychotherapy with Children, W.W. Norton & Co., New York, 1942, pp. 311.

made to discover the reason why fewer girls than boys of the older age groups needed the help of the Institute.

There was no evidence of thumb-sucking and nail-biting in this group of twenty-five very superior children; two habits which are common among the complaints of average children. Although there were two reports of over-stimulation of the sex instincts, there were no complaints of the sex perversions found in children, such as peeping, exhibitionism, cruelty, masturbation, or homosexuality. Very superior children have emotional problems which are apparent in a diversity of symptoms, however. Fears, temper tantrums, eating and sleeping difficulties were frequent complaints of the very young children. None of the girls suffered from psychosomatic disorders, yet the only two cases of truancy which were reported were of girls in the oldest age group. These are observations from the material collected in twenty-five cases only, so that even tentative generalizations cannot be made from such a small sample, which yields so few examples of each disorder.

The socio-economic condition of the family was a more important factor in the lives of the adolescent children than in children of the other two age groups. A very superior child, who has the ability and ambition to proceed with higher education, is limited in his choice of an occupation if the financial circumstances of the family place on him a responsibility for helping to swell the family budget.

Parental attitudes and home situations have a marked influence on the social adjustment and the emotional development of very superior children as well as on normal children. Difficulties arising out of father-child relationships were present in the lives of each child showing

signs of personality maladjustment. The absence of a large number of problems in children of the older age group seems to agree with the theory that superior children are less likely to retain their problems than normal children.(1)

The home is the environment in which the child gains experience with social relations, and in order to understand those factors which influence his home adjustment, the next chapter deals with the home environment and family relationships.

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(1) Hollingworth, op. cit. p. 60.

CHAPTER III

THE VERY SUPERIOR CHILD'S ADJUSTMENT IN THE HOME

A child's home life is dependent on the kind of home he lives in, and the other people living there as well as his own ability to adjust to this kind of social living. In discussing the home adjustment of very superior children, we shall first look at some generalizations about the influence of the home on personality development. The economic condition of the families of the children studied will be reviewed next. The family constellation and parental attitudes will then be considered before an attempt is made to evaluate the home adjustment of these very superior children.

A. General Considerations

Whether a good environment or a rich mental endowment is the greatest asset in a child's life has long been a subject for debate. The intelligence scale has proved a very useful guide to a better understanding of mental capacity, but measuring social maturity is more difficult because emotional responses are more dependent on environmental factors than are intellectual responses. Dr. A.E. Doll has worked out a scale for measuring the social quotient in a manner similar to that used for the intelligence quotient, except that the information about the child's social development is given by one who has observed repeated responses to specific situations.(1) Because this cannot be controlled

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(1) Lurie, Newburger, et al, "Intelligence Quotient and Social Quotient", American Journal of Orthopsychiatry, January, 1941, p. 112.

as a test situation can, the reliability of the social quotient is doubtful. With improvements, it too, may become very useful in judging a person's ability to meet social demands. At present we can make use of our observations of children with similar intelligence in respect to their reactions to different environmental situations.

The slogan "give to receive", may well be applied to the home situation where parents are rearing children. Kind, loving parents who give an abundance of love and affection to their children will reap rewards when they mature into well-adjusted adults. For the first five or six years of life, the home is the child's chief environment, and plays an active part in moulding the character and establishing certain patterns of behaviour which form personality. A highly intelligent mind, cultivated by a healthy environment, has the potentiality of making a great contribution to society, as well as providing happiness and security for the possessor. But who can say what damage may be done by unhealthy surroundings?

A child's adjustment in the home depends on many things. There is very likely to be some difficulty with the child of low intelligence. More demands are made on the parents by reason of the fact that such a child cannot do certain things, and he requires more supervision than does the average child. In the home adjustment of very superior children, the difficulties, which can be attributed to the intelligence factor, are usually those which result from his intelligence being at variance with that of other members of the family. There were a few cases in this study where this was known to have been an obstacle to good home adjustment. For the most part, however, the intelligence of the different family members is not known.

Besides the intelligence, such things as economic condition of the family, family constellation, cultural conflicts and relationships with siblings, exert an influence on the child's adjustment, directly or indirectly. Parental attitudes, however, seem to the writer to be the most important factor.

B. The Economic Condition of the Family

Parents, who have sufficient income to provide adequately for their children's needs, are less likely to become anxious over financial problems than are those who do not know where the next meal is coming from. As the Institute's services are planned for those who cannot afford the fees of a private psychiatrist, none of the children in this study came from homes where the income could be considered high, but there were children representing three other income groups. From an examination of Table III it can be seen that only three out of twenty-five children came from homes where the income was insufficient to provide necessary maintenance and was being supplemented by assistance from a family agency. For the most part, physical conditions of the home were average, which indicates that neither crowded conditions nor financial difficulties can be considered an important factor in the social adjustment of superior children. This agrees with Conklin's studies which have been mentioned earlier.(1)

The most important observation is that all children who desired vocational guidance were from dependent or marginal income families, who were unable to provide more than the bare necessities of life. The choice of a career for such children seems to be somewhat limited to making the

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(1) Supra, p. 6.

TABLE III

PRESENTING PROBLEMS OF CHILDREN WITH VERY SUPERIOR INTELLIGENCE (a)

ACCORDING TO ECONOMIC CONDITION OF FAMILY (b)

Presenting Problem	Total	Economic Condition		
		Dependent	Marginal	Adequate
All Problems	25	3	11	11
Mental Health Study	6		3	3
Vocational Guidance	5	1	4	
Behaviour	4		2	2
Poor Social Adjustment	1			1
School Difficulties	1			1
Enuresis	3			3
Nervousness	1		1	
Physical Complaints	2	1		1
Speech	1	1		
Tic	1		1	

(a) I.Q. of 120 or over.

(b) "Dependent" means income has to be supplemented.
"Marginal" means income sufficient for bare necessities.
"Adequate" means income sufficient to provide extras.

best possible choice from a group of vocations which do not require too costly training. Although there are scholarships available to worthy students, these are often inadequate for the needs of a child who feels he should be helping to swell the family budget, and in any case such scholarships are too few in this country to benefit more than a very limited number of people.

C. Family Constellation

1. Ordinal Position of the Child. - Although many studies take into account the ordinal position of the child included in the study group, the findings of this study indicate that this is important only as it affects the parental attitudes or the possessive feelings of the child. For example, there is great danger of parental rejection when a child's birth follows a miscarriage, as was the case with E.G. cited earlier.(1) The first-born child may have difficulty sharing his parents with a new-born sibling.(2) Provided parents do not become worried over financial problems, large families create no greater difficulty in social adjustment than do smaller ones. Indeed there may be some value in the group pressure which is found in larger families. On the other hand the only child has to depend more on outside groups for this pressure than the child in a large family who learns to share and take some family responsibility.

2. Absence of a Parent From the Home. - The importance of both parents in a child's development during the oedipal phase has been discussed.(3) After the child has solved the oedipal complex he is ready

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(1) Supra, p. 30 and 31.

(2) Supra, p. 29.

(3) See Chapter II, p. 16 and 17.

to identify with the parent of the same sex. The absence of that parent may disrupt the normal process of emotional growth. Normal development may take place in both the oedipal and phallic phases if there is a substitute parent. For example, when an uncle visits the home regularly in the father's absence, he may serve as the object for the child's affections. Although the importance of a mother figure has long been recognized, the child's need of a father for satisfactory emotional development is not yet universally accepted. Perhaps this is why some of the cases studied had little information about the father's relationship with the child.

Eleven of the twenty-five children studied were in homes where the father had been absent at one time or another. This seemed to affect the children adversely in direct proportion to the degree of disturbance it created for the mother, and in direct proportion to the relationships which had previously been established between parents and child. One example will illustrate such a situation:

> D.V.'s father had been in a mental hospital for some time prior to referral, during which time it had been necessary for the family to seek financial help. The mother was genuinely attached to her husband and the children. She was a very understanding and mature person who continued to regard her husband as head of the house, and to maintain close contact with him during his period of hospitalization, and she helped the children to do the same. Both parents had always been loving and affectionate with their children. The boy who came to the Institute for vocational guidance, was doing excellent work in school at that time, was well-liked by all who knew him, was active in many organizations and student groups, and got along well at home.

On the other hand, J.T., a girl of approximately the same age who also came for vocational guidance, was having more difficulty in her relationships both at home and at school.

> Her mother was reported to be basically loving, but she had little understanding of the girl and her needs. The father had been alcoholic before his hospitalization, and there was a history of marital discord and quarrelling while he was in the

home. J. had shown signs of leadership until the previous year, when she lost many friends, became careless in her appearance, and began to fall behind in her school work. Sometimes she remained away all day without her mother's knowledge.

There are many problems facing a motherless child, but as there was no instance in this group of a child left without a mother, they will not be discussed here. There were three children who had been placed for foster home care, but in every case the mother continued to visit regularly. It was found that where the mother-child relationships had been based on love and affection, the children seemed little affected by placement; they continued to feel secure in the relationship with their mothers, and they adjusted well in the foster homes. Where the child had not enjoyed such security, he was more upset, he was continually bidding for attention and he had great difficulty in sharing adults with other children.

3. Cultural Conflicts. - When different cultural habits and customs are mixed in the parents, it not only creates difficulty for them, but the anxiety and tension is likely to be projected onto the child, as in the case of J.T.

> J.T.'s mother was an English war bride who married a Jewish Canadian soldier. When she came to live with her in-laws in Canada, she found herself in a community of people with Jewish customs and adhering to the Hebrew Faith. She found adjustment in a new country even more difficult than one whose cultural background was the same as the people of the adopted country. Evidence of this was the fact that most of the conversation with the social worker throughout the contact centred around this problem. It was felt at the clinic that the child was not a serious personality problem, but was suffering because of the mother's anxiety.

4. Relationship to Siblings. - Sibling rivalry is the most common reason why children in the same families do not get along together. That

love and hate are closely interwoven is indisputable, and as in the cases of parents, the mixture of these feelings for siblings causes some conflict and emotional disturbance in the life of a child. For this reason, we say that feelings of jealousy are normal. When they become exaggerated, however, they become harmful. Exaggerated feelings of jealousy are fostered by rejecting parents, or by parents who are ignorant of the indications of such feelings, which are sometimes thought to be expressions of unusual love for the baby. In either case, the parents may be helped to understand the situation and change their attitudes if necessary. Jealousy was apparent in several of the children studied here, but in every case, there was an indication that the child was doubtful about the parents' affection for him.

In all these things it can be seen that the child's reactions to various situations depends to a large extent upon the parents' attitudes. As Anna Freud found in her work with children who were evacuated from London areas during the blitz, the children reflected very closely the feelings of their mothers about the bombings, but otherwise they seemed to be little affected by such harrowing conditions.(1)

D. Parental Attitudes

Leo Kanner maintains that although attitudes are too complex and their manifestations too variable to lend themselves to accurate measurements, there are general trends which give clues as to whether they are healthy, unhealthy or malignant.(2) Exposed to unwholesome attitudes the

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(1) Freud and Burlington, "War and Children", New York, 1943.

(2) L. Kanner, Child Psychiatry, p. 118.

the child must adjust to his situation by changing the balance of the forces within his psyche. Changes in the ego and superego which follow interfere with successful social adjustment.(1)

1. Sexual Over-stimulation by Parent. - When a parent of the opposite sex fondles a child excessively, expresses love in many little ways perceptible to the keen discernment of the child alone, over-stimulation of sexual desires is likely to result. The daughter who is thus treated by a very fond father continues to hope in vain for gratification, but cannot break loose from these ties for fear of losing the chance of having her wishes fulfilled. Normal relations with people of the opposite sex become well nigh impossible in such a situation, as is demonstrated in the boy who remains faithful throughout life to a mother who chose him as the object of her love, rather than her husband.

2. Severely Strict or Demanding Parents. - If the parent's attitudes are too strict and severe, if he is continually demanding better behaviour, normal expression of hostility and aggression are repressed by the child, either because he fears the punishment he might receive or has already experienced. One boy who continued to get along well at home but expressed his aggression against others in the community, was reacting this way because of too strict parents.

3. Weak Fathers. - Gordon Hamilton maintains that the "unwise, harsh, weak or indifferent father contributes to the failures of the phallic period what the rejecting mother does to the little child".(2) The mascu-

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(1) English and Pearson, op. cit., p. 58.

(2) Hamilton, op. cit., p. 215.

line characteristics of the boy make him naturally more aggressive than the girl, but if the father's personality is largely feminine, the process of identification which occurs during the latency period becomes increasingly difficult, and emotional growth is impeded. One boy who was referred for Mental Health Study because of his poor work at school was thought to be following in his father's footsteps.

> Although I.M.'s mother said that previous school teachers believed the boy to be socialized beyond his years, the principal who talked with the writer in a follow-up interview disagreed with this, saying that the boy didn't fit in with the rest of the group at all. He seemed to be lacking in ambition, unable to attend to his work, and causing great concern to the teacher. The principal felt that his trouble was largely due to the fact that the mother was the ambitious one, and the father seemed content to let her assume more of the responsibility both for the household and for managing the children. This mother was a successful career woman, who spent most of the time at business. The father had a much more modest role as proprietor of a small business which took a great deal of his time, but netted little returns for such time-consuming effort.

4. Parental Attitudes Towards Punishment. - The effects of punishment are so closely tied up with the feelings of the administrator and the recipient that information obtained about parental attitudes to punishment has been used mainly as an indication of the parent-child relationships. Punishment can only be useful insofar as it is corrective, and if the child, especially one who is already rejected, regards the punishment as an indication of withdrawal of love, he will be more severely damaged than helped by it. Hollingworth's theory that discipline becomes difficult when the child's intelligence is superior to that of the parents[1] is supported by evidence in several cases of this study, mostly those of younger children.

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(1) L. Hollingworth, op. cit., p. 56.

> One mother complained that discipline was difficult because her little girl of 2.8 years would often say when she had done something wrong, "Now don't be nasty, be nice mummy". A method of punishment which was effective at one time was useless another.

There are factors related to punishment which affect its usefulness, such as the release of emotional tension for the administrator, whether the punishment was deserved or not, and the aim behind it. The aim of discipline is to help the child form an adequate superego, and there is some controversy about its value as a growth stimulant. If it is to be effective at all, care must be taken that the child does not feel unloved or rejected because of his misdeeds.

Insisting that the punishment meted out was just what was desired seems to be not only a defence for the child's own ego, but acts as a reversal of the punishment, and has been used in two or three of these cases. It can also be an effective way of avoiding further punishment, for the parents may give up attempts if they become discouraged with the results. Such things were evident in several instances with these superior children, and seem to be directly connected with high intelligence. In one case the mother assumed an attitude of complete helplessness because she said "What can I do with such a brilliant boy?".

5. Rejection. - Rejection is the most devastating and ruinous of all parental attitudes. While there is no absolute form of rejection, there are degrees which vary from overt neglect and hostility to overprotection. Kanner expresses the belief that rejection may be distinguished by three main types of behaviour; overt hostility and neglect, perfectionism, and compensatory overprotection.(1)

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(1) Kanner, op. cit., p. 118.

There are few parents who admit that they hate their children, that they never did want them, and do not desire to be bothered with them. Parents who leave their children are running away from responsibilities too great to carry. Those who remain to inflict cruelty or emotional starvation do so because of unconscious motives which are not easily recognized. There are cases in which the mother herself was deprived in childhood, so that she is not emotionally mature enough to nurture her children. The woman who has had a successful career may find the marriage disappointing, and foster ideas of returning to business at the earliest opportunity. If pregnancy interrupts her desires, the baby may be very unwelcome. A mother still suffering from the loss of a baby in childbirth or early infancy may not have recovered sufficiently by the time she again becomes pregnant. This was evident in the case of E.G.; described earlier.(1)

The most common indications of maternal rejection are a history of difficult pregnancy, and birth, a confession that the child was unplanned, and statements that the child does not seem to be like the mother's family, or possesses all the undesirable qualities inherited from the family tree.

If there are strained marital relations, a parent may hopefully look to the baby to improve the situation and restore satisfactions previously enjoyed in marriage. When this does not work out, the care of the child becomes an added burden.

a) Neglect. - Because society does not condone the neglectful or overtly hostile parent, it is easy to cope with this situation and often possible to remove children from such an environment. Where the rejection

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(1) Supra, p. 30 and 31.

is cloaked in the guise of perfectionism or overprotection, however, it is more difficult to persuade the public that the children are being severely damaged, and in most cases it is impossible to provide a more wholesome environment unless and until the parents' attitudes can be changed. Suggestion of removal meets with strong opposition because the defences, which have protected the parent from pressure of the guilt aroused by his true feelings, are now broken down.

b) Perfectionism and overprotection. - Perfectionistic parents are likewise rejecting parents. They cannot bear to face the reality situation; hence they rationalize that they will be able to love the child more when he has additional attributes which are lovable. Efforts are then aimed at making him over into a more perfect child.

An overprotecting parent is usually attempting to suppress his own feelings of aggression. Because he feels guilty about hostile feelings towards his child, he attempts to appease his conscience by being overly careful of the child, persuading himself that he cannot possibly hate the child when he is willing to sacrifice and do so much for him, and to devote a great deal of time and interest in his welfare. A.A.'s experience is an example.

> The father was a very sympathetic husband who used to take over many of the household duties because of the mother's illness, which was of a neurotic nature. When the boy expressed a desire to join the YMCA and go swimming regularly, the father refused on the grounds that he was afraid some harm might befall the boy, and that he didn't trust the friend who was going to take him.

There is a form of overprotection which is non-rejecting; that is, where the parent finds many hopes fulfilled in the birth of the baby. Fearing he might lose the child, he guards against that possibility by be-

coming over-careful and protective. This is especially true when a mother has waited several years after marriage for her first child. Such seemed to be the case with D.R.'s own mother, who had waited ten years after marriage before he was born. In addition to this, her husband's departure for overseas was an added challenge to her to be sure the baby was well taken care of while his father was away.(1)

E. Evaluation of the Home Adjustment of Very Superior Children

A child's adjustment in the home has been considered in the light of his behaviour and activities there. The various personality traits have been listed as desirable and undesirable according as they assisted or hindered the child's ability to get along with other members of the family.(2) Adjustment in the home is considered to be good if the child has a predominance of desirable personality traits, and poor if he has more of the undesirable ones. Applying this scale to all the children, it was found that thirteen of the twenty-five children were well adjusted and twelve were poorly adjusted in the home.

In every case of rejection by the mother the child was poorly adjusted in the home. In many of these jealousy and sibling rivalry were present, and in two instances the rejection was disguised in overprotection. There was but one instance of non-rejective overprotection, in which case the child adjusted to the family very well.

As mentioned earlier, almost half of the cases studied had histories of fathers who were absent at one time or another. The effects of

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(1) See history of D.R., Supra, p. 17 and 18.

(2) See Appendix C for personality scale.

such absences are related to the age of the child and the mother's attitudes during that time. It was found that in all cases where the mother maintained a warm, affectionate attitude towards the child, the home adjustment was good. Where the child did not feel secure in his mother's love, and where the mother herself was disturbed by the father's absence, the home adjustment was poor.

It can be seen, then, that according to this study economic conditions, ordinal position and cultural conflicts do not influence the superior child's social adjustment to the same extent as the absence of a parent, or parental attitudes do. A wholesome parental attitude is one which aids normal psycho-sexual and emotional growth, it consists of a genuine fondness for the child, unhampered by the need to seek satisfactions in the parent-child relationship which would normally be obtained elsewhere. For the best social adjustment, predominantly wholesome attitudes, and parents who possess characteristics which are predominantly in agreement with their sex are essentials. Unwholesome attitudes are the worst barrier to the superior child's social adjustment in the home.

Whether the things which hamper his home adjustment have a similar effect on school adjustment requires further study. As school occupies a great deal of the growing child's time, and as it implies a certain authority and control which is similar to that found in the home, this will be considered in the next chapter.

CHAPTER IV

SCHOOL ADJUSTMENT

Superior children may have difficulty in adjusting to the demands of school by reason of their superiority. We shall first consider some of the reasons for this, and then discuss the work done in school by the children in this study group, the way they related to schoolmates, and the relationship between home adjustment and school adjustment.

A. School Difficulties

1. In General. - Attending school for the first time is a new situation which is approached with varied feelings, depending on past experiences. In the words of Marion Kenworthy

> "The wide range of response possibilities found in children suggests how completely the child brings to new situations feeling tones that are the product of all the experiences through which he has lived."(1)

If the child is an outgoing, adventurous type of person, secure in the relationships he has already established with those in the home circle, he is likely to bring a natural curiosity and eagerness to explore what actually happens in school. Parents can do much to foster this attitude by careful preparation of the child for his first school experience. Reports from other children about school and the teachers will also affect him at this time, as preconceived ideas of school may not be in accord with reality, or may be strengthened by the initial ex-

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(1) M.E. Kenworthy, "Social Maladjustment (Emotional) in the Intellectually Normal", Mental Hygiene, Oct. 1930, p. 850.

perience in the classroom. The child may expect reactions from the teacher similar to those of his mother or father, and either be disappointed or relieved if they are not. The personality of the teacher is a very important factor in school adjustment. For the child coming from an unhappy home environment where he is under constant pressure and emotional strain, a severe, strict, disciplinarian type of teacher would only exaggerate these unhappy feelings. A kind, sympathetic, understanding teacher who shows some tenderness for him would do much to alleviate his distress. The child who is well adjusted at home may approach the school experience with greater ease, thus helping to establish a good relationship with the teacher on first acquaintance. This may not be quite as easy if the teacher's manner seems somewhat formidable, but should not prove as difficult as for the child already used to unsatisfactory reactions from the people around him.

2. Of Superiority. - For the superior child there are special difficulties which may face him. Held to the pace of the average child, he may find the work too easy to call forth much effort on his part, and revert to habits which provide amusement for him, but annoy the rest of the class and the teacher. He may engage in day-dreaming, or fantastic plans which are the products of a keen imagination. He may turn his efforts to more constructive usee such as reading literature not assigned, but in the classroom this requires an understanding teacher who can accept such behaviour quietly, helping the other children to do the same.

If he is in a class which challenges his mental abilities, he may have greater difficulty adjusting to his schoolmates because of being smaller, younger, or less mature emotionally. The degree of difficulty

that this creates for him will depend on the amount of variance between his mental development and that of his physical, emotional and social development. As the school policy for the Province of Quebec (as in most other provinces of the Dominion) is to promote a child at the end of the school year only, provided the work has been satisfactory, the greatest difficulty for the children studied resulted from a difference between mental and social maturity, or because the school work was not challenging enough.

The writer found that the information about school to be found in the records was not always sufficient for purposes of this study, and conducted follow-up interviews with principals or school teachers if the principal was not familiar with the child concerned.

B. School Achievement

Table IV indicates the grade placement of these children. Of the twenty children who had been or were attending school at the time of referral, three were in kindergarten, and under the age of six.(1) Twelve of the twenty were doing good work, with five of them ranking among the highest in the class, and being considered one of the best pupils. This 60 per cent varies slightly with the findings of Phyllis Blanchard, who found in a study of children treated at the Philadelphia Child Guidance Clinic that

> "Of sixty cases of gifted children studied and treated by the clinic only a small number showed any difficulty with their school work. Four of them were failing, however, and six were

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(1) Two boys desiring Vocational Guidance were not attending school at time of referral, but have been included as information about their school adjustment was readily available.

TABLE IV

RELATIONSHIP BETWEEN PRESENTING PROBLEMS OF VERY SUPERIOR CHILDREN (a) AND SCHOOL ACHIEVEMENT (b)

Presenting Problem	Total	School Achievement		
		Backward	Satisfactory	Advanced
All Problems	20	5	14	1
Behaviour	2		1	1
Enuresis	3	1	2	
Mental Health Study	5	1	4	
Physical Complaints	2	1	1	
School Difficulties	1		1	
Social Maladjustment	1		1	
Speech	1		1	
Vocational Guidance	5	2	3	

(a) Children with an I.Q. of 120 or over seen at Mental Hygiene Institute, Montreal, during 1948 and 1949.

(b) "Satisfactory school achievement" means that grade placement is equal to that of the average child in the classroom, using Grade I as the placement for six-year-olds, with advancement at the rate of one grade per school year.

> doing poor work in school. Thirty-six of the children had always obtained high marks, and nine were much accelerated in grade placement",(1)

showing a total of 83 per cent doing well in school. The ratio of those getting top marks is also different, 1:4 in this study as against 3:5 in Miss Blanchard's study.

Using six years as the standard age for Grade I placement, and the normal rate of progress as one grade every school year, only one child in this study was found to be advanced in placement according to his chronological age:(2) five were in grades below the average, and fourteen were in the same grade as the majority of children of the same age. All were retarded in placement according to their mental age; i.e., were in grades where the work was not challenging their full capacities.

C. Relationship Between Problems and School Work

1. In Good Students. - All children suffering from enuresis were getting along well in school, as were three children referred for Mental Health Study and four coming for Vocational Guidance. The young boy refusing to speak was considered to be one of the best students in the class, although this habit was irritating to the teacher who felt, however, that he was too advanced for kindergarten. One boy was in a Jewish School where the curriculum was heavy, containing courses in Hebrew history, language and religious education.

> The principal felt that he compared favourably with many other children in the school, but that he was not outstanding in achievement, and that this was possibly due to the fact that

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(1) P. Blanchard, Proceedings of First International Congress on Mental Hygiene, p. 63.

(2) See Table IV, p. 54 A.

> many pupils were of superior intelligence, or they would not have remained in that school.

That disturbed children will sometimes seek to compensate for their deprivations by turning their efforts towards intellectual pursuits seems indicated in the history of D.R., the enuretic boy who was living with his stepmother.(1)

> D.R. did very good work in school, although he was one grade behind the average child of his age. He seemed to like school, and got along well there, though he was not very well liked by the other children. The principal felt that school was a great relief for this boy who suffered so much at home.

2. <u>In Poor Students</u>. - Among the complaints about those children doing poorly in school were the behaviour problems, social maladjustment, school difficulty and the physical symptom of hoarseness. The school reports of two children referred for Mental Health Study were not satisfactory and formed the basis for the request to have them tested. The importance of a good teacher-pupil relationship is illustrated in the following case.

> Although A.A., the boy with the hoarse voice, was reported to be doing very poor work in school, the previous teacher had given an excellent report of him, and claimed his work was very satisfactory. The principal felt that this second teacher had very high standards, and gave high marks very sparingly. He said that he was not at all concerned with this boy, and was sure he would pass.

There was one other instance of a change in performance with a change in teachers, the little boy improving in all respects when he passed from kindergarten to Grade I. Besides the influence of the teacher-pupil relationship, poor school work may be due to the result of a poor attitude and general dislike for the school experience. It may be on

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(1) Supra, p. 17 and 18.

account of a dislike for rigid discipline anywhere, or because of attitudes which have already been established as a result of previous experience.

To understand further why some children of superior intelligence do good work in school, and some do very poor work, the relationship between school behaviour and achievement has been examined.

3. Behaviour of Good Students. - Table V gives the behaviour traits of children doing well in school as related to the problems presented at the time of referral.(1) From an examination of this table it will be seen that of all children who were reported as behaving well and causing no trouble in the classroom, none of these was aggressive, careless or wasted time. For all twelve children there was but one complaint of each of the following characteristics: inattentiveness, restlessness, or inability to apply oneself to the work given.

Although the teacher in kindergarten was very upset by the silence of R.H. the teacher in Grade I accepted it very wisely. In the follow-up interview she said she had not urged him to participate in reading or activities which required him to talk, but was pleased with the progress he was beginning to make.

The attitudes of the teachers in this case seemed to be extremely important for this child, and difference could be easily detected by the writer during the separate interviews with each of them.

> The kindergarten teacher found his silence very annoying and irksome. Throughout the year he remained silent, although

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(1) See Table V, p. 57 A.

TABLE V

RELATIONSHIP BETWEEN BEHAVIOUR TRAITS AND PRESENTING PROBLEMS OF VERY SUPERIOR CHILDREN (a)

DOING GOOD WORK IN SCHOOL

Behaviour Traits	Total	Presenting Problems				
		Enuresis	M.H.S.	Physical Complaint	Speech	Vocational Guidance
All Traits	26	5	6	2	3	10
Acceptable	12	3	3	1	1	4
Attentive	4	2	2			
Aggressive	0					
Ambitious	3					3
Careless	0					
Diligent	3		1			2
Does Not Apply Self	1			1		
Inattentive	1				1	
Restless	1					1
Quiet	1				1	
Wasted Time	0					

(a) Children with an I.Q. of 120 or over seen at Mental Hygiene Institute during 1948 and 1949.

he had begun to speak shortly before he was taken ill and had to remain in the hospital and at home for several weeks. When he passed into Grade I, the teacher ignored his silence, trying to encourage him to feel that he belonged to the group. At the time of the follow-up interview he was beginning to talk more freely, had become very friendly with one little boy, and was joining in play with others, whereas before he used to sit in a corner by himself.

Three of the children in this group at the age of ten years were in the habit of reading heavy literature in their spare time, such as biographies of great leaders, histories and dramas. One of these boys reported that he found the work in school too easy. This would be in accordance with the theory that regular schools have little to offer children of superior intelligence,(1) so it seems that some consideration should be given to enriching the curriculum, preferably with some subject or work which the child decides upon.

4. Behaviour of Poor Students. - The most common complaints, which were found in six of the eight children doing poorly in school, were inattentiveness and not applying himself to his studies, as shown in Table VI. Carelessness was reported to be characteristic of four of these children, and aggressiveness was a complaint common to the behaviour problems and socially maladjusted, who together were responsible for half the total number of complaints about behaviour in school of children in this group.

P.F., who was a serious behaviour problem, and had always been overprotected by his mother, seemed to be suffering by reason of his advanced grade and the fact that he was smaller than the other boys in

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(1) Hollingworth, op. cit., p. 50.

TABLE VI

RELATIONSHIP BETWEEN BEHAVIOUR TRAITS AND PRESENTING PROBLEMS OF VERY SUPERIOR CHILDREN (a) DOING POOR WORK IN SCHOOL

Behaviour Traits	Total	Presenting Problems					
		Behaviour	M.H.S.	Physical Symptoms	School Diff.	Social Maladj.	Voc. Guid.
All Traits	22	7	4	2	2	4	3
Acceptable	0						
Aggressive	3	2				1	
Ambitious	0						
Attentive	0						
Careless	4	2	1				1
Diligent	0						
Does Not Apply Self	6	1	1	1	1	1	1
Inattentive	6	1	2	1	1	1	
Restless	1					1	
Quiet	1						1
Wasted Time	1	1					

(a) Children with an I.Q. of 120 or over seen at Mental Hygiene Institute during 1948 and 1949.

his class.

> He had been in Grade IV the previous year, at the age of nine years. He found the work too easy there, wasted his time and developed careless habits. He skipped Grade V, and was in Grade VI at the time of referral, where he was reported to be doing better work. However, he was not getting along with the other boys of the class. He found them older by two or three years, husky, and eager to tease him, taking his possessions whenever they got a chance. He felt that he could not fight back, and the mother said he was developing an inferiority complex because of it. He had begun to refuse to go to school; even refusing to get dressed in the mornings, and as his mother worked to support him and herself, she found this behaviour very difficult to cope with. He was reported to be aggressive, inattentive, with a genuine dislike for school and discipline of any kind.

The home situation seemed to be largely responsible for the inattentiveness of F.N. His parents were very demanding and caused a great deal of difficulty and many arguments which centred around his school work.

> Referred because of his very poor work in school he found it hard to concentrate and get the marks his parents expected. He felt that his younger brother was favoured at home, and that he couldn't meet the demands of his parents. Although he said he liked the teacher he had, he was fearful of the one he would have if he passed into the next grade. He said he had a very bad temper of which he was ashamed.

In each of these boys were feelings of inferiority and inadequacy, making concentration difficult. In the former, there are complications which seem to be directly related to his intelligence, in that he was placed in a grade with older boys, more mature physically and emotionally. He was giving up, with an attitude of hopelessness. The second boy was more inclined to strive for acceptance, as he remarked that "he would have to tame a few of those boys".

D. Relationship With Schoolmates And Home Adjustment

1. Children With Good Home Adjustment. - Half the school children were considered to be well adjusted in the home,[1] and of this number,

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(1) As evaluated in Chapter III.

only 50 per cent were reported to play well with other children and have a great many friends. Of the remaining 50 per cent only one boy was openly aggressive and hostile; a direct result of repression of such feelings for his parents.

> At the age of 6 years, 10 months, D.M. was reported to be happy, energetic, restless and constantly on the go when at home. He was, however, quick-tempered. In the classroom he was lazy, aggressive, stubborn, restless and inattentive. At one time he had a fight and walked a distance of two miles home. Although he seemed to be a leader, he played with one boy mostly and had few friends.

The most common indication of a poor relationship with schoolmates was a description of the child playing by himself most of the time, which was reported in four of the ten children with good home adjustments. The boy with dermatitis tried desperately to make friends, but he felt that he could not hold them for any length of time because of his skin condition; an example of the way physical symptoms can be used to absorb the blame for poor social development. Another example of this is H.S., a girl of 13 years, 5 months.

> She liked her teacher, and was reported to be studious, but seemed to block at anything difficult. For the previous few months she had been truanting, then lying to her mother about it. She said she felt that the girls looked at her and laughed when she went into the classroom late, as often happened. She felt that because most of the others were Jewish they resented her because she was not. She was bothered about the way they talked about each other behind their backs. School was a very unattractive place for her because of her loneliness there.

2. <u>Children With Poor Home Adjustment</u>. - Of the ten children with poor home adjustments, only three were able to establish good relationships with their schoolmates, and two of these were children whose early life had been happy and undisturbed. The boy whose difficulties at home centred around his poor school work was reported to get along with other

children as well as any child at school. He played well, did not get into difficulty any oftener than the normal child of school age.

Seven of these ten children had a great deal of difficulty with their social relationships at school. In all these cases the child felt rejected by the mother, or was very jealous of another member of the family, and half of them were also doing poor work. The behaviour problems and socially maladjusted child did not get along with other children because of their aggressiveness; their way of showing hostility towards their parents and other people. In two cases the mother was considered to be immature and inadequate herself, but in each of these, the children improved in their social relationships as soon as the situation changed somewhat. Those children who were rejected by their mothers seemed unable to relate to anyone at any time, whereas those whose difficulties at home originated from some other cause could relate periodically or to one or two selected children. The following report indicates the difficulties of one rejected boy.

> A.A., whose mother not only rejected him, but who was neurotic and immature herself, did not have a friend at school. He was described by the principal as being a very odd child in appearance and mannerisms, who had been the butt of all the school jokes. His co-ordination seemed to be very poor, and he had no idea whatsoever of how to be sociable. He is big for his grade, eccentric in behaviour, nervous and high strung, but seems to lack initiative to retaliate when the other boys play jokes on him. Rather, he assumes an attitude of "Look what they've done to me now".

In addition to this, the boy used to get up around five o'clock in the mornings to deliver papers before school, as the family were experiencing very hard times financially. There is a possibility of physical debility, as the family have been carried by a Welfare Agency for several years, and the mother is a very poor manager.

E. Relationship Between Home Adjustment And School Adjustment

It will be seen that the home environment has a decided influence on the life of a child, but that adverse circumstances at home do not necessarily mean that the child will do poorly in school, for only half the children with poor home adjustments were not doing satisfactory school work. The majority of those did not get along with their schoolmates. Poor home adjustments are reflected much more accurately in the social relationships with other children, as 70 per cent of these children did not play or mix well with schoolmates. The early life situations seemed much more important influences on the children's ability to establish good social relationships, for those children who had been happy and well-cared-for in their early childhood, although from homes broken at the time of referral, were well developed socially. Unfortunate circumstances which occur in the family during a child's latency or adolescent period are not as harmful to the school experience as those which take place earlier, or as unwholesome parental attitudes. Foster home and school adjustment were much more satisfactory in children who had received sufficient psychological nourishment than in those who had been rejected or over-protected by their parents. This agrees with the findings of other studies.

> "There was also a definite relationship between high intelligence rating and improvement in adjustment. More important, however, were the parents' attitudes and factors connected with home environment in general."(1)

"A close relationship between parents' attitudes toward the children

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(1) B. Stout Griffiths, "The Influence of Parent-child and Teacher-child Relationships on School Adjustment", Thesis Abstract, Smith College Studies in Social Work, 1940-41, p. 173.

> and their adjustment in school was found. Teacher-child relationships were not so closely related to adjustment----There was also a close relationship between the emotional aspects of the home and changes in adjustment of some children."(1)

It would seem that those children with outlets for their emotional disturbances, such as physical symptoms and enuresis, adjust better in school than those who act out their impulses in socially unacceptable ways.

Further financial help is needed to encourage superior children to proceed with formal education or training to fit them for occupations where they will be able to make their optimal contribution to society.

There is an indication of the trend toward socialization in the child's relationship with his schoolmates, but as there is a degree of restriction inherent in the school environment, the social adjustment of these superior children outside the home and school will be considered more fully in the next chapter.

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(1) M.M. Stimson, "The Social Adjustment of Children in Kindergarten and Primary School, a Follow-up Study", Thesis Abstract, Smith College Studies in Social Work, 1940-41, p. 173.

CHAPTER V

THE ADJUSTMENT IN RECREATION AND PLAY

The limited number of very superior children is a condition which may affect the choice of playmates and recreational activities of such children. Special difficulties arising out of superiority will be discussed before we examine the social activities of the children of this study group. An attempt will then be made to see if there is any relationship between the home adjustment and social adjustment, or between school adjustment and social adjustment. As parental attitudes were found to be so important in the home adjustment of these children, their effect on play experiences will also be considered.

A. General Considerations

The greatest difficulty of very superior children in play experiences is when their physical and emotional growth is behind that of their intellectual development. Older children whose activities appeal to the gifted child may not want to be bothered with a person so small, or with one whose emotions are less controlled than theirs. Yet the play of his own age group is unattractive to the very superior child whose imagination and problem-solving ability is equal to that of children two or three years older. The other children may resent evidences of his superiority, and resort to bullying him in retaliation, as seemed to happen with P.F. whose difficulties with school children has already been described.(1) He withdrew from all activities, not even agreeing to go skating or skiing.

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(1) Supra, p. 26.

Membership in groups which might appeal to the gifted child is often restricted to certain ages, so that he often cannot join a club which is attractive and challenging to his mentality until he meets these age requirements. Provided his emotional growth has been satisfactory, the very superior child is better able to cope with these obstacles than the average child, and may devise schemes to make his own ideas attractive to other children, using his abilities to lead groups of followers.

If the child is hampered by poor emotional development, he may prefer to choose one or two companions whose interests are similar and whose needs complementary. He may associate with older people, or amuse himself by reading or engaging in hobbies which do not require an effort to adjust to the group. This was found to be the case in over a third of the children studied, as illustrated in the following.

> M.K., who could not keep a friend because he thought they avoided him on account of his skin condition, had little experience in group activities. He wouldn't join in any games or sports where his arms or legs might show. At home, he spent most of his spare time playing chess with his grandfather, collecting old coins and stamps.

He was more fortunate in having someone who would give his time to the boy, than many children who are sent off to bed when there is an interesting bridge game in the offing.

B. Social Activities of Very Superior Children in This Study Group

The majority of these very superior children had membership in one or more children's clubs, and were interested in intellectual and cultural pursuits. Organizations which challenged their intellectual capacities, such as scouts, cubs, guides, C.G.I.T., etc., were the most popular, and half the children were interested in church activities. Music, arts, crafts, and reading were the hobbies which occupied their

attention, suggestive of the theory that superior mentality goes hand in hand with special talents: or, in terms of Spearman's equation that intelligence is equal to a general knowledge, g, plus special abilities in specific areas, s, the greater amount of g, the greater probability that s will be greater.(1)

Of the entire group only 12 per cent were not able to get along with other children to the extent that they had no playmates or friends. The children referred because of their behaviour were the only ones who took no interest in any social activities, sports, did not belong to any clubs, and could not play well with children. The boy referred because of his poor social relationships in the community did belong to the YMCA where his father taught wrestling and boxing, but he had no friends there because of his acts of aggressiveness.

There was more evidence of difficulty in play experiences because of their superiority among the group of younger children. It was frequently reported that the child preferred to play alone or with older children.(2)

> J.T., a little girl of 3 years, 7 months, was rather seclusive, often preferring to play alone than to desire the company of the other children in the neighbourhood who were not going to school. She loved books, would insist on having things re-read to her, after which she recited poems as long as 12 verses without any difficulty.

C. Relationship Between Home Adjustment and Play Experiences

There seemed to be little correlation between home adjustment

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(1) C.R. Griffith, An Introduction to Applied Psychology, New York, 1946, p. 400.

(2) See history given on pages 17 and 18.

and social adjustment with playmates or participation in group activities, as only half of those who had any difficulty in outside groups were considered to be poorly adjusted in the home. That children find relief from pressures at home in such activities seems to be apparent, for one of the most seriously handicapped and greatest problem children was able to adjust quickly in a group setting.

> D.K., the behaviour problem who was a product of severe maternal rejection, enrolled in the Arts and Crafts Group of a group work agency. The social worker prepared the way by giving the social history to the group worker and asking that special interest be taken in him for the first few attendances. After two or three weeks, he was reported to be adjusting very well and responding to the acceptance which the group gave him. The mother also reported that he looked forward to the day when the group would meet, and that she was planning on enrolling him in other groups.

D. Relationship Between School Adjustment and Play Experiences

There seemed to be a closer relationship between the very superior child's ability to relate to other children in unorganized play or in groups, and the way they got along with other children at school. The majority of those who had difficulty at school had poor relations with other children outside of the school environment. Only one boy belonged to a recreational organization.

Children who had only one or two friends at school were inclined to occupy themselves in church activities and cultural pursuits, more than taking an active participation in groups. It is interesting to note that most of these were children with an I.Q. over 130, which seems to indicate that the social adjustment becomes increasingly difficult with higher intellectual ability.

E. Social Adjustment and Parental Attitudes

The children who were most advanced in their social development

were from homes where the parents' attitudes were wholesome. If one parent appeared apathetic but the other was loving, kind and affectionate, the superior child had little difficulty in relating to other people, but where the child was insecure with both parents, he was much more handicapped in his social relationships. Even in cases where the father was absent from the home, social adjustment was good if the mother maintained a close relationship with the children. This is illustrated by the case of D.V., mentioned earlier[1] who was little disturbed by the fact that his father was in a mental hospital.

> He continued to develop his leadership qualities, which were apparent in many ways. He excelled in his school work, was well liked there by both teachers and pupils, belonged to the Rosemount Boys Club, of which he was a counsellor. He was president of the Young Peoples Association and took an active part in the Y.P. music festival, where he won many honours. Because of his abilities and the financial hardship at home, continued attendance at high school was made possible by the waiving of fees.

The large number of children in the two older age groups who participated in various clubs and organizations is another indication that with greater intelligence a child is better able to work through his own difficulties in time. It also seems to denote his ability to establish new patterns of behaviour in new situations where the tension is relieved. In some cases the inner conflicts may remain severe enough to cause much unhappiness, and should be treated wherever possible, so that these superior children will be able to use their talents to the best advantage.

What forms of treatment were carried out, and how the social worker assisted, both in the clinic setting and in another social agency,

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(1) Supra, p. 42.

will be discussed in Chapter VI.

CHAPTER VI

DIAGNOSIS AND TREATMENT

As diagnosis and treatment are two of the main functions of a child guidance clinic, a general discussion of these services will be given before the social worker's role is examined.

A. General Discussion

Emotional disturbances in children are usually indicated by inhibited or uncontrolled behaviour, social maladjustment, inability to use intellectual powers fully, or by the presence of neurotic symptoms. Unlike the normal person who has attained a balance between instinctive drives and outer pressures, the maladjusted person is in conflict because of the imbalance between these opposing forces. Treatment of disturbed children is aimed at bringing them into balance.

Before treatment can begin, however, an adequate diagnosis of the child's problem is essential. This demands a thorough study of his personality development to determine the amount of inner control or the strength of the ego. His behaviour will indicate whether a strict superego has prevented development of an adequate ego, or if a weak superego has allowed too much of the id to find expression in behaviour which is unacceptable to society.

The information contained in the social history, and the social worker's impressions of the parental attitudes, gained during the pre-

liminary interviews with the mother[1] enable the psychiatrist to evaluate the forces in the child's environment which have helped to mould his personality. After his first interview with the patient, the psychiatrist is often in a position to formulate a tentative diagnosis as a guide to the type of treatment required; a diagnosis which may be revised as contact with the patient continues. Unlike the older profession of medicine from which psychiatry has emerged, specific symptoms are not always positive indications of one clearly defined emotional disturbance. The difficulty lies in the fact that people's reactions to similar situations are not always the same, and that a diversity of emotional responses result from a particular stimulus.

With children, diagnosis is less clearly formulated than with adults. In some child guidance clinics these problems have been given serious consideration. In the Jewish Board of Guardians in New York, attempts have been made to develop a method for psychological treatment in the following ways:

> "Diagnostic concepts were established and utilized in planning for all children who came to the agency. Specific treatments were developed. A programme of training was undertaken to prepare the staff".[2]

It was decided that the best way to achieve the most complete collaboration of psychiatry and social case work which is essential in child guidance was for the psychiatric social worker to undertake therapy under the close supervision of a psychiatrist. This method has proved very successful, and is possible by reason of the fact that the therapist-child relationship differs from the transference relationship of the therapist and

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(1) See description of the Institute procedures, p. 9.

(2) Hamilton, op. cit., Preface.

adult.

In child therapy the object is for the therapist to be permissive enough for the child to feel free to express feelings about his parents which he dare not express directly to them for fear of losing their love. This eliminates the need to repress the hostile feelings and the danger of their threatening presence in the unconscious is removed. Normal functioning is impossible when a great deal of energy is diverted from the usual tasks of life to the job of keeping the unconscious material from breaking through into the conscious, and expended in the anxiety aroused by the fear that some day this will happen.

Depending on the diagnosis, treatment will be directed towards establishing a better balance between the id and the ego by means of strengthening or weakening the superego. Gordon Hamilton states that

> "The purpose of therapy for the child is to alleviate guilt and anxiety, to release aggression and repressed impulses, (sometimes to aid in repression) and to correct fantasies and bring the child more in touch with reality, or to encourage better assimilation of reality, or both."(1)

Allan points out that parents are involved in their children's problems whether they like it or not, and must participate in treatment if it is to be successful.(2) They may at first be very opposed to the idea of their involvement, but every effort should be made to enable them to agree to a treatment plan which includes them. Psychiatrists and social workers must not be deluded by the various mechanisms parents use

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(1) Hamilton, op. cit., p. 174.

(2) F. Allan, "Evolution of Treatment Philosophy in Child Guidance", Mental Hygiene, 1930, pp. 1-11.

to absolve themselves of blame. Successful treatment is dependent upon the parents' cooperation because most often changes in their attitudes are essential before any permanent results can be achieved.

Care must also be taken that treatment is not terminated too soon. Often parents will want to withdraw the child from attendance at the clinic at first signs of improvement and may require a great deal of encouragement before they can appreciate the value of continuing until a more permanent cure has been effected.

Treatment of children is aimed at the restoration of personality to a greater degree of normalcy, and is apparent in the alleviation of symptoms, in improved social adjustment, greater emotional stability and better general health.(1) Margaret Gerard says

> "Because the pre-school child's superego and ego are in a very immature stage of development and still function only within the framework of adult admonition and encouragement, methods of ego training play a much larger role in treatment than is usually necessary in the latency period".(2)

If the older child's emotional development has been arrested at an early stage, however, he may require a similar type of treatment to that of the pre-school child.

Because of the various factors involved, treatment should be based on individual findings. There can be no prescribed treatment for a given problem until the environmental factors as well as the internal conflicts have been evaluated.

The objectives of the Mental Hygiene Institute have been largely

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(1) Kriegman and Hilgard, op. cit., p. 251.

(2) M. Gerard, "Treatment of the Young Child", American Journal of Orthopsychiatry, July, 1948, p. 414.

preventive and educative rather than therapeutic until recently. The limited amount of information available regarding the psychiatric social worker's role in the treatment process precludes a thorough discussion of this aspect of the study. Now that treatment is receiving greater emphasis, it would seem advisable to examine diagnostic procedures and treatment methods with a view to gaining closer co-operation between members of the therapeutic team. As this is not the purpose of this study, consideration will be given to the psychiatrist's findings and recommendations only as they affect the discussion of the use made of them, and how the social worker helped the child and parents to make them meaningful.

B. The Social Worker's Role

The psychiatric social worker's role in the treatment of very superior children is similar to that of any other social worker, and differs only by reason of the agency function. In many cases studied, the services requested of the Mental Hygiene Institute were for the purpose of giving direction to the social treatment to be carried on by workers in other agencies.

1. The Social Worker in a Referring Agency. - Where a psychological evaluation was all that was requested the clinical findings were reported back to the referring agency responsible for carrying on treatment. It was found that the use made by other agencies of these findings and recommendations depended to a large extent on the function of the referring agency. Where the focus was on the child, case work services were directed toward relieving environmental pressure, which entailed working with the parents, with school teachers, and alleviating conditions which were harmful to the child's development. At times a treatment plan was evolved in

conference with members of the Institute Staff and representatives of interested agencies participating. It was sometimes decided that the social worker from the referring agency who had already established a good relationship with the parents was in a better position to help the child who did not need psychotherapy by continuing to give service to the family.

A review of the records of agencies left with this responsibility indicated that the clinical setting has advantages over a family agency when changes in parental attitudes towards the child are desired. Parents who have become used to receiving help from a family agency are overburdened with their own problems, so that they cannot participate in the treatment of their children. If they are immature and dependent persons themselves, they have little to offer a child who needs the type of treatment recommended in a child guidance clinic. In such cases, it might prove useful to work out a treatment plan which would involve cooperation between the clinic worker and another social agency worker. This would necessitate treatment of the child under supervision of the psychiatrist, and should be undertaken only in cases which are limited by the parents' incapacity to change their attitudes. It is felt that efforts to work with the child of very superior intelligence, even with such limitations, would be profitable. The case work treatment was found to change little in direction after the clinical findings had been received in all cases referred from a family agency. Services were not given by the hospital social worker after the report from the Mental Hygiene Institute was received. This was a case in which the child was referred because of physical symptoms which were considered to be functional as medical examination revealed no organic cause for his symptoms.

In cases where the agency's function centred around the child,

clinical findings were used more extensively for the purpose of helping the child. The case of C.W. is an illustration of this.

> Referred by the Juvenile Court for Vocational Guidance, it was decided that psychiatric treatment was not immediately necessary, but that the Probation Officer should continue to work with the boy, who was to return for a further interview. This decision was made on the basis of the psychiatrist's findings that the boy "had not developed a sense of belonging or feelings of responsibility because of the separation from his father, a broken home and several moves in placement". In the follow-up interview with the social worker it was learned that failure to return to the clinic was due to the fact that the boy had accepted employment in the merchant navy and had sailed on a ship before arrangements could be made for a second visit to the clinic.

It is the Institute's policy to leave the responsibility for return visits to the referring agencies or parents. A carding system at the Institute whereby these things could be recorded, might be useful in providing a check on all cases where the recommendations include a request for the patient's return. The boy's superior mentality was apparent during his contact with the case-worker, and was a great asset in the way he was able to use case-work services.

> In discussing the way in which clinical findings were helpful the social worker reported that he was impressed with the boy's capacity to reason and evaluate his own actions. He had remarked on the advantages of a good home and the benefits of feeling loved by mentioning how "lucky" the social worker was to have such a fine home and family. The social worker used this, in conjunction with the knowledge gained from the clinical diagnosis, to show the boy that these were benefits which could be his if he would regulate his life to the demands of society. Through the social worker's interest in him, the boy developed a feeling of usefulness and belonging, which was instrumental in bringing about a change in behaviour.

The social worker from the agency which referred F.N. because of his school difficulties was able to help the boy by working with the parents and school teachers.

> The findings of one psychiatric interview indicated that the boy "was suffering from feelings of inadequacy because of the high standards demanded by his parents". It was suggested

> to the parents in this interview that they reduce their standards and demand less of their boy. It was also recommended that they bring the boy back to the clinic in a month's time.

The interview with the social worker from the referring agency indicated that the father resented being told that he was too strict and he refused to return with the boy. This is a good illustration of the care which must be taken when dealing with parents of disturbed children. It must be remembered that parents are what they are because of their previous experiences, especially those which occurred during childhood. Although they may be intelligent, their emotional development will determine to what extent they can use such advice. There are cases in which advice such as was given in this case will be all that is required, but it is necessary to establish the parents' capacity to accept and use it as a helpful suggestion rather than as a criticism, if this method of treatment is to be useful. Case-work services around the school environment were more helpful in this case.

> The social worker visited the parents several times, and continued to show an interest in the boy's problems. He discussed these with the school principal and teacher, whose attitudes changed with better understanding of the boy. Changes in the teacher's attitudes were more noticeable than changes in parental attitudes, and did help the boy somewhat. He began to show improvement in his work, and his marks were much higher.

Strauss maintains that a child needs the opportunity to develop new habits and reactions in a group situation with other children, where they can express themselves and cultivate a desire for self-understanding.(1) Such an opportunity was given to D.M., the boy referred because of social

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(1) B.V. Strauss, "What Constitutes Intensive Therapy in a Child Guidance Clinic", Journal of Orthopsychiatry, October, 1948, p. 725.

maladjustment.

> He was described by the psychiatrist as "reacting with a certain amount of aggressive behaviour to the demanding attitude of his rigid parents for strict conformity". Recommendations were made that the parents be encouraged to mitigate their demands and lower their standards. The group work agency who referred him, arranged for the boy to have a camping experience. For the first week of his camp life, the child was allowed maximum freedom. He did as he pleased with no restrictions other than those imposed to insure the safety of the other boys. After that, however, they were gradually imposed until he was able to comply with all the rules of the camp. For the final two weeks he was well adjusted, showed no signs of the previous exaggerated aggressive behaviour, and has been able to get along with other children since that time.
>
> Upon his return to school he showed a great deal of improvement. He had no difficulty with the other children, and his work was much better.

The social worker concerned felt that the clinic's services had been a great help in focusing the problem on the parents. A change in the father's work relieved him of much of his own anxiety, and the social worker's interviews with him were profitable in that a definite change in his attitude was noticeable in a short time. The situation at school was relieved when the boy was promoted into a higher grade with a less demanding teacher.

Treatment in this instance consisted of a combination of environmental manipulation and therapeutic group activity in which the boy was able to express many hostile feelings. The group work agencies have much to offer those children who do need such a setting in which to work through their difficulties. They are often called upon by psychiatric social workers also.

2. <u>The Psychiatric Social Worker as a Member of the Clinic Team.</u> - Although case-work in a psychiatric setting requires no special skills which differ from those of a case-worker in any social agency, the frame

of reference within which she works makes psychiatric social work a specialty. The first big difference is that parents who bring their children to a Child Guidance Clinic present the child as the problem and hesitate to recognize their own involvement. The social worker must use her skills to help the mother focus the problem not on the child alone, but on their relationship. Helping the client to see the problem in the right perspective is one of the initial moves in any case-work process, once the decision has been made to accept the agency's services. The role of the psychiatric social worker as part of the diagnostic clinic team has already been discussed in an earlier chapter.(1) How she assists in the treatment process can best be understood by an examination of the various ways in which the clinic team may operate.

The prevalence of unwholesome parental attitudes found in the cases studied indicates that the modification of their attitudes towards their children is as important in treatment of very superior children as it is in treatment of average children. Bronner describes four types of treatment which may be used in an attempt to change the attitudes of parents.(2) There is the direct advice and suggestion which has already been mentioned,(3) and is used most extensively by the psychiatrists in cases referred for Mental Health Study, and Vocational Guidance. The second method is that of education. This is involved to some extent in all cases, as it is the process whereby the parent gains understanding of

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(1) See Chapter II.

(2) E.B. Bronner, "Can Parents' Attitudes Toward Problem Children Be Modified by Child Guidance Treatment", Smith College Studies in Social Work, Sept. 1936, p. 13.

(3) See Chapter II, p. 20-24.

the child, and uses it as a dynamic force in changing his attitudes.

Insight therapy is an attempt to help the parent gain understanding of his own problems, his mechanisms and motivations. In some cases the transference relationship is necessary in order to discover unconscious motives and their effects upon the parent-child relationship. This was used in one case where it was felt that the mother needed psychiatric help if the child was to be helped to solve the oedipal conflict which was causing so much difficulty for her, and so much annoyance to the mother. When it was discovered that the mother had never worked through her relationship with her own father, it was decided in conference that she should be given an opportunity to do this in a transference relationship with the psychiatrist. The social worker accepted responsibility for carrying on play therapy with the child, while the psychiatrist helped the mother gain insight into her own difficulties. Due to incomplete recording it has been impossible to assess the amount of insight the mother gained, other than by inference from her reports of the child's improvement and a change in their relationship. The social worker's role in the play therapy indicates very clearly what may be accomplished in this way.

> The first two interviews were devoted to establishing a good relationship with the child. She was first prepared for the play experiences, then taken to the play room, where she was given a good deal of freedom. During the second period she included the worker in her play and assigned a role to her. She was prepared for the ending of the interview period, and insisted on putting the toys away carefully. The worker felt that throughout this period the child expected punishment.
>
> During the third period, the patient was able to express considerable hostility, using a "mummy" doll to act out her feelings. After breaking it she brought it to the worker to be fixed. She suggested that they pretend that "Mummy" is dead--we don't want her".

In this interview there was an indication of the guilt feelings which resulted from her acts of hostility towards her mother. Evidence of her

acceptance of the worker and greater confidence was also apparent in her request for help with repairing the doll. Being able to express her feelings would have a therapeutic effect of relieving anxiety over having them.

> In the fourth period the child was able to express more openly these feelings, saying "Funny mummy, I don't love her", and throwing the doll aside. At this time she expressed considerable interest in the father doll--undressed and examined the genital area, pointing out the difference between the daddy doll and the mummy doll.
>
> A box of cornflakes was used for a make-believe breakfast, and the worker gave the remainder in the box to the patient to take home. The child expressed jealousy by asking the worker not to give any to her little girl---there was an explanation of the fact that worker had no little girl, but no interpretation of the meaning of her remark.
>
> When her mood changed, she became aggressive and dependent on the worker's attention. Activities were necessarily limited and she became negative saying she didn't want to come back. The worker verbalized the child's anger, and in time the patient accepted the limitations and ended the interview.

By this time we can see considerable movement, as the child is much more spontaneous in expressing her feelings. She responds to the interpretation given, and has gained a degree of control by being able to accept the limits imposed by the worker.

> In the fifth interview the patient displayed a spontaneous and happy attitude, and was able to accept a limitation which was necessary very early in the interview. Patient mentioned worker's little girl again, and this time worker assured her that although she had no little girl of her own, there were other girls who came to see her, but that there was only one little E----. There was evidence of the conflict to remain a little girl and the desire to grow up. Worker accepted this need, but added that some day she would be big enough to go to school.

This suggestion was made by way of preparation, because the mother had expressed her intention to send the patient to nursery school very shortly; as she was pregnant and wanted to make plans for the future. As they were interrupted in this interview E---- made a marked bid for worker's attention which was necessarily diverted for a time. Following

this the worker was absent on account of illness, and another worker saw the patient at her next visit. When the regular worker returned she verbalized the patient's fear that she might have gone and left her without any warning.

> When the patient again asked about worker's other little girl, interpretation that worker might like some other child better than the patient was given, after which the child nodded in agreement. Further interpretation was made that the patient really meant that she was afraid her mother might like the new baby better than she liked the patient, to which she responded with a big smile after a simple discussion.
>
> She was still showing signs of fear, although she was able to use the toilet after showing a slight hesitation. When this produced no surprise reaction on the part of the worker, she went ahead, but asked that the toilet not be flushed.
>
> A small gift was given as compensation for the worker's absence the previous week, and the child tested out the worker's sincerity by asking if she could take the bird's wings off. When worker said she could do what she liked with it, as it belonged to her, she seemed satisfied. At first she said she would give the toy to the new baby, but was pleased when worker told her it was for her to keep if she wanted to.
>
> Initially afraid of a toy fire engine which she saw in the waiting-room, she overcame this fear and was able to pick it up and play with it while waiting for the mother.

By this time, the child was showing a great improvement in the home. Her mother stated that she was sleeping much better, that when she did wake up she wouldn't insist on the father coming to her, and that she would go back to sleep herself. She still had many fears, but they were not so pronounced. The attachment to her father was not as strong, and the parents were able to enjoy their child for the first time in many months.

> At the next interview she showed more fear over the fire engine, but her play was generally more relaxed and spontaneous. For the first time in several interviews she did not ask about the other little girls. Plans for attending nursery school were discussed, and she seemed ready to take this step.

The mother was finding it difficult to attend clinic regularly on account of her condition, and expressed a desire to discontinue treatment, as

there was so much improvement. The advisability of continuing was explained to her, but when the social worker next telephoned the mother, she learned that the patient had begun nursery school where she was getting along nicely, and that the mother did not plan on returning to the clinic.

It would seem that such intensive work with both parent and child is helpful in those cases where there are signs of inner conflict in each person. The treatment must be carefully planned and carried out in the fullest cooperation and understanding of the work being done by each member of the team.

A fourth type of treatment has been described as the attitude therapy. This is possible in only a few cases where the parent consciously recognizes her need for help with her own problems, and is willing to enter into a treatment relationship with the worker. Environmental change is one of the important tasks of the psychiatric social worker. Besides working with the school, the parents, and other environmental factors, it is sometimes necessary to decide whether there is likely to be improvement as long as the child remains in his home. Case-work skills are useful in assessing the positives and negatives of the home situation. This knowledge is valuable when a decision regarding removal of the child has to be made.

C. Summary

It has been impossible in this study to differentiate between intensive and short-term therapy on the basis of the number of visits to the clinic. In the majority of cases the child was not seen more than once, but as other agencies carried responsibility for social treatment, it is difficult to say how intensive was the service given. It is apparent

that the kind of treatment depends on the degree of disturbance, and the child's ability to use the help offered, as well as the extent of the parents' participation. It can be seen that a great deal was accomplished in a very few interviews where the therapist and social worker combined their efforts in a cooperative treatment plan. For the less disturbed children, however, social case-work carried on by other agencies can be very helpful and is often sufficient for the very superior child showing signs of a mild emotional disturbance. It is not within the scope of this study to compare the effectiveness of the treatment of very superior children with that of the average child, but it is evident that in all cases where treatment was undertaken with the direct aim of helping the child there were signs of improvement. Improvement was not apparent in all cases where the service given was consultative only, however. This suggests that very superior children selected for this study did not always receive as much benefit from their visits to the Institute as they would have if therapy had been prescribed. The decision to undertake more treatment at the Mental Hygiene Institute is a very wise one, and should improve the services available to highly intelligent children.

CHAPTER VII

FINDINGS AND CONCLUSIONS

An attempt has been made to ascertain the circumstances which were responsible for the referrals of twenty-five very superior children to the Mental Hygiene Institute during 1948 and 1949, and to evaluate their social adjustment as reflected in their behaviour at home, school and play. A review of the way the clinical team operates has helped to show how the case worker may contribute her skills in the diagnosis and treatment of emotionally disturbed children. The help given children who are less disturbed has also been discussed, as it shows the contribution of social workers in other agencies.

From an examination of the reasons for referral it was found that the Institute's services were sought for a variety of reasons. Although there were more than half of the cases in which a specific personality problem was presented, 44 per cent of the children came for Mental Health Study or Vocational Guidance only. The social history and clinical findings revealed that 63.6 per cent of the children thus referred had symptoms of personality problems or social maladjustment which precipitated the request. A more adequate screening system at the Institute would be an added safeguard that children in need of psychiatric help would be given every opportunity to use treatment, whether a specific request had been made for it or not. An intake policy which provides for a review of all social histories prepared by referring agencies might

prove a valuable asset in this regard, and offer another opportunity for the social worker to use her skills in the clinical setting.

The problems which were discovered included all types of emotional disturbances, with a variety of symptoms. Nail-biting and thumb-sucking were not present, and sex perversions, which are frequently found in older children, were not reported in any case. It was observed that the proportion of problems for the oldest age group was considerably less than for the youngest age group, which seems to bear out the theory that very superior children can overcome their difficulties better than average children in time.

There was an equal number of boys and girls in the first age group of this study, but a predominance of boys in the two older age groups. This was more marked in the puberty period, and might be related to the fact that boys are more seriously disturbed by a father's absence from the home during that period than girls are. As the sample was small, this theory would need further study before any conclusions could be made.

The social adjustment of very superior children was considered first from the viewpoint of the home environment. The economic condition of the family, cultural conflicts, and ordinal position of the child do not in themselves denote barriers to a good home adjustment of very superior children. Their effects on the parents' attitudes towards the children are of much greater importance.

Evidence produced in this study indicates that the influence of the father's absence from the home is related to the age of the child at the time of his absence, to the previous relationship between the father and child, and to the continued relationship with the mother. The degree

of emotional maturity and the mother's attitude towards the child are more important factors affecting his home adjustment at this time.

The findings of this study indicate that the most important factor influencing the home adjustment is the attitudes of the parents. Unwholesome attitudes create difficulties because they retard emotional development. Rejection by the mother was found to be the most frequent and most harmful of all, and in every case where this was apparent, the very superior child's adjustment in the home was poor.

There is such a close relationship between parental quarrelling and the parents' attitudes that no attempt was made to discover the effects of marital discord on very superior children.

The adjustment in school was next considered. It was found that all the very superior children studied were in grade placements below their intellectual level. In many cases the children were enriching their activities by supplementary reading of a serious nature, such as histories, autobiographies, and philosophical works. Of the total number of children attending school, 60 per cent were doing good work, with one quarter of these ranking among the highest in the class. There was only one boy out of the twenty who was in an advanced grade according to his chronological age. He was having difficulty with his schoolmates who were inclined to bully him. It is felt that this is no indication that all very superior children advanced in school would have social difficulties arising out of their higher intelligence, as this boy was a behaviour problem at home also.

There was little relationship between the very superior child's

ability to get along with members of his family and school achievement, as half the children with poor home adjustments were doing satisfactory work at school. Poor home adjustments seem to be much more accurately reflected in the very superior' child's ability to get along with his schoolmates, as 70 per cent of the children who were unable to make an adequate adjustment to members of the family were also having difficulty with their social relationships at school.

Only 50 per cent of the children considered to be well adjusted at home were able to establish good relationships with schoolmates. The most common description of their social activities at school was that of solitude. There was only one case of this group of children well adjusted at home where the child was openly aggressive and hostile.

Behaviour in school influenced the type of work done. Children reported to be predominately inattentive, careless and aggressive, or who did not apply themselves to their studies, were all reported to be doing poor work in school. Those whose behaviour was for the most part acceptable to the teacher, and who attended to their work diligently were doing good work in school.

It was observed that very superior children with neurotic symptoms, habit disorders and psychosomatic complaints seemed to have less difficulty with their school work than those who act out their feelings in aggressive and anti-social behaviour.

The present system of granting scholarships is inadequate to meet the needs of all children who could use such help. A larger number of more substantial scholarships, or a change in the present educational

system to provide free tuition for higher education would do a great deal to help adolescents who are forced to sacrifice the education they would like because of adverse financial circumstances in the home.

In the group of very superior children under six years of age there was evidence of difficulty in play experiences which was directly related to their intelligence. The majority of the reports indicated a preference for older playmates, keen interest in stories and reading, and a great enjoyment in memorizing and reciting verses. The older children's interests were in intellectual pursuits, reading being a favourite pastime. Membership in clubs which offered intellectual stimulation was reported in all but two of the children in the older age groups.

The emotional problems did not seem to be an insurmountable barrier to the establishment of good social relationships, as the majority of children studied were engaged in social activities of one kind or another.

The majority of very superior children who could not get along with schoolmates also had difficulty with children outside of the school environment. Those who found it hard to make friends at school occupied themselves in church activities and cultural pursuits more often than in recreational activities and participation in group endeavours. Musical interests were noticeable in the list of activities.

The very superior children who were insecure in their relationship with both parents had the greatest degree of difficulty in social relationships outside the home, and those who enjoyed the love and affection of both parents found no trouble in making friends at school and elsewhere. There seemed to be little difficulty if the mother's

attitude was favourable to good emotional development of her child.

The most important factor inhibiting the social adjustment of very superior children evidenced in this study was the attitudes of the parents, and the degree of sublimation which the child had been able to make in regard to his hostile feelings. Where these feelings expressed themselves in aggressive behaviour, social adjustment was very difficult. Where the expression took the form of neurotic or psychosomatic symptoms, social adjustment was less difficult. Very superior children whose parents were loving and affectionate during infancy and early childhood were not as seriously disturbed by adverse conditions in later childhood as those who had suffered emotional deprivation during the formative years.

The treatment given varied according to the diagnosis. It ranged in intensity from suggestion and advice to very intensive therapy in which the psychiatrist and social worker collaborated in treating both child and mother. Improvement was noticeable in all cases treated at the clinic, but was not always apparent where the responsibility for treatment was delegated to the referring agencies.

In view of the frequent reports of difficulty at school and the importance of the teacher-pupil relationship on the child's ability to work well in school, it is suggested that case work with the teachers might prove of great help to the very superior child having difficulty. During the follow-up interviews several teachers and principals indicated that they would welcome any efforts to help such children. There was some skepticism about the value of a diagnostic report without attempts to treat. The community is becoming aware of the importance of

psychiatric treatment, but there is a great deal of education of this nature still needed.

The case worker in any agency can use case work skills to help these children with their problems, but the clinic offers the advantage of being better equipped to handle emotional disturbances which create difficulties for these very superior children. As unwholesome attitudes were found to be the most prevalent obstacle to emotional and social development of the very superior children, changing the parental attitudes would appear to be the most important task of the psychiatric social worker. This would assist these children to make the most of their intellectual capacities.

APPENDIX "A"

KEY CARD

1. Name_____ 2. Referred by_____ 3. I.Q._____

4. Age at time of referral_____

5. Father_____ 6. Age_____ 7. Racial Background_____

8. Mother_____ 9. Age_____ 10. Racial Background_____

11. Siblings_____ Ages_____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

12. Sex. M_____ F_____

13. Sex interests_____

14. Sex education_____

15. Religion_____

16. Physical development: Normal_____ Backward_____ Advanced_____

17. Age of toilet training_____

18. Age of puberty development_____

19. Age of walking_____

20. Age of talking_____

21. Illnesses_____

_____

22. Problem presented by informant_____

23. Problem presented by patient_____

24. Problem noted by psychiatrist_____

25. Age of beginning school_____

KEY CARD

26. Present school and grade _____

27. Relationship with teacher _____

28. Relationship with schoolmates _____

29. Academic achievement in relation to C.A. _____

30. Academic achievement in relation to M.A. _____

31. Behaviour in school: Aggressive _____ Restless _____

Withdrawn _____ Inattentive _____

Acceptable _____ Attentive _____

Other _____

32. Relates to playmates at school?

Aggressive _____ Submissive _____

Leads _____ Follows _____

Sadistic _____ Kind _____

Plays poorly _____ Plays well _____

Other traits _____

33. Home adjustment: Helpful _____ Source of irritation _____

Happy _____ Unhappy _____

Teases siblings _____ Is kind to them _____

34. Relationship with father _____

35. Relationship with mother _____

36. Relationship with siblings _____

_____

37. Home economic conditions _____

38. Living arrangements _____

39. Mother's attitude toward problem _____

toward behaviour _____

KEY CARD

39. Mother's attitude toward child _____

toward discipline _____

40. Father's attitude toward problem _____

toward behaviour _____

toward child _____

toward discipline _____

41. Methods of discipline used _____

_____

42. How does subject relate to playmates?

Aggressive _____ Submissive _____

Leads _____ Follows _____

Sadistic _____ Kind _____

Plays well _____ Plays poorly _____

Has many friends _____ Has few friends _____

43. What clubs does he/she belong to? _____

_____

44. Was he/she urged to join by parents? _____

45. Outside interests: Music _____ Dancing _____ Sports _____

Crafts _____ Other _____

_____

46. Habits _____

Lying _____ Stealing _____ Truanting _____

Food _____ Sleep _____

47. Personality traits

Happy _____ Unhappy _____

Energetic _____ Selfish _____

KEY CARD

47. Personality traits

Generous_____ Miserly_____

Independent_____ Dependent_____

Persistent_____ Uncooperative_____

Cooperative_____ Defiant_____

Stubborn_____ Negativistic_____

Ambitious_____ Shows off_____

Exuberant_____ Conscientious_____

48. Was treatment prescribed_____ _____

49. Was intensive therapy recommended_____

50. Was short term therapy recommended_____

51. Did treatment consist of case-work services by M.H.I._____

By other agency_____

Cooperative_____

52. Was treatment aimed at changing family attitudes_____

attitudes of school teachers_____

both home and school attitudes_____

relieving inner conflicts_____

53. What was social worker's role_____

_____

_____

54. Other comments_____

MENTAL HYGIENE INSTITUTE

531 Pine Avenue W.
Montreal

Outline - Suggestive for Use in Preparation of Psychiatric Social History.

Name: Age: Date:

Telephone No.:

Informants:

Reasons for and circumstances of Referral: Why is the patient being referred to the Institute? What further understanding of him does the Agency wish at present?

What interpretation have the patient and family been given of the Institute's service? What is the reaction of the patient, and his family, toward coming to the Institute?

Present Illness or Unusual Behaviour: (Adults)

Outline in detail: Date of onset, early changes, development. Concrete illustrations of changes in behaviour before and after onset. Significant attendant circumstances. Frequency of manifestations. Duration. Any free intervals.

Ideas not based on facts - description of grudge attitudes, ideas that people are against, depreciatory ideas, exaggerated ideas of importance or possessions, ideas of reproach or sin, seeing or hearing imaginary things. Periods of elation, depression, suicidal ideas, excitement, indifference, restlessness. Undue crying, laughing. Mannerisms. Overactivity. Slowness. Change in appetite, sleep, care of person. Loss of interest. Withdrawal. Speech irrelevancy - defect, rapid, slow. Memory defect - for what type of events and going back how far. Periods of confusion; question orientation for time and place; quasi-normal ideas; worries; fears; defective judgment. Conduct disorders, lying, stealing, sex experiences, profanity, violence, suicidal or homicidal threats or acts. Shocks, convulsions, dizziness, fainting, headaches. Extreme emotional experiences. Physical complaints. Treatment employed and effect. Note onset, frequency and duration of all symptoms.

Problem: (Children)

For each complaint (See below) note age at onset, earliest manifestations, frequency, duration, severity, circumstances accompanying the occurrence of any manifestations or form of behaviour, detailed description, relation to other difficulties, response to treatment or attempts to ameliorate. List complaints in order of importance.

Temper: Screaming, feet-stamping, breath-holding, head-banging, throwing things, hitting, etc. Causes of temper outburst. Toward whom directed most frequently. Subsequent behaviour - admits wrong, sulks, sleepy.

Stealing. Lying. Truancy. Spells. Sex-experiences. Masturbation. Enuresis. Thumb-sucking; nail-biting. Restlessness. Incorrigibility. Stubbornness. Fear and timidity; shyness. Seclusiveness. Cruelty. Extreme aggressiveness or dependency. Food fads. Sleep disturbances. School problems. Physical complaints. Early shocks or emotional experiences. Speech defects. Backwardness; indications such as delayed development, lack of understanding, response, inability to talk, mix with other children, school retardation, etc.

Personal History:

Developmental: (Details for use in children's cases chiefly).

Ante-Natal: Note any state of physical or mental health of either parent at time of conception; welcome, expected or accidental pregnancy. Condition of mother during pregnancy, malnutrition, illness, emotional disturbance, bodily injury which might have affected foetus, threatened interruption of pregnancy (attempted abortion); employment of mother during pregnancy.

Natal: Place and date of birth. Full term or premature; first labour or multiple; duration of labour; normal or instrumental delivery; injuries to child during birth. Malformations. Blue baby. Convulsions.

Infancy and Childhood: Feeding - breast or bottle. Schedule, weaning; Note nutritional difficulties. Excessive crying, temper, fear.
Teeting: Age of first tooth, number at end of first year, second year. Difficulties (?)

Walking: Age of holding head up, sitting, standing, first steps. Peculiarities in early stages of walking.

Talking: Age of commencement, peculiarities, stuttering, lisping.

Handedness: Right, left, ambidextrous. (Patient, and other members of family).

Establishment of Toilet Habits. Details re: toilet training. Methods of training and correction (children). Response.

Puberty: For boys: Age first established; how shown, growth during puberty; fatigueability, etc.
For girls: Menses, when established; regularity, amount, pain, emotional reactions; if abnormal, what measures taken.

Chronological Statement: (In brief). Where patient has lived since birth; dates; circumstances of coming to this country.

Educational: Age of starting school; leaving; reason. Grade attained. Grades repeated. Double promotions. Changes in school. Verbatim reports from teachers when possible. General attendance, academic status. Reactions to different subjects. Any special training. Ease or difficulty in learning. Interest and application. Relationship to school-mates, teachers. Behaviour in school. Attitude of school and home toward patient's school life, especially any problem.

Economic: Age on going to work. Type of occupation, earnings, promotions and discharges. Reports from employers. List of positions held with dates. Attitude toward work, employers and fellow workers.

Occupations and incomes of each working member of the family. Rent, insurance. Unions. Savings. Debts. Other social agencies interested.

Home: Neighbourhood. Housing facilities, number of rooms, sleeping arrangements, sanitary conditions, orderliness, type of furnishings. Composition of the family. Relatives, lodgers. Language spoken in the home. Relationships of members of the family to each other. (Note marked fondness for or dislike for member, especially in relation to patient). Idea of home life. Social life in the family, recreational facilities, group recreation or individual. Intellectual and social interests. (The essential thing is to give a picture of the psychic and physical environment to which the patient has had to adjust, e.g., proverty, cramped living quarters, frequent changes of residence, congenial home atmosphere or friction, etc.[3/4]

Court Record:

Marital History of patient: Date and place of marriage. Name and address of husband or wife. Complete history of spouse, if significant. Attitude toward each other. Incompatibility - sexual or otherwise. Divorce or separation.

Children: Names and ages; education, occupation, personality, health. Other significant information.

Personality: Make-up and temperament - <u>previous to changes manifested in present problem</u>.
Intellectual capacity; Abilities and disabilities as compared with others.
Energy: Lively, active, pushing, sluggish, lazy, talkative or quiet.
Habits of activity: Systematic, definite, consistent, efficient, practical, desultory.
Social Attitude: Degree of independence; ability to get along with others; sympathetic, generous, suspicious, jealous, sensitive, confiding, seclusive, social, egotistic, irritable or their opposites. Reaction to criticism, to pain or illness. Relations with opposite sex. Interest in personal appearance.

Recreation or Play: Children: History of play habits (noting changes at any period); attitude toward play; proportion of time devoted to active play, to more quiet types of play; camp experience, club membership, role assumed; to what extent has patient been social or seclusive in play activities; kind of companions, how intense in play. Other leisure activities; reading, interest in athletics, in mechanical activities, domestic, music, drawing, pets, attendance at movies, outings, etc.

Adults: Interests or character of amusements, associates, hobbies, various activities, as suggested for children.

Habits: <u>Food</u>: Appetite, diet, special cravings, regularity of meals.
<u>Sleep</u>: Hours, restlessness, dreams, night terrors, talking or walking.
Sleeping arrangements; question separate room.

Elimination: Bowel and bladder control, difficulties.
Sex: Present sex life. Form of expression, overt or latent. Masturbation. Sex irregularities. Sex information - how obtained, and reaction.
Tobacco, alcohol, drugs.
Cleanliness: Habitual condition, undue fussiness or carelessness.

Religion: Describe the religions affiliation of family; interest in church activities. Patient's attitude toward religion; form of religious expression. Has anyone in the Church a special interest in the family?

Health: Diseases: Measles; mumps; whooping-cough; scarlet fever; typhoid; rheumatic fever; otitis; chorea; infantile paralysis; meningitis; encephalitis; convulsions; gonorrhea; syphilis; other physical complaints (gastric upsets, headaches, etc.), for each give date, duration, severity, complications, medical examination and treatment, sequelae. Please give verified medical reports - hospital or physician.

Injuries: Dates; severity; length of time unconscious; length of time convalescent; treatment (giving hospital or physician's reports); sequelae.

Family History

Father: Give full name, age, birthplace, present address, health, if dead give age and cause of death. General education, vocational adjustment. Character, disposition, habits. Note any peculiarities. Attitude toward and relations with patient. Changes. Relationship with mate. Relationship with other members of the family. Any significant information re: father's childhood; his relationship with his parents and siblings.

Mother: Same information as for father.

Siblings: (List, including patient, in chronological order. Include miscarriages, abortions, still births and deaths, with reasons advanced).

Name, age, school grade, occupations, noting general adjustment. Health. General description of character and disposition; any peculiarities (?) Home adjustment. Relationship with patient.

Father's Family and Mother's Family:

For grandparents, aunts, uncles, cousins, note name, age, birthplace, present address, health. If dead, age at and cause of death. Character, disposition, activities; any outstanding traits, peculiarities, difficulties. Nervous or mental disease or disorder. Suicides; alcoholism, drug-addiction; vagrancy; criminality, etc. Contact with patient and family.

Referring Agency's experience with family and proposed plan of treatment (not already included).

APPENDIX "C"

Desirable Personality Traits	Undesirable Personality Traits
Happy	Unhappy
Energetic	Lazy
Conscientious	Stubborn
Generous	Miserly
Independent	Dependent
Persistent	Negativistic
Cooperative	Uncooperative
Helpful	Source of irritation
Ambitious	Defiant
Unselfish	Selfish
Reliable	Unreliable
	Teases sibs
	Jealous
	Inability to compete

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