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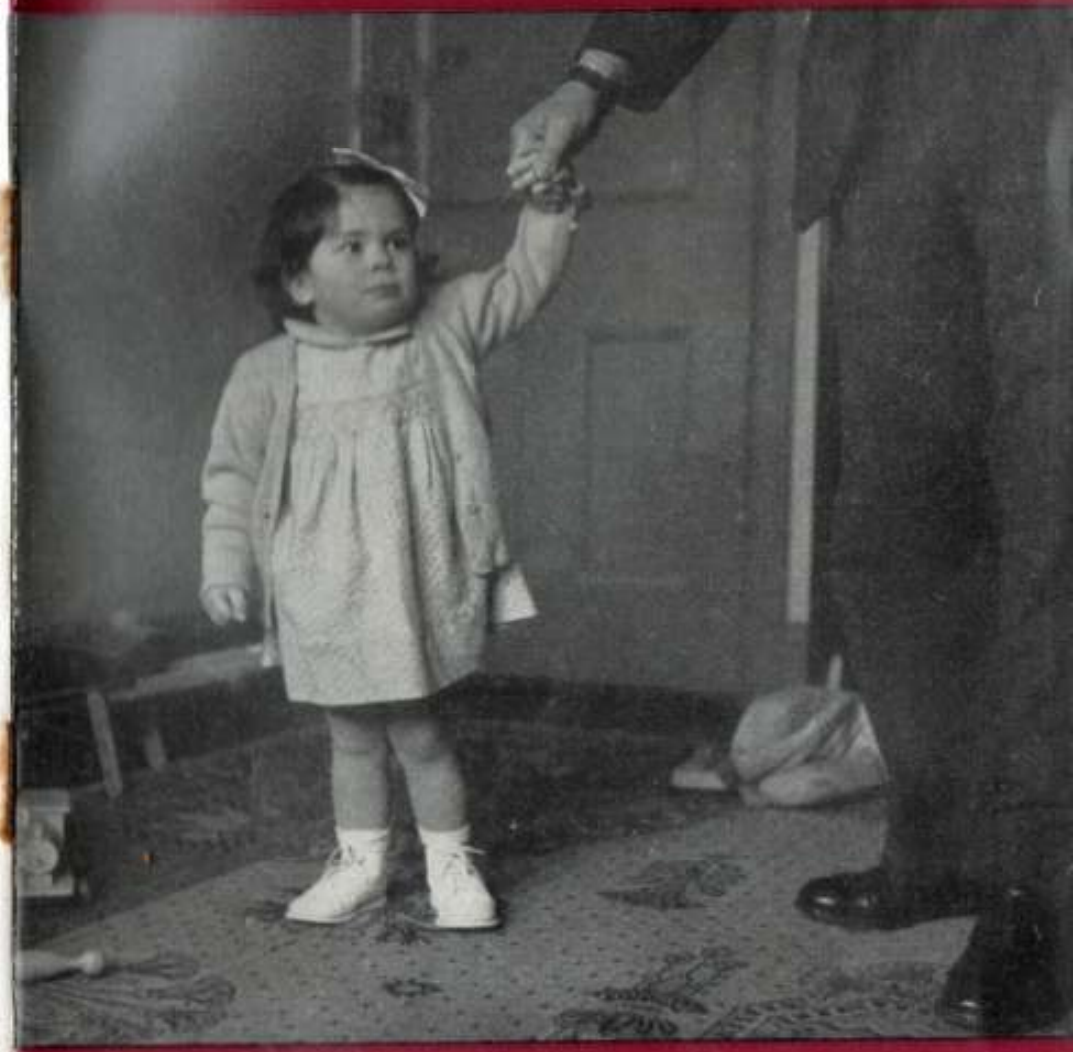
CHILD GUIDANCE

SISTER MARIE HILDA S.N.D., B.A.



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FOREWORD

BY REV. J. LEYCESTER KING, S.J.

WE have here a plain and matter-of-fact account of what a Child Guidance Clinic is, and of the work it does. In past years, the work of Child Guidance Clinics has had to be carried on in the face of opposition, apathy, misunderstanding, and even sheer ignorance of the issues at stake. All honour therefore to those who, like Sister Marie Hilda, have believed in their own clear appreciation of the value of such work, and carried on with it in spite of all difficulties. I believe that those who have hitherto engaged in this work will be found to have been pioneers in a movement which in the near future is destined to spread to many times its present volume.

It is an old saying that the boy is father to the man. Now this principle undoubtedly leads to an unduly pessimistic view if it is taken too strictly. For psychological ills, no less than for physical disorders, the ***vis medicatrix naturae*** is a potent force for readjustment; and many an "unsatisfactory" boy or girl has grown into a stable, integrated, and outstandingly valuable adult. In particular, the psychological changes occurring in the individual during the later stages of adolescence are often dramatic. It remains true, however, that by far the greater part of those psychological maladies which beset mankind in adult life have their origins in infancy and childhood. The abnormalities which are significant here are not merely a displacement from the normal path, running somewhat separate from it and yet parallel to it. Rather they are in the nature of a *deviation*, an abnormal *direction* which leads the individual farther and farther away from reality as the years roll by. It is rare indeed that the effects of such deviation can be wholly corrected when the matter is first tackled at the adult stage; at best they can be palliated, or some countervailing adjustment effected—an adjustment that is often

very costly to the personality-resources of the sufferer. But if such a deviation can be dealt with in its early beginnings, the outlook is vastly more promising. Insight into the root cause of an abnormality is often made easy by reason of the relatively uncomplicated nature of the child's attitudes and reactions. Remedial measures, which are so often concerned more with the environment than with the child itself, are similarly facilitated, since the various components of a child's environment lend themselves to modification and alteration much more readily than is the case with the adult, who to a great extent may be said to generate his own environment.

Speaking from the purely economic point of view, I feel that I do not exaggerate in estimating that for every £1 expended on Child Guidance Clinic work, at least £10 is saved for the public purse in making institutional and other provision for adult psychological disabilities. It is, however, far more important to remember that the children themselves are the nation's only real capital, and to realise that we have been, and still are, profligate in the safeguarding and disposal of that capital, which is already all too small for the enterprises which the nation will be called upon to undertake in the next decade or two!

Here is work calling for the whole range of the Christian virtues, coupled with expert training in a most fascinating branch of science. It is much to be hoped that many of our young Catholics will forthwith engage on such training, since in its post-war development this work is likely to absorb far more recruits than are at present available or even in sight of becoming available.

CHILD GUIDANCE

By Sister MARIE HILDA, S.N.D., B.A.

The purpose of this pamphlet is to explain the practice of Child Guidance as carried out in the Notre Dame Clinic, Glasgow.

With this object in view let us consider:—

First, the kind of children attending the Clinic.
Secondly, the members composing the Clinic staff.
Thirdly, the clinical methods of procedure.

I.—The Children attending the Clinic

The child most in need of guidance is generally referred to as the "difficult" or "problem" child.

Every year of life brings its own special difficulties to the growing child, *e.g.*, learning to walk and to talk, first meetings with strangers, the arrival of a new baby in the home, the first days at school, the demands of successive class teachers, the making of new friends, the physical changes at puberty followed by the independence of adolescence.

The majority of children meet these periods of stress and strain more or less successfully. However, just as there are some children who have little resistance against epidemic disease, so there are some children who seem less capable of standing up to life's changing situations without developing abnormalities of mind or conduct. All children have temporary lapses of maladjustment, it is the persistent recurrence of abnormal conduct that characterises the problem child.

In general, then, a problem child is one, who in trying to solve life's difficulties, has developed persistent undesirable forms of behaviour, which do not yield to ordinary disciplinary measures of home or school.

The various types of problem child may be grouped as follows:—

First: *Troublesome children, i.e.,* those showing abnormal and persistent restlessness, inattentiveness, laziness, carelessness, and untidiness in person and work.

Parents and teacher find such children a constant trial to their patience. In their attempts to train them to normality they apply scoldings, threats, punishments, bribes; all these remedial measures are of the emergency type, *i.e.,* they are directed towards the symptoms rather than to the underlying conditions which cause the laziness, lack of neatness, etc., hence they can never effect lasting reformation. The general health, the level of the intelligence, and the home or school environment must be thoroughly investigated before the source of the trouble can be discovered and on this discovery the treatment must be based. The ordinary adult has neither the time nor the experience to carry out such an enquiry.

Secondly: *Aggressive children, i.e.,* those subject to food fads, temper-tantrums, destructiveness, enuresis, impertinence, and defiance.

Here again it must be emphasised that the vital thing is not the temper, destructiveness, or defiance—these are merely danger signals which warn us to search deeper for the hidden sources from which they spring. Adults, with psychological insight, are needed to diagnose and treat problems of this kind. The more efficient insight comes as a result of candid self-examination of the motives underlying one's own acts of aggression.

Thirdly: *Nervous children, i.e.,* those suffering from deep feelings of inferiority, shown by shyness, fears, stutters, enuresis, phantasies, depression, scruples, and obsessions.

These are much more serious problems than any mentioned in the previous groups, but since they are less annoying to parent and teacher, they often escape notice. However, these children are in need of expert advice and treatment to enable them to take their rightful place in the group. One does not suddenly become a "misfit" in society; nervous breakdown (relatively common nowadays in adolescence as in middle age) might have been averted if

these tendencies to excessive introversion had received attention in childhood when the personality is malleable.

Fourthly: *Delinquent children,* so called because of their anti-social behaviour such as lying, stealing, sex and other perversions which come within the pale of the law.

It must be borne in mind that honesty in deed and truth in word are not inherited, they have to be acquired in much the same way as the multiplication tables, *i.e.,* by frequent repetition and application to numerous examples. *E.g.,* a child learns that $3 \times 4 = 12$, he has also to be taught $4 \times 3 = 12$; similarly a child learns it is wrong to take pennies out of another's purse or pocket, he has also to learn, that it is wrong to take pennies left about. Some children find these lessons in honesty and truth hard to learn; so strong is their acquisitive instinct, they tend to lay claim to all things attractive; so vivid is their imagination, they find it difficult to discriminate between fancy and fact. Especially in these cases is prevention better than cure and much depends on early training in the home.

In the case of honesty, the child's personal belongings must be respected if he is to be taught to respect the property of others. Gradually he should be given entire jurisdiction over his toys, his books, his clothes, his savings; only thus will he learn to appreciate the difference between mine and thine.

Similarly with regard to truth; if in the home promises are always kept, straightforward answers always given; if unpleasant situations are faced and not dodged and if frankness exists amongst the different members of the family, the child will grow to realise the value of truth, for example is better than precept. Clinic experience tends to show that imitation of adults is responsible for most children's lapses from truth and honesty.

Fifthly: *Dull children, i.e.,* those having no special ability and little intelligence, though not actually mental defectives. They have no interest in school routine and no hobby in the home, hence they tend to become malcontents, truants, and rebels and to swell the ranks of the delinquent

group. They are most difficult children to handle and they form a considerable proportion (20 to 30 per cent) of those annually attending the clinic. Low intelligence prevents them from co-operating in any constructive policy and inefficiency does not allow of steady occupation or employment which would keep them out of mischief. Many of these children are under probation and the magistrates have recommended a weekly appearance at the clinic. One can hope to influence them by an appeal to the heart though not to the head.

Sixthly: *Mental defectives*, those children unable to profit by instruction in the ordinary school or those who are excluded from every type of school as being ineducable. These children are brought only for diagnosis and advice; they cease to attend as soon as the clinic report is completed.

Every type of problem child enumerated in these six groups can be found amongst the 2,450 children referred to the Notre Dame Clinic since its inception in 1931. They have come from every grade of society (it is not only the poor who have maladjusted children!), *e.g.*, the son of a millionaire came to be cured of a bad stutter, a doctor's daughter of nightmares and sleep-walking; a captain's boy was referred for burglary, and the child of a minister for pilfering.

Though the majority of the children are Catholics, yet every religious denomination has been represented—there have been children of Jews, Presbyterians, and Anglicans; children whose parents belonged to the Salvation Army, the Catholic Apostolic Church, and to no church at all!

Nor are problem children confined to any age or any school; there have been a few under two and a few over seventeen years. They have come from Nursery or Montessori school, Advanced Centre, Secondary and High Schools, though the greater number attend the Primary Department of the Elementary Schools and their ages range from five to twelve years.

It is the aim of a Child Guidance Clinic to minister to the needs of all these maladjusted children by a team of trained experts, psychiatrists, psychologists, and social workers.

II.—The Members composing the Clinic Staff

The members of the Clinic staff may be either male or female, with the exception of the Social Worker, who is usually a woman. As Clinics are now being opened in many cities there is a great demand for trained workers. Some indication will, therefore, be given of training. The qualifications demanded by the British Child Guidance Council are as follows:—

The Psychiatrist should be a registered medical practitioner with a Diploma for Psychological Medicine or its equivalent, combined with practical experience in a mental hospital or psychiatric clinic. Besides these academic qualifications he needs a sympathetic understanding of child psychology, for it is his business, having diagnosed the problem, to frame, in accordance with individual capacity, a constructive policy towards reformation.

The Psychologist should possess an Honours Degree in Psychology (such as the Hons. B.A. of London or Ed.B. of Glasgow) or its equivalent, combined with experience in the teaching and testing of children, so as to be able not only to estimate their scholastic attainments and their level of intelligence but also to obtain an insight into their personality. Clinical psychologists usually take the teacher's training after graduation, then teach for a few years before taking a course in a clinic.

The Social Worker should hold a theoretical and practical diploma in General Social Science, together with a special certificate in Mental Hygiene, for thus will she be able to evaluate the evidence gathered in the home visits and to help the parents to self-adjustment and then to co-operate in the re-adjustment of their problem children. The Social Science Diploma may be taken at any University either after matriculation or after graduation, and may extend over one or two years according to previous education. Students generally spend several years in some form of social work before taking the Mental Health Course as no one under twenty-three years of age is eligible for the latter. The training for the Mental Health Diploma may be

taken at the London School of Economics or at Edinburgh University and lasts one year. There are a number of scholarships available but the selection is very severe.

These, then, are the essential members of the Clinic Staff; if there be a Special Department for Speech and Play, then *Speech* and *Play Therapists* will be required.

The Speech Therapist requires to have a diploma from the British Society of Speech Therapists, 86, Harley Street, London, W.1. This diploma is conferred after two years of study and is a guarantee that the *Speech Therapist* has a thorough knowledge of the physiology of the bodily mechanisms connected with speech and a grasp of the psychological principles underlying his therapeutic methods. Above all, his personality must be such as will inspire his patient with courage, confidence, and optimism.

The Play Therapist requires a general knowledge of Developmental Psychology with a special study of the Theory of Play and its practical importance in the life of a child. He needs much experience of observing and interpreting Free Play and he requires a calm and detached attitude of non-interference in the playrooms. Application for training for Play Therapy should be made to Child Guidance Council, 39, Queen Anne Street, London, W.1.

So far the Notre Dame Clinic resembles all the clinics organised on the team system, but being essentially a Catholic clinic, it has a *Chaplain*, appointed by His Grace the Archbishop of Glasgow. It is the duty of the Chaplain to give advice to the staff if ethical problems arise and to help in the diagnosis and readjustment of the child's behaviour where the cause is due to religious difficulties.

Catholicity is not a separate department of life, it is an all-pervading influence. Were religious practice always in full conformity with religious belief, there would be less need for Guidance Clinics for Catholic children; when this harmonious relationship is lacking, either in child or adult, a whole crop of neuroses, connected with religion, tend to assert themselves in the shape of phobias, scruples, superstition, and obsessions in the nervous type or of provocation, bigotry, and fanaticism in the aggressive group. In such cases the Chaplain may render valuable service both to parents and children.

III.—Clinical Methods of Procedure

Perhaps the best way to explain the clinical methods of procedure is to ask you to accompany me in an imaginary tour of the clinic premises and see what is happening in the respective departments on an ordinary afternoon session.

Let us begin with the *Psychiatrist*, who is having an initial interview with a child referred for stealing considerable sums of money from the home. A detailed history of the home conditions as well as life-history of the young delinquent has been obtained by the Social Worker from the parent. Furnished with this information, the psychiatrist proceeds to establish friendly intercourse so as to discover the child's attitude to his own misdemeanours. When a good contact has been secured an endeavour is made by direct methods to find out what he has done with the stolen money, for this will give a clue to motivation.

If it has been spent on sweets or food of any kind for his own consumption, then malnutrition or greed may be the cause. A blood test is sometimes taken to see if there be real sugar deficiency in the system, *e.g.*, one small girl pilferer was cured immediately on this discovery; the stealing ceased as soon as the lack of sugar was remedied by a generous supply of jam! If the money has been spent on cigarettes by the boy or finery by the girl, love of notice, showing off, or vanity may be the cause. Sound business instincts were shown by the boy who sold the cigarettes and the girl who sold the face powder to classmates and took their chums to tea and the pictures with the proceeds!

If the money is shared or spent on presents for friends, or teacher, it often shows a craving for affection and popularity, *e.g.*, one adolescent girl, longing for attention from her teacher, used to buy flowers with the stolen money for the Class May Altar.

If the money is hidden or thrown away, it is usually a

sign of jealousy or revenge or it may point to a pathological condition corresponding to what used to be known as kleptomania. If the child steals as a member of a gang, it may be due to love of adventure, loyalty to chums, or human respect.

But perhaps a child is morose, aggressive, or untruthful, or unable to express himself; then the psychiatrist must try an indirect method of approach. He may use an Association Test. In case there are any unfamiliar with this technique, I shall briefly explain. A list of words is prepared, some relating to known circumstances of the pilferer, others neutral. The child is asked to give the first word that comes to mind on hearing each of the prepared words. Suppose, for instance, the words—purse, drawer, pocket, uncle, father, etc., are distributed amongst neutral words such as cup, table, floor, window, etc. The time taken to respond is measured on a stop-watch and recorded together with the response. A lengthy interval or an abnormal response may be significant and give a clue to the psychiatrist which he can follow up and so obtain the truth.

Another indirect method tried out by the psychiatrist is play-observation; the child is encouraged to select toys from a miscellaneous assortment of small figures and objects, with which he plays, and in talking about them, quite often reveals his attitude to persons and things. Or the child is asked to make up a story or draw a picture with coloured crayons and these will usually refer to the difficulties of the moment; or again his dreams may point to unfulfilled wishes.

Two or three interviews may be required before the child's confidence is gained and he is assured that the psychiatrist is a friend to be trusted. It is evident, however, that no fixed rule can be followed by a psychiatrist in the diagnosis or treatment of a problem. So varied are the symptoms and their underlying cause, so different are the children's temperaments that the psychiatrist must depend on his own intuition, the result of long experience. However, he must be a keen observer and a sympathetic listener in order that he may establish a friendly relationship, for only thus will the mutual plan of action have a chance of success.

Let us now visit the *Psychological Department.* Here the child is put at ease on seeing picture puzzles and coloured mosaics, which he is invited to examine. Then follows an oral intelligence test, during which his type of personality is estimated according to the child's manner of response. All these given tests are standardised for children from two years to twenty-two. Accordingly, the child's mental age is ascertained which may be above, equal to, or below his chronological age. The mental ratio or resultant intelligence quotient shows how the child compares with children of his own age.

It is evident that the level of intelligence will influence the kind of treatment administered, for the more intelligent a child is, the more insight he will have into the problematic situation and the more he will be able to co-operate in the remedial measure adopted.

But the psychologist is not content with the intelligence quotient alone; he proceeds to discover the educational quotient or the child's level of scholastic attainments, especially in the three "tool" subjects—reading, spelling, and arithmetic.

Repeatedly it has been shown that there is a very close connection between educational retardation and delinquency. What else can be expected, but some form of naughtiness, from a child who is unable to keep up with his class-mates, whether it be due to long absence from school or to dull intelligence? He must of necessity become a dreamer, a dawdler, a plotter of mischief, a truant, or a rebel. If children could be brought up to their own mental level in school work, the number of delinquents would certainly decrease. Especially is this true in the case of reading. Psychological research shows that formal reading should not be taught before the *mental age of six* is reached; there are few schools where reading is not begun with all entering school at the age of five. This is largely responsible for the number of children with reading disabilities and their consequent backwardness in many subjects of the school curriculum. Having found the intelligence quotient and the educational quotient, the psychologist is able to decide as to the advisability of giving individual

coaching to reduce the discrepancy between these two ratios.

It is now time for us to visit the *Play Rooms*. In the Notre Dame Clinic there are three play rooms.

The play rooms are used as "shock-absorbers." The new girl readily loses her fears if she is introduced into the *Imaginative Play Room*. Here she finds a real house with bedroom, sitting-room, and kitchen in which she and several others can play together; a shop where she can buy and sell groceries and sweets, etc.; a tea room where she can have a dolls' party; a telephone box from which she can call up her friends; a choice of costumes in which she can disguise her identity. The new boy enters the *Social Play Room* and soon feels at home playing billiards or ping-pong, or building bridges or cranes, or manipulating the points and reversing the engines on an electric railway. Or the new child may go to the *Constructive Play Room* where sand, water, plasticine, paints, and tools offer outlets for energy and self-expression.

But the play rooms are not only "shock absorbers." Herein the Play Therapists have ample opportunities for observing personality traits. Each year of life, from infancy to late adolescence, has its own characteristic play activities, hence these give some indication of the personality development of the individual, *e.g.*, a child of 10 or 11 years content to play with toys and join in the games of the seven-year-old child may be dull in intelligence, or may be satisfying her protective or dominating instincts or may be overtaking play activities that have never been experienced.

Again, in social play, character types are much in evidence; the bully, the cheat, the leader, the follower, the coward are readily detected. Dramatic play is a revelation; it may be realistic or idealistic, *i.e.*, the child in playing house or school may reproduce actual circumstances or may create desired conditions, in either case invaluable for diagnosis.

Pictures made with paints or crayons or tiny models on the sand tray often give the Play Therapists a clue to present grievances, *e.g.*, burying a boy-doll in the sand or

turning the mother-doll into the pig-sty, surely indicate a temporary faulty relationship with brother or parent.

The play rooms also have curative significance; water play seems to have special therapeutic value with children suffering from enuresis; hammers, saws, and screwdrivers work wonders with the destructive and aggressive child; whereas the nervous child, dressed up as a cowboy or postman or lady of fashion, soon gains assurance and confidence.

Are there any accidents in the play rooms you may ask? Yes, to the toys, but not to the children. Except in the case of mental defectives most children's accidents are due to the fussy interference or unnecessary prohibition of adults. There is little or no interference on the part of the Play Therapists; short of injury to life or limb, the play is unchecked. On the other hand, even toys deliberately broken have wrought character-reformation well worth the destruction, *e.g.*, a small boy of four who loved to create sensations, deliberately smashed a doll on each of three successive visits. No one took any notice, no one reprimanded him. He has never broken anything since and he has taken his place in the group.

These visits to the play rooms will have shown the value of free play in revealing and resolving the mental conflicts of the problem child.

A *Speech Therapy Department* in a Child Guidance Clinic needs no defence, for it is common knowledge that mental conflict is the source of most speech disorders. Clinical treatment for stutterers, as opposed to special classes, has many advantages. Not only is individual treatment possible, but the child benefits by having the full service of the Clinic Staff at his disposal.

The earlier the speech disorder is treated the more likelihood there is of a speedy and permanent cure. Many pre-school children are now attending for cleft-palate speech, emotional mutism, retarded speech development as well as bad stuttering, all of whom give promise of successful therapy.

It is considered wiser to continue treatment over long periods and to discharge the child only when the speech

defect has been cured completely. Even this does not exclude the possibility of a relapse or of some other neurotic manifestation in times of great stress.

Let us now enter the room of the *Social Worker*, the last member of the team to be visited but by no means the least in importance. It is she who furnishes to the other members of the staff details of the home and the attitude of the parents; it is her business to make the parents realise their share of responsibility for the child's behaviour (often a difficult task!); it is she who must show the parent how the remedial measures adopted in the clinic can be continued in the home; it is she who visits the schools and tries to enlist the sympathy of the child's teacher.

If the Social Worker can secure whole-hearted co-operation, the adjustment of the child is a future certainty; if on the contrary the home and school do not co-operate, either through lack of understanding or lack of good will, little can be effected, unless in the case of an adolescent who is of such superior mentality that he can adjust himself unaided by parent or teacher..

In the *Clerical Department* one may see the files, registers, and case records being kept up to date by a devoted band of voluntary workers.

When the new child has been interviewed by all members of the team, a conference is held; the information gathered is pooled, suggestions are offered, a course of treatment outlined, *e.g.*, direct psychiatry will benefit an intelligent child; play therapy will relieve tension in the nervous child and help to socialise the aggressive and delinquent child; psychological coaching will encourage the dull and retarded child.

A child is considered *adjusted* and discharged when the personality difficulties underlying the symptoms for which she has been referred, have disappeared. *Partial adjustment* implies that personal or environmental obstacles still remain, though the problem has been ameliorated and the child continues to pay occasional visits to the clinic, or the home is visited at regular intervals. When no appreciable improvement seems possible, the child is considered *unadjusted* and nothing further is done. In estimating final

results, as in most human enterprises, success and failure are evenly balanced, but clinic workers think themselves well repaid if either parent or child return for help when further difficulties arise.

Now I should like to try and meet some objections, levelled at Child Guidance Theory and Practice.

1.—It is said that misbehaviour and delinquency are exonerated and the child freed from moral censure.

In so far as misdeeds are usually treated as mere symptoms, the criticism is just; but in children the hidden cause is usually a greater moral evil and, once discovered, *it* becomes the object of attack. The clinic considers it best to pull up the roots rather than cut down the branches, *i.e.*, the clinic thinks *motive* more important than the resultant action and surely this is in accordance with Catholic doctrine?

2.—It is said that perverse conduct as a consequence of original sin is discredited and the blame laid rather on environmental conditions.

This criticism has some justification, for the clinic does tend to lay the chief burden of responsibility on those in authority over the child, for it recognises the enormous influence of suggestion and example, especially in the early years. Is it not just in the ease with which bad example is followed that the effect of original sin is manifested?

All Catholics would surely agree that the number of problem children would be infinitely less, if ideal family conditions existed as in the home of St Teresa of Lisieux. Hence, might it not be better to stress more the effects of the Sacrament of Baptism rather than those resulting from original sin?

3.—It is said that the priest in the Confessional is the proper person to deal with delinquent children and not a psychiatrist in a clinic.

This, of course, is true if the delinquency is grave and the child morally responsible, for only from a priest can absolution be obtained. Few priests, however, have

time to investigate the source of individual delinquency or to elaborate a course of treatment leading to amendment. It is interesting to note that many children and adolescents have been referred to the Notre Dame Clinic by different confessors who have realised that the delinquencies needed psycho-therapy instead of spiritual direction.

4.—It is said that parents and teachers who are good disciplinarians can handle their own "problem" children better than strangers in a clinic, no matter how expert.

This may be true, but unfortunately good discipline usually means harsh punishment. Stern measures may cause the offending symptoms to disappear more readily than they are likely to do by the application of the leisurely clinic methods, but the source is left untouched and probably another outlet is sought, less obvious to the adult but more disastrous to the child.

5.—It is said that a trained psychologist in every school would meet the need of Child Guidance and save expense.

There is danger here, for a psychologist is not medically trained and might make a wrong diagnosis by not recognising incipient mental disease. Besides, the psychologist would not have the time to visit the homes and treat the parents, nor would there be any play therapy. With regard to expense why not pool the salaries of these psychologists and form a team working in a clinic?

To sum up, the object of Child Guidance is, in childhood, to socialise the neurotic and the aggressive, encourage the dull and retarded, and redeem the delinquent, and thus to decrease the number of mental breakdowns and to lessen the number of prison inmates in later life. By its constructive methods, the clinic hopes to build up integrated personalities capable of taking their place as members of the family, of the Church, and of the State.

PUBLISHED BY THE INCORPORATED CATHOLIC TRUTH SOCIETY, LONDON,
AND PRINTED BY THE BURLEIGH PRESS, LEWINS MEAD, BRISTOL
Printed in England S 10M *February*, 1958
60th Thousand CS