THE FOLLOW-UP OF A CHILD GUIDANCE CLINIC POPULATION

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I—Introduction

We all know cases who have got better and we like to think that we played a part in causing their improvement. To prove this is, however, a very different matter. We have all read the follow-up studies based on a carefully selected group of cases where the authors report on those whom they could trace—but what of the untraced? At times, an overall survey of one's case material may reveal facts unnoticed in the preoccupation with the day to day clinical work.

In an attempt to look at their work in a more impersonal fashion the Staff of the Bristol Child Guidance Clinic decided to take all those cases who first attended in 1946 and see what had happened to them by 1951. For purposes of comparison each case was assessed on a five-point scale for the complex variable Adjustment-Maladjustment, these terms being used to cover an individual's reaction to his environment and to himself, no matter whether the reactions were shown in the social, intellectual, emotional or physical field.

In order to make the assessment as objective as possible, the following precautions were taken:

(i) The field workers and judges were not members of the clinic staff.

(ii) The data referred to well-defined aspects of behaviour, e.g. how many friends, rather than sociability.

(iii) The facts, though gathered in slightly different ways, were of the same type and presented to the judges in the same way, thus eliminating variation due as much to the difference in methods of presentation as to changes in the individual.

(iv) Whenever possible the results were expressed in numerical form so that statistical methods could be applied and the reliability and validity of the assessment estimated.

II—Method

A record form (App. I) was devised. The items were selected on the basis that they were important in the child's adjustment, were capable of objective assessment and had, for the most part, been recorded in the original clinic histories.

As we wished eventually to use the method (devised by C.J.B.) for comparing referred and non-referred cases, the complete group of 340 cases referred for the first time in 1946, the first post-war year, was chosen for the sample. Eight of these cases were found to have married and were excluded from the assessment procedure as the interview method was inappropriate.

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Tracing

As a first approach a letter was sent to the last known address of the parents. A card with only an identifying number and a stamped addressed envelope were enclosed. The card asked if the child was fit and well, how he or she got on at school or work and how he or she got on with the family. The present address was also asked for. This card was not meant to provide follow-up material but solely to trace change of address.

Two fourth-year university students in psychology filled up a record form for every case using the 1946 diagnostic interviews as their only source of data. They visited all addresses in Bristol obtained through the reply cards and if the card had not been returned, the last known address. Enquiries were also made at the house on either side. If the neighbours knew the present address and it was in Bristol this new address was also visited. They filled up an identical record form based on an interview, if possible, with the mother, as she had usually been the informant in 1946. They did not consult the original record before visiting.

When children were resident in institutions a questionnaire was sent to a responsible person there and the interview form completed from it. At the same time parents living outside Bristol were sent a card asking whether they would consent to complete a questionnaire. If they agreed a questionnaire was sent and, when returned, an interview form was completed from it. If the parents refused or did not return the questionnaire no further action was taken at this stage.

By the end of August, 1951, after two months interviewing, 202 cases had been traced. These constitute the Main Sample (MS). It was felt, however, that the problem of cases difficult to trace needed further study and accordingly in 1952 a woman sociology graduate carried out further tracing of two sub-samples of the 138 originally not traced. Sample A was a random sub-sample of 35 cases. Sample B consisted of 28 cases who had Bristol addresses but who had not been visited earlier either owing to the isolation of their addresses or because they had had to be traced through several addresses and were located too late for inclusion in the MS. Sample A, being random, included certain cases found in Sample B.

When the interviewers had completed their work there were two forms for each child, identifiable by code number but otherwise indistinguishable though, in certain cases, age or details of work might have indicated that it could be only a follow-up record.

Judging

A University lecturer in Psychology, a Medical Officer at a Mental Hospital, a Headmaster of a Special School, a Psychiatric Social Worker and a Youth Employment Officer were then invited to act as judges. Each judge was provided with a set of instructions and then given a copy of each record that had been obtained. The records were arranged in the same random order for each judge. Thirty identical pairs of records were included so that reliability could be measured. Each judge, working separately, rated every record on a five-point scale. Neither the purpose nor the design of the study was known to the judges.

Treatment of Results

When the five sets of records were returned there were ten ratings for each child, five for 1946, five for 1951. As the mean scatter of the individual judges'

ratings corresponded closely the five ratings for each individual were added together, giving pooled ratings for 1946 and 1951 with a possible range from 5–25. The difference between these two pooled ratings gave a Pooled Improvement Rating for each child, with a possible range from +20 to −20.

III—Results—Method

Qualitative

The interviewers found the majority of informants very co-operative, and in only two cases was information refused. There was no objective check on the reliability of the informants but they appeared to be as reliable as in ordinary clinic work.

The possibility that the greater knowledge about younger children still at home might influence the assessment was considered. This was checked upon statistically and we consider that it is unlikely that the ratings were biassed by this factor.

The record form was found simple to use and adequate for a pilot survey. For further work, the form would be modified in the following ways:

(i) Enlarge the list of symptoms and, where possible, rate separately for extent and frequency, e.g. stammers in all, most, specific situations: stammers over most, few words.

(ii) Include information on known physical disabilities.

(iii) Extend the "Home" section, if possible, with more factual categories.

Quantitative; Reliability and Validity

(i) Reliability of interviewers:

Statistical checks of their work were possible and revealed no significant differences.

(ii) Reliability of judges:

To check the reliability of the individual judges, about 30 record sheets, which were duplicates of cases already included except for minor changes in I.Q. and age, were mixed with the MS records. In fact the judges did not recognize these "duplicates".

The reliability of the judges as measured by the correlation of their ratings on these pairs was:

Judge	A.	r = ·934** n = 31
	B.	r = ·927** n = 26
	C.	r = ·846** n = 35
	D.	r = ·520** n = 35
	E.	r = ·800** n = 31

If the ratings on these duplicate records are pooled the reliability for the judges' pooled ratings becomes—r = ·941** n = 24.§

This result confirms the desirability of employing more than one judge. The reliability is raised above that of the most reliable single judge.

(iii) Reliability of judges after lapse of time:

When the A and B samples were judged a year after the MS, duplicates of records previously judged (25 for 1946 and 10 for 1951) were introduced to measure the consistency of the judges after a period of time.

§ The varying numbers here are due to the fact that some duplicates were mislaid.

** Indicates significant at p = ·01 level.

* Indicates significant at p = ·05 level.

The reliability of the individual judges after a lapse of a year was:

Judge A. r=·770** n=35
B. r=·724** n=35
C. r=·866** n=35
D. r=·601** n=35
E. r=·520** n=35

If the ratings on these duplicate records are pooled the reliability for the judges' pooled ratings after a lapse of a year becomes r=·886** n=35. On their second rating of the records the judges rated slightly but not significantly higher. This applies to both 1946 and 1951 records.

It may be concluded that in spite of variability between and within the judges' ratings the reliability of the method of assessment, both immediately and after a lapse of a year, was high and quite comparable with reliability in other methods of case study.

(iv) Agreement between judges:

In both the MS and the A and B samples the distributions of the individual judges' ratings were more or less the same. Mean and standard deviations were computed for each judge and were found not to differ significantly between the judges.

As this was so the average inter-correlation between all the judges could be calculated. (Kelly. Guilford. Psychometric Methods, p. 370.)

In the MS these average inter-correlations were:

$\bar{r}$ pq=·745** for the 1946 records. 202 records. 5 judges.
$\bar{r}$ pq=·685** for the 1951 records. 202 records. 5 judges.

In the A+B samples combined, which were assessed a year later, the average inter-correlations are:

$\bar{r}$ pq=·453** for the 1946 records. 141 records. 5 judges.
$\bar{r}$ pq=·661** for the 1952 records. 61 records. 5 judges.

(v) Disagreement between judges:

There were occasional differences of 1 or 2 points, differences of 3 or 4 were exceptional. Disagreements of this type are part of the rating procedure and are a reflection of the contribution of each judges' training and outlook to the final assessment.

More questionable, however, are differences of direction. When, for instance, a small Pooled Improvement Rating is due to some judges rating the individual improved and some rating him deteriorated. Forty-five such cases were found in the Whole Sample of 243 cases including all those cases where one judge or more had disagreed in direction with one or more of the others, whether or not some judges had rated no change, the latter being taken to be disagreement in degree. These 45 "direction disagreement" cases were found not to have influenced findings in the Whole Sample.

(vi) Validation of 1946 Pooled Ratings:

An attempt was made to check the validity of the method by comparison with an external criterion. Judge A. was familiar with the layout of clinic case papers and rated 30 cases randomly selected, using the records of the same diagnostic interviews as had been used earlier by the interviewers. The correlation between his ratings and the pooled rating of the judges was

r= ·640** n=30. The correlation between this same judge's rating from case papers and from record forms was r= ·815** n=28. Since this judge's reliability on the MS was very high it can be concluded that so far as validation against case papers is concerned the method is adequate.

(vii) Validation of the 1951 Pooled Ratings:

Thirty-five cases were selected randomly from the MS and 23 of these children were interviewed by one of us (R.F.B.) the majority at the clinic, the parents not being seen. Some interviews took place nearly a year after the follow-up interview.

The results were much less satisfactory in this check, the correlation being r=(·090) NS n=23 which is not significant.

Two cases were of special interest. In one the boy had appeared in the Juvenile Court in the interval between the follow-up assessment and the psychiatric interview and this probably accounted for the psychiatrist's rating of 2 versus the judge's agreed rating of 5. In the second case a boy (aged 17·3 years I.Q. 129) was rated low by the judges (1·6) and high (5) by the psychiatrist. Investigations revealed that the record sheet showed a number of aggressive pastimes and recent psychosomatic symptoms. The symptoms were not disclosed by the boy to the psychiatrist who considered that as the aggressive tendencies appeared to be successfully sublimated (collecting antique weapons and fencing club) he could not be considered maladjusted, though liable to react excessively to any unusual stress. Apart from the difference in information available the judges and the psychiatrist differed as to the degree to which prognosis was to be considered.

However, if these two cases, where special circumstance intervened, are omitted the correlation becomes r= ·623** n=21.

These two discrepant cases together with the time-lag between interviews and the small number of cases interviewed by the psychiatrist, indicate that validity in this study cannot be taken as proven. In any further study we should use more than one psychiatric rating as an external criterion, both child and parent would be interviewed and validation would be carried out immediately.

The extreme difficulty of validation in this field may be illustrated by the fact that using similar rating scales, and rating new cases presented at our weekly case conferences, agreement between 6 members of the clinic staff, two psychiatrists, two psychologists and two psychiatric social workers, varied from r= ·844** n=24 to r= ·534** n=24.

IV—The "Not Traced"

(a) *Main Sample and Population*

The Main Sample consisted of 202 cases. Could one assume that the remaining 40 per cent. resembled those traced? The MS was compared with those who at that time were not traced, referred to hereafter as the Not Yet Traced (NYT).

The MS was representative of the year's cases as regards age and intelligence. As might be expected the mean age of those NYT was higher than of those in the MS. This difference was significant.

Mean age on referral. MS = 9·6 n=202
Mean age on referral. NYT=10·6 n=138
t=2·331* Df=338

The NYT differed in referral source, significantly more coming from "Other Agencies". Substantially more treatment cases were found in the MS. More surprising was the finding that fewer females and more males appeared in the MS than was to be expected by chance.

(b) *Random Sample of the Not Yet Traced* (*Sample A*)

This sub-sample was a random one of 35 cases drawn from the 138 cases remaining after the first sampling.

After some difficulty we were able to trace and interview 24 cases from this sub-sample (17 per cent. of the NYT). These 24 proved to be characteristic of the 35 cases originally taken, at least so far as age, sex, intelligence, referral source and disposal were concerned. In fact, all 35 cases were traced but not all could be interviewed and assessed. Of the 11 thus traced but not assessed; 1 had been killed in Korea, 1 was married and 2 had emigrated to Australia. The parents refused to give information in 2 further cases and 2 cases were in a Borstal institution and could not be interviewed. In the remaining 3 cases we had information indicating that they were doing well but the evidence was insufficient for a record form to be adequately completed.

The 24 cases in Sample A thus obtained were not significantly different from the NYT in age, intelligence, sex, referral source or disposal.

The sample had, however, a significantly lower 1946 Pooled Rating than the MS:

MS Mean 1946 PR=15·401
Sample A, Obtained Mean 1946 PR=13·542
t=2·877** Df=241

The difference between means of Pooled Improvement Rating, was not significant.

MS Mean PIR=4·084
Sample A, Obtained Mean PIR=4·542
t=(·522) NS Df=241

It can be stated that Sample A did not differ significantly from the NYT and in improvement was not significantly different from the MS.

The fact that Sample A as obtained has a significantly lower 1946 Pooled Rating is of interest and suggests that the NYT cases might have been more maladjusted on referral.

(c) *Second Sample of Those Traced in Bristol* (*Sample B*)

This sub-sample consisted of cases who had been traced provisionally to Bristol addresses, but who for various reasons had not been included in the MS. Of 28 such cases 24 were assessed. Four cases could not be traced by the MS criterion of tracing.

Sample B thus obtained was compared with the NYT and was not significantly different as regards intelligence, sex, referral source or disposal.

It was found however to be significantly younger. This result is to be expected in view of the fact that these cases would have been able to have been included in the MS had time allowed, and thus show the same tendency as the MS in this respect. In fact, the mean age of Sample B as obtained is not significantly different from that of the MS. As with Sample A the mean 1946 Pooled Rating is significantly lower than that of the MS and the mean Pooled Improvement Rating not significantly different.

(*d*) *The Finally Not Traced*

The Whole Sample consisted of 243 cases, the sum of the MS and Samples A and B. The remainder are the Not Traced (NT).

Unfortunately it cannot be said, even of this study, that those individuals

in the NT were solely those who were most difficult to trace, for other factors such as marriage, lack of co-operation, difficulty of making contact, all entered in.

The length of time available for locating cases will always be a factor in determining the group of "untraced cases". We were surprisingly fortunate in being able to locate all the cases in what had been drawn as a random sample of the NYT but, even there, two cases who had emigrated could not be assessed, for the sample had to be judged before arrangements could be made to have questionnaires completed in Australia.

The following findings regarding the NT may be of use in other surveys:

(*i*) They tend to be older. WS Mean age on referral=9·6. NT Mean age on referral=11·2. t=3·269** Df=338.

(*ii*) There are few treatment cases, this being probably due to the fact that the time lapse between the follow-up and the last date the child was seen was under 3 years.

(*iii*) Intelligence level is not associated with presence in the NT.

(*iv*) The proportion of juvenile court cases was higher in the NT though not significantly so.

(*v*) Other Agency referrals are significantly more frequent in the NT: School Medical referrals in the WS.

(*vi*) The NT contains a significantly greater proportion of girls. It has not been possible to determine whether this sex difference is entirely due to local conditions or may have a more general application.

V—Results—Follow-up

The pooled ratings show an improvement in the cases on follow-up in 1951 within the MS.

Pooled Ratings for 1946 records n=15·401 SD=3·59 n=202
Pooled Ratings for 1951 records n=19·485 SD=4·83 n=202
Correlation between the Pooled Ratings in 1946–1951 r=+·184**

The difference between the means 4·084, is significant at p=·01. This improvement does not tell us anything about the work of the clinic unless we have a control group with which to compare results.

Before turning to the breakdown of the follow-up results we would remind readers that we were working with histories taken five years previously. Some of the characteristics we would like to have studied, for instance the effect of the stability of the mother, had been inadequately recorded in 1946. We could not assume that the absence of an entry necessarily meant that the entry would have been "normal". Further, no attempt was made to check the mother's original statements, e.g. that she had, in fact, had a prolonged labour. Despite these limitations a wide range of characteristics were known sufficiently accurately to make useful comparisons possible.

The method of dealing with "not known" categories should be explained. A table was constructed splitting the sample into variable A/Not A and into variable B Known/Not Known. If there was no significant association between variable A and B Known/Not Known the "not known" were discarded. If there was a significant association the "not known" were added into the cells such that the difference between the cells was reduced to a minimum.

Besides source of referral, sex, age, and intelligence (App. II), we had adequate information on abnormal or difficult birth, feeding difficulties, toilet training, early separation from mother, position in family (App. II) (recorded as only, eldest, mid-sibling or youngest), family situation (adopted, fostered, institutional, step-parent, and parent deceased).

Reasons for referral were classified according to List C of The National Association for Mental Health Inter-Clinic Child Guidance Committee (App. III).

Disposal categories were taken from the Clinic "status at closure", i.e. Treatment Improved, Treatment "in statu quo". Supervision Improved, Supervision I.S.Q. and Consultation Only. Treatments closed through lack of co-operation were few in number and are mostly included in the second category, unless it was clear that treatment had achieved some positive result.

In this paper the results of only the more important comparisons will be referred to, in particular those which are considered to be applicable to the work of other clinics.

Differences Associated with Sex

In our sample the usual preponderance of males occurred—163 boys to 80 girls.

No significant associations were found between sex and 1946 Pooled Ratings, Pooled Improvement Ratings, intelligence, early difficulties of development, position in family or source of referral.

The girls in the sample were significantly older than the boys ($p < \cdot 05$). There was also a significant association between girls and abnormal family situations, i.e. adopted, foster, institutional, step-parent or parent deceased and this was true even after the Juvenile Court referrals had been removed. This association in part is due to the significantly high proportion of girls with deceased fathers: there were only 3 cases in all with deceased mothers.

	Male	Female	Total	
Deceased Father	7	9	16	Whole Sample excluding Outside Bristol and Juvenile Court referrals
Family Situation "Normal"	107	44	151	
	114	53	167	$\chi^2 = 4 \cdot 908^*$ Df=1

There was no significant deviation from chance occurrence when sex was compared with the reasons for referral. Eight boys were referred for truancy, 6 boys for masturbation, but no girl was referred for either of these symptoms. These figures are too small to apply statistical tests.

One quite unexpected finding was that sex is associated with disposal; this is dealt with later.

Differences Associated with Age

The older children tended to have lower 1946 Pooled Ratings and tended to improve more than the younger children. This is in conflict with the generally accepted idea that treatment or advice is more effective with younger children. In the Whole Sample, less Juvenile Court cases, the following correlations were found:

1946 Pooled Rating and Age	$r = -\cdot 216^{**}$	n=210
Pooled Improvement Rating and Age	$r = +\cdot 226^{**}$	n=210

Differences Associated with Intelligence

There was no significant correlation between intelligence and either 1946 Pooled Rating or Pooled Improvement Rating in the Whole Sample. In the Treatment Group there were the same findings, a result which does not support the practice of treating only those children with higher I.Q.s.

Differences Associated with Early Difficulties of Development

Early difficulties of development were classified under four headings:

(1) Difficult Birth—41 cases.

(Instrumental 16; Breech or Face Presentation 5; Six or more weeks premature 7; Others, e.g. jaundice, long labour 13.)

(2) Difficult Feeding—53 cases. (Food fads after the age of three are not included.)

(Sudden loss of milk 14; Bottle fed and unsatisfied over long period 16; Refusal of breast or bottle 9; Weaning difficulties 7; Others, e.g. slowness, tantrums before age 2, 5.)

(3) Difficult Toilet Training—51 cases.

(Tantrums—difficulty over "potting" 13; Very slow in training 10; Never fully established 28, of which 17 were referred for enuresis.)

(4) Early Separation—54 cases. Early separation was split into separation occurring under 2 years and separation between 2–6 years old. In fact there was no significant difference between these two groups as regards 1946 Pooled Rating and Pooled Improvement Rating so that they have been added to make an Early Separation (under 6) group. Under age 2 all separations from natural mother included, between 2 and 6 all separations from mother for more than one month, less if there was confirmatory evidence of trauma.

(Hospitalization 23; Evacuation, Adoption, Fostering 13; Illness, death or desertion of mother 9; Other 9.)

It is a rather striking finding of our survey that the scaled assessments of general adjustment, made without any theoretical preconceptions of the importance of these factors, should yet show significant differences when the sample is split according to these four headings.

Early Separation is significantly associated with abnormal family situations so we shall deal first with Difficult Birth, Difficult Feeding and Difficult Toilet Training groups only, which are not complicated by this factor to a significant extent. Comparing the three groups: (*i*) the "All Normal", where each of these factors was known to be normal, (*ii*) "Not Known", where these factors were possibly normal but for whom definite evidence of normality was lacking for one or more factors but none was definitely abnormal, (*iii*) "Difficult" where there was definite evidence of difficulty in one or more factors:

(i)	All Normal	Mean 1946 PR=15·000	Mean PIR=5·162	n= 68
(ii)	Not Known	Mean 1946 PR=14·514	Mean PIR=4·814	n=105
(iii)	Difficult	Mean 1946 PR=15·571	Mean PIR=2·886	n= 70

Analysis of variance shows the differences in 1946 Pooled Rating to be not significant, and the differences in Pooled Improvement Rating to be highly significant ($p < \cdot 01$).

Difficult Feeding and Difficult Toilet Training together affect the individual to a far greater extent than either one by itself.

(*a*)	Normal Feeding and Normal Toilet Training	Mean PIR= 5·123	n=81
(*b*)	Difficult Feeding and Normal Toilet Training	Mean PIR= 4·358	n=26
(*c*)	Normal Feeding and Difficult Toilet Training	Mean PIR= 3·00	n=27
(*d*)	Difficult Feeding and Difficult Toilet Training	Mean PIR=−·800	n=15

Groups *a* and *b* are significantly different from group *d* at the ·01 level: group *c* from group *d* at the ·05 level and group *a* from group *c* at the ·05 level. The differences between group *a* and group *b* and between group *b* and group *c* are not significant.

The four factors will now be considered separately.

Comparing Difficult Births with the remainder there is no significant difference in 1946 Pooled Rating but there is a significant difference in Pooled Improvement Rating.

Difficult Birth	Mean PIR=2·561	n= 41
Normal plus Not Known Birth	Mean PIR=4·386	n=202
t=2·247*	Df=241	

The same findings occur with Difficult Feeding; the difference in 1946 Pooled Rating is not significant, the difference in Pooled Improvement Rating is significant.

Difficult Feeding	Mean PIR=2·471 n= 51
Normal plus Not Known Feeding	Mean PIR=4·386 n=192
t=2·395* Df=241	

If the Difficult Toilet Training group is analysed by itself the 1946 Pooled Ratings were significantly higher and there was a significantly lower Pooled Improvement Rating. If, however, those cases referred for excretory disorders are removed, also eleven cases of enuresis not referred for this symptom, then the same effect of Difficult Toilet Training appears as in the group for Difficult Birth and for Difficult Feeding.

Difficult Toilet Training (less those referred as Enuretics and those not referred for this symptom)	Mean PIR=−·895 n= 19
Normal Toilet Training plus Not Known Toilet Training (less those referred as Enuretics and those Enuretics not referred for this symptom)	Mean PIR=4·839 n=176
t=3·990** Df=191	

It was found that there was a tendency for Difficult Birth to predispose the child towards the adverse effects of Difficult Feeding, Difficult Toilet Training and Early Separation though not at a statistically significant level.

In our sample, first, i.e. oldest and only children, occurred significantly more often in the Difficult Birth, Feeding and Toilet Training group, a finding that confirms the common, but seldom substantiated, view that first children have more to contend with than subsequent siblings.

First Children and Early Difficulties

	Normal	Difficult	Total	
Older and Only Children	29	62	91	
Youngest and Mid-siblings	39	41	80	χ^2=5·065* Df=1 (Not known omitted)
	68	103	171	

We conclude therefore that Difficulties in birth, feeding and toilet training do not produce more severe maladjustment but improvement is less, or at least slower. Also first children will tend to show less, or slower, improvement.

The Early Separation group shows a significantly lower 1946 Pooled Rating than the remainder of the sample, but the Pooled Improvement Ratings are not significantly different. However, this finding is considerably influenced by the cases adopted, fostered and institutionalized in all of which there was early separation.

When such cases, where early separation is in fact a part of a family break-up, are excluded there are no significant differences between the Separated, Separation Not Known, and Not Separated groups. The tendency of the means is the same as for the other early difficulty groups. We are not able to show, therefore, in our sample, that early separation alone and not accompanied by family break-up, has a definite effect on later maladjustment.

Early Separation appeared to be significantly associated with those referred as "unmanageable". However, this was in fact due to the relatively large

number of adopted, foster, step or institution children in this category, nearly all of whom had experienced early separation.

We did not find early separation to be associated with any other characteristic studied. In particular there was no higher proportion of early separated among the Juvenile Court referrals as compared with all other referrals.

Differences Associated with Position in Family

When position in family was analysed it was found that oldest and only children tended ($p < \cdot 10$) to be more frequently referred on account of fears than youngest or mid-siblings. They were less frequently referred for stealing ($p < \cdot 10$). Only children were less likely to be referred on account of excretory disorders ($p < \cdot 10$). Oldest, youngest and mid-siblings did not differ with regard to 1946 Pooled Ratings but oldest tended ($p < \cdot 10$) to show less improvement than youngest or mid-siblings.

Differences Associated with Disposal

In the sample of 243 cases there were 166 consultation cases. Sixty-five children were taken on with their parents for treatment (eclectic psychotherapy, at least once per week) and 12 cases were supervised (parent and usually child being seen at 4–6 weeks intervals). As the supervision group is so small comparisons have only been made between the Treatment and the Not Treatment groups where there was no significant difference as regards 1946 Pooled Ratings and Pooled Improvement Ratings although the Treatment group tended to show slightly more improvement.

Treatment	Mean 1946 PR=15·015 n= 65	Mean PIR=4·631
Not Treatment	Mean 1946 PR=15·140 n=178	Mean PIR=3·876
	t=(·250) NS Df=241	t=(1·084) NS Df=241

At first sight this might suggest that treatment had achieved little. However, it should be pointed out that treatment cases were easier to locate as they had often been in touch with the clinic within the last three years: in fact, 91 per cent. of treatment cases were included in the sample. If it had been possible to compare all treatment cases with all non-treated the tendency to greater improvement in the treated cases might have been more marked and in fact significant. Further, cases are selected for treatment precisely for the reason that without treatment they are considered to be unlikely to improve.

With the Treatment group there was no significant difference between Short, Medium and Long Term Treatment cases.§ Nor was there a significant difference in 1946 Pooled Rating or Pooled Improvement Rating between cases closed Treatment Improved (47) and Treatment ISQ (18).

There was, however, one quite unexpected finding within the Treatment group namely that the sexes were dealt with differently. This question of sex differentiation came up in other ways even with regard to the returning of the preliminary tracing cards when parents of boys returned the card more often than parents of girls.

Population (less Outside Bristol cases)

	Male	Female	Total	
Card returned by Parent	103	41	144	
Card not returned	94	73	167	χ^2=7·735** Df=1
Total	197	114	311	
Card returned by G.P.O.	16	13	29	

§ Short=under ten sessions. Medium=ten to fifteen sessions. Long=over sixteen sessions.

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The girls in the Treatment Group showed a significantly higher 1946 Pooled Rating than the boys but no significant difference as regards Pooled Improvement Rating:

Boys	Mean 1946 PR=14·481 n=52	Mean PIR=3·923
Girls	Mean 1946 PR=17·154 n=13	Mean PIR=4·808
	t=2·948** Df=63	t=(·634) NS Df=63

Further while the ratio of boys to girls referred was 2 : 1 the ratio treated was 4 : 1. This difference, significant in the whole sample, remains so when Outside Bristol cases, a biassed group both with regard to sex and treatment, are removed.

Whole Sample (less Outside Bristol cases)

	Treated	Not Treated	Total	
Boys	50	103	153	
Girls	13	59	72	χ^2=5·194* p<·02 Df=1
	63	162	225	

When this group was broken up into the three main divisions for referral symptoms, namely, Nervous Disorders, Habit Disorders and Physical Symptoms, and Behaviour Disorders, it was found that the association of differential treatment was only significant for the second group; Habit Disorders and Physical Symptoms.

Habit Disorders and Physical Symptoms Referral Group

	Treatment	No Treatment	Total	
Boys	21	25	46	
Girls	3	20	23	χ^2 7·187** Df=1
	24	45	69	

We have, so far, been unable to find a satisfactory explanation of why it is harder for girls with such symptoms to obtain treatment The fact that we might avoid treating adolescent girls or girls from broken homes has been gone into and the association between treatment and sex is still significant ($p<·05$) for children from normal homes and for children aged 7–12 on referral. The tendency remains, though at a lower level ($p<·10$) even when the cases are split according to the psychiatrist making the diagnosis, one of whom at the time was male, the other female.

This particular finding may be of only local importance but as the sexes do not appear in equal proportions in the Child Guidance population throughout the country it may be of interest elsewhere.

Differences Associated with Bristol Child Guidance Clinic Administration

A survey of this type also throws light on local arrangements and we analysed our results in terms of referral source, time awaiting consultation, time between consultation and treatment and re-referral. It allowed us to see whether the full range of problems was being referred from each source or whether there was a high degree of, possibly unconscious, pre-selection. These findings being largely the result of such local factors as public relation-

ships of the Clinic, professional interests of the Staff, etc., are not being given in this paper.

VI. Summary

1. A relatively simple interview record and rating method was designed to be used in a five-year follow-up of Child Guidance cases.

2. The method was found to be satisfactory in operation and as reliable as most personality assessments. Certain modifications would be introduced if the method were to be used in a more extended survey.

3. The results of studying not traced cases emphasizes that in any enquiry of this kind the not traced should be as intensively studied as the traced, for in our sample some of the differences between these groups were significant.

4. The sample improved between 1946 and 1951.

5. Early Difficulties in Birth, Feeding and Toilet Training do not affect maladjustment on referral but make for slower, or less, improvement and this holds when these factors are considered separately. Difficult Birth tends to predispose the child towards the adverse effects of Difficult Feeding, Toilet Training and Early Separation. Difficult Feeding and Difficult Toilet Training occurring together affect the individual to a far greater extent than either occurring by itself.

6. A number of sex differences were found in our sample. Girls were older on referral than boys. Girls taken on for treatment tended to be less maladjusted than boys. Proportionately fewer girls were treated, a difference due partly to a tendency not to treat girls with habit disorders and other physical symptoms. The reasons for referral did not differ proportionately between the sexes.

7. Only children and oldest siblings are found more frequently in the Difficult Birth, Difficult Feeding and Difficult Toilet Training Group than other children, not, however, to a significant extent when these factors are considered separately. Oldest siblings show a tendency to less or slower improvement than other siblings.

8. The results give no clear evidence of the effect of treatment but suggest that had it been possible to trace the whole population there might have been evidence for treatment leading to more or quicker improvement.

9. This survey fulfilled its limited purpose of studying our clinic population five years after its referral. The reasons for the overall improvement were not the subject of this survey and would require the comparison of a clinic population with an equivalent unreferred population. In our opinion, an objective and reasonably economical study can be made of the results of Child Guidance practice and methods of this kind could be applied to normal or selected control groups.

Acknowledgments

We wish to express our thanks to Professor R. H. Parry, M.D., F.R.C.P., D.P.H., M.O.H. Bristol, and to G. H. Sylvester, Esq., M.A., Director of Education, for permission to carry out this research, to the staff of the Bristol Child Guidance Clinic whose original reports made this research possible, to the judges and especially to Mrs. R. Somers, Miss B. Atkinson, Mr. J. Tong, the field workers, also to Miss C. Clarke for much help in preparing the figures.

APPENDIX I

Record Form

Bristol Child Guidance Clinic — Confidential

No. Age Sex I.Q. Informant

Symptoms

Type:

Wetting	Spitefulness	Deceit	Suicide—threat attempt
Soiling	Nailbiting	Timidity	Stealing
Masturbation	Tics	Tempers	Truancy
Stammering	Nightmares	Withdrawal	*Other offences*
Destructiveness	Insomnia	Daydreaming	

Treatment:

Hosp. Mental Hosp. G.P. C.G.C. S.M.O. *Other*

Length of Treatment Days Wks. Mnths. Yrs.

School

Type (R)	Secondary Modern or Primary	Technical	Grammar	Approved	Special ESN/D/B/OA	*Other*
Likes	Very much	Quite	Indif.	Dislikes	Hates	

Appendix I—*continued*

STAYS AWAY	Alm. never	Seldom	Now and then	Quite often	Great deal	
TROUBLE	Alm. never	Seldom	Now and then	Quite often	Great deal	
REPORT	Works well	Average	Badly			
SCHOOL FRIENDS	Many	Few	1–2	None		
COMPLAINTS	Lazy	No concentration	Always fooling	Doesn't mix	Passive	*Other*

WORK

CURRENT JOB			CURRENT UNEM.	PERIOD UNEM.		*Reason*	
PREV. UNEM.	*No.*		*Length*	*Reason*			
NAT. SERVICE	Current	Past	None	*Reason*	Army	RAF	Navy
PROSPECTS	Definite	Some idea	No idea	EARNINGS			
PREV. JOBS			REASONS FOR LEAVING				

No.					
SATISFACTION	Likes very much	Quite	Indif.	Dislikes	Hates
STAYS AWAY	Almost never	Seldom	Now and then	Quite often	Great deal

HOME

AT HOME	AWAY	*Reason*	CONTACTS HOME	Frequently	Infrequently	Never
PREVIOUS ABSENCES	*No.*	*Length*	*Reason*			
HELPS AT HOME	Frequently	Infrequently	Never			
RELATION WITH PARENTS (F. & M.)	Very good	Good	Fair	Poor	Bad	
RELATION WITH SIBLINGS	Very good	Good	Fair	Poor	Bad	
RELATION WITH INDIVIDUAL SIBLINGS	Very much	Quite	Indifferent	Dislikes	Hates	
FAMILY OUTINGS	Great deal	Quite often	Now and then	Seldom	Almost never	
CONTACT OUTSIDE FAMILIES	Great deal	Quite often	Now and then	Seldom	Almost never	

LEISURE

NUMBER EVENINGS OUT	CINEMA VISITS	Never	Less than 1 p.w.	1 p.w.	2 p.w.	3 or 3+	
ACTIVITIES	Home	Out	*Specific activities*	(2 p.w.)			

SOCIAL

FRIENDS (B & G)	Many	Few	1–2	None	ADULT FRIENDS		
AGES OF FRIENDS	Much older	Older	Same age	Younger	Much younger		
CHANGES OF FRIENDS (B & G)	Never	Occasionally	Often	GANG MEMBER	Leads	Mucks in	Follows
FRIENDS TO HOME	Yes	No	ATT. TO VISITORS	Sociable	Indifferent	Unsociable	

PERSONAL

Single	Engaged	Steady B G friend	Broken Engagement		*Other*
PSYCHOSOMATIC (rate)	Headache	Migraine	Fatigue	Digestive	*Other*
	Asthma	Hayfever	Rheumatism	Epilepsy	
ACCIDENTS	*No.*	*When*	*Type*		
ILLNESSES	*No.*	*When*	*Type*		
WORRIES	*Health*		*Others*		

CLUBS

No.	*Type*	*Frequency*	Leader	Mucks in	Follows

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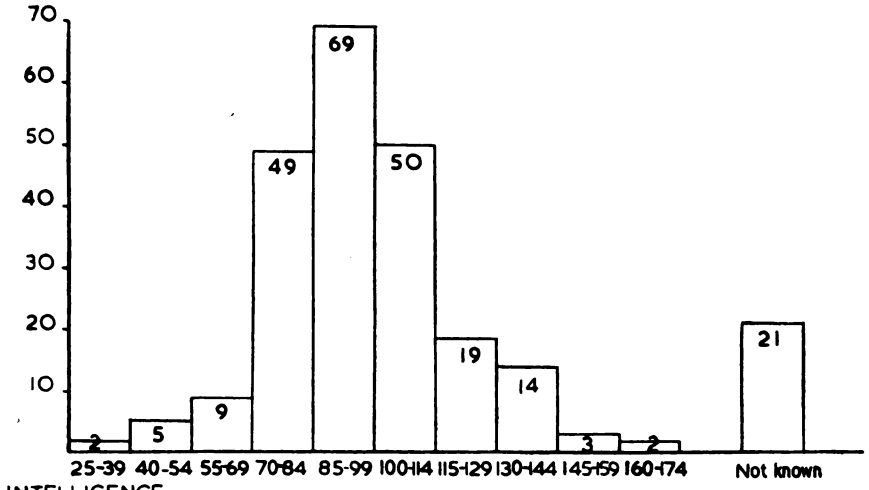
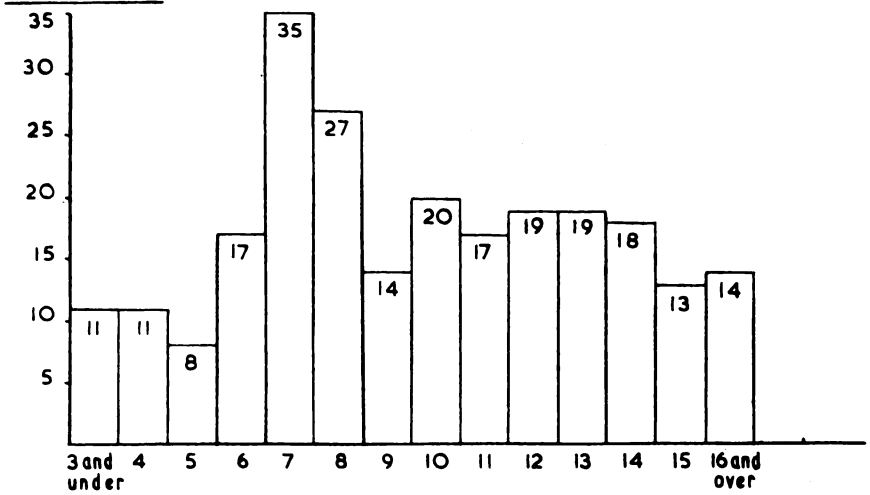
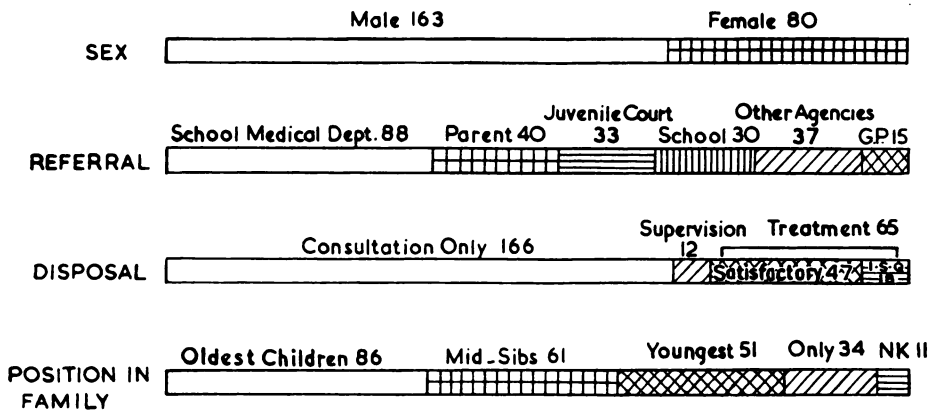
APPENDIX II

Distributions in the Whole Sample, 1946







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APPENDIX III

Reason for referral:

The Classification used is according to the list issued by the Inter-Clinic Child Guidance Conference before the war; only the major reason given at the time of referral was listed:

		including:	*Boys*	*Girls*	*Total*
I. NERVOUS DISORDERS:					
1. Fears	—	anxiety, phobias, timidity, oversensitivity	13	8	21
2. Seclusiveness	—	unsociability, solitariness	2	0	2
3. Depression	—	brooding, melancholy periods	2	1	3
4. Excitability	—	over-activity	1	0	1
5. Apathy	—	lethargy, unresponsiveness, no interests	1	2	3
					30
II. HABIT DISORDERS AND PHYSICAL SYMPTOMS:		*including:*	*Boys*	*Girls*	*Total*
1. Speech disorders	—	stammering, speech defects, hysterical aphonia, inability to speak	6	2	8
2. Sleep disorders	—	night-terrors, sleep-walking, insomnia, talking in sleep	5	2	7
3. Movement disorders	—	twitching, tics, habit-spasms, head-banging, thumb-sucking, nail-biting	6	2	8
4. Feeding disorders	—	refusal of food, food-fads, nervous vomiting, putting things in mouth	1	1	2
5. Excretory disorders	—	constipation, enuresis, faecal incontinence, refusal to use lavatory	26	13	39
6. Nervous pains and Paralyses	—	hysterical paralyses, nervous dyspepsia, pains in limbs, headache, functional deafness	0	3	3
7. Fits	—	epilepsy, hysterical fits, periods of unconsciousness, loss of memory	2	0	2
					69
III. BEHAVIOUR DISORDERS:		*including:*	*Boys*	*Girls*	*Total*
1. Unmanageable	—	disobedience, beyond control, persistent negativism, defiance, refusal to work or go to school	19	11	30
2. Temper	—	tantrums, anger, screaming fits	7	2	9
3. Aggressiveness	—	bullying, destructiveness, spitefulness, cruelty	5	1	6
4. Jealous behaviour	—		1	0	1
5. Demanding attention	—		3	2	5
6. Stealing	—	begging	20	11	31
7. Lying and romancing	—		2	0	2
8. Truancy, attention	—	wandering, staying out late	8	0	8
9. Sex difficulty attention	—	masturbation, sex play, homosexuality	6	0	6
10. Adolescent sex	—		1	1	2
					100
IV. EDUCATIONAL AND VOCATIONAL DIFFICULTIES:		*including:*	*Boys*	*Girls*	*Total*
1. Backwardness attention	—	mental retardation, school failure	12	6	18
2. Inability to concentrate	—	day-dreaming, inattention	1	2	3
3. Special disabilities	—	high-frequency deafness, word-blindness, handedness	1	0	1
4. Miscellaneous	—		12	10	22
					44