TWO YEARS' EXPERIENCE OF CHILD GUIDANCE SERVICE IN SINGAPORE

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SYNOPSIS

An analysis of 132 cases accepted by the Child Guidance Clinic over a period of two years shows that 40.1% of the referrals came from the School Health Service. Most of the patients resided in postal district 3. Problems dealt with were of a complex nature involving interaction of emotional, social and educational factors. Children from Eurasian/European/*et al* and Indian families were slightly over-represented while children of Chinese and Malay families were slightly under-represented. Two-thirds of the total cases came from families whose breadwinner held skilled/clerical and semi-skilled jobs. The ages of the patients ranged from 5 to 16 with the highest number of cases between 13-14. Boys were more prone to maladjustment or were more likely to be referred. 72.7% of the patients were from English medium schools. The bulk of the cases were primary school children. A significantly large number of retarded children was referred for maladjustment.

INTRODUCTION

The purpose of this paper is to record some observations made during two years of child guidance experience in Singapore. Child guidance service is only a recent development in the Republic. A semblance of such a service was first provided during 1968-1969 by a psychiatrist and a psychologist at Woodbridge Hospital. It was actually more a programme of mutual referrals rather than the traditional child guidance team approach.

It was not until 7th April, 1970 that a proper Child Guidance Clinic was opened at 4 College Road, Outram Road General Hospital. At its commencement the Clinic was staffed by a psychiatrist, psychologist, psychiatric social worker and a nurse and operated on an equivalence of two full days a week. However, in mid-January 1971 the building had to be abandoned when it was declared unfit for occupation. The Clinic resumed service on 17th March, 1971 this time on a three days per week basis at the Kallang Maternal and Child Health Clinic. The staff was further strengthened by a medical officer and another social worker. Administratively, the Clinic came under the jurisdiction of the Medical Superintendent of Woodbridge Hospital.

Function of the Clinic

The Clinic deals with maladjusted children up to the age of 16 years. Functionally, the Clinic is geared for bettering the adjustment of children to their immediate environment with special concern for their emotional and social relationships. For this reason the staff has to consider the medical, psychological and social aspects of each child referred to the Clinic.

The term "child guidance" is misleading as it suggests that the emphasis is on the child. This does not adequately describe the philosophy nor the function of the Clinic. It has often been found that the child may need very little treatment but that the parents may "use" the child in seeking out help for themselves. In fact, it may be necessary to treat the whole family as a problem.

Team Work

The concept of team work is important as the collaboration of the different professional members is needed to understand the problems of the child. These complex problems (psychiatric, psychological, social and educational) require the psychiatrist, psychologist and social worker to play a role at the different stages of diagnosis, treatment and management of the child. Visits by team members to the child's home and school are sometimes necessary as part of the treatment process. Indeed, this multidisciplinary approach is characteristic of other child guidance centres overseas (Buckle and Lebovici, 1960).

RESULTS AND DISCUSSION

Between 7th April, 1970 and 31st May, 1972 there were 132 cases accepted by the Clinic for management. This paper is therefore a report of an analysis of these cases with reference to the following factors: source of referrals, type of

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problems presented, ethnic grouping, age, sex, parent's occupational status, type of school, educational level and I.Q. of patients.

Source of Referrals

The Clinic received referrals from various sources (*see* Table I).

TABLE I

SOURCES OF REFERRALS

Referring Agency	No. of Cases	%
School Health Service	53	40·1
Juvenile Court	28	21·2
General Hospitals	19	14·3
Woodbridge Hospital	5	3·8
Outpatient Clinics	16	12·1
Red Cross Home/ Association for the Blind	1 each	1·6 (0·8 × 2)
Singapore Children's Society/Anglican School Counselling Service/Social Welfare Department	3 each	6·9 (2·3 × 3)
TOTAL	132	100·0

A large proportion of the referrals came from the School Health Service and the Juvenile Court followed closely by the general hospitals (notably the Paediatrics Department) and outpatient clinics in that order. This seems to imply that most of the problems stemmed from the context of the schools.

It is noted from Table II that a majority of the patients came from postal district 3 which is one of the most densely populated areas in the Republic. This makes it necessary to consider siting any future child guidance clinic in this district not only for the convenience of the patients but also in order for the professional members to deal with the presenting problem in its immediate context.

Presenting Problems

Accurate classification of the types of problems presented by the young patients is difficult because children's problems do not lend themselves to clear-cut nosology (Kessler, 1966, p. 87). The commonly used adult psychiatric diagnostic categories are often irrelevant when applied to children's abnormal behaviour.

TABLE II

PERCENTAGE DISTRIBUTION OF CASES BY POSTAL DISTRICTS

Postal District	No. of Cases	%
1, 4, 6, 9, 21, 23, 24, 26	1 each	9·6 (1·2 × 8)
2	4	4·8
3	23	27·3
7	6	7·1
8	2	2·4
10, 11, 16, 27	3 each	14·4 (3·6 × 4)
12	6	7·1
13	5	6·0
14	8	9·4
15	4	4·8
19	6	7·1
TOTAL	84*	100·0

* Figure for period 1.1.71 to 31.12.71 only.

Specific symptoms frequently met in the Clinic include behaviour and conduct disorders (e.g. stealing, aggression, etc.), poor school achievement, school phobia, vomitting and asthma of psychosomatic nature, etc.

In this paper, the presenting problems may be classified in broad terms, viz. emotional, social and educational. Emotional problems include all behavioural difficulties of the child. Social problems indicate that the difficulties encompassed the other family members as well. This may also include financial difficulties, etc. Educational problems suggest truancy, poor school achievement, etc. Table III suggests that most of the problem are of

TABLE III

PERCENTAGE DISTRIBUTION OF PRESENTING PROBLEMS

Type of Problems	No. of Cases	%
Emotional	5	6·0
Social	4	4·8
Emotional/Social	45	53·8
Emotional/Educational	7	8·3
Social/Educational	3	3·6
Emotional/Social/ Educational	19	22·6
Legal*	1	1·2
TOTAL	84†	100·0

* Compensation case.

† Figure for period 1.1.71 to 31.12.71 only.

a complex nature implicating either emotional/social or emotional/social/educational factors. Thus, social or educational difficulties per se only accounted for a negligible proportion of the cases.

Ethnic Group

Table IV presents the percentage distribution of cases by ethnic grouping and a comparison with the mid-1968 Singapore population distribution. The data suggest that children from Eurasian/European/*et al* and Indian families were more likely to present with problems of maladjustment but not significantly so. The Malay and Chinese groups were slightly under-represented. This is again not significant statistically. Tsoi (1970) in his study on attempted suicide and his observation of hospital admission rates of psychiatric patients showed that the Indians tended to be over-represented while the Malays showed the opposite trend.

TABLE IV

PERCENTAGE DISTRIBUTION OF CASES BY ETHNIC GROUP AND A COMPARISON WITH THE MID-1968 SINGAPORE POPULATION

Ethnic Group	No. of Cases	%	Control %	X^2 (p>0.05)
Chinese	93	70·4	74·2	0·08
Malay	9	6·8	14·6	2·8
Indian*	17	12·9	8·1	1·09
Eurasian	6	4·5		
European	4	3·1 } 10·0	3·1	3·64
Others	3	2·3		
TOTAL	132	100·0	100.0	—

*Includes Pakistani/Ceylonese.

Sex and Age

Table V suggests that boys were either more prone to maladjustment or were more likely to be referred to the Clinic ($X^2 = 8·0$, df = 1, $p<0·01$).

TABLE V

PERCENTAGE DISTRIBUTION BY SEX AND A COMPARISON WITH THE MID-1968 SINGAPORE POPULATION

Sex	No. of Cases	%	Control %
Male	95	71·9	53·5
Female	37	28·1	46·5
TOTAL	132	100·0	100·0

Table VI shows that the ages between 13-14 have the highest number of cases. This may probably be due to the fact that the boys and girls have to face the pressure of the Primary 6 examinations as well as having to make new adjustments in secondary school.

TABLE VI

PERCENTAGE DISTRIBUTION OF CASES BY AGE

Age (Yrs.)	No. of Cases	%
Below 5	1	0·8
5 - 6	5	3·8
7 - 8	23	17·4
9 - 10	16	12·1
11 - 12	23	17·4
13 - 14	42	31·8
15 - 16	22	16·7
TOTAL	132	100·0

Parent's Occupational Status

As seen in Table VII, children from skilled/clerical families were more likely to have problems of maladjustment or to be referred. Together with those from semi-skilled families, they formed two-thirds of the total cases. However, since there is no available control figures for occupational groups, it would not be possible to state with certainty whether the skilled/clerical and semi-skilled families overcontribute to children's maladjustment problems.

TABLE VII

PERCENTAGE DISTRIBUTION OF CASES BY PARENT'S OCCUPATIONAL STATUS

Parent's Occupational Status	No. of Cases	%
Professional/Managerial	9	6·8
Semi-Professional	13	9·8
Skilled/Clerical	54	40·9
Semi-Skilled	37	28·0
Unskilled/Labourer	12	9·1
Unemployed/Pensioner	2	1·5
Deceased	1	0·8
Unknown	4	3·1
TOTAL	132	100·0

Type of School and Educational Level

Table VIII shows that although more children from English medium schools have problems of maladjustment or were more likely to be referred as compared with Chinese medium and other types of school, this was found to be not significant statistically ($X^2 = 2{\cdot}02$, df = 2, $p > 0{\cdot}05$). Most of the cases were from the primary education level (*see* Table IX). This was largely due to the fact that the Clinic takes in patients up to the age of 16 years.

TABLE VIII

PERCENTAGE DISTRIBUTION OF CASES BY TYPE OF SCHOOL AND A COMPARISON WITH THE SCHOOL POPULATION DISTRIBUTION

Type of School	No. of Cases	%	Controls %*
English	96	72·7	63·3
Chinese	31	23·5	31·6
Others	5	3·5	5·1
TOTAL	132	100·0	100·0

*Figures for February 1971.

TABLE IX

PERCENTAGE DISTRIBUTION OF CASES BY LEVEL OF EDUCATION

Educational Level	No. of Cases	%
Kindergarten	3	2·3
Primary	91	68·9
Secondary	34	25·7
Not in School	4	3·1
TOTAL	132	100·0

IQ Distribution

Most of the cases assessed by means of intelligence tests were within the average normal range of IQ (*see* Table X). This was a fair proportion as compared to the expected percentage distribution in the normal population. However, a significantly large porportion ($X^2 = 9{\cdot}5$, $p < 0{\cdot}01$) of mentally retarded children were referred to the Clinic for maladjustment.

TABLE X

PERCENTAGE DISTRIBUTION OF IQ AND A COMPARISON WITH THE EXPECTED PERCENTAGE IN A NORMAL POPULATION*

IQ Range	No. of Cases	%	Control %
130 and above (V. Superior)	1	0·9	2·2
120 - 129 (Superior)	2	1·9	6·7
110 - 119 (Bright Normal)	6	5·8	16·1
90 - 109 (Average)	46	44·2	50·0
80 - 89 (Dull Normal)	13	12·6	16·1
70 - 79 (Borderline)	10	9·6	6·7
69 and below (Mental Defective)	26	25·0	2·2
Unknown	28	—	—
TOTAL	104†	100·0	100·0

*WISC Manual, p. 16.

†Excluding 28 unknown cases.

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