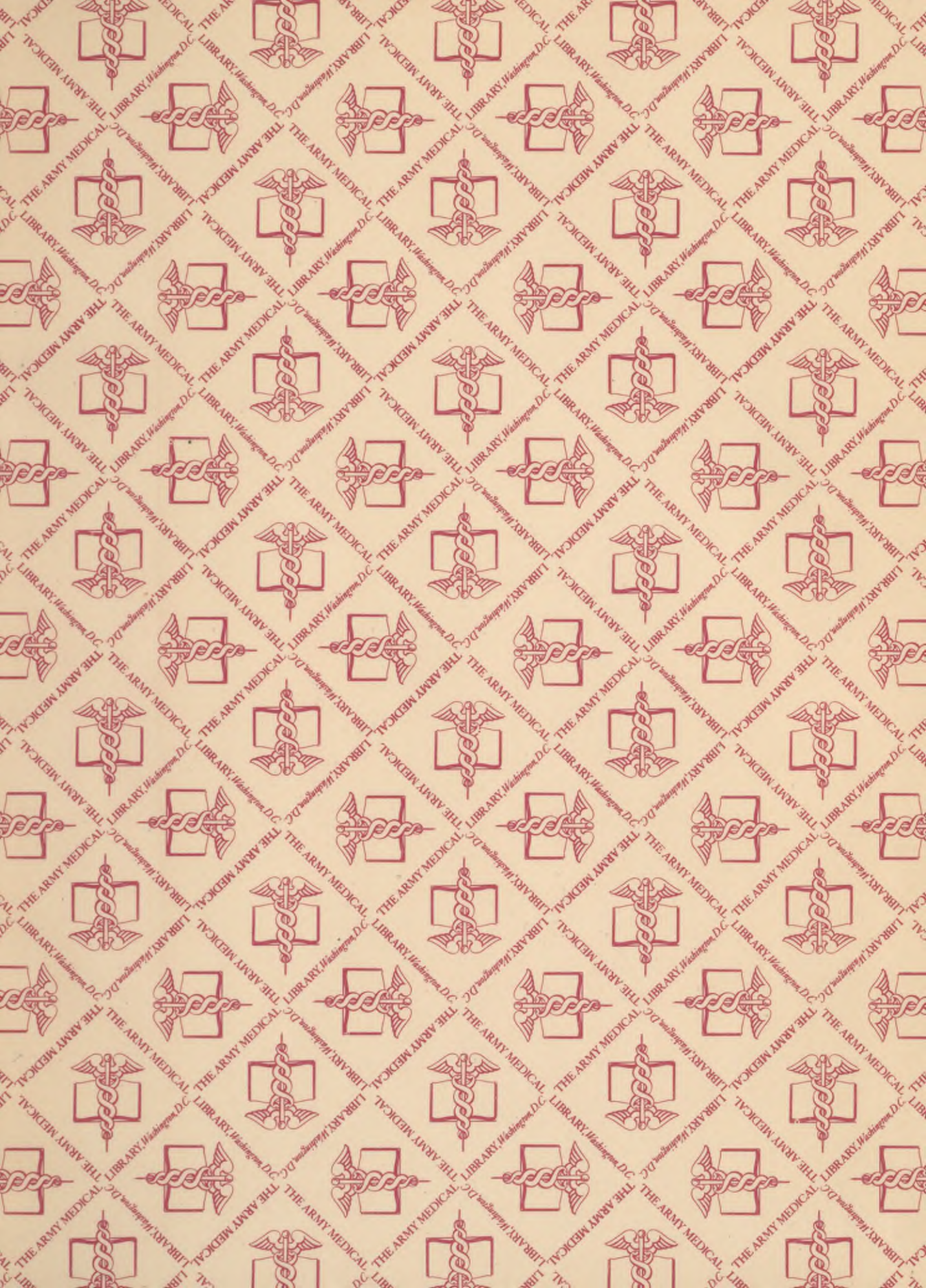
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A Manual for Psychiatrists at the Institute for Juvenile Research

 Illinois. ... Chicago

PREFACE

This manual was compiled by the psychiatrists of the Institute for Juvenile Research and is designed primarily for the use of psychiatrists beginning their work here. The first sections deal more with orientation to the history and clinical structures of the Institute; the latter sections are concerned chiefly with clinical procedures.

The manual should be used only as a guide since the complexity of interpersonal relationships contraindicates any rigid system of understanding or dealing with a child's problem. Since our concepts change with time, it is foreseen that occasional revisions will be necessary.

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HISTORY OF THE INSTITUTE FOR JUVENILE RESEARCH

SECTION A

The child guidance clinic attempts to make a modest and specific contribution to the welfare of children. Historically, however, it owes its existence to the broader concern of various groups, to the age-old and varied problems of delinquency, mental disease, and dependency. Child guidance clinics have attempted to provide guidance at those points where the understanding and service which other social agencies have mustered to meet a child's need are not sufficient. Such an attempt might be presumptuous except for the fact that the clinics offer not merely one line of attack on these difficult problems, but a synthesis of techniques not often brought together elsewhere, and more effective in combination than they could be singly.

The functions of the child guidance clinics are threefold: they study and treat patients; they seek to interest other community agencies in the prevention of behavior and personality disorders in children by promising methods of dealing with them when they occur; and they attempt to reveal to the community, through the first-hand study of individual children, the unmet needs of groups of children. This Institute also undertakes the systematic analysis of case material in the hope of contributing more exact knowledge of child behavior; and it provides training for students of various professions.

Although the term "child guidance clinic" was not coined until 1922, the essentials of the clinic scheme had been finding their way into existence for more than a decade before that year. In 1915, Dr. William Healy wrote:

> "The idea that the individual must be carefully studied in order that crime may be ameliorated has been steadily growing since the day of Lombroso."*

Dr. Healy's own contribution to the growth of this idea had already become an outstanding one. He had concentrated study from the medical, psychological, and social point of view on youthful offenders, with the aim of searching out the causes of their misbehavior and finding ways of preventing them from developing into adult criminals. A Chicago child guidance clinic latter called the Juvenile Psychopathic Institute, founded by him in 1909, was unquestionably the pioneer in this field. To some degree, the way had indeed already been blazed by Lightner Witmer's Psychological Clinic, established in 1896 at the University of Pennsylvania, but Dr. Healy's procedure included new scientific approaches from both the medical and psychological angles, and the predominant interest in delinquency also set his clinic apart from previous organizations whose services had been primarily to education.

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*William Healy: The Individual Delinquent. Boston: Little Brown and Co., 1920, page 25

The Chicago Juvenile Court (Juvenile Court of Cook County), which the Institute undertook to serve, was itself a pioneer of only ten years' standing, which had been hailed as a contribution to the solution of the problems of juvenile delinquency. It had, however, found its efforts hampered by lack of any means of scientific analysis of the human nature with which it dealt. The separation of youthful from adult offenders, the provision by probation officers and co-operating agencies of a certain amount of information about backgrounds and early histories, the substitution of humanly normal contacts for legalistic relations between culprit and judge, the probationary supervision of offenders - all these features of the new court, while sound in themselves, had failed to bring about so great a reduction in juvenile delinquency as had been hoped for. It seemed that the individual boy or girl who violated the law was usually a far more difficult person to understand and help than anyone had anticipated. The Chicago Juvenile Court judge, Merrit W. Pinckney, realizing this, welcomed co-operation from a new quarter, and the director of the new clinic, while deeply interested in the research aspects of his job, gave himself unstintingly to practical case-by-case matters. Not until five years of service had been performed did he gather his main findings together into a book, The Individual Delinquent, which soon came to be regarded as authoritative the world over.

Before this formulation reached the public, the work of the Chicago Institute had begun to exert an influence upon other communities through visiting psychologists, psychiatrists, social workers, and juvenile court judges. While, from the first, the Chicago clinic recognized the importance of social factors in causation and cure, making a keen evaluation of all the background facts supplied by co-operating social agencies, and relying on their workers for collaboration, it did not have a regular full-time social worker on its paid staff. During the years of Dr. Healy's service in Chicago, however, social workers came to be employed by a number of State mental hospitals and clinics in New York and Massachusetts, while in 1912 and 1913 such workers were appointed to the staffs of two new hospitals of a more modern type - the Boston Psychopathic Hospital and the Henry Phipps Psychiatric Clinic of Johns Hopkins Hospital, which worked with children as well as with adults. Dr. Herman M. Adler, coming from the Boston Psychopathic Hospital, naturally introduced into the Chicago Institute the type of social work with which he was familiar, and the Judge Baker Foundation also added a social worker to its staff. In the four centers mentioned, what may be termed the foundations of scientific child guidance were laid.*

Through the generosity of Mrs. William F. Dummer, the Juvenile Psychopathic Institute was supported as an adjunct of the Cook County Juvenile Court for five years and was housed in the old Juvenile Detention Home on Ewing Street, about a block from Hull House. Its

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*The preceding paragraphs were abstracted from Child Guidance Clinics, by George S. Stevenson and Geddes Smith. New York: Commonwealth Fund, 1934

prime objective was to discover the sources and possible prevention of delinquency, and its first officers, Mrs. Dummer, Mrs. Julia C. Lathrop, and Mrs. George R. Dean, wisely chose as its first director, Dr. William Healy, already becoming well-known through his work with problem children.

From 1914 to 1917, the Institute was a county agency supported by Cook County funds and was housed in the Psychopathic Division of Cook County Hospital. In 1917, Dr. Healy resigned to become head of the Judge Baker Foundation in Boston. That same year the Juvenile Psychopathic Institute was taken over by the State of Illinois as part of the newly-established Department of Public Welfare, and Dr. Herman M. Adler, Professor of Psychiatry at Harvard Medical School, accepted the appointment of State Criminologist in Illinois and Director of the Juvenile Psychopathic Institute. Thus, the Institute came to represent the preventive work of the Division of the Criminologist. During a short absence of Dr. Adler when he was released to become a medical officer with the Armed Forces, for the duration of World War I, Dr. H. Douglas Singer, State Alienist, was Acting Director of the Institute. Until 1920 the clinic continued to be housed in the Psychopathic Division of the Cook County Hospital.

In August 1920, several months after Dr. Adler returned to the Institute, the name of the Clinic was changed to Institute for Juvenile Research, a title which represented more nearly its objectives and aims, for it was the hope of the staff that cases could be carefully selected and studied intensively with the purpose of finding out why children misbehave. In this same year, 1920, the Clinic was moved to a State building at 721 South Wood Street.

In 1923, the first (rural) community clinic was organized. Under this policy, about thirty locally controlled clinics were established. The Institute co-operated in their organization with the understanding that the people of the community must be ready and desirous of such a clinic and willing to give themselves to assure its success. The Institute for Juvenile Research has been sending clinical teams to these clinics which have acted merely as consultants and advisers.

In 1926, the Institute, because of its rapid growth, was moved to larger quarters in a State building at 907 South Lincoln Street (now 905 South Wolcott Avenue). In this year, research under the new Behavior Research Fund Staff began. This was a five-year project which was financed by public subscription. One of the outgrowths of the Behavior Research Fund was the formation of the Chicago Area Project. This project was founded as a corporation in 1934 to develop a program for the treatment of delinquents and the prevention of delinquency by utilizing the social forces inherent in the life of the community. The Project is part of the Illinois Department of Public Welfare, but is, in part, privately endowed. It has been associated with the Institute for Juvenile Research and has had Clifford R. Shaw as Administrative Director since its inception.

In 1930, Dr. Adler resigned as State Criminologist and Director of the Institute, having served in this capacity for thirteen years. He was succeeded in both offices by Dr. Paul L. Schroeder, who had worked with him for six years as Chief of the Psychiatric Service. In that year, the Institute moved into the new building at 907 South Wolcott Avenue which had been built for it by the State of Illinois and where it is housed today.

In the summer of 1941, the Institute, by legislative action, was separated from the Division of the Criminologist and became a separate division under the Department of Public Welfare. Dr. Schroeder was appointed Superintendent to continue as its head. Under the new law the Institute's duties are defined as follows:

> "The Division herein created shall conduct scientific studies, diagnose and promote the treatment of children who are delinquent, mentally ill, mentally defective, or socially maladjusted, or who are in danger of becoming so, to the end that delinquency, crime, mental disorders and other forms of human maladjustment may be prevented. In the administration of this Act, the Division shall make personal examination and social studies of such children and shall make its services and treatment available to children in the custody or under the control of the Department of Public Welfare or of any court, school, public or private social agency, or parent or guardian."

The budget allowance for the Institute in 1948 provided for 19 psychiatrists, 14 psychologists, and 8 social workers (a few of these positions to be filled by persons not working in the Institute building). This does not include other professional workers or students. According to the Secretary of the American Board of Psychiatry and Neurology, the Institute for Juvenile Research is the largest child guidance clinic in the United States.

In January, 1942, the Institute was given charge of a children's ward in the Illinois Neuropsychiatric Institute. It was supervised at first by Doctors Stanislaus Szurek and Adelaide Johnson. They were succeeded, in turn, by several others, and in January, 1948, Dr. Harry Segenreich was placed in charge.

This ward is the only state facility for the treatment of normally intelligent children who present seriously handicapping neuroses, behavior disorders, psychotic, or pre-psychotic patterns. Since only a very few children can be afforded this treatment, the service to the general public is primarily educational and informative; the result of an experimental approach, a research technique, and a teaching program. The detailed functioning of the ward is described elsewhere.

SECTION B

ORGANIZATION OF THE INSTITUTE FOR JUVENILE RESEARCH

a. Administrative

Although the Institute for Juvenile Research has been in existence for many years, in 1943 it became a separate division under the Department of Public Welfare. The Bill passed by the Legislature reads in part as follows:

> "Section 1. There is established under the authority and supervision of the Department of Public Welfare a Division to be known as the Institute for Juvenile Research. Upon the taking effect of this Act, the Director of the Department of Public Welfare shall appoint a qualified person as Superintendent of said Division, and such other employees and assistants as may be necessary to provide a proper administration of this Act."

The Superintendent of the Institute for Juvenile Research is responsible for the administration of the several divisions, or departments in the Institute. These include:

1. The Administrative section (stenographers, clerks, typists).
2. The Psychiatric Division (Fellows, staff psychiatrists).
3. Psychological Division (Students, staff psychologists).
4. Social Service Division (Students, child guidance counsellors, supervisors).
5. Sociology Department (community workers, sociologists).

In addition there are the Psychophysiological Laboratory and the Recreational Therapy section.

Some explanation regarding the functions of these divisions may ne necessary.

The functions of the psychiatric, psychological, and social service divisions are mainly in the fields of diagnosis and treatment of individual child problems. The sociology department is quite separate. It deals with community problems concerning juvenile delinquency and handles them on a local community basis. The Psychophysiological section aids in the diagnosis, principally by means of electroencephalographic studies.

Besides the service functions of the Institute for Juvenile Research, various research projects are carried out by the separate divisions, either singly or collaboratively.

b. Clinical

Our sources of referral are parents, schools, doctors, social agencies, health departments, and courts. Whatever the source of referral, an application must be filled out and forwarded to us. It has been found more effective and more productive of successful handling if the application is filled out by the parents. This is so because little can be done for the child without the co-operation of the family. Applications filled out by social agencies and teachers carry the element of coercion and frequently raise parental antagonism.

Since public agencies are usually aware of our services, it might be informative to describe the course of a private or family referral. A mother is concerned about her boy and happens to hear about our services. She usually either calls up or drops into our clinic, and an intake social service worker talks with her. During the conversation an explanation of our services and of the mechanics of application is carried out. Besides this, the intake worker strives to make the contact therapeutic by varying amounts of reassurance and acceptance. The waiting period is explained - two to three months between application and examination; two to five months between examination and treatment. At this time written permission is secured from parent to obtain pertinent information from doctors, schools, and social agencies.

After the application is in our hands, the intake committee decides whether we will see the case. Since we are a public agency, there are few instances in which we would decline to examine the child. The application and other material then go into the files and are again pulled out when the case is to be scheduled for diagnostic examination. The scheduling is done by a group of three individuals, one from each department (psychiatric, psychological, and social service). Although usually each department participates in the diagnostic study, frequently there are variations such as the following: if the child has already had a psychometric examination, e.g., from the Bureau of Child Study, it is not necessary for us to repeat the examination. In such a case the psychology department is not scheduled for participation in our diagnostic study. Also, if a social agency has already provided us with an extensive history on the family, it is not necessary for a social history to be taken by our own social service department. If the child is grossly retarded and presents few or no emotional problems, it will not be necessary for a psychiatrist to see the child or the parents. After the case is scheduled the case folder goes to the administrative section where letters of appointment are sent to the family. Usually the social history and psychometric tests are done on one morning and two weeks later the psychiatric examination is made.

When the psychiatric examination is completed a diagnostic staff meeting is held in the afternoon. In this staffing, recommendations as to disposition are made. If placement of the child outside of the family is recommended, then frequently a conference is arranged with the referring

agency, or with the agency which will handle placement, in order to acquaint them with our evaluation of the case. If treatment at the Institute for Juvenile Research is recommended, then the case folder goes to the treatment intake committee, where the advisability of treatment is gone into again and assignment to one of the three departments is made. Then two to five months thereafter, depending upon the emergency nature of the case and on the availability of a therapist, treatment is usually begun. The prospective therapist usually writes to the family inviting them to begin the therapeutic interviews. During the course of treatment staff conferences are held to evaluate the progress of treatment, to redefine goals of treatment, or to close the case.

SECTION C

PSYCHIATRIC WARD FOR CHILDREN

The children's Psychiatric Ward was established to furnish residential therapy, offer means for research and special study, and provide opportunities for the training of nurses. The Ward is located on the sixth floor of the psychiatric wing of the Illinois Neuropsychiatric Institute building. It was opened in December 1941.

The bed capacity is held to twelve. Entrance into the Ward is through locked, shatter-proofed, glass-paned doors into a central corridor, in the center of which is a slightly projecting nurses' charting room. This has a safety glass door and windows permitting observation of all activities in all directions of the hall. The ward rooms and offices, as well as bathrooms, toilet rooms, closets, and dining room open into this corridor. At the far end is a door opening into a wire-enclosed out-door porch.

Furniture in each of the rooms is sparce. There are hospital-type beds and bedside cabinets, but no decorations, curtains, or draperies. However, in the lounge there are many comfortable chairs, a piano, draperies, pictures, and other furnishings to make the room as home-like as possible. The dining-room adjoins the lounge. There is a playroom as well as a closet in which the clothes of all the children are kept.

Administration of the Ward

The State Department of Public Welfare provides the physical maintenence of the Ward including supplies and equipment. Maintenance is obtained through the regular channels established for the entire Illinois Neuropsychiatric Institute. The Superintendent of the Institute for Juvenile Research directs the Ward activities through the Chief of the Children's Psychiatric Service, who is a member of the psychiatric staff of the Institute for Juvenile Research. Staff members from the various departments of the Institute function as psychotherapists, psychologists, educational and recreational therapists, and social workers. Because of the Ward's physical location in the Illinois Neuropsychiatric Institute building, general administrative policies are established by the Director of INI. The nursing staff is provided by the School of Psychiatric Nursing of INI and is supervised by that organization. The nursing staff consists of full-time graduate nurses. In addition there are affiliates, post-graduate students, as well as under-graduate nurses. Attendants are also provided. One nurse is designed as head nurse of the Ward. These persons all wear street clothes while on duty. Domestic care is provided by the dietitian and housekeeper. In addition, the resident of the Pediatric Service of the University of Illinois Hospital is also available. The resident of psychiatry during his three months' service at the Institute for Juvenile Research provides residential care for the Ward.

Chart I offers a diagrammatic representation of the organization.

Admissions to Ward

Applicants for admission to the Ward are first examined at the Institute for Juvenile Research or in one of its regional clinics, and are then referred to the Chief of the Children's Psychiatric Service from the Intake Committee. Cases for admission are selected by him. The selection of cases is subject to the limitations of the physical plant as well as that of facilities and staff. The upper age limit is twelve years and the lower, approximately five. There are no restrictions as to sex or color. Children whose behavior is such that they might cause serious damage to the building or to other patients are usually unacceptable. Only those children whose symptoms are amenable to treatment are accepted unless they offer special research or training value. Cases referred from the regional clinics are interviewed by personnel from the Ward Services, and subsequently discussed for admission. Patient and parent, therefore, are asked to come to Chicago for interview and then return home at their own expense. It is advisable to avoid making any promises concerning acceptance or date of admission to the Ward until the child has been definitely accepted.

Treatment of Ward Children

Treatment of Ward children is carried by members of the staff of the Institute for Juvenile Research. A patient is assigned to a staff member in the same manner as in all Institute therapy cases. The frequency with which a patient is seen rests upon the judgement of his therapist, but the patient is usually seen about twice a week, preferably in a playroom at the Institute for Juvenile Research. There are, however, no fixed limitations. The therapist may call for the patient at the Ward or make arrangements to have him brought over to the Institute. This decision too is left to the therapist. Collaborative therapy is also given to the parents of Ward children as in other cases of the Institute.

The Ward personnel provide the proper environment for the patient during his residence. This environmental therapeutic milieu is supervised by trained personnel. Problems are brought up and discussed at the Ward staff meetings held bi-weekly in the Institute for Juvenile Research building, at which all Ward personnel are present and which therapists should attend fairly frequently in order to exchange ideas, to learn what has been occurring on the Ward, and to offer therapeutic material to the Ward personnel. Thus, collaboration can be accomplished as well as a thorough understanding of the dynamics, movement, and progress of each case.

SECTION D

DUTIES AND RESPONSIBILITIES OF THE PSYCHIATRIST

AT THE INSTITUTE FOR JUVENILE RESEARCH AND IN THE REGIONS OF THE STATE

The main function of the psychiatrist in a child guidance clinic is the integration of all available data concerning the problems of a given child for the sole purpose of initiating corrective procedures. The social service and psychology departments contribute part of these data; the psychiatrist the rest. The psychiatrist is responsible for the examination of the child and parents assigned to him on his Diagnostic Applications Service (DAS) day. To help him in his evaluation it is best that he first secure adequate knowledge of the presenting problem by reading the DAS application and the social history. Usually an evaluation of the child's general intelligence and behavior in the test situation is provided by the psychologist. It is often helpful for the psychiatrist to acquaint himself also with these results before he attempts to study the child psychiatrically.

He then sees the child. If the child is very young or immature, the play interview technic is used. It is the responsibility of the psychiatrist to set the proper limits on the child's behavior so that no wanton destruction takes place, and when he leaves the playroom he should see to it that it is in a satisfactory condition.* With older and more mature children the face to face interview can be used for which interviewing rooms are available.

It is the responsibility of the psychiatrist to perform a physical examination including a complete neurological examination on all children that are seen by him. Only when the child has been under medical care and a report of his physical condition is available, is a physical examination unnecessary. In the case of pre-adolescent or adolescent girls, if the psychiatrist is a male, it is necessary to have either a mother or a psychologist present while the examination is performed. If the psychiatrist is not satisfied with his own examination and feels that a more specialized examination is needed, it is his duty to refer the child either to the parents' private physician or to the proper department at the University of Illinois Hospital. In such a case he will contact the social service department of that hospital and make an appointment for the child. It is the duty of a Fellow to complete all assigned physicals on mental defectives for whom psychology has recommended commitment. Such an examination is usually not an exhaustive one, but provides a general evaluation of the child's physical condition. The results of the physical examination are recorded in detail on the three-page white form, and a summary of the important findings on the single-page blue form, both of which may be found in the examination room.

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*See page 5 of this section for further details about playrooms.

Occasionally an electroencephalogram is indicated. In such an event it is the duty of the psychiatrist to complete the forms for this examination, securing the necessary data from the social service history or through direct questioning of the parents. It is his responsibility also to make an appointment with Dr. Darrow and to see to it that the parents are properly notified. He may obtain from Room 210 the forms which give the parents the necessary directions for preparing the child for this examination.

After the examination of the child is completed the parents are seen. If both parents are available each one is seen separately. If no parents are present and the child has been referred through some agency, the accompanying worker is then seen. The psychiatrist in his interview tries to secure the dynamics of the problem and to evaluate the treatability of the parents. If he believes that placement is indicated he should find out how the parents feel about this. If he thinks the case should be closed he should tentatively close it, leaving an opening in the event the staff reverses his decision. Usually it is better to close cases in a completion interview with the significant parent. It is of the utmost importance that a signed permission blank be secured from the parents which will enable us to give information to the proper sources when such an action is necessary. If permission is obtained at the time of the interview, the energy and time involved in sending a letter to the parents asking for such permission can be saved.

At the DAS staff the psychiatrist presents the problem and any pertinent information in this area. After the staff jointly makes disposition of the case it is the duty of the psychiatrist to carry out, with his particular case, any procedures recommended by the staff. The psychiatrist will write all reporting letters to agencies, physicians, and occasionally to other sources, if he is the only person assigned to the case. The reporting letter is written for the Superintendent of the Institute and signed with his or her name. For this reason care should be exercised in making any commitments. Agencies should be given a summary of our examination and our staff recommendations, but only such material should be included as the agency can accept. The following are sections which are included in a letter:

The letter begins, "We wish to report to you the results of our examination of the above-named child who was seen here on such-and-such a date." The next paragraph reads, "A physical examination disclosed..... It was recommended that..... An electrocardiographic examination was also made and the following was reported ....." Or, "No physical examination was made because a report from your physician (or agency) was available and there were no indications for repeating the procedure."

The next paragraph gives the psychological findings. In reporting the psychological findings no IQ ratings should be given to any

agencies except those connected with the court, the Illinois Children's Home and Aid Society, the Jewish Children's Bureau, etc. Agencies have a tendency to misinterpret our scores and reports to them should read as follows: "On the Stanford-Binet (or other tests) John earned a rating which indicated he was of average general intelligence." In a letter to the court, one may say, "On the Stanford-Binet (or other tests) John, with a chronological age of ..... earned a mental age of ..... giving him an IQ of ..... which classifies him as of ..... general intelligence. In all cases the statement should then be made as to whether the psychologist considered the rating reliable.

The next paragraph contains the psychiatric evaluation of the child and a summary of the interview with the parent or parents. Both these statements should be very brief and in terms which are not confusing and which the average worker may understand.

A paragraph is now included in which the staff opinion and any recommendations which have been made are given. This information is usually presented as follows: "It is the opinion of the staff that John Doe is a disturbed child due to such-and-such. It was felt that such-and-such might be of value," or, "It was suggested that John Doe might benefit if ....." It might be well for the psychiatrist to remember that the paragraph containing the recommendations is usually the part of the letter most important to the agency.

The letter is closed by saying, "If in any way we can be of further help to you, please feel free to call upon us."

It is advisable to use the child's first name whenever possible, for this helps to add a more personal touch to the letter.

It is the duty of the psychiatrist to be present at any conferences that are scheduled with an agency. He is to see all parents in completion and is responsible for restaffing the case in DAS if necessary. If the staff recommends short service interviews, it may be his function to give these interviews and to restaff the case on completion, or earlier, if such is the recommendation of the staff.

The psychiatrist is also responsible for completing all forms which are to be used later for research purposes.

After the DAS presentation the psychiatrist is responsible for the dictation of his examination and for placing these reports in the proper records. So far as possible, it is his duty, after the DAS staff is completed, to follow the case through to its completion. If a Rorschach, a Thematic Apperception Test (TAT), or other psychological test is necessary, the psychiatrist should consult with the psychologist to set hours such that the parents will not be required to come back more often than necessary. Steps in this procedure are indicated on the DAS sheet and these should be consulted until some final disposition of the case is made. However, it is helpful to make notes of

DAS recommendations as not infrequently they are omitted from the DAS sheet or, if recorded, may not be clear.

In addition to the duties and responsibilities set forth in the preceding pages, the psychiatrist is required at times to speak to Parent-Teacher Associations and other interested groups. Occasionally small groups are assigned to him for teaching purposes.

The procedures just presented hold also for the several Regions of the State. The difference is that the facilities which are available at the Institute for Juvenile Research are usually not present in the Regions and consequently some changes are necessary. The beginning staff member usually accompanies some experienced staff member to the Regional clinic until such a time as he is able to carry on alone. It is the responsibility of the psychiatrist when traveling to a Regional clinic to order his train ticket at the information desk in the lobby of the Institute for Juvenile Research and to make arrangements for hotel accommodations. Usually a team consisting of a psychiatrist, a psychologist, and a social worker travels to a certain Region. In some Regions a permanent staff is present consisting either of a social worker or a psychologist, or a social worker and a psychologist. In these Regions the procedures may differ in certain respects. The psychiatrist, as at the Institute for Juvenile Research, studies the problem, secures all available information from social service and psychology, examines the child psychiatrically, and interviews the parents. In the Regions, because of limited facilities and lack of time, all physical examinations are usually completed by the local physicians. If any further examinations are indicated the psychiatrist suggests to the agency or to the parents that these be made.

The psychiatrist is the moderator in the DAS staff of a Regional clinic. He presents his findings and together with the other members of his team makes suitable recommendations. The responsibilities of the psychiatrist are quite flexible. Where a permanent staff is available, as in East St. Louis, the psychiatrist dictates his findings and recommendations after the DAS staff and the permanent staff write the reporting letters and carry out recommendations. In such a clinic student social workers carry the treatment and the psychiatrist usually supervises treatment and holds treatment staffs. Where no permanent staff are available, no treatment is feasible, as a rule. In all the Regions the available community resources are made use of as much as possible. The social worker arranges conferences with the court, social agencies, schools, etc., and the psychiatrist acts as the moderator. It is his duty, too, in such Regions to talk to various groups in line with community education and do such teaching as is required.

On returning to the Institute for Juvenile Research it is the duty of the psychiatrist to write reporting letters to the proper sources giving a complete report of the examinations and the recommendations which have been made. This is only necessary when no permanent

staff is present in the Region. It is his responsibility upon his return to the Institute to fill out a complete expense account which must be turned in to the finance department as soon as possible. It is of the utmost importance that if any changes in the traveling schedule are necessary the psychiatrist notify the three interested departments: first the downstate Region, second, the clinic manager, and third, the staff psychiatrist who arranges the DAS schedule.

It might be well in closing to summarize the functions of the psychiatric staff at different levels:

Residents in affiliation:	
Beginning Fellows:	Diagnostic procedures
Advanced Fellows:	Diagnostic procedures Treatment Accompanying more experienced staff members to Regional clinics Giving talks
Junior Staff Members:	Diagnostic procedures Treatment Regional clinics Moderator at DAS Giving talks
Senior Staff Members:	Treatment Supervision of psychiatrists at above level Moderator at DAS Teaching Giving talks Administrative procedures such as scheduling DAS cases, etc.

Research projects may be carried out by any member of the staff. Work on such projects is usually done in addition to the other required duties.

Playrooms

There are three playrooms, two on the second-floor and one on the fourth-floor, all available for diagnostic or therapeutic interviews. The playrooms on second-floor are kept locked and the keys are in the receptionist's desk. The fourth-floor playroom, which is just off the lecture hall, is unlocked. Material for use in the playrooms are on shelves in these rooms. Additional material is stored in the closet on

the second-floor opposite the elevator. The key to this closet is likewise in the receptionist's desk. Equipment and material in this closet are essentially for therapy and should be replaced at the conclusion of the therapeutic hour. All toys and material are purchased from a limited budget by members of the Playroom Committee, composed of one member each from psychiatry, psychology, and social service. The therapist is responsible for the maintenance of the playroom used. There is no provision for help to arrange the toys and equipment. The only service provided is janitorial (sweeping and mopping of floors), which is done in the evening. Thus co-operation is sought from personnel using rooms in cleaning paint brushes, capping paint jars, sweeping up sand from the floor, etc.

To assure privacy, as well as availability of a playroom, a schedule is maintained. This schedule is posted on the inside of the therapeutic supply closet door. Each therapist signs up for the hour desired. Provision is made to start the therapeutic hour on the hour or half hour. In order to keep the schedule up-to-date, and to provide maximum availability of playrooms, each therapist is requested to reserve a playroom each month. On the last week of the month therapists are reminded by a notice on bulletin boards to renew the reservation of the hour they have used. Failure to renew indicates that the therapist no longer has any need for the playroom. On and after the first of the month anyone can reserve unused hours. A therapist reserves a playroom by signing his name on the posted schedule in the appropriate hour. He may drop his reservation of the hour at any time by erasing his name from the undesired hour. Certain times are reserved for diagnostic and ward use, which get priority.

SECTION E

DIAGNOSTIC INTERVIEW WITH THE CHILD

It is difficult to generalize concerning the psychiatric examination of a child since there are many variable factors involved. These will be discussed in more detail later. The interview is likely to lead into many digressions dependent on the child's interests and the material that comes out.

In most instances, the child has already made one visit to the clinic and therefore does not have the initial fear or hesitancy or questions about the clinic procedure. In cases where no previous psychological examination was done here, this must be kept in mind so that the initial contact with the child can be a reassuring one. The method of approach which will usually produce the best results is to treat the child essentially as one would any normal child under an ordinary situation.

When the psychiatrist goes into the waiting room to take the child for the examination, it is the usual procedure for him to introduce himself by name. In some instances, however, where there is a history of fear of doctors or the child may seem a little hesitant, it may be well not to emphasize the fact that the examiner is a doctor because of many children's association of doctors with painful procedures. The mother will sometimes begin to come with the child for the interview and is to be told very gently that the doctor will see the child alone and will talk with her later. If the child refuses to come without the mother, as happens with some insecure children, the mother can be taken into the playroom with a suggestion that she leave when the child has become interested in something in the playroom.

The actual form of the interview depends on the age, intelligence, and responsiveness of the child. It is our feeling that up into the latency period or the age of about ten or eleven, the playroom situation is usually the best one. With children beyond this age it is usually possible to have a regular interviewing situation.

In the playroom there should be no questions and little conversation until the child has had an opportunity to look around and become somewhat relaxed. If there is spontaneous conversation, the examiner will, of course, respond to it. If the child is hesitant about handling the toys, he can be told that while in the playroom he is allowed to play with anything he wants to.

When the child is relaxed and is over his first reaction, it is well to start with some innocuous conversation on general subjects which are applicable to any child, that is, questions about his recreational

activities, school, movies, etc. Sometimes, if there is a severe school problem, the school questions should not be touched upon too early. After some general conversation, the interview should be led to more pertinent subjects. It is important with children to use their own language, that is, to speak in terms that they can understand, such as, for example, using the word "ditching" and "skipping" school instead of "truancy."

It is important to try to get information on possible conflictual things by indirection, that is, in leading up to conversation about the parents, ask about the child's sisters and brothers, if any, then, if there are none, whether he would like any and whether he thinks his parents would. If there are siblings, one can bring up the matter of possible fighting or arguing with them and thus introduce the parents by saying, "What does your mother do about this?" or, "What does your father do?" These questions can lead to others about activities which may be shared with the parents, punishments which the parents may give, and questions about other adults in the patient's life.

The asking of a direct question, such as, "Do you like your father or mother best?" Can lead to a great deal of anxiety on the part of the child, as might be expected when one stops to think about the conflicts which these children have concerning their parents and that these conflicts are frequently the chief reason for their referral to us. Some such question as "Of all the people you know in the world who do you like the best?" would be much less threatening. A common answer to this is "God," and the child should then be asked, "Well, of all the people on earth?" One should also remember that a child's answers to direct and pointed significant questions are always open to doubt since children learn very early the expected and proper answers to questions that adults ask and tend to give these as a routine without very much thought.

It is well also to get across to the child the fact that negatives are acceptable, that is, accept the fact and possibly verbalize it that most children fight with their brothers and sisters; that lots of children do not like school; and that these things do not set him apart from others.

There are certain standard questions which are a part of the stock of most child psychiatrists, particularly in their early experience in diagnostic interviews with children. These questions are asked not for factual information, but to give some leads as to the child's fantasy life, his identifications with adults or other children, and his possible conflicts. These questions include those of having him make three wishes for what he would like to have if he were allowed to wish for anything he wanted; questions about sleep, leading up to information about sleeping arrangements as well as dreams and nightmares; questions

about daydreams, if the child is old enough to understand the meaning; his likes and dislikes in school subjects, types of movies and playmates. His ambition is a clue to his fantasy life or his identifications. Asking him what age he would like to be and why, sometimes gives a clue to his attitudes toward growing up.

The matter of sex discussion can sometimes be omitted entirely if it is not especially pertinent to the problem or is likely to disturb the child. If it is to be discussed, it should be approached indirectly such as with questions about babies. It is well to remember that in many cases parents do not welcome a discussion of this matter with their children.

If there seems to be some resistance or confusion on the part of the child, it is well to get his idea as to why he came. If he does not know, or has a wrong idea, it can be explained in very simple terms that the children who come here do so because they are having some kind of trouble and the examiner wonders what his particular trouble might be, and if there is anything we can do to help. It will probably be necessary to let him know that you realize he has difficulties and have been given information so that we can help him.

At some time during the interview it is well to reassure the child about the confidential nature of the interview and also to inform him that the examiner is going to talk to the mother but does not need to tell her things the child would rather not have repeated.

The interview with the older child in the interview situation is patterned pretty much along these same lines. As will be seen, no specific form can be given for this interview as it leads into various subjects which may be important in one child's problem and have no significance in another. Also remember that some children, especially those from the juvenile court, are very fearful that they may be coming here in order to be sent to "reform school" or "to find out if they are crazy."

If it seems as though treatment might be indicated, this matter can be brought up with the child in the form of asking him whether he might like to come back for further help with his problems.

If a physical examination is indicated, it can be done either before or after the psychiatric interview, depending upon convenience and also on the attitude of the child. Sometimes the physical examination can be used as a means of establishing good rapport. At other times it will have to be left until rapport has been established and anxiety reduced through the interview.

Each individual psychiatrist will, as time goes on and he becomes experienced, develop his own technics for examination. These will depend on his own attitudes, interests, and inclinations. The important

thing is to get pertinent information for the case. Remember also that negatives are as important as positives, that is, that if a child blocks on a question this is significant and can be interpreted as well as if he had given a direct answer. The child's reaction with the parent in the waiting-room should also be noted as it often contributes significant information concerning the relationships.

The matter of taking notes during the interview frequently comes up. Most psychiatrists feel that it does not impair the relationships or cause any blocking. If there is a question about it the child can be reassured that the examiner does not want to forget anything and is going to discuss his problems with the other people who have seen him and who might be able to help him.

Remember at all times that most of these children come to us primarily because of poor relationships with adults and therefore cannot be expected to form good relationships immediately.

The diagnostic interview should also be regarded, insomuch as possible, as a therapeutic interview since frequently this is the psychiatrist's only contact with the child. This can be used therefore to give reassurance and to decrease anxiety. In follow-ups we have found in a surprising number of instances that actually a diagnostic interview had also been therapeutic.

In any case where you have a question about the examination do not hesitate to discuss it with the psychiatrist who is moderator for the day, or with any of the senior psychiatrsts if the moderator is not available at the moment you need him.

SECTION F

INTERVIEW WITH THE PARENT

The parent usually interviewed is the mother because, in most cases, fathers cannot leave work and also many parents tend to feel that problems such as are considered in our clinic are the function of the mother to handle.

In some instances a history has already been taken in our clinic or has been received from the juvenile court or some other outside agency. In these cases the psychiatrist will have the only contact with the mother. In other cases, where it does not seem necessary to obtain a detailed history and the social service department may not have taken a history, it is then the function of the psychiatrist, as a part of his interview with the mother, to obtain such material concerning her own or the father's background, or the child's development as may be pertinent to the particular situation or problem.

In instances where a history has already been taken it is well to avoid a repitition of the history material and to tell the mother that the information has already been received from the historian or from the application. It is often best to open the conversation by asking what disturbs the parent most. This will usually lead to a statement of the problem which can then be discussed in terms of our findings. The mother should be given information about the finings on the physical examination, their significance, and our recommendations. She should be given also information about the psychological examination and this should be done carefully, not in numerical IQ's but in general as to what the child can be expected to accomplish. For instance, with superior children, there may be a tendency for parents to put on pressure and this should be avoided by pointing out that there are physical and emotional factors to be considered as well as intellectual ones. With the dull child, the parent should be reassured as to the child's adequacy for making a living.

Some parents also need reassurance that their child is not considered mentally "abnormal."

The interview from this point on is subject to many variations depending on the attitudes and the anxieties of the mother and the amount of interpretation that she is able to take at this first interview. It is important to avoid an attitude of hostility or of placing blame for the child's problems. If the mother verbalizes the opinion that she is probably responsible for the child's problems, that is an opening for discussing her own problems which have made her react toward the child in the way that she does.

The interview should be kept therapeutic. There should be some discussion of the mother's feelings and this can lead to a discussion of the relationship between the parents without giving the impression that

we are trying to pry into her personal affairs. It is usually a simple matter also to lead the mother into a discussion of her own and the father's background in terms of the child's problems rather than as a matter of information which should already be known to the examiner. In this interview too there are certain questions which many examiners ask rather routinely in order to get some idea of the mother's attitudes or to give an opening for discussion. For example, she is asked if the child reminds her particularly of any one or resembles any one in the family in order to see if there is any identification, especially of a hostile nature. Another question is whether she feels the child is happy or unhappy. One of the questions also which may or may not have been covered in the history regards sleeping arrangements. This can be led up to in a non-threatening manner by asking about the child's sleeping habits, such as restlessness, nightmares, etc., and then determining what the sleeping arrangements are in the family.

During the interview the examiner should be evaluating in his own mind the possibilities for psychotherapeutic treatment. If the mother seems a good therapeutic risk, the possibility can be discussed with her in terms of treatment of herself or of both herself and the child. This can be interpreted as an attempt to help her with her attitudes so that she can handle the child better. Mother should be told that our decision about this matter will be reached after all the examiners have had a chance to discuss it. Some of the interview should include a discussion of her own ideas for handling the problem and ideas about placement, institution, foster home, change of school, etc.

In your report on the interview it is also important to give information as to how treatment was presented and the mother's reaction to it. Since we have a long waiting list for treatment, it is frequently decided by the psychiatrist at the time of the first interview or by the diagnostic staff that a further evaluation of the mother should be made before treatment is undertaken to determine what help she received from the first interview and evaluate again treatment possibilities. If the case is recommended for treatment either in the first diagnostic staff or in later follow-ups, it is considered by the Treatment Committee. If the Committee decides that the case should not be accepted for treatment a report of their decision with the reasons is put into the record and the examining psychiatrist is then asked to see the mother and take this matter up with her.

In some cases it may be necessary to give the mother specific advice about handling certain problems. If it seems that she will be unable to carry out this specific advice because of her own emotional conflicts, it may be well to emphasize at this point that sometimes parents cannot do the things that are advised because of their own feelings. This is important because frequently when specific advice is given, the parents become extremely anxious because they are unable

to carry out the recommendations and therefore feel very guilty. One sees this frequently, for instance, when specific advice is given as to how to handle feeding problems. A mother may be told very clearly not to pay any attention to the child if he does not eat but her own anxiety is so great that she is unable to follow these instructions and then become more anxious, more guilty, and also hostile toward the person who gave her these instructions. It is better to discuss either at the diagnostic interview or in subsequent interviews the reason why she has this difficulty and approach it in that way.

If, during the course of the interview, it seems a good idea to have an interview with the father, this should be discussed with the mother in terms of getting a complete picture, but the examiner should not be insistent if he encounters some resistance. She should be told that we will send an appointment directly to the father.

The interview with the father would follow essentially the same pattern as that with the mother. If both parents come in for the examination, it is well to watch them together to get an idea of the interplay of relationships and this should be done after individual interviews with them. If interpretation is necessary, it is well to give this to both parents at the same time so that they cannot misquote.

At the end of the interview, the mother should be asked whether she wishes any report sent, or she should be told that certain people, who may be specified, such as the school, the doctor, or a certain agency, wish a report and she should be asked if she is willing to give signed permission, emphasizing that we do not give out any information without permission from the parents.

SECTION G

POSSIBLE DISPOSITION OF CASES

Introduction

The suggestions and remarks in this section will be of value in your handling of that part of the interview with the parent which deals with the help that the Institute can give in the case. Although in your first cases you will most frequently end the interview with the parent by stating that the final decision regarding disposition will be made at the staff conference, later you will be able to anticipate the staff's recommendation and handle the parent more individually.

It is probably tempting, in view of certain successes of psychotherapy, to advise every parent that the child and/or parent will be seen in therapeutic interviews. However, there are strong, practical and clinical considerations which should limit the number of cases recommended for therapy. First, there is a long waiting list for treatment and there is a shortage of therapists. The clinical considerations will be given in more detail later on but can be briefly summarized thus:

> Some cases cannot benefit by, some are not ready for, and some do not need extended therapeutic interviews.

Many cases can be disposed of on the diagnostic level. The indications for such disposition are covered in the section entitled "Closed." In other cases there may be some doubt as to disposition, and further observations may be necessary before deciding to close or to treat. This matter is discussed in the section "Temporizing Measures." Finally, some cases meet the criteria for therapeutic interviews, indications for which are given in the section entitled "Treatment."

I Closed

Closing the case on the diagnostic level signifies that the Institute has given the maximum amount of help at the stated time. This does not necessarily mean that we are no longer interested in the case. The principal reasons for closing a case are these:

A. Lack of anxiety

1. In the parent

> Since the successful handling and treatment of a child's problem depend on the constructive concern that the parent has about the problem, lack of parental anxiety is probably the chief reason for closing the case. Juvenile court cases are a striking example of this lack of anxiety which also shows up in cases in which schools or agencies have been mainly interested in referring the child, the parents all the while being apathetic about the problem.

While complete lack of anxiety is rather easy to detect, one must be careful not to over-evaluate the seeming anxiety shown by a parent who has been pressed by the court, school, or agency. These parents are anxious about adverse public opinion and come in to placate the pressuring forces. They do not make good treatment cases.

Another clue to lack of anxiety is a series of broken appointments for the diagnostic interview.

2. In the child

Most children do not show anxiety about their problems; they are more complained against than complaining. It is only in adolescents that some anxiety on their part is necessary for treatment to be successful.

B. Resistiveness to treatment

1. In the parent

Many parents are concerned about or irritated by the child but resist strongly the idea of therapy for themselves as part of the collaborative treatment plan. The anxiety is there but treatment is a threat to them. They tend to project the blame for the child's problem on physical causes, neighborhood, school, the other parent, etc. With special and delicate handling, they may sometimes be made secure enough to be accepting of treatment. More often, however, the case has to be closed because of the marked resistiveness.

2. In the child

Usually children are not resistive to the idea of therapeutic interviews. In some cases, however, and more especially in adolescents, this factor may be strongly present and is usually due to the manner in which the parent or agency has presented the Institute to the child. A punitive presentation will make a child quite resistive. If this factor is rather predominant in adolescents, treatment would be difficult and therefore the case should be closed.

C. Personality problem too severe

1. In the parent

Untreatable situations occur when the significant parent is very narcissistic, schizoid, completely rejecting, alcoholic, narcotic, feeble-minded, etc. Less severe parental disturbances are treatable if anxiety and willingness are present.

However, the goal of treatment with said parent would then be a limited one. For example, a possessive, compulsive mother who would need analytic therapy three or four times a week to alleviate her neurosis, might, by once-a-week therapy at the Institute, be able to get help with her seductiveness toward her son.

2. In the child

Children presenting emotional problems who are too retarded or psychotic, or who have organic handicaps such as blindness, deafness, mutism, encephalitis, etc., are generally not taken on for treatment unless a member of the staff especially desires to do so. Psychotic children or children with severe hostile or impulsive behavior usually cannot be treated on an out-patient basis. Unfortunately, in-patient facilities are rare and expensive - our Ward takes only two or three a year. Thus, for want of facilities such cases frequently must be closed. We usually consider personality problems too severe and fixed in cases where children have shown a long and chronic history of delinquent behavior which points toward the diagnosis of psychopathic personality. This feature is occasionally seen in the juvenile court cases referred to us.

D. Minimal personality disturbances in the child

Frequently the child's problem is too minor in that it falls within the limits of normal behavorial deviation and in such cases it is the parents' anxiety with which we have to deal. A common example of this occurs when parents have a healthily aggressive boy, but when they read in the newspapers about cases such as that of the Heirens or Lang boy they begin to become anxious for fear their boy might turn out the same way. This anxiety can of course be easily handled by reassurance if the child's problem is indeed very minor.

Often the parents are anxious at the time of application but by the time of the diagnostic study their anxiety has been relieved. This phenomenon occurs quite often and seems to be the result of the ability of the parents to crystalize their feelings into taking action.

In this same connection, cases frequently come to us in which there has been a gradual resolution of the problem in that the child is slowly improving. We feel that we should not intervene with treatment in such cases but rather should allow the natural strengths and assets of the family unit to manifest themselves. Parents in cases such as these need only reassurance that there is nothing to worry about in the child, that the parents are doing as much as they can, and that the mother can come back at some later time if improvement stops. Often the diagnostic examination will result in lessening of the parent's anxiety. Since some therapy (suggestive, cathartic, explanatory) is going on in the diagnostic procedure, we should not be surprised that parental anxiety will drop after such an examination.

E. Child's problem not in an emotional area

Here are function is principally diagnostic rather than therapeutic. These cases include:

1. Feeble-minded children whose parents desire commitment.

2. Infants examined with the prospect of adoption. (Psychologists are usually the only members of the staff who see cases of types 1, and 2.)

3. Social agencies who plan to place children sometimes ask for an evaluation to determine whether the child is disturbed or retarded. Frequently the child has no emotional disturbance per se, but there is a sociological disturbance in that the child has no family. Social agencies are then advised as to whether or not the child is disturbed and they can, on the basis of our findings, seek proper placement. If the child is disturbed we sometimes consider him for treatment if the disturbance continues after placement outside the home has been obtained.

F. Realistic or administrative difficulties

Occasionally the family lives in an outlying region which is too far for the parent and/or child to come in for therapy. Again, the parent may work all day or cannot leave infant children, or is pregnant, etc. These cases obviously have to be closed until the family can make convenient arrangements.

On the administrative side it has not been our policy to work collaboratively with other agencies or psychiatrists. For example, if a mother is in treatment with a private psychiatrist, we would not take the child on for therapy at the Institute for Juvenile Research.

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Closing a case on the diagnostic level still leaves us with the responsibility for giving some help with the problem. Even if the case, for any of the reasons just given, is not suitable for extended treatment, we can make certain recommendations which are therapeutic in nature.

1. Environmental manipulation

The most heroic manipulation is placement of the child away from home, either in a foster home or boarding school. This recommendation should not be made too lightly for the reasons that good placements are not plentiful and that there is a certain emotional trauma associated with separation from the family. In cases in which, however, there is a more or less chronic disturbance in the child and little hope of changing the pathologic family situation, placement appears to be the only solution.

Lesser manipulations include such recommendations as

a. The family move away from the deteriorated, delinquent neighborhood;
b. the friction-producing in-laws or grandparents move out of the home;
c. change in school curriculum or change of schools be made (This recommendation should be made only after consultation with our psychology department);
d. the child be sent to camp for the summer;
e. a preschool child be sent to nursery school.

2. Advice to parents about handling their child

It is still not quite settled as to how effective advice to the parents is in helping the child's problem. With flexible, mature parents it might be of value, otherwise probably not. In some cases advice is given to let the child have a regular allowance, to spend more time playing with the child, to be firm with the child, to be more permissive with the child, etc. Usually these suggestions are easy for the psychiatrist to make but frequently difficult for the parents to follow, due to their own personality difficulties.

3. Referral to other therapeutic facilities

a. Children with organic pathology can be referred to the appropriate clinic.

b. Occasional use may be made of such group programs as those of the Boy Scouts, church groups, community projects, etc., in cases in which more adequate socialization is desirable.

c. To parents who are financially able and desire rather immediate treatment of the child we suggest that they seek help from a private child-psychiatrist.

d. Frequently the parent is the disturbed person rather than the child. In cases in which the parental disturbance is rather chronic and the child's disturbance mild or purely reactive, we usually refer the parent to an adult clinic or make a recommendation that he or she seek private psychiatric help.

It may be seen in our closing of the case that we strive for a course of action satisfying both to the referring source and ourselves. It is also our policy to leave the door open for parents or agencies to return to us in case they want further help.

II. Temporizing Measures

In many instances it is not immediately clear as to how the case may be best handled. In such cases we have recourse to the following procedures which give us time and information for further evaluation.

A. Completion

Completion essentially means the securing of certain additional information which is necessary for evaluation. For example, if we want to learn about the father from himself rather than from the mother's report of him, we can tell mother that our recommendation will be postponed until after we see father. In the case of a child we would occasionally like to have an EEG, or a Rorschach, or a school report before we commit ourselves.

B. Conference

Occasionally when a social agency has referred the child we would like a more or less informal talk with the agency worker, either to get more information from her or to make more detailed recommendations as to handling. In such a conference a better opportunity is provided to observe the anxieties and limitations of the worker and to handle them in a therapeutic manner.

C. Service interview

Sometimes we feel that two or three interviews with the parent in addition to the original diagnostic interview would be sufficient therapeutically to help the child. Such interviews would be more clearly indicated when the child is either mildly disturbed or is acutely and strongly reacting to some temporary unwholesome stress in the family situation. When the child is chronically and markedly disturbed, such interviews would be mainly used therapeutically to help the parent accept placement of the child away from home if that was our goal.

Service interviews, however, may also be used for the purpose of prognosis. Frequently we are not quite sure that the parent will respond well to treatment. Our doubt makes us reluctant, on the one hand, to refuse therapy, and, on the other hand, to commit ourselves to a lengthy and probably unsuccessful treatment program. In such instances, if the parent is seen two or three times more, we can observe how he or she responds to the therapeutic situation. Decision as to treatment will then be easier.

D. Follow-up

Follow-up significes that we see the parent and/or child again, usually from one to six months after the diagnostic interview. This procedure is mainly used when the child is quite disturbed and when there is some obstacle to treatment or placement. When the obstacle to therapy is realistic (e.g. out of town cases; mother working) follow-up is done on our initiative. (We send the appointment letter.) When the obstacle to therapy is due to parental resistiveness or lack of anxiety, we usually leave the initiative for follow-up to the parent (parent writes in asking for the promised appointment). In this way the procedure can be used to test the amount of anxiety present in the parent.

III. Treatment

Although we strive to be therapeutic in all of our early contacts with the child and parents, we reserve the term "treatment" for a series of regular weekly interviews which usually last from three to eighteen months. The goal of treatment varies in each case but is centered around amelioration of the child's problem. Thus, for example, in treating the parent it may not be necessary to bring about some personality change in her or him if short term supportive therapy will enable the parent to take a step which is advantageous to the child.

In the section entitled "Closed" were mentioned the contraindications to treatment. As for indications, we might describe the ideal case: A parent, anxious about a real problem in the child, seems to have a good personality make-up, is interested, realizes more or less his or her involvement in the child's disturbance, and appears to have made an effort to solve the problem prior to coming to the Institute. Such ideal cases are unfortunately the exception rather than the rule. Thus we frequently have to embark on the treatment of a problem when the case is somewhat less than ideal.

Therapy is carried on by members of the departments of psychiatry, social service, and psychology. If both the child and parent are to be treated, two therapists are necessary. This is known as collaborative treatment. Frequently, however, this is not necessary and either child or parent may be treated alone. ("Parent" refers to real, step, or foster parent.) The indications for such recommendations are:

A. Treatment of child and parent

In most cases in which the child displays a neurotic pattern (i.e., negative or sterotyped, non-adaptive behavior which springs from inner conflicts) he should receive individual treatment. The significant parent should be seen in therapeutic interviews at the same time for one or both of the following reasons:

1. To decrease any unhealthy attitudes which contribute to the perpetuation of the child's disturbance

2. To prepare the parent for the eventual more healthy changes in the child's behavior, e.g., an inhibited child becoming normally aggressive. (For a fuller explanation of the neurotic pattern as opposed to the non-neurotic reactive pattern, see Witmer's Psychiatric Interviews with Children, New York: The Commonwealth Fund, 1947.)

B. Treatment of parent alone

1. Frequently we see children whose disturbance is more superficial and who seem to be reactive to the anxiety, inconsistency, ambivalence, etc., of the parents. In these cases it is common, for example, to have the school report state that the child presents no problem, whereas the mother complains bitterly or anxiously of the way the child behaves at home. Another clue to the fact that the child has not a fixed non-adaptive disturbance is that the permissive and accepting atmosphere of the psychiatric examination we find the child to be rather responsive, spontaneous, and free of significant psychopathology. In such cases we would treat parent alone.

2. When a child is in the preschool period and there seems to be very good evidence for considering the mother directly causative of the problem, and when the child's neurotic pattern does not yet seem to be "fixed," then treatment of the mother alone is generally indicated. This is a difficult period in which to determine whether or not the child requires treatment in addition to the mother's treatment. Generally speaking, the Institute's policy has been to treat only mothers of preschool children, feeling that when the attitudes of mothers are modified in this group of children the seemingly neurotic pattern of the child clears up. It must be emphasized that most normal children go through a so-called neurotic stage so that when they are seen at the Institute the picture may be confusing and may appear to be one of a neurotic pattern.

3. Parents who cannot accept their child's retardation may need help. Here the parent would be seen alone. The psychology department has had more experience with parents who cannot accept the fact that their child is slow and, although the usual service interviews by the psychologist will generally suffice to bring about the desired result, occasionally longer treatment is necessary.

C. Treatment of the child alone

1. Children in institutions have to be treated alone. Attempts to modify the environment at the institution have to be made through occasional conference or phone calls with the adminstrative head, house parent, or social workers.

2. Rather infrequently we treat a child or adolescent alone without the parent being in actual treatment. The child's therapist has the responsibility for being in occasional contact with the parent (more often by phone calls) in order to prepare the parent for certain changes, explain certain symptoms, or make suggestions.

This procedure is more often used in private practice where the expense of double therapists may be too much for the family. The indications for such procedure at the Institute have not been definitely formu-

lated as yet. At present, due to a shortage of therapists, we are experimenting further with this procedure. It would seem that in cases in which the child has a neurotic pattern and the parents for some reason or other are no longer contributing to its perpetuation, treatment of the child alone may be attempted.

3. Medication cases are carried occasionally by staff members when a project of a certain kind is being carried out. A psychiatrist may be interested in treating epileptics or choreic children with drugs. Here the child can be treated alone with occasional phone call contacts with the parents.

Concluding remarks

It must be emphasized again that the foregoing suggestions can be used only as a guide in your thinking and handling of the disposition of a case. There are so many individual variations with every case that a rigid adherence to the explanations in this section would be unwise. However, by using these suggestions as a guide, you will probably feel more comfortable in your interview with the parent and better able, at the DAS staffing of the case to contribute to the thinking concerning disposition.

SECTION H

DIAGNOSTIC APPLICATIONS SERVICE PRESENTATION

Introduction

It is hoped that the suggestions offered here will be helpful to the reader in arriving at stimulating and instructive DAS presentations and discussions. The remarks which follow pertain more to the form of presentation than to its contents. That a presentation should be inspiring is obvious, since usually from four to ten persons have to listen to it. A poor staff presentation will lose the interest of the listeners and cause them to become restless so that when the time for discussion comes their only thought will be to get on to the next case. Sometimes even the moderator may betray these symptoms and is thus unable to contribute his best to the discussion.

The things which make for a good presentation are the same as those which make for a good lecture, speech, or story. Most important is preparation. The essential and important facts in the case should be known well enough so that one need not refer too closely to the chart during his presentation. Questions may arise such as, "How does one know what the essential facts are and what the non-essential?" "Isn't it the moderator's teaching function to separate the wheat from the chaff?" If we are going to make the presentation interesting there will have to be some preliminary sifting and organizing on our part. In other words, thought should be devoted to the case before it is presented. Usually a half hour or so of such preparation will suffice. A good presenation is characterized by

1. Proper emphasis
2. Continuity
3. Succinctness

By proper emphasis is meant the high-lighing of important dynamic factors; by continuity, the logical, causative progression of events. Succinctness needs no definition.

One must keep in mind the primary purpose of the DAS staff which is the securing and exposition of enough information so that the proper disposition of the case can be made. The teaching function of DAS is secondary to this purpose. Frequently a case can be presented in such a way that both disposition and teaching can be accomplished, but if one of these, due to pressure of time, has to take precedence, it should be the disposition.

Before presenting a case you should have some idea as to the amount of time in DAS at your disposal, and how best use may be made of it. You should, in time, be able to anticipate what factors in a case will form the problem meriting general discussion. Selectivity must operate here since the time which can be given to any one case precludes

a discussion of all the factors. In a particular case it may be very clear that the mother needs treatment, but the problem for discussion is whether she can be treated at the Institute, or whether she needs more intensive treatment. In another case the disposition may be clear (the mother and child are treatable and anxious for treatment) but the problem necessitating discussion centers around the etiology of the child's disturbance. In yet another case, for example, a schizophrenic whom we would not treat, the discussion may concern the prognosis or the disposition.

Actual Presentation

The following suggestions apply to the actual presentation; the spirit rather than the exact letter of the suggestions should be kept in mind.

Introduction:

1. In the introductory paragraph the high-lights of the problem and the reasons for referral to us are given: "This is the case of Johnny Black, an eleven-year-old boy, referred to the Institute primarily because of his stealing. Other problems also are concerned with socially unacceptable behavior, and include his lying, fighting, and truancy. The referral was made through the impetus of the mother, who consulted the juvenile court, which, in turn, sent the mother and boy here."

2. In this paragraph the family setting and pertinent social and economic factors are briefly given: "Johnny is the oldest in a sibship of five and has two younger brothers and two younger sisters. He lives with his parents and siblings in a run-down neighborhood. Father is employed as a truck driver; the mother does part-time work and the economic status is marginal."

3. In this paragraph the problem is gone into more fully and the emotional reason for referral is given: "Johnny's stealing and other problems began around five years ago, about the time the youngest brother was born, and has continued in an episodic fashion to the present time. The stealing is only from members of the family. The father is angry at the boy because of his stealing and the mother is concerned. It was the mother's concern, heightened by her reading of recent newspaper reports of crimes, of juvenile delinquencies, that made her seek help at this particular time."

Social history

This is usually given by the social worker; she will pick up where you have left off. If you have to present the social history, please do not read it. You should have familiarized yourself with it prior to the staff meeting. When you give the social history, it is better to interpolate your own findings with those of the social worker rather than to wait until you report your contacts with the mother.

Since you cannot report all the information gathered in the social history, only the high-lights, or psychopathologic features, should be emphasized. If the child's early development was within the limits of normal, a simple statement such as "Early development was unremarkable," will suffice. To report the features of the parental backgrounds in a succinct way is somewhat more difficult and will depend upon experience. Most important are the stresses which the parent underwent in childhood and the type of child he or she was. For example: "Mother, being the eldest child, had undue responsibility for the care of her siblings. Her mother was rather accepting, but always sickly, her father was very strict, especially about mother's dating, but was not otherwise punitive. As a child mother accepted these limitations with outward conformity, but admits inward resentment." Since our focus is on the child, we should be particularly alert to pick out and emphasize those stresses in the parental backgound which have contributed to present attitudes toward the child.

Psychological:

This presentation is made by a psychologist and includes the reading of the school report.

Psychiatric on the child:

Before giving the results of the psychiatric examination you should state the results of the physical, if made, and if not made, tell why it was not done. Then you can proceed to the psychiatric examination. For a time at least, give a complete account of what kind of child you have seen and what transpired during the interview. Later, with more experience, you will be able to report the significant and omit the less significant data.

Psychiatric on mother:

Again, do not repeat what the social worker has said. Either say you agree with the social worker, or point out where you differ. Try to emphasize.

1. How the mother feels and acts toward the child.

2. What, in the present family setting, makes her act as she does?

3. What, in the mother's background, predisposes her to such attitudes?

4. What kind of personality has mother?

5. How treatable is she?

6. Parent's ideas re solution; attitudes toward treatment, placement, etc.

7. How was the situation left with mother?

The following is an example: "Mother was essentially as described by the social worker. She did not show with me the tearfulness that she showed during the history taking. She seems guilty and permissive toward the boy as evidenced by..... (Give actual observations from the examination). These attitudes might be connected with her hostility and guilt toward her own younger siblings whom she had to take care of. Also, it might be connected with her attempt to abort this unwanted child. At present she is insecure because of the precarious economic status, and because of father's irresponsible attitudes which deprive her of dependent satisfactions. Mother seemed to be an anxious type of person, with a capacity to give, and with some insight into her own involvement in the child's disturbance. She was anxious for help when this was suggested and explained. She was told that we would contact her if treatment was indeed recommended by our staff, and in the event it was not recommended that I would see her again to talk over other plans."

Recommendations:

Even though the recommendations are a function of the entire DAS staff, you should venture an opinion as to what seems to you the best wayto handle your case. In forming your opinions, the section on "Possible Disposition of Cases" will be helpful.

Postponement of staffing:

Occasionally you do not have enough information to staff a case, even though you have seen the child in the morning. This situation will arise if the significant parent (mother) failed to come in. For example, you saw a boy, but the mother was sick and had the father bring him in. Sometimes even if the mother and the boy have been seen, you may want to see the father before fully evaluating the case. In such instances all you need to do at the afternoon staffing is to say, "In the case of Johnny Jones, I would like to postpone staffing until I have seen the father."

Presentation of case for re-staffing:

In presenting a case that has been staffed previously, the reason for re-staffing should be made clear and used as a point of departure for the presentation. A very short summary of the significant features should be included. For example: "This is the case of an eleven-year-old boy, referred because of enuresis. Re-staffing had been recommended because there was a question as to whether this boy was too disturbed for therapy, or was possibly psychotic. Therefore a Rorschach was done." (Then the psychologist reports the Rorschach.)

Example: "This is an eight-year-old girl, referred for excessive masturbation. Although mother had led a rather promiscuous life in her youth, and it was possible that she was unconsciously encouraging of the girl's behavior, restaffing was recommended in order to see what part the father played in the picture." (Then psychiatrist reports on interview with father.)

Example: "This is the case of a ten-year-old, passive boy with a reading difficulty. Two service interviews were had with mother to evaluate treatibility. What essentially happened during these interviews was....."

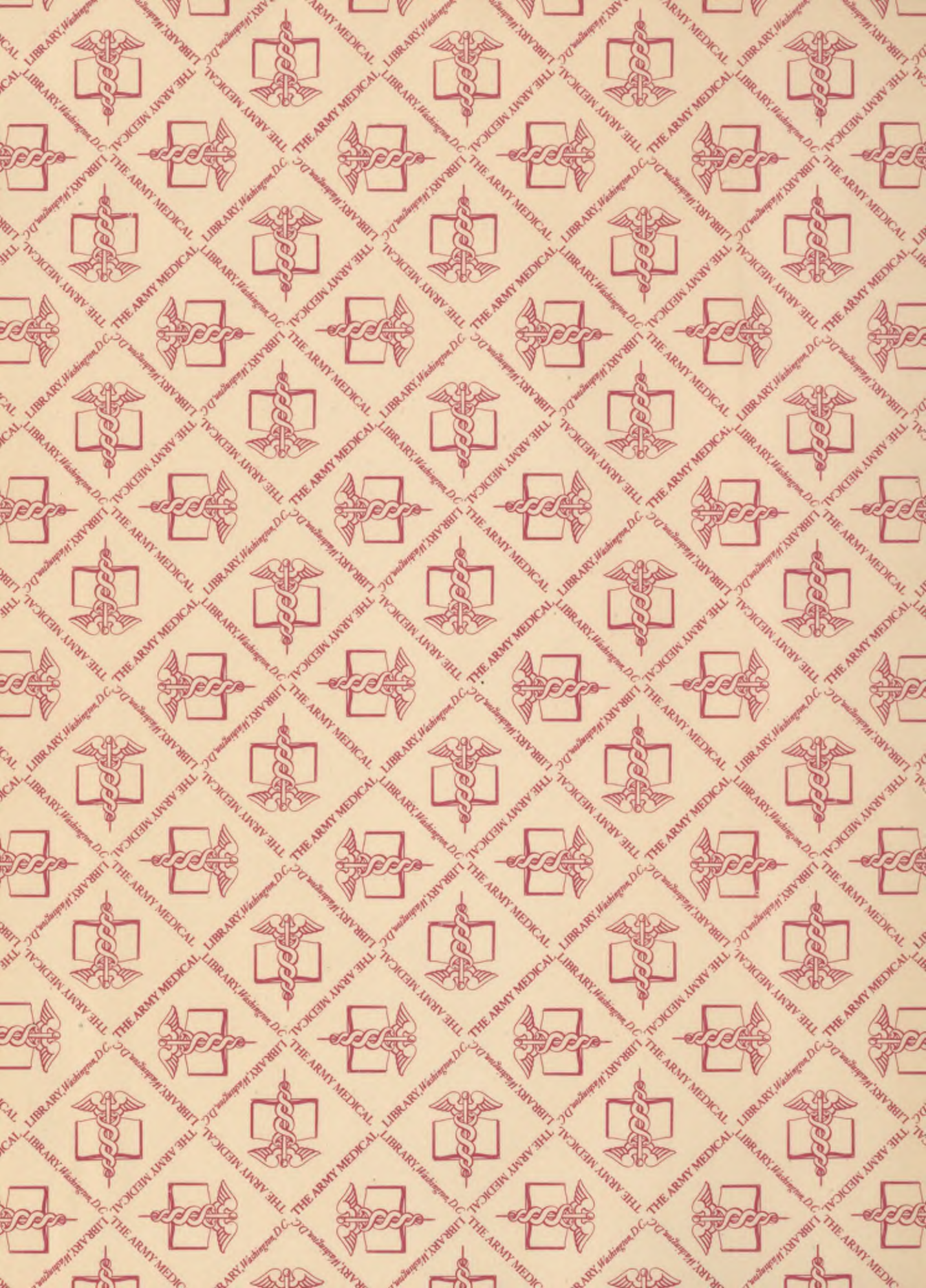
Function of moderator:

The moderator's function is primarily to aid in the disposition of the case, and secondarily, to teach. As was said earlier, both functions can often be carried out. Because of the pressure of time and the number of cases, the moderator has frequently to act as a "traffic manager," interrupting at times to get the significant material, at other times making a seemingly arbitrary decision about the disposition.

Since there are individual differences in the evaluation of the dynamics or disposition of a case, we should not be surprised if one moderator gives a particular impression of a case and the next moderator gives a different impression of an apparently similar case. By exposure to varying points of view, you can develop your own feeling and philosophy about the cases you will see.

Closing Remarks

The foregoing suggestions are aimed at achieving an ideal presentation. Often, due to factors beyond our control, a particular case will have to be presented less than ideally. Also, it is not expected that right from the beginning your presentations will be crystal clear. Some time and experience are needed for that. However, if the suggestions presented here are kept in mind, not only you, but the rest of us, will benefit much.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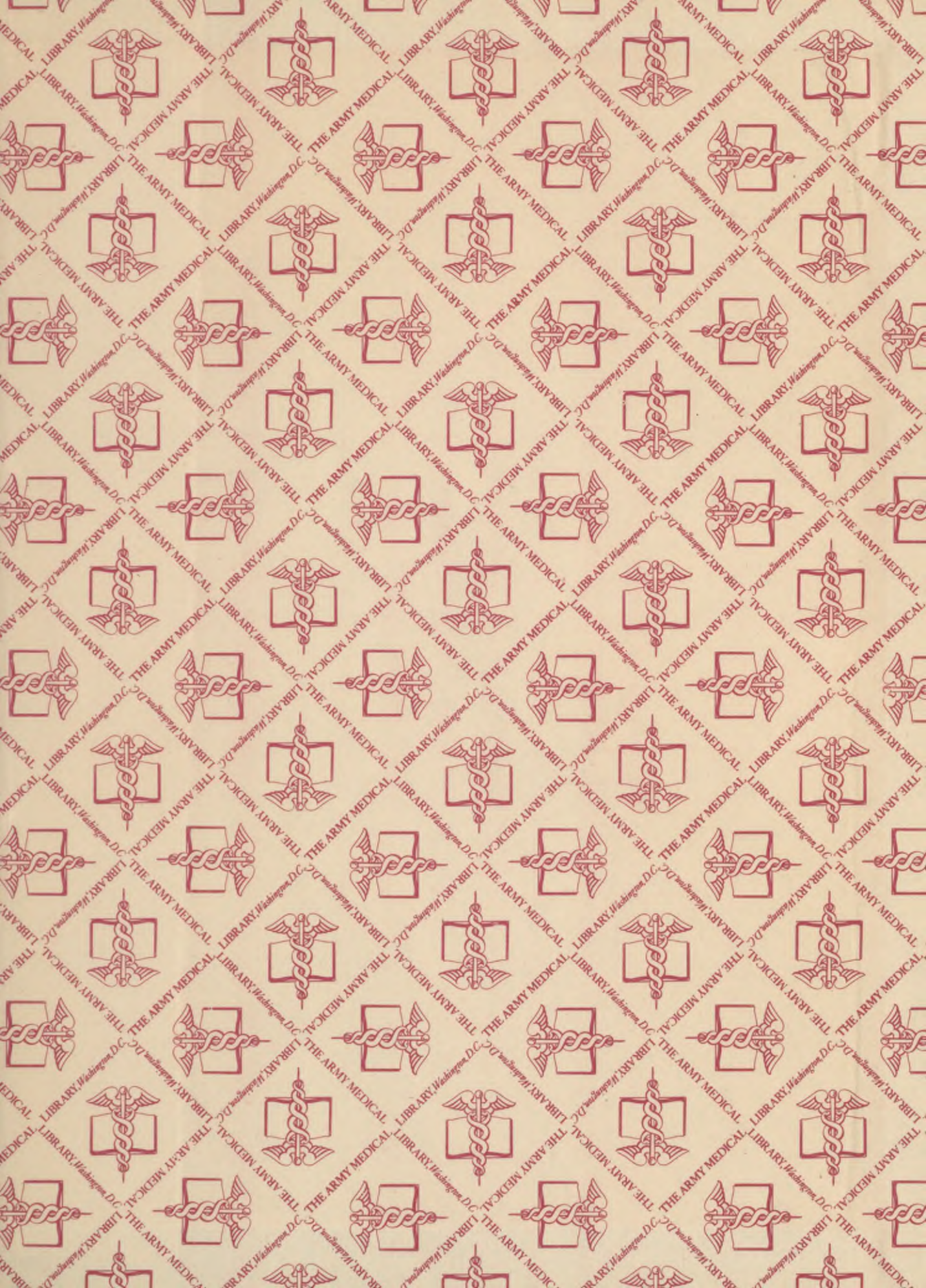
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