A COMPARATIVE STUDY OF FOUR MICHIGAN CHILD GUIDANCE CLINICS

THESIS FOR THE DEGREE OF
MASTER OF SOCIAL WORK
MICHIGAN STATE UNIVERSITY

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A COMPARATIVE STUDY OF FOUR MICHIGAN CHILD GUIDANCE CLINICS

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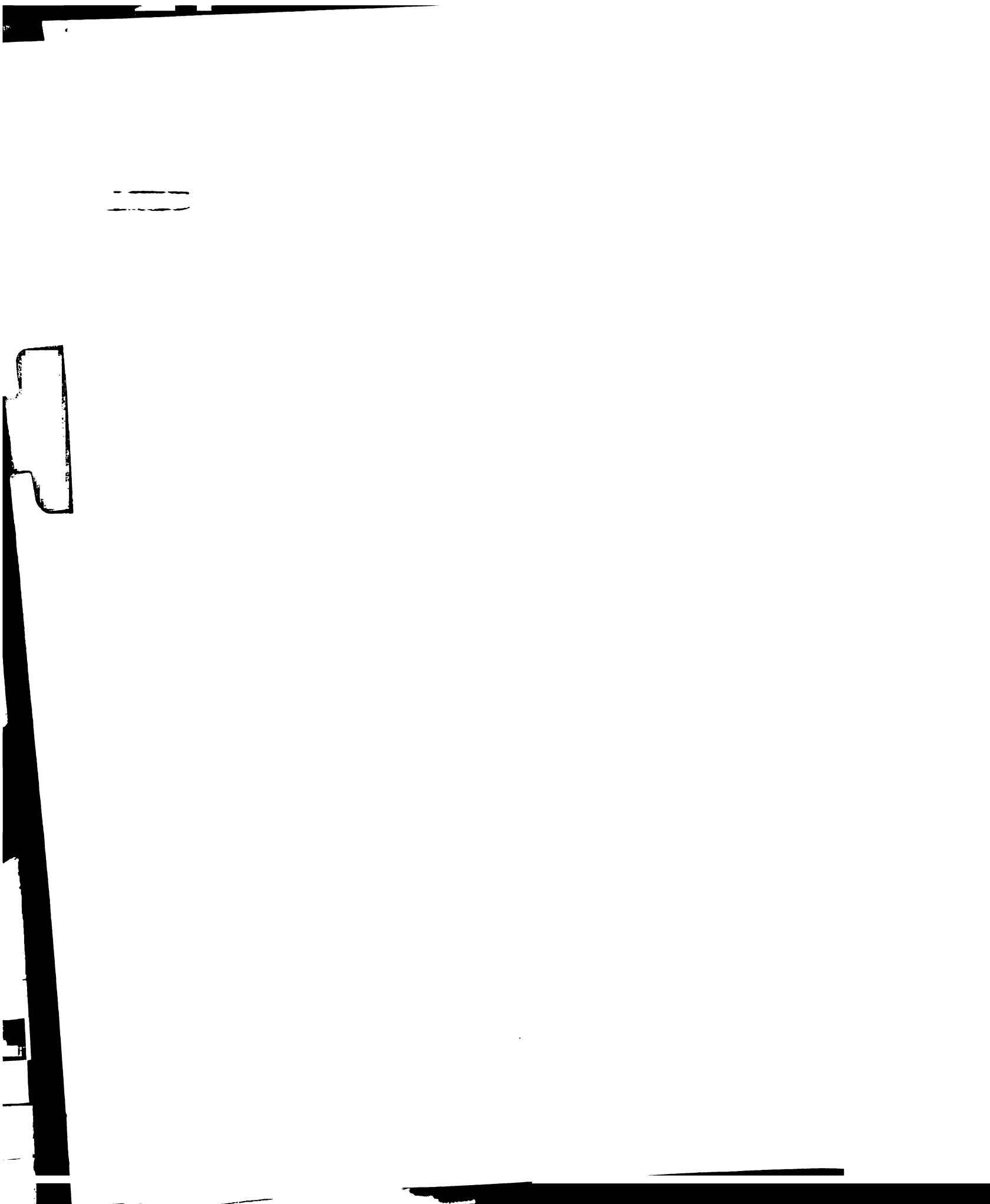

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CHAPTER I

INTRODUCTION

This is a descriptive study of four Michigan Child Guidance Clinics located in the cities of Battle Creek, Flint, Kalamazoo, and Lansing. The purpose is to examine operational similarities and differences among these clinics. The first area of study is an analysis of staffing patterns. A description of the existing staffing patterns is given to show how these affect the philosophy and operation of the clinics. This covers the process that begins when the client first contacts the clinic, through the diagnostic study, to determination of the disposition. Then treatment methods are explored. This covers the period between acceptance for treatment and termination. The various methods of financing are described next. This includes financial arrangements between state and local clinics, resources, means of soliciting funds, budgeting, and expenditures. Finally, a study is made of community relations as affected by each clinic's interpretation of its function. This includes activities devoted to interpretation of the clinic, community education, and public relations.

This study was undertaken by five students in their second year of training in the Michigan State University Graduate School of Social Work. Two students were placed at the Battle Creek clinic while one student was at each of the others. As each clinic serves a fairly comparable geographical area, it was felt that a comparative study of these clinics could be made.

The following table gives the population and number of counties served by each clinic:[1]

Clinic	Population	Counties
Battle Creek	44,169	2
Flint	196,940	3
Kalamazoo	82,089	5
Lansing	107,807	4

Even though there is substantial difference in the size of population served by these clinics, they have a comparable clientele, drawn partially from highly industrial urban areas and partially from the surrounding rural areas. Each community also has a network of social agencies that is available for collaboration.

The plan to carry out a study of the four clinics emerged as the result of discussions among the five students placed in these clinics. The students noticed similarities and differences in the procedures of their clinics, and came to the conclusion that an exploration of the reasons for these variations would be interesting to them and might reveal certain patterns that would be of importance to the clinic administrations. Permission to proceed with the study was secured from the School of Social Work, and the administrators of the four clinics. The State Department of Mental Health expressed interest and provided cooperation.

The next step was to determine what specific areas of clinic operation to study. The major decision was whether to examine one area

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[1] U.S., Bureau of the Census, U.S. Census of Population, 1960 pp. 10-13

of clinic process intensively or to study the entire clinical procedure more generally. The later was decided upon because of the lack of general studies on clinic operations. It was felt that an exploratory examination of the entire clinic process might point to areas in need of further intensive study.

A number of possibilities, such as client perceptions of the clinic and community attitudes concerning the clinic were discarded. It was felt that these areas fell outside the purpose of the study and were large enough areas to merit a more intensive separate analysis. It was finally decided to cover the five areas of clinic operations noted above and to examine them in each of the clinics.

A variety of techniques were used in eliciting the information for the study. There was first a preliminary phase in which unstructured interviews were conducted in some of the clinics as well as with officials in the State Department of Mental Health. A review was made of some clinic documents such as bylaws, minutes, and rules and regulations. An examination of current literature revealed few comparable studies, however, there was considerable information that could be used for specific related topics.

A more specific interview schedule was then devised as a basis for obtaining detailed information from each clinic. Interviews were held with various members of different disciplines of the clinics' staffs using the interview schedule. The State Department of Mental Health and the four clinics cooperated in giving the students many relevant documents, reports, statistics and other information they thought would be of help. Other procedures and techniques were used in the student's

selected areas of study. These are described in the following chapters in the individual presentations. All of the above information was then compiled into a written account of what had been found in each clinic. Each student selected one of the five areas for a more intensive examination and report of his findings, using the compiled material as a guide.

Each student approached his project through an analysis of one aspect of operation common to each clinic. Following this, the student explored a more specific aspect of clinic policy drawing upon sources in the literature as well as data from the clinics. Thus, Eleanor Keyes completed an analysis of staffing patterns which was reviewed against the wider background of interdisciplinary relationships on the psychiatric team and the kinds of problems and issues involved in these relationships. Chapter II covers team relationships while Chapter III deals with staffing patterns of the four clinics.

A pattern of adequate fanancing must be established by each clinic to provide service. In Chapter IV Wayne Babcock describes the patterns of financing found in the four clinics. Fee charging has become more prominant in all social agencies. The issues involved in charging fees for service are explored in Chapter V.

An examination of intake procedures is described by Marjorie Sharpe in Chapter VI which is followed by theoretical discussion regarding intake in Chapter VII. Thomas Ruhala used this as a point of departure to discuss joint interviewing of the family in Chapter VIII. As the Flint and Lansing Child Guidance Clinics are engaged in experimental projects using the technique of joint interviewing, a review of these

developments is included as pertinent to a descriptive study of these four clinics. The practices of joint interviewing used in diagnosis at the Flint clinic and in treatment at the Lansing clinic are reported.

Treatment is one of the primary functions of all child guidance clinics. In Chapter IX Ray Hughes reviews the various philosophies and policies of treatment which prevail in the four clinics. Termination follows treatment and isdiscussed in Chapter X. Community relations are an integral part of every clinic's service to its community. Thomas Ruhala analyzes the various procedures used by these four clinics in Chapter XI. Finally, similarities and differences among the four clinics are summarized in Chapter XII.

It should be noted that the material presented does not necessarily reflect policies or statements of either the State Department of Mental Health or the Child Guidance Clinics. Rather, it is a composite of findings from many sources, and is, therefore, the sole responsibility of the students.

CHAPTER II

TEAM RELATIONSHIPS

Any discussion, or even thought, regarding staffing of a Child Guidance Clinic leads automatically to the team approach of orthopsychiatry. Webster defines orthopsychiatry as "Prophylactic psychiatry, concerned especially with incipient mental and behavioral disorders in childhood and youth."[1] A Psychiatric Glossary states: "Orthopsychiatry: Psychiatry concerned with the study of children. Emphasis is placed on preventive techniques to promote normal, healthy emotional growth and development."[2] A Comprehensive Dictionary of Psychology and Psychoanalytical Terms defines orthopsychiatry as "the study of mental disorder with emphasis upon earlytreatment and prevention, and based on the combined resources of psychiatry, pediatrics, psychology, and social work."[3] Thus the important factors are preventive psychiatry using the team approach.

McBee defines the orthopsychiatric clinic as:

> "...one in which the services of all three professional groups -- psychiatry, psychology, and social work -- are available and coordinated as necessary in the interest of

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[1] Webster's New International Dictionary (2nd ed. unabridged Springfield, Mass: G. and C. Merriam Co., 1957), p. 1724

[2] American Psychiatric Association, A Psychiatric Glossary (Washington, D.C.: American Psychiatric Association, 1960) p. 48

[3] Horace B. English and Ava Champney English, A Comprehensive Dictionary of Psychological and Psychoanalytical Terms (New York: Longmans, Green and Co., 1958), p. 364

> the patient. In such a clinic, the psychiatrist always has the responsibility for the treatment of the patient whether he does the treatment himself or delegates it. It is not necessary that the psychiatrist be the administrator of the clinic. It is essential that all three professions participate in the planning and review of cases and in policy making."[4]

Historical Background:

When psychiatry, social work, and psychology were brought together in the early 1920's orthopsychiatry was born. They were brought together as full fledged members of the team in Child Guidance Clinics. These were first established shortly after World War I as a means of learning about the emotional life of children and instituting a treatment program to eliminate emotional conflict. Psychiatry, profoundly impressed by the research findings of psychoanalysis, had come to recognize that emotional conflicts in the early years caused the serious emotional conflicts and illnesses of adult life. These three disciplines found that by working together they could obtain a comprehensive picture of the important factors in a child's emotional life.

Historically there had already developed a close kinship between psychiatry and social work.

> The psychological concepts of Adolph Meyer, that at this time (1916-1917) were coming to be progressively more accepted by psychiatrists, led a new groundwork and rationale for activities of mental health associations. Meyer's ideas turned attention to the individual's interaction with his environment...The dynamic psychology of Freud was also having a significant

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[4] Marian McBee, Chairman, "Symposium, 1950 Training in the Field of Orthopsychiatry: Findings of the Membership Study in Relation to Training and Membership," American Journal of Orthopsychiatry, Oct. 1950 pp. 692-693

> influence. The insights into human behavior it afforded were to be a factor in the collaboration of psychiatry and social work...Moreover, the application of psychiatric principles to social work techniques progressed with a sweep and a speed that left a profound influence on the entire social work profession. As a result, the alignment of social work and psychiatry for collaborative service to the mentally ill seems to have become a permanent development. Significantly too, in the field of emotional disorder of childhood, the community environment came to be seen as a most important factor in treatment programs for disturbed children.[5]

In addition to the psychiatrist's developing interest in the environment and the social worker's interest in Freudian psychology there is another area these two disciplines share in common. Basically, the aim of both is greater individual self-realization. This is practiced through freedom of choice, self-motivation and self-direction. These are principles underlying the healthy growth and development of personalities. Both disciplines can flourish only in a democracy so this regard for the individual's personality makes democracy more than a political system. It is the life's blood of these professions as practiced in the United States. In addition to this basic alliance of social work and psychiatry in the democratic tradition. Cannery's first principle of teamwork develops this further when he states:

> Teamwork is incompatible with an authoritarian ideology. Without a firm conviction of the essential dignity and worth of all men, without the recognition of the responsibility of each of us for his fellow man, teamwork and the welfare philosophy which it is designed to implement make little sense. Thus the "team" is not an end.

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[5] Group for the Advancement of Psychiatry, The Psychiatrist and his Roles in a Mental Health Association, Report #44 Formulated by the Committee on Public Education (New York: Group for the Advancement of Psychiatry, February 1960) p. 44.

> It is a means designed to serve the ultimate realization of the potentiality of those whom we are dedicated to serve.[6]

Cennery then develops the team relationship still further, saying:

2. Teamwork is a fellowship of men and ideas. No group can long endure as ameaningful entity without common ethos. The bond which unifies the clinical team is the bond of service and the dedication of the collective talents of its individual members to the realization of that end. It is a fellowship of interdependent inquiry. Differences may and do exist between individual members and disciplines, but without some common denominator of effective teamwork lies in the conception of men as the product of a biological, psychological, and social continuum...The method of the team is the method of disciplined scientific inquiry jointly pursued...

3. Effective teamwork rests on the premise that the whole is greater than the sum of the parts...Teamwork is...a conviction that the integration of distinct and overlapping skills gives rise to unique insights and unique therapeutic possibilities. Teamwork is predicted on the individuality of the participating disciplines. The team is an homogenized whole. Its strength derives from the preservation of difference. Before one can become a useful member of an interdisciplinary process he must first have established his identity within his own profession...

4. Teamwork is an interpersonal process...teamwork does not just happen, it develops from a discovery of self and of others and from a conscious effort to implement this insight in the joint activity.

5. Teamwork implies a capacity for growth and change. Teamwork is a dynamic process...

6. Teamwork implies the understanding and acceptance of authority... each clinical decision is an expression of greater or lesser probablity in which each must share, some to a greater and some to a lesser degree. But all must be bound by the validity of group decision...The authority of the team is the authority of reason and competence. The mature individual finds little difficulty in relating to this concept.[7]

The psychiatric experiences of World War I increased interest in working with children and stimulated the development of psychiatric clinics for children. At this time:

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[6] Maurice F. Cennery, "The Climate of Effective Teamwork", Journal of Psychiatric Social Work, XXII (January 1953) p. 59

[7] Ibid. pp59-60

> Child analysts devoted their major efforts to the study and modification of conflicting trends within the child, drawing the parents into the treatment situation in a widely variable way, often through the parents' personal analysis. A specifically American contribution to child psychiatry was the Child Guidance Clinic, a structure which developed out of the interest of psychiatry, psychology, and social work in how to help disturbed children and their parents. The professional knowledge of these groups gradually fused and made clearer the concept that a child is in a dynamic relation to significant people in his environment. Out of this concept evolved a therapeutic philosophy which included modification of both environment and child in ways most favorable for his psychological growth. This philosophy was implemented in the team or collaborative approach, which provided for active participation of parents in a therapeutic process focused on the disturbances in the parent child relationship. Parent participation was felt to be a necessity since, in most instances, the child is brought for help because the parents are concerned about him--a child does not seek help because of his own insight. Experience in child guidance practice demonstrated also that a child can sustain a change in his personality only with the support of his parents or their substitutes. While it is clear that child guidance clinics did not discover the important influence of the parent on the emotional development of the child, the fact remains that the collaborative work of these clinics has refined the professional skill needed to include parents in the clinic service designed to help a child with his emotional difficulties.[8]

With the change in emphasis from diagnostic to therapeutic, the shortage of therapeutic personnel became acute. Some of the therapeutic work had to be turned over to non-medical personnel. Over the years, more of the therapy has been carried on by social workers and psychologists. The role of the social worker developed from history taking into casework, which eventually developed into therapy. At first this was carried on with the parents; later social workers found they could treat the children themselves. Along with the psychologist's testing there developed

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[8]Group for the Advancement of Psychiatry, Basic Concepts in Child Psychiatry, Report #12 Formulated by the Committee on Child Psychiatry (Topeka, Kansas: Group for the Advancement of Psychiatry, April 1950) p. 3

the inclusion of work on educational remedial problems which led to the recognition that remedial problems fundamentally involve general personality problems requiring the usual psychotherapeutic methods. This experience concomitant with the use of these methods led to its application to other types of problems. Concurrently, the psychiatrist made some shifts in the direction of his interests by sometimes taking the parents for therapy as well as child patients.

Team Configurations:

Today, there are many definitions of "team" and many different kinds of teams in operation. It is always a group of persons giving direct service to an individual or a family treating the emotional climate in which a child grows. The most common composition of the team consists of the three disciplines of psychiatry, social work, and psychology. "Here the lines of specialization are hazy. Some attempts have been made to make a clear distinction as to the division of labor. However, the consensus seems to be that clear cut distinctions are difficult to make."[9]

There are several configurations found in organization of recognized standing. Each requires separate consideration. In some organizations the three professions provide two types of service -- therapy and casework. Some diagnostic formulation is a basis for therapy but psychological examinations, as such, have been sharply curtailed or almost eliminated as part of the routine for handling cases. This has been

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[9]Daniel N. Wiener and Otto N. Raths, Jr., "Contribution s of the Mental Hygiene Clinic Team to Clinic Decisions", American Journal of Orthopsychiatry XXIX (April 1959) p. 350

done deliberately because of the conviction that psychological examinations are not indicated in the process of treatment offered by the organization. The three professions are still represented on the staffs of most of these agencies, but we have three professions with two basic functions -- psychotherapy and casework. This situation seems to have developed as a result of changes in practice, such as the increased use of nonmedically trained personnel for treatment, and the growing emphasis on the selective, rather than the routine use of any procedure in a specific case. It is felt that an early development of a treatment relationship is fostered and time is not lost with such a policy.

A second type is found in organizations where the psychiatrist is a regular staff member, has supervisory administrative duties, participates in the formulation of policy, but does not devote any appreciable time to direct service to patients. Instead, psychiatrists in these organizations function as consultants to other staff members who carry most of the cases. This might be a logical outgrowth of the practice of using psychologists and social workers for therapy, hastened, perhaps, by the shortage of personnel.[10]

The two kinds of situations just described represent changes in function for the three disciplines. There are two other groups of organizations which represent a greater departure from the original pattern of the clinic team.

In one group of organizations the basic composition of the clinic

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[10] Morris Krugman, "A Study of Current Trends in the Use and Coordination of Professional Services of Psychiatry, Psychology, and Social Work in Mental Hygiene Clinics and Other Psychiatric Agencies and Institutions", American Journal of Orthopsychiatry, XX (January 1950) pp. 58-62

team has been changed. Only two disciplines are represented on the staff of certain clinics, either psychiatrist or social worker, or psychologist and social worker. In these organizations the services of the third are available by some special arrangement. The psychiatrist or psychologist may be a consultant on a fee basis, or his time may be made available by another agency to see referral cases. The number of cases seen by this outside consultant is usually a small proportion of the total case load. This consultant takes no part in formulation of policy on the work done by the organization or on the type of case to be referred to him. He has no responsibility for deciding when or how a specific case should be handled or referred. He sees the cases sent to him and makes a report, either in writing or at a staff conference which he attends. It would be rare for this outside consultant to carry any cases for the agency on a continuing basis, but he may be consulted about changes which occur in cases he has seen.[11]

Team Functions:

As mentioned previously, there is much that is basically common between psychiatry and social work leading to considerable overlapping in functions resulting in some lack of clarity in functions. The psychiatrist's special contribution to the team is his continuing interest in medicine with an emphasis upon pediatrics. This includes continuing study and learning in the processes involved in somatic expressions of psychic phenomena as well as knowledge regarding the development of the normal infant. Another specific contribution of psychiatry to the team

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[11] Ibid.

is the psychiatrist's ability to deal directly with the unconscious.

Social work brought to the team the knowledge that the child is not an independent individual but is influenced by his environment including his family upon whom he is dependent. Therefore, treatment of the child could not disregard familial situations from which he cannot be separated. Thus the social worker's understanding of psyche-social factors, with emphasis upon social aspects brings into focus the difficulties created by the individual's problem in carrying out his various social roles. Although the caseworker may never deal with the unconscious material directly, he must understand it in order to relate treatment to the realities of daily life.

Most schools of internal medicine today recognize the social implications of illness and teach students the social side of medicine. No other discipline is more complex than social work and it actively touches more people than any other. Where there are human relations, there is social work, as whatever affects the behavior of man in his relations to others is important to social work.[12]

This is again an actual overlapping of the two fields. There are several areas other than actual psychiatry which is now also emphasized as important to the psychiatrist.

> ...he must have knowledge of, and ability to work with, community organizations. He must know something about community resources, and how they may be used for the benefit of the clinic patients. As a member of the clinic organization, he does not need to know all the details,

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[12]Spafford Ackerly, "The Clinic Team", American Journal of Psychiatry, XVII (April 1947) p. 12

> but he certainly should be alert to the over-all picture of the community.[13]

Required in the curriculum of graduate schools of social work are courses in Community Organization and Social Welfare Organization. The similarity between these subjects and Dr. Lawson's statement of psychiatric requirements is obvious. The psychiatric and social work approach to the patient is similar because it is through interviewing as opposed to the psychological approach through testing. Both disciplines are involved in the intake procedure while the psychologist is usually later with his testing. Just as medicine now recognizes the social implications of illness, the social work training period includes psychiatric components and its implications which establishes another common bond.

Of the three disciplines involved in the clinic team, psychiatric social work has taken its task most seriously and made the most definite efforts to determine its functions and to train for these in an organized fashion. In more recent years and in a somewhat less organized way, psychiatry has also attempted to establish standards of training. Clinical psychology is the last discipline to establish itself. It was necessary for clinical psychology to go through the stage of breaking away from academic psychology in order to establish its field of work on an adequate practical basis. There is now a trend toward reamalgamation with the parent body. Because the other two disciplines did not have this sharp contrast with their origins, they were able to deal with their problems earlier and so establish themselves in the field of psychopathology

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[13] Lawson G. Lowrey, "Symposium 1950 Training in the Field of Orthopsychiatry; Findings of the Membership Study in Relation to Traing and Membership", American Journal of Orthopsychiatry, Chairman Marian McBee, XX(Oct. 1950) pp. 676-677

earlier.[14] Today the psychologist's contribution has many sides, any of which may be emphasized according to his training, experience, and interest. He may be a psychometrist, a diagnostician of personality structure, or a psychotherapist. Basically, his functions are changing in the direction of broader responsibility in cases, particularly in treatment. The field of clinical psychology is expecting competence in three major areas: "...diagnosis...research...and therapy, the use of techniques for improving the condition of the person who comes for help."[15]

In 1959, The American Orthopsychiatric Association completed a study of orthopsychiatric clinics, agencies, and hospitals from six regions: Chicago, Cleveland, Detroit, New England, New York City, and Washington D.C.[16] This report indicates that all three disciplines engage in psychotherapy.

> About a half to a third of those using more than one discipline for psychotherapy said there were no differences in methods and goals, although some of these had previously made differences in assignments. However, a little less than a third actually made no differential between professions in assignment, methods or goals. The attempts of others to describe methods and goals of treatment were not always successful. The descriptions of social service treatment were the clearest, involving ego-supportive methods geared toward rather well-defined goals, but again the differentiation from "casework" was often discussed. Psychiatric treatment was more usually described according to method by such terms as "intensive", "deep", or "uncovering". Also mentioned were certain types of cases to be treated by psychiatrists such as psychosomatic diseases, or conditions in which drugs were being used. There was seldom

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[14] David Shakow, "Clinical Psychology: An Evaluation", Orthopsychiatry, 1923-1948: Retrospect and Prospect, Ed. Lawson G. Lowery & Victoria Sloane (New York: American Orthopsychiatric Association, 1948) pp. 231-247

[15] Ibid., p. 237

[16] W. Mason Mathews, "The Psychotherapeutic Function of the Orthopsychiatric Team: Report of the Committee on Psychotherapy. Panel, 1959", American Journal of Orthopsychiatry, XXX (January 1960) pp. 49-86

any attempt to describe the methods and goals of psychology.[17] Only a few clinics specified types of cases or kinds of psychotherapy appropriate for psychologists. In these settings where psychologists do psychotherapy, they do not work with cases selected for them specifically because of their profession. It again emphasizes that the psychologist does not present a clearly percieved image with respect to his therapeutic role.

The study[18] indicates that there is no established basis for distinguishing how assignments to the different disciplines are determined or that the therapist's experience and attitudes are considered. The general pattern in child guidance clinics is for social workers most frequently to treat the parents and psychiatrists and psychologists to tract the children. However, in contarst to this, in one region social workers do the largest amount of psychotherapy with children. Reasons for assignment to the psychiatrist were most often given in terms of severity of pathology, depth of material to be dealt with, or goals involving personality change. This policy was not always followed because in some clinics the most severly disturbed patients were assigned to social workers and the psychiatrist was assigned those patients with particularly good prognosis. A sizable number of clinics responding stated that social work focused on reality and did supportive casework. These clinics differentiated casework from psychotherapy as a form of treatment. Sometimes expediency is the decisive factor in assignment which means using the

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[17] Helen R. Beiser, "3: Implementation of Treatment", American Journal of Orthopsychiatry, XXX (January 1960) pp. 59-60

[18] op. cit. Mathews

available personnel. There are the two extremes where at one end the medical responsibility for psychotherapy is taken by limiting this function to the psychiatrist. At the other extreme, responsibility is on the basis of administrative structure, that is, a physician holds an administrative post but has no connection with therapy. The majority plans for a psychiatrist to have some contact by supervision, consultation, or case conference.

The bulk of supervision is done by psychiatrists who also do the most unsupervised psychotherapy. Most of the cross-discipline supervision is in the form of a psychiatrist supervising a social worker or a psychologist (even in social agencies). More psychiatrists are consultants than any other profession. Most chief-administrators (hence, policy makers) are psychiatrists. A situation common primarily in Michigan is that of non medical clinic directors sharing supervisory responsibility with a part-time consulting psychiatrist. Thus, the director, who may be a social worker or a psychologist, supervises representatives of the other disciplines. "The most striking finding of this portion of our survey was the relative infrequency of psychologists functioning in a supervisory role."[19]

> Ordinarily the psychiatrist is acknowledged as the senior member of the team. There is a tendency to preconceive of him as the team leader and the focus of vital team decisions. From our data, however, this does not appear to be true or justified for the specific decisions studied. There are indications that the social worker is closer to the center of team activities and decisions and a tendency for psychologists and psychiatrists to move in his direction, atleast in our

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[19] Saul I. Harrison, "5: Direct Supervision of the Psychotherapist as a Teaching Method", American Journal of Orthopsychiatry, Chairman W. Mason Mathews, XXX (January 1960) . p 77

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team process.[20]

This may be true for two reasons. The social worker, because of history taking, may be more familiar with the past history of the patients and with current environmental stress factors. He appears to have greater optimism and enthusiasm concerning help for patients and their families as contrasted to the more pessimistic and cynical attitudes of the psychologist and psychiatrist. As a result, social workers are frequently given the "green light" on their own terms. The social worker, additionally, seems more willing to admit and accept disequilibrium among team members. To have a democratic group, it is necessary to have people who accept emotionally as well as intellectually the relative equality of other group members. There must be freedom of discussion and decisions made by the group. Experience in working with one's teammates brings about a deeper understanding of communication. Acceptance of each other leads to positive working relationships with the ability to talk about difficulties and uncertainties in team conferences.

Although it is difficult to distinguish psychotherapeutic differences between the various disciplines, there remains a tendency toward the preservation of original professional identity with the disciplines joined in the common enterprise of psychotherapeutic teamwork.[21] The majority of organizations make use of the specific skills pertaining to each discipline. Maintenance of original professional identity thus appears to be important to the members of the different disciplines

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[20] Wiener, op.cit.

[21] Mathews, op.cit.

also there would not be the struggle for this. There is considerable obscuring of professional boundaries which appears to be due to the methods and goals set by the administration. Yet, the orthopsychiatric team was formed to bring a multidisciplinary approach using the knowledge and skills of the three professions. The original aim was for each profession to contribute its own special and particular functions which would be integrated to the solution of the presenting problem. One way that a discipline's focus is able to prserve its original integrity is for a team member to be supervised by one of his own field, e.g. the social worker's supervisor and not the team leader remains responsible for management of the social worker's treatment.

Relationships between team members can easily influence the course of treatment. Hostility against a team mate can include members of the family being traeted by the teammate.

> It has been said that teams in their relationships tend to reproduce relationships of family members they treat. ...Team members relate to each other as individuals, but each participant's identification with his member of the family influences his relationship with his teammate in many ways; and feelings for a teammate may color one's perception of other members of the family.[22]

If it was thought that one teammate was damaging rather than helping his member of the family, others on the team might feel they could not work with this therapist and become discouraged about working with him in other cases. If a therapist feels criticized he may lose confidence. Yet members may gain support and encouragement from each other and

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[22] Lotte Perutz, "Treatment Teams at the James Jackson Putnam Children's Center", Smith College Studies in Social Work, XXVIII (Oct. 1957) pp. 1-31

obtain growth through new knowledge, broadened viewpoints, and the ability to cooperate. Problems of professional rivalry and personal differences can be faced in a mature way which develops personal growth and professional ethics. Current case materials can be the focus for teaching. In a favorable setting, teamwork increases rapport between disciplines and enables more adequate supervision by senior members. It can be used as a tool for the assignment of caseleads and responsibilities, and for generating therapeutic enthusiasm. Perutz believes that the close relationship between therapists as well as the relationship of clients and team members is the reason parent and child frequently work on the same material simultaneously.[23] Along with this is the sharing of responsibilities which are easier to carry than if this rests on one individual alone.

> From the study of our material one cannot avoid the impression that in function, as well as in training and teaching, interdisciplinary teamwork-psychotherapy is only in its early phase. Whenever it actually exists, it is usually only partially applied, its structure and concepts are vague, and its inner cohesion weak or not definitely established. Lack of training standards, lack of available personnel, lack of inner conviction, lack of security, and competition for status in the relations of the different disciplines are manifest in many of the orthopsychiatric settings which we have explored.[24]

There is lack of clarity regarding the professional boundaries in the practice of psychotherapy within a given setting as well as between settings. In many clinics, the three disciplines have become so

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[23] Ibid. p. 25

[24] Wilfred C. Hulse and Mortimer Schiffer, "4: The Psychotherapeutic Training of the Team Members and its Influence on the Team", American Journal of Orthopsychiatry, Chairman W. Mason Mathews, XXX (Jan. 1960) p. 69

inter-mixed as to lose any semblance of specificity. The direction has been to make to psychotherapist of everyone on the staff with some abadonment of what the social worker and psychologist have to offer from their specialized training(the obvious status seeking implications involved would provide material for another paper). What social workers and psychologists may in effect be saying is that their own specializations have little to offer to the help of emotionally disturbed people unless they transform themselves into psychiatrists. This may force psychiatrists to learn social work and psychology. The growth of the team should rest in its effective integration of knowledge from these three disciplines plus related fields. Its strength should be in the checks and balances of this composition.

Summary:

The foregoing review of interdisciplinary relations indicates a tendency for the functions of the three disciplines to overlap considerably. Despite emphasis on therapeutic activity, it is likely that there will continue to be specialization in those aspects which a discipline's training emphasizes: the psychiatrist tends to work with the unconscious and the handling of psychosomatic problems; the social worker tends to emphasize social and environmental aspects of presenting problems; and the psychologist tends to emphasize diagnostic and research responsibilities.

One major value of the team approach is the availability, where appropriate, of joint study representing three disciplinary orientations. This interchange and mutual sharing are important because problems of disturbed human personalities are so complex that without it we run the

danger of omission rather than commission.

We have the beginnings of an integrated interdisciplinary psychotherapeutic team. We have far to go before we can expect uniformly satisfactory results.

CHAPTER III

STAFFING PATTERNS

We can understand the operation of orthopsychiatric teams through a study of the staffing patterns of existing child guidance clinics. All child guidance clinics in Michigan operate under the State Department of Mental Health which has established a basic staffing pattern whereby

> "...the department will supply funds for three professional workers consisting of a psychiatric director, a psychiatric social worker, and a clinical psychologist; or in those instances when a psychiatrist director is not available and a psychiatric service is supplied on a consulting or part time basis, the department will supply funds for one additional psychiatric social worker or psychologist as the administrative director."[1]

After a clinic has been in operation for two years and conditions so warrant, the state department will furnish funds for additional psychiatric social worker or clinical psychologist. The local board must assume the responsibility when there develops a need for a fifth staff member. Any further staff additions after this will be made on the basis of equal sharing of financial support between the local board and the Department of Mental Health.[2]

When possible, the director of each clinic should be a psychiatrist,

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[1] State of Michigan, Department of Mental Health, Michigan Child Guidance Clinics: Programs and Policy Statement, (Lansing, Michigan: State of Michigan, 1956), p. 17

[2] Ibid.

however, exceptions may be made when a psychiatrist is not available. In such cases, a member of either of the other disciplines may be appointed and the psychiatrist (full or part time) should be used in a clinical relationship. The director is responsible for the development and administration of the clinic's services, supervision of clinic personnel, recommendation of policies to the board and department, and provision of professional leadership in community mental hygiene activities, and development of sound inter-agency and community relations. The staffs shall be composed of child psychiatrists, psychiatric social workers, and clinical psychologists who shall be directly responsible to the director.[3]

Staffs:

We can understand the operation of clinic staffs only in the frame work of a specific setting. In our study we found differences and similarities in the staff composition and function of four Michigan Child Guidance Clinics.

TABLE 1

Staffs of Four Michigan Child Guidance Clinics as of March 1961

Clinic	Psychiatrist	Social Worker	Psychologist	Nurse	Speech Therapist
Battle Creek	two consultants	4*	2		
Flint **	1	3½	2*	1	
Kalamazoo	1*	4	1		½
Lansing	1*	4	2 1/10		

*Discipline of Administrative Director
** The psychiatrist is clinical director and the psychologist is administrative director

3 Ibid. p.11-16

As can be seen from Table 1, all clinics have more or less folowed the basic staffing patterns recommended by the Department of Mental Health. All clinics have vacancies in various disciplines which do not show in the above table.

Expediancy has been involved in the selection of many of the personnel. Availability of staff is considered one of the prime determining factors. Clinics generally attempt to follow the recommended staffing patterns but may be unable to do so due to lack of personnel available. As a result, there are frequently openings for one discipline when another may be available. The four clinics train social work students and so develop a resource from which they may draw. In addition, one administrative assistant stated that social workers have the least definite diagnostic skills but the greatest all around skills which is indicated by the social in social work. Therefore, social workers are the preferred discipline to add to a staff. Lansing and Flint have psychologist interns, thus developing a resource for themselves.

Intake Procedures:

Intake is an important function of the professional staff. The following table points out the many similarities and few differences that exist in the four clinics studied.

TABLE 2

Specific Functions of Three Disciplines in Intake Procedures

Clinic	Psychiatrist	Social Worker	Psychologist
Battle Creek	1.3.	2.b.3.	2.b.3
Flint*	1.2.3.	2.3.	1.3.
Kalamazoo	1.2.3.	2.a.	1.a.
Lansing	1.2.3.	2.a.	1.a.

TABLE 2 "Continued"

1. interviews child
2. interviews parent
3. makes clinical clinical diagnosis
a. refers parent or child to psychiatrist when needed
b. decides who should see child
*. Flint uses a set team approach for intake procedure

Interpretation of this table shows that intake procedures for Kalamazoo and Lansing are identical. Social workers interview all parents; psychologists test children. Either or both may refer his client to the psychiatrist when needed. Flint operates in this same manner with the addition that they have definite teams who are assigned to work together regularly. The psychiatrist is a member of one of these teams. With one exception, these teams are composed of members of two disciplines. The exception is the one team composed of two social workers. On occassion any staff member may do an intake alone seeing both parent and child. Battle Creek has either social worker or psychologist interviewing parents at the time of intake. The intake worker determines whether the child should be included in the study. Workers at all four clinics refer the child to the psychiatrist when there appears to be a medical or serious psychiatric problem. The psychiatrist is the only one permitted to make a clinical diagnosis in Kalamazoo and Lansing. This is considered a medical problem with personal responsibility resting with the medical person. Flint permits all disciplines to participate in diagnosis. Any one staff member may make the final diagnostic decision, however, in practice this rarely happens. The supervisor of the staff person would enter into the decision in some way. No one individual or discipline has final and exclusive responsibility for the diagnosis. The psychiatrist

may assume responsibility for making the final diagnostic decision at Battle Creek, but frequently these may be made by the clinic administrator in the absence of the psychiatrist. This is definitely contrary to policies of Kalamazoo and Lansing though it concurs with Flint which permits other than the psychiatrist to make diagnosis.

Treatment:

All three disciplines are involved in treatment in all four clinics although the psychiatrist does only limited treatment at Battle Creek because there is no staff psychiatrist. Flint does not see any difference in the treatment functions of the disciplines but rather a difference in individual skills. Kalamazoo questioned whether there is any distinction between psychotherapy and casework. Definable distinctions in treatment methods are not deliniated by any of the clinics' staff members, although specific medical problems are always referred to the medical authority of each clinic. This is the area that the American Orthopsychiatric Association study[4] emphasized needed further understanding and clarification. As pointed out in that study, there is a lack of clarity and understanding of the roles of the therapeutic team whereby social workers and psychologists do psychotherapy. The four clinics studied appear to be members of the "psychotherapy group" which stresses the overlapping of the functions of the three disciplines. In contrast to this method the American Orthopsychiatric Association emphasizes the special equipment and contribution that each discipline would offer to treatment.

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[4]See Chapter II.

Any member of the family may be assigned for treatment to any member of any discipline with consideration given to age, sex, problem, and particular abilities of the therapist. Thus it is in the function of treatment that all four of the clinics follow an identical pattern: all medical problems are referred to the psychiatrist but any member of any of the disciplines may be assigned to any member of the client team. Battle Creek operates in a slightly different manner. Due to the shortage of psychiatric personnel on the staff, the administrator assumes many of the duties performed by the psychiatrists at the other clinics. The psychiatrists work on a consultative basis with diagnosis their primary function.

Teamwork Methods:

As each of these clinics emphasizes early treatment and prevention and utilizes the services of the three professional groups - psychiatry, psychology, and social work - each clinic is orthopsychiatric. The services of the three disciplines are more or less available for each patient and are coordinated in the interest of the patient. They seek to obtain a comprehensive picture of the important factors in the child's emotional life in order to give the best diagnostic, consultive, and therapeutic service possible. Thus the services of the team are available to clients and so each clinic functions with orthopsychiatric teams. These teams are utilized to serve the realization of the potentialities of its clients.

The previous chapter points out that team work and authoritarian ideology are incompatible. None of the four clinics studied presents a

picture of an authoritarian setting. In three of the clinics, the psychiatrist automatically assumes the role of leader by reason of position as administrator. In addition, this is accepted by staff members because of the belief of the psychiatrist's superior training. All three clinics have case conferences with psychiatrists whenever they are believed necessary because of diagnostic or therapeutic problems. This leadership role does not lessen the importance of the team approach. During case conferences, anyone working on the case gives his interpretation of facts and expression of ideas. Others on the staff may also express thoughts. The psychiatrist then makes decisions regarding the case generally and specifically. In one sense, Kalamazoo and Lansing may be considered more authoritarian because only the psychiatrist may diagnose. On the other hand, this may be a clearer definition and perception of roles. Thus the basic administrative composition of the clinics may affect leadership.

The staffing patterns of the four clinics are given below. The profession of each clinic's administrative director and the composition of the clinic staffs are shown:

Battle Creek	Flint
1 Social Worker-- Administrative Director	1 Psychologist--Administrative Director
3 Social Workers	1 Psychiatrist--Clinical Director
2 Psychologists	1 Psychologist
2 Psychiatric Consultants	3½ Social Workers

Kalamazoo	Lansing
1 Psychiatrist--Administrative Director	1 Psychiatrist--Administrative Director
1 Social Worker--Administrative Assistant	1 Social Worker--Administrative Assistant
3 Social Workers	3 Social Workers
1 Psychologist	2 1/10 Psychologists

Flint and Kalamazoo are different from the other two clinics in that each has a fourth profession represented on its staff; Flint has a registered nurse and Kalamazoo has a speech therapist. Both of these professional persons were added to the staffs in order to enable the clinics to offer what it regarded as essential services to the community. The nurse has knowledge of medical aspects of clients, acts as a liason between county health departments in making referrals to the clinic, and is able to help train medical personnel in the community to look for emotional overtones to physical illness. In addition, she is a member of an intake team participating in both intake and treatment under the supervision of the chief social worker. She carries a caseload comparable to a member of any other discipline and sometimes conducts group therapy with parents. The speech therapist in Kalamazoo is considered experimental. She was added to the staff because of the social work philosophy of beginning where the client feels the problem is. Just as a child who is unable to read feels this is his problem and the area where he needs help, the child who has a speech problem wants help with this. Each of the three major professional disciplines working in child guidance clinics deals with communication. The speech therapist is an additional facility the clinic has available to learn more about communication.

Summary:

The State Department of Mental Health, under which these clinics operate designates only the duties of the director and the basic composition of the staff. It is up to the director to staff his clinics and determine policies. Therefore, there are variations in staffing patterns, intake

procedures, treatment policies, and interpretations of teamwork reflecting the director's philosophy. These variations are also a reflection of the democratic philosophy of individual self-realization practiced through freedom of choice and self-direction which are underlying principles of the disciplines composing the orthopsychiatric team.

CHAPTER IV

FINANCES

The financial arrangements of the child guidance clinics in Michigan are different in many aspects from the pattern of financing usually found in social agencies. In a quite extensive search of the literature, the writer could find few reports on comparable arrangements, although there have been somewhat similar developments in other states such as New York and California at later periods.

In Michigan, responsibility for financing is divided between the State Department of Mental Health and the local community. Local sources are quite varied, but the state is the biggest contributor in all cases. The arrangement began by the Children's Fund of Michigan establishing the Children's Center in Detroit in 1930 and later a child guidance clinic in Traverse City in 1937. This served as the impetus for the later growth of child guidance clinics in Michigan. The Children's fund offered money to the Department of Mental Health for a demonstration project to be located ina community that would share in the cost. This clinic was established in Lansing, Michigan in 1938.

The present statute of joint financing by state and local communities was imbodied in state legislation in 1938.

> Since 1938 the Michigan legislature has annually appropriated funds to the Department for the administration, supervision, and development of the child guidance clinic program. Out of this appropriation come the funds for the salaries and expenses of the basic professional clinic staffs and

> the expenses incidental to departmental administration and supervision. The establishment of new clinics is determined by legislative appropriation.[1]

Since 1938, the child guidance program has been gradually expanded. All the counties in the state are presently assigned for service to one of the eighteen clinics.[2]

This principle of combined financing between the government and the local community is in line with some of the current theory of financing social services.

> This author joins with many others who view with pride, rather than alarm, the partnership of government and voluntary agencies in joint efforts for human welfare. ...In the final analysis, the attitude of the citizen, and the statesmanship of the health and social work professions will determine the price to be paid for the conservation of human resources.[3]

A more recent program based on a similar financial arrangement to Michigan, was established in New York in 1954 after considerable planning.

> An act was established for a permanent system of State Aid to localities for the operation of community mental health services. Perhaps the most fundamental principle in the act is its placing of operating responsibility on local government, with the state paying half the cost. This emphasis on local responsibility is consistent with the 'home rule' principle embodied in much of New York State Law. It is also based on the professional conviction that a local mental health

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[1] Michigan Child Guidance Clinics, Program and Policy Statement, State Department of Mental Health, Lansing, Michigan, 1956, p. 8

[2] Ibid, pp. 8-9.

[3] Leonard W. Mayo, The Survey, Vol. 86, No. 2, February 1950, (Survey Associates Inc., Pennsylvania), p. 59

> program can succeed only to the extent that local citizens accept it and identify with it.[4]

A number of other states have also instituted similar programs in the past decade or so within variations of arrangements. There are a number of ways in which clinics can be financed and administered. The range runs from state control to local autonomy, with the usual arrangement falling somewhere between the two extremes. There are, of course, arguments both for and against each type of arrangement. However, it is not the purpose of this study to determine what the better type of arrangement is, rather to report on the arrangement in Michigan, specifically as applies to the four clinics under study.

In Michigan the local finances, coupled with the State's monetary support, supply the necessary funds for the operation of the clinics. At the present time the State is supplying approximately 60% of the total operating funds for clinic operations. The remaining 40% is derived from local tax resources or private local funds.

In order to enter the program the local community must have established a base for the financing of its share of total costs.

> It must be understood that if such a clinic is established that; evidence shall be furnished of continuing financial support from local governmental and/or other sources for local operating expenses, supplies, materials and secretarial services.[5]

After the Department of Mental Health approve the community's application for a clinic, the Department includes the State's share of the cost in the

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[4] Robert Hunt, American Journal of Psychiatry, Vol. 113, February 1957 (The Lord Baltimore Press, Inc., Baltimore Md., 1957), pp. 680-685

[5] Program and Policy Statement, 1956, op.cit., p. 10

next budget request. If the appropriation is approved, the clinic can start drawing funds the following July. The clinic board is to take responsibility for the raising of local funds needed for the support of the clinic, and is to work with the State Department of Mental Health in matters concerning finances.

The distribution of financial support between the Department and the clinic board is established in the department's Policy and Program Statement and consists of the following: During the first two years of a clinic's operation, the Department will supply funds for three professional workers, consisting of a psychiatric director, a psychiatric social worker, and a clinical psychologist; or in those instances when a psychiatrist is not available and psychiatric service is supplied on a consulting or part-time basis, the Department will supply funds for one additional psychiatric social worker or psychologist as the administrative director. "The Department will supply funds for essential travel expenses of state paid staff and occasionally to professional conferences approved by the Department. The local board shall supply funds for such expenses of locally paid staff members."[6]

After the clinic has been in existence for two years, and if the need warrants it, the Department will supply another social worker or psychologist. If still additional staff is required, the funds for the next staff member are the responsibility of the local clinic board. If further staff is required, the funds for them will be supplied on an equal sharing basis between the Department and the local clinic board.

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[6] Program and Policy Statement, 1961, op.cit., p. 27

Throughout all the clinic's operation, the clinic board will continue to supply funds for the operating expenses for the local clinic and its maintenance.

Financial Base of the Four Clinics under Study:

Let us now examine the operating budgets of each of the four clinics, Battle Creek, Flint, Kalamazoo, and Lansing for the fiscal year of 1959-60.

TABLE 3

Sources of Funds of Four Michigan Child Guidance Clinics and Amounts Recieved From Each Source in 1959-60

	Battle Creek	Flint	Kalamazoo	Lansing
State	42,241	43,209	38,400	70,168
County	31,283	6,000	7,000	15,425
Schools			11,884	8,263
Cities			1,500	
Chest		37,910	17,053	30,487
Foundations	11,550	3,240	11,500	
Fees	(now)			
Other	1,200	2,629	3,700	1,083
Total	86,274	92,988	91,037	125,426

The number of resources for each of the local clinics is quite varied as can be noted from the above, ranging from four to seven sources. This range is above the average of sources per clinic noted in a national study by the American Psychiatric Association, which found that;

> Complete responses to the questions concerned with financing were received from 73 of the 95 responding clinics...None of the clinics received support from only one financial source. Thirteen clinics recieved support from two sources, 19 from three sources, 24 from four, 12 from

five and five from six different sources.[7]

The wide variety of sources is perhaps also due to the following of recommendations laid down by the State Department of Mental Health;

> The use of many sources of local financial participation is to be encouraged. This results in a more equitable plan of responsibility on the part of the many different communities served by the clinic. It is advisable, however, to encourage local tax sources to provide the basic operating budget as a public service and to ensure continuity of program.[8]

The Department also recommends that long-term pledges and allocations should be encouraged, rather than less sure sources, and it would appear that this has been carried out most cases. The funds from the local sources are to be turned over to the clinic board and deposited to the clinic's account, for exclusive use by the board. Funds are to be given directly to the board, rather than having the clinic's requisition funds for specific purposes. It was felt this would deter financial sources from putting pressures on the clinic for services that might not be in the clinic's best interest.

At the time of the 1959-60 statistics, no clinic charged a fee. This is especially interesting in the light of the present popular trend of fee charging by social agencies. However, one clinic has since instituted the fee policy, and the entire subject of fees will be dealt with more extensively in Chapter X.

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[7]Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Variations in Organization Practices Among Child Guidance Clinics, 1955, Fact Sheet, No. 6, June 1958 (Washington D.C. 1958), pp. 3-4

[8]Program and Policy Statement, 1956, op.cit., p. 19

The amount of state funds allocated to each local clinic is determined by the salaried and travel expenses incurred in clinic work by state paid staff members. The amount is fairly constant, with only yearly increments for salary or staff changes bringing about any change of any amount. The funds are kept within the State Department treasury and they periodically send out the funds in forms of checks to the clinics.

There is very little contact between the Department and the local community clinic concerning their financial matters. The Department is available for consultation on local financial matters, and also makes an annual audit of State funds each clinic receives, but there is no organized working together, the Department preferring to allow the community to operate autonomously. The clinics do submit a budget to the Department, preferably six months before it is to become effective to allow for ample time to obtain the required moneys.

There is some variation in the financing practices of local community clinics. A description of the local financing will be given for each of the four clinics.

Financial Arrangements at the Battle Creek Child Guidance Clinic:

Battle Creek Child Guidance Clinic is a corporated enterprise and the details for financing are contained in its by-laws. A standing committee on the finance determines the planning for financial needs. The director determines the budget from the past year's expenditures and anticipated changes for the ensuing year. The board inspects and approves the budget, with this usually occuring in conjunction with the meeting with the County Board of Supervisers Committee on Child Guidance Clinics. Battle Creek receives funds from the State, Kellogg Foundation (this grant was

curtailed December 1, 1960, however.), and from membership fees and contributions, and the primary local source -- the County Board of Supervisors. There are two contributing counties, with each asked to contribute a proportionate share to the number served in their county. The clinic board, with or without the director, presents the budgetary request to Branch county, and if they approve the request, they will write a check for the annual request to be deposited in the clinic's account.

The process is considerably more complicated with Calhoun County. The Board of Supervisors of Calhoun County appoints a Child Guidance Clinic Committee which goes over the budget with the Clinic Board and the director line by line. After such revisions as they may request have been made, the clinic board, with or without the clinic director, will present the budget request before the entire board of supervisors for their consideration. After it has been approved, the clinic must submit a request for a third of its appropriated funds every four months, to be deposited in the clinic's account. Fees have been recently instituted, but have not been in effect long enough to determine the amount of income they will furnish. The membership fees and contributions make between one and two thousand dollars annually with a total membership of 15,000 paying members.

The housing of the Battle Creek Child Guidance Clinic and the furnishings and the equipment are the property of the clinic corporation. The funds for the above were obtained from donations and special drives.

The handling and disbursement of funds is cared for by the treasurer, with the responsibilities outlined in the bylaws.

> The treasurer shall be chosen from the members of the Board of Directors. He shall have custody of all corporate funds and securities, and shall keep in books belonging to the corporation, complete and accurate accounts of all receipts and disbursements made by the Corporation. He shall deposit all moneys, securities and other valuable effects in the name of the Corporation as may be ordered by the Board, taking proper vouchers for such disbursements and render a complete and accurate account of all transactions as treasurer, and of the financial condition of the Corporation.[9]

The actual disbursement of funds is prescribed in the following statement. "All checks, drafts, and orders for the payment of money shall be signed in the name of the Corporation and shall be signed by the treasurer, and countersigned by one other officer."[10]

The finance committee and the director of the Battle Creek Child Guidance Clinic are currently studying other possibilities for additional finances in order to compensate for the withdrawal of the Kellogg Foundation funds which occured December 1960. The school systems are presently considered the primary source for these funds. The Community Chest was not able to contribute when the agency was first initiated, and it was felt the schools were not ready at that time.

Financial Arrangement at the Flint Child Guidance Clinic:

The Flint Child Guidance Clinic is a corporated enterprise with the financial arrangements for the clinic stated in the by-laws. The Board of Directors, consisting of not less than thirty members is distributed among three counties. The Board of Directors is responsible for the raising of local funds in the counties served, which is needed

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[9]The Amended By-Laws of the Battle Creek Child Guidance Clinic, Inc. (1958), Article IV, Section V.

[10]Ibid, Article V, Section 1.

for the support, maintenance and operation of the clinic. The Board has a standing committee on finance which consists of not less than three members and is to handle all financial matters relevant to the clinic's operation.

The financial base of the clinic is distributed among the following resources; State Department of Mental Health, Community Chest, County, Foundations, and the other catagory, consisting of miscellaneous finances and membership fees. The sources are ranked in descending order, according to the amount contributed.

All financial matters of the clinic rest with the financial committee, of which the treasurer of the Board of Directors is the chairman.

> It shall be the duty of this committee to consider all matters relating to the financing of the clinic and recommend to the Board of Directors measures to insure the continuing financial stability of the Clinic and to assist in the receiving of and accounting for such funds. The Finance Committee shall submit for adoption by the Board of Directors a budget of estimated expenses of operating the Clinic for the ensuing year. The budget may be revised from time to time, but total expenditures shall be made only in accordance with the budget which has been approved by the Board of Directors.[11]

The Flint Child Guidance Clinic, as with all the clinics under study, is attempting to widen its financial base in order to procure more staff. In a summary of facts by the Advisory Board, they noted the following in relation to financial operations;

In the fiscal year 1957-58, of the 13 child guidance

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[11] Flint Child Guidance Clinic Constitution and By-Laws, Article VI, Section V, (January 1959), (Flint, Michigan) p.4.

> in southern Michigan, the Flint Clinic ranked 12th in percentage of state tax funds received for its support (40.66%), and 11th in terms of the allocation per capita ($0.093). In respect to local tax funds made available for its support, the Flint Clinic ranked 13th of the 13 clinics.[12]

The funds received from the various sources are paid directly to the clinic and deposited in the Corporation's account. Disbursements are administered by the treasurer.

Fee charging has been investigated as a further possibility for the obtaining of funds. Fee charging was regarded as a wise move and preparation for fee charging in the future has been initiated.

Financial Arrangements at the Kalamazoo Child Guidance Clinic:

The Kalamazoo Child Guidance Clinic is a corporated enterprise with the outline of financing contained in its by-laws. Kalamazoo Clinic has the widest financial base of the four clinics under study. In addition to state funds its sources include city, Community Chest, county, schools, foundations, plus membership fees and contributions.

Kalamazoo Clinic has a Standing Finance committee composed of the director, treasurer and five members of the Board of Trustees, representing the counties served. It is the duty of the finance committee to advise the Board of Trustees in regard to property, investments, and administration of financial matters of the corporation and to act as a budget committee.

The budget is composed by the director, his administrative assistant along with the finance committee, and is approved by the total board. Originally the director, along with the board, interpreted the clinic to the various sources and explained why their help was needed

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[12] Summary of Facts Regarding Staffing and Financing of the Flint Child Guidance Clinic, The Advisory Board, (May 1959, Flint, Michigan), pp.1-2

financially. He was consequently able to arrange the wide base they now have. Presently the finance committee along with the director, present their operating budgets and requests for funds to each of the different sources annually.

Counties contribute funds to the clinic through County Boards of Supervisors, Boards of Education, Community Chest and miscellaneous voluntary contributions with the exception of Kalamazoo County. The Boards of Education give 31¢ per school child. Because Kalamazoo County contributes more through the community chest and the city contributes a flat amount, their quota per school child is considerably less.

The number of cases accepted for service per county is figured on a basis of the percentage of referrals made the previous year plus the percentage of contributions divided by two. This, too, correlates with the assessed valuation.

The disbursement of funds is handled by the treasurer in a similar manner to the procedure of the other clinics. "The treasurer of this corporation shall have the custody of its funds and property and such other duties and authority as the Board of Trustees may confer upon him."[13]

Nearly 50% of the financing for the present clinic building and furnishings was paid for by the Office of Hospital Survey and Construction utilizing funds appropriated by the Hill-Burton Act. The balance was paid for by donations and service club drives. The property is owned by the City of Kalamazoo, as a governmental unit was required to be eligible

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[13] Kalamazoo Child Guidance Clinic, By-Laws, Kalamazoo, Michigan, Unpublished.

for the Hill-Burton funds.

The Board is still plagued by the problem of finding a way by which the financing of the clinic can have a greater degree of certainty than exists at present. A committee has been appointed to study the total fiscal problem and make recommendations. The committee is presently studying fee charging, and will be making a decision concerning this in the near future. The Kalamazoo Clinic also plans to attempt to get additional funds from tax sources in order to stabilize finances.

Financial Arrangements at the Lansing Child Guidance Clinic:

The Lansing Child Guidance Clinic was the earliest clinic in the state of Michigan and is an incorporated clinic. The financial base for the Lansing Clinic includes the following resources; State Department of Mental Health, Community Chest, County, Schools, membership fees, donations and etc. The resources were listed in descending order, according to the amount given.

The management of the property of the clinic, its funds and the business of the Corporation, is vested in the Board of Directors which consists of 24 members. The funds are handled by the treasurer whose duties are described in the by-laws.

> The treasurer shall attend to the finances of the corporation and has the custody of its funds and such funds shall be deposited in the corporation name in banks designated by the Board of Directors and subject to checks signed as designated by the Board of Directors.[14]

The clinic administration and the executive committee of the clinic

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[14] Constitution and By-Laws of the Lansing Child Guidance Clinic, July 1952 Article V, Section 4, Lansing, Michigan, p.2

board (5-7members) decide the budget for the ensuing year, according to the needs of the clinic. This is determined by the studying of the past year's expenses and adding any increased costs or anticipated expenditures for the next year. After the budget is drawn up, it is submitted to and must be approved by the total Board of Directors. The budget is then also submitted to the Lansing Community Chest and these other resources that may request it. In the past year three resources, besides the community chest, requested that the budget be submitted to them.

The finances are paid directly to the clinic to be deposited in the Corporation's account. There is a flat rate per child charged to the schools with Class A schools expected to pay 30¢ per child and Class B schools 20¢ per child. Because the large percent of children served are referred from schools, the clinic feels justified in requesting a certain percent of its funds from the Boards of Education.

The amounts expected from the community chests of counties contributing to the clinic varies. The amounts requested are determined according to the number of children served from the different areas and this amount increases or decreases according to the number served.

One of the budget problems is the time that is involved. In addition to the bookkeeping time and preparation of the budget, much time is required in procuring the requested amounts from the various resources. As noted before, the budget must be submitted to a number of different sources, which demands time in explaining the budget.

Fees are not being used as a financial resource, although it has been considered by the staff. It was feared that it would jeopardize the present sources and could result in a reduction of their contributions

at this time.

Summary and Conclusions:

There are several similarities and differences which were noted in the financial arrangements of the four clinics. The main difference appear to be the variations in the number of types of sources from which funds are solicited. When anticipated changes in the next several years occur, however, this area of difference will break down. For example, Battle Creek Child Guidance Clinic is the only agency presently charging fees, but this move is now under consideration by the other three clinics. Three clinics receive grants from the Community Chests and two from schools. Again, Clinics not now obtaining funds from such sources are expecting to approach them in the future.

The present financial arrangements seem to be the result of convenience and availability of funds at the time the clinic was initiated. As costs of services are growing and some of the sources are withdrawing their support, the clinics are being forced to widen their financial base with the pattern becoming more similar between the four clinics.

There are slight variations in budgetary procedure. This seems to be in response to local sources requiring certain arrangements in reviewing the budget. In all the clinics, the budget is drawn up by a finance committee of the board, with the assistance of either the director of the clinic or his assistant.

The similarities are by far greater than the differences. All clinics are incorporated with property and funds under control of the Board of Directors of the Corporation.

Disbursement by all four clinics are made through the treasurer, in two clinics with the sanction of the board, and in the other two clinics by a co-signature of another designated member of the board.

As noted above the budgetary procedure is similar in its joint make-up between staff and board. The actual steps followed in gaining approval of the budget by different sources varies in response to established requirements.

Another similarity is found in the increasing budgets of all four clinics as they try to meet the rising costs of services and needs for expansion. The final similarity is the attempt of each of the four clinics to widen its financial base, always with the desire of finding a more sure means of finance.

In conclusion, all four clinics have carried out the recommendations of the State Department as outlined in its Program and Policy Statement. The trend would appear to be toward greater similarity in financing between the clinics, even though they represent four quite different metropolitan areas.

CHAPTER V

FEE CHARGING

A Study of Fee Charging at the Battle Creek Child Guidance Clinic:

A more detailed examination will now be made of policies in regard to charging fees, which are an optional part of the financial base for child guidance clinics. At present only one of the four clinics under study, the Battle Creek Child Guidance Clinic, has instituted a fee system. However, it is one of the trends in financing of modern day social services, and the possibility of fees is also being considered by several more of the clinics under study.

Several procedures were used in studying the fee system at the Battle Creek Clinic. First, the literature was surveyed in order to determine the current status of fee charging. Second, an open ended questionnaire consisting of ten questions was devised in an attempt to learn the staff's attitudes concerning fee charging.

In this chapter the theoretical aspects of fee charging will be examined. The experiences with fee charging by other agencies as reported in the literature will be described. The fee system of the Battle Creek Clinic as it is currently operating will then be discussed. Following this, an analysis of the staff's attitude toward fee charging at the Battle Creek Clinic will be reported. The chapter will then be concluded

with an analysis of fee charging for a three month period as reported in the agency records.

Fee charging in social agencies was initiated in the middle forties. Ambivalent feelings marked the initiation of the fee charging policy. On the one hand, there was conviction that the professional competency of the social worker had reached the level where he was qualified to charge a fee. It was also felt that with increasing numbers of clients coming from the middle class or above who had the ability to pay for the services, and in fact, expected to pay, warranted the charging of a fee. On the other hand, the concept of offering a free service to all who requested it was being questioned. There was the additional belief that an agency instituted by the community should not charge a fee for services to the clientele of the community. The result has been slow movement toward fee charging, uncoordinated in approach, and with considerable misgivings and hesitancy.

Much of the same deliberateness and hesitancy in entering the fee charging policy is still being reflected in the literature of today. There is little consensus on the amount to be paid, and what minimum and maximum fees should be. A study in New York in 1958 found the following;

> Three out of every four clinics charged fees of some or all of their patients for some or all of the services provided. In some clinics, high income groups received services free and in others low income groups were charged a substantial fee for clinic services. There was no community wide pattern in fee charging in this area of service.[1]

The above study is one of several attempts to determine a more uniform

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[1] "Fee Charging in Voluntary Psychiatric Outpatient Clinics in New York City", Community Council of Greater New York, (New York, N.Y., Feb. 1958), p. ii

means and order in fee charging. Another example is the policy for fee charging set up by the Department of Mental Health in Michigan.[2]

The growth of the practice of charging fees seems to reflect growing feelings of competency on the part of the profession of social work. The profession feels that it has both the knowledge and skill to enable its practitioners to serve persons from all classes. The idea is becoming more prevelant that fees have a therapeutic value, and that those who can afford to pay for services expect to do so. There is the further impression that not charging a fee, from those who can afford to pay, may indicate several negative things to them. First, that we are not competent enough to demand a fee for our services as the other professions do. Second, that those who can pay feel reduced to a pauper like status in taking services and not being required to pay.[3]

> The social worker has meant that their services exist for clients in all economic strata. The public, on the other hand, has assumed that social services exist for people who cannot pay. Charging a fee for casework services has partially helped to bridge this gap.[4]

Some of the positives in fee charging would include:

(1) Paying for goods or services is an integral part of our culture;

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[2] Manual for Fee Collection in Psychiatric Outpatient Services, Department of Mental Health, (Lansing, Michigan, December 1957)

[3] Ruth Fizdale, "A New Look at Fee Charging", Social Casework, Vol. XXXVLLI No. 2, (Albany, New York, Feb., 1957), pp.63-69;
Tina C. Jacobs, "Attitudes of Social Workers Toward Fees", Social Casework, Vol. XXXVIII, No. 5, March 1957, pp. 198-202;
Alice T. Dashiell, "Fees for Social Welfare Services", The Social Welfare Forum 1951, (Columbia University Press, New York, 1951), pp. 263-270

[4] A New Look at Fee Charging, op. cit. p. 67

(2) The growth of professional competence warrants charging fees; (3) The handling of fees can be a therapeutic tool; (4) A source of income in widening the base of financing; (5) Attempts to make the clinic more self supporting; (6) The upper class client and the community expect the agency to charge fees; (7) Aids client involvement in treatment; (8) Can be used as a measure of motivation or to interpret resistance. However, most of these are impressions only. One study which instituted a flat $10.00 per hour fee for interviews found that they reached a substantially larger portion of the upper classes than do the agencies with a sliding fee, (50% as opposed to 15%). This study also questioned the accuracy of the impression that the sliding fee scale as used by most agencies is a legitimate practice.

> When a client is told that certain expenditures can be taken into account and others can not, by an agency in setting the fee, he may feel that his way of life is being controlled. Since this information is being transmitted to him by the caseworker, the client may become concerned with whether he can rely upon the worker's integrity to permit him to make his own decisions in other areas of his life. His concept of the worker as a person able to understand his needs and values may be blurred.[5]

The negatives against using fees would include: (1) The concept of charging fees is incongruous with the philosophy of social work; (2) Can be used as a controlling device; (3) Tends to work against those who cannot pay; (4) Staff time could be utilized more profitably in working on direct problems; (5) Tends to discriminate against the thrifty; (6) Not accepted by agency board or the community; (7) Tends to increase the distance between the middle class worker and the lower class client, who cannot

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[5] Ibid. p. 76

afford to pay. One author points out that many of the positives currently being claimed in favor of fees are really only impressions and without any substantial documentation. The author conducted a study on the difference between fee and non-fee paying clients. He found that,

> It is submitted that fee and non-fee clients in their respective relationships with the same caseworker constitute two different groups of clients, and that casework techniques as projected by these caseworkers do work much more successfully with the fee than with the non-fee client.[6]

Some further questioning of the value of a fee policy is also raised in a Digest of Special Reports from Eleven Agencies on Selected Aspects of Fee Charging for Casework Service. They noted in their digest that many of the impressions currently held about the positives and negatives in fee charging are in dire need of validation. The areas especially in need of further study is the degree to which fee charging actually facilitates diagnosis and treatment. If fee charging does enhance workability of clients, with what catagories of problems is it most and least effective as an aid in working with. The question of the amount of the fee also needs standardization and further determination of the amount to be charged, as well as the base for charging. Much additional study is needed in these and other related problems before we can say with any degree of certainty just what the value of fee charging is.[7]

In establishing a fee policy there are some agencies that feel only

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[6] Nathaniel Goodman, "Are there Differences Between Fee and Non-Fee Cases", Journal of Social Work, Vol. 5, No. 4, Oct. 1960 (NASW, Albany, N.Y. 1960) p. 52.

[7] "Digest of Special Reports from Eleven Agencies on Selected Aspects of Fee Charging for Casework Service", (FSAA, New York, N.Y., Information Service, June 1954, FE 735) p. 5

a low uniform rate is equitable and will insure optimal use of the agency. The fee should apply to everyone so that no distinctions are drawn between persons from different economic or social levels. The charge should be kept low enough so it will not be a factor in discouraging participation of persons with little initial motivation in taking agency services.

There are those who feel that fees should represent the actual cost of providing service with adjustments made to those who cannot afford that amount. In this way funds from community contributors will provide for those who cannot afford to pay, rather than subsidizing service for those who could afford to pay the full cost of service.[8]

There is much variation in the ways in which fees are assessed, even among those who use a sliding scale. The fee scales are the most commonly used device, and are usually based on a scedule which considers family income, size of family, and takes into consideration special obligations and commitments that might make fee paying more difficult. A number of agencies use the "City Worker's Family Budget" developed by the Bureau of Labor Statistics, to set the base above which fees are charged. However, many agencies devise their own scales in order to fit the functions they want the fee charging to perform. In nearly all cases, agency services are not denied to those who cannot pay. Most agencies insist that the fee plan be used flexibly and allow changes to suit particular situations.

In evaluating the hazards and values of fee charging, it would appear that most of the hazards can be overcome through advance preparation

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[8] William C. Lamson, "Fee Charging in Mental Health Clinics", Community Services Branch, NIPH (Public Health Service, Bethesda, Md., Jan. 1955), p. 3

of the staff in applying the fee and in preparing the community to accept the fee.

> A most important factor in the applicability of a fee system in any agency is the attitude and understanding of the professional staff who are going to administer it. To be effective, a fee plan, like any other part of agency policy, must have the acceptanceof staff members.[9]

In terms of community acceptance, The Digest of Eleven Family Agencies found that;

> Occasionally, misunderstanding arises in other agencies in the community, and clients may sometimes express the opinion that their contributions to the chest should entitle them to free service. Such difficulties are regarded as springing from lack of community interpretation programs on the part of agencies. It seemed to be generally thought that problems with communities around fee charging could be minimized by careful explanation.[10]

In general, the experience of other agencies as reported in the literature indicates that fees are rapidly becoming a part of agencies' financial base. There are numerous rationales used to support the instituting of fees, but the validity of these reasons is being questioned. There is no set pattern in the field for establishing the amounts to be paid or what the criteria should be for setting upper and lower limits of the fee plan. There is general consensus that no client should be turned away because he cannot afford to pay a fee. In order to intiate a fee program smoothly, it requires adequate time and interpretation of the policy to the staff, board, client and the community in order to gain their acceptance. Considerable more study is needed on the process of assessing of fees to more accurately determine the positives and negatives

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[9] Attitudes of Social Workers Toward Fees, op. Cit. p. 199

[10] Digest of Special Reports, Op. Cit., pp 3-4

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of fee charging and to set equitable and standardized procedures for charging fees for services.

Initiation of the Fee Charging Policy at Battle Creek Child Guidance Clinic:

The initiation of a fee program at the Battle Creek Child Guidance Clinic with a view toward examining its present functioning will now be presented.

The idea of establishing a fee policy had been under consideration for some time. It was felt fees would be used as a needed resource for finances, as well as have the other values which have been outlined. The Battle Creek Child Guidance Clinic frequently tests out new innovations and policies on an experimental basis. This was true in the case of the fee program. The primary drawback was some concern about the community's readiness to accept fees. Another agency in the community had started a fee policy, but received considerable pressure against it by labor, who felt that they were making contributions to the United Fund and should not be required to pay again when requesting service.

The staff had discussed the policy, as had the board, and most were in favor of charging fees.

The Calhoun County Council of Social Agencies, with financial assistance from the Kellogg Foundation, conducted a survey of social services in the city of Battle Creek in 1959 and made the following recommendation concerning the initiation of fees at the clinic.

> It is strongly recommended that the clinic proceed to develop and institute a realistic system of fees and charges for its services...The clinic is used by a cross section of the population and probably by a fairly significant number of self-supporting families. These persons should share in the cost of paying for specific services rendered to them.

> Fees should be arranged on a sliding scale with the maximum fixed at the actual cost of the service. Charges in any instance should range downward from this amount to nothing. In no instance should any person be denied service because of inability to pay, nor should payment or non-payment result in any differential in service or access to service. In this connection the clinic has a responsibility not only to itself but in relation to other agencies in the community who may find their efforts to develop and institute fee policies impeded by the present practice of the clinic not charging them.[11]

The Leedy report, as the survey is called, substantiated the clinic's impressions that the community was ready for the initiation of a fee policy. With the backing of the community power figures, the community council, board, and staff; the plans for the fee policy were formulated.

The board and director drew up a statement of policy on fees for the clinic, in which they noted many of the values indicated earlier. They further decided that the fee schedule to be drawn up should be flexible and allow for variations to suit particular needs and incomes (See schedule in appendix). Fees are paid on a weekly basis for the whole family rather than on a per interview basis. The maximum fee is $13.00, which is felt to approximate the actual cost per treatment interview to the clinic.

No client will be denied service because of inability to pay, nor are other agencies making referrals expected to pay, except where they have budget appropriations for this purpose. There is also no fee for the initial contact by the client with the clinic. It is felt that

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[11] Russell Leedy, Survey of Health, Welfare, Recreation and Youth Services and Needs in the Battle Creek Area, April-December, 1959 (Battle Creek Area United Fund and the Calhoun County Community Council, 1959), pp. 16-17

this first interview should be used to determine whether the problem belongs at the clinic and to explain procedure, including fees, and that there should be no cost for this service.

In as much as the cost for intake studies is considerable more in staff time, and because it is a once only activity, the clinic feels it can charge more for this service. At present the intake fee is four times the weekly amount for a full work-up. The minimum fee for intake is $10.00 and the maximum is $50.00. However, service will not be denied, in any form, to those unable to pay the minimum fee.

In order to keep resistance toward fee paying to a minimum, a policy was set up for interpreting fees to the client. The fee is first introduced at the initial phone call by the client. At the time of the screening interview, it is again discussed in fuller detail. The final setting of the fee takes place at the time of the interpretive interview. (For form of this purpose, see appendix) If the case is picked up later for treatment, fees are again discussed and alterations are made, if warranted by extenuating circumstances. Fees will again be discussed during treatment if the income changes or the client becomes resistant to making payments. Actual payment of the fee is handled by the secretary, who also is responsible to notify the worker in case of non-payment of fees.[12]

Following this drafting of a policy statement, an intensive community education endeavor was embarked upon to notify the public of

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[12]Statement of Policy on Fees, Battle Creek Child Guidance Clinic, Unpublished, pp. 1-5

this change. The fee policy was publicized for schools, social agencies, physicians, and in the local newspapers in belief that adequate preparation of parents, before referral, will make future clinic contacts with the family more meaningful and therapeutic. It was also felt that the better the community understood the fee policy, the less resistance there would be to its initiation. Consequently, a series of newsletters were sent to the institutional settings and several articles explaining fees were published in the newspaper. The plan is to present the fee policy on several more occasions during the first several years of its use. Fee charging was then begun on July 1, 1961.

Staff Attitudes Toward Fee Charging:

The fee system has now been in effect for eight months. It was decided to interview the staff to learn the staff's present attitudes toward charging fees. An open ended questionnaire was devised, consisting of ten questions. Five of the six full time staff members were interviewed, the sixth member being on vacation. The psychiatrists were not interviewed for several reasons. They work at the clinic on a part time basis and there have been several changes of psychiatrists in recent months. The present psychiatrists were not at the clinic before fees were initiated. In addition, the way the intake process is carried out at the clinic, the psychiatrist would have no occasion to discuss fees with the parents.

In discussing the attitudes of the staff, the responses to each of the questions will be examined. The first question was, "What is your general attitude at this time concerning fees?" Three indicated they were strongly in favor of fees, while two indicated that in general they were

not in favor of fees. Those in favor felt that the fee policy is fulfilling all the purposes they had expected and have noted no reason not to have fees. Two staff members gave the following reasons for finding fee charging undesirable; (1) It puts a monetary basis to giving services and (2) both felt fees could be therapeutic, but not with all cases, and we do not know as yet with what types of cases fees actually are therapeutic or with what cases they may do harm. The latter occurs from withdrawal from treatment or increased resistance from clients who would otherwise be reached.

The second question, "what is the purpose of charging fees" had general consensus among all the staff. Charging fees provided (1) financial gain for the clinic's support, (2) and aid in judgement of client's motivation, (3) the client has an investment in treatment, (4) fee charging can be therapeutic, (5) the value of the service given warrants charging a fee. All staff members gave the first three above points as being the purpose of charging fees. Two staff members noted the fourth reason with one staff member giving the fifth reason.

In response to whether the staff felt the fees were fulfilling their purpose, there was general consensus that they were. One staff member doubted whether the fees would be of much financial assistance. In general all the staff felt that as long as the fee schedule remains flexible, as it is at present, the fee policy should fulfill its purpose.

There was some diversity in opinion on how fees affect treatment. The staff agreed that there were some positive aspects. These that were mentioned were as follows; money's symbolic meanings as evidenced by the client's handling of fees can indicate some of his conflicts, some of

which are quite basic; money means love to some clients, so they can return a measure of the love received; feel they are getting something for an investment; makes client feel he is a participant and not totally dependent on altruism; can be a good indicator of motivation and resistance. On the other hand several of the staff members expressed negative effects. These included; stirs up hostile feelings; may bring about premature termination; indiscriminate fee charging to all categories of problems, when we do not know with which categories of clients fee charging is therapeutic.

The next question concerned the staff's general attitude toward fees and any changes in their attitudes. It was felt that in general the staff goes along with fees charging, accepting it much better now that some of the initial anxieties about charging fees have been worked through. Several staff members noted that the degree of acceptance of fees is as variable as the number of workers in the clinic, and that each one's attitude is quite related to the worker's own personality and previous training and experiences. It was felt that the attitude has changed more positively toward fees as tends to enhance the feelings of professionalism of the workers. All felt that it was important to have a general favorable attitude, especially since the board and community were desirous of this move. It was again felt that the flexibility of the fee policy at the clinic has helped considerably in allowing each worker to work out his adjustment to the fee policy.

The question concerning the client's attitude toward fees noted a general consensus of opinion that the clients reacted quite favorably. There was some initial anxiety about the amount, but they usually felt it

was quite fair and were satisfied if they were getting the help they had expected. The staff did not feel it was a strong deterrent, atleast for those people who were already being seen. Several staff members suspected, but could not confirm, that some clients hesitated in calling in because of fees. All staff members felt a study should be done in this specific area as there are not enough facts known at this time.

The staff felt the community's attitude was generally favorable toward the clinic charging fees. All staff members felt the community desired and expected the clinic to charge fees and had the confidence in the staff to do this. One staff member noted that the general community would be more eager for fees than the client, because it lessens the demands of the clinic on tax funds. Another noted that the community could feel that we were making an effort not to tax them anymore than necessary and were taking what measures we could to support ourselves without reducing service to clients.

The staff was somewhat split as to whether it is incongruous for a public supported agency to charge fees. The staff agreed that it involves a change in thinking from our older traditional concepts, but felt it was a positive change. One staff member stated that community criticism would be more warranted if we did not charge fees to improve the clinic's financial situation, then would be warranted from the charging of fees. The staff members that held negative opinions felt that the amount of income that would be realized from fees would not make up for the increased resistance by clients who had to pay fees.

There was a wide range of differing opinions on the question regarding the negatives of fee charging. The range of negative points held

in fee charging was from none by one staff member to six by another member of the staff. The negatives in fee charging included the following: (1) Charging fees increases resistance and gives the client a tangible excuse for termination. (2) Indiscriminate application of fee policy to the full range of problems, without knowing to which it is actually beneficial. (3) Miscalculating a fee can be quite damaging to the client. (4) Failing to adjust fee with income changes due to hesitancy of client or therapist to bring the matter up. (5) The time it takes to work out fees and do paper work could be better utilized especially since it is not a big source of income. (6) May tend to deter clients from intake and treatment who otherwise could have accepted it. (7) Failure to handle problems around fees can have negative effect on the future course of the client.

Whether fees have affected the caseload in any manner was another question. The staff agreed that further study and more time would be needed before definite statements could be made either way. This is due to the fact that the treatment caseload changeover is quite slow and any noticeable change would require quite a little more time than has elapsed since the fee policy was initiated. The general impressions were split among the staff with half feeling that fees had no effect on caseloads, while the other half had the impression that the new policy has resulted in some drop outs. After a year or so with the fee policy, more definite trends may be established on any effects on caselead. The staff who felt it caused drop outs did not feel they could point to any particular catagories of families or person such as a socio-economic class, that would affect the over-all caseload. They again indicated that this question

needs specific studying to determine the effect of fee charging on the caseload.

The final question was concerned with the staff's opinions of fees as a adequate source of income. There was agreement that a certain amount of income would be realized, but that it should not be required to be a major source. The staff members were hesitant to predict how much income should be expected from fees, estimating that a few years would be required before definite statements could be made. All the staff felt that the money realized from fees should be utilized to expand services, rather than to replace present financial sources. Several staff members also noted that the fee would help considerably in filling the gap left by the expiration of the Kellogg Foundation grant.

A study of the case records concerning fees and their effect upon the caseload had been planned. However, this was not carried out for two reasons. First, because the fee policy is relatively new and the recording of fees by the staff is not yet uniform. There is a form which is to be filled out after fees have been determined. However, in a sample of the cases selected, in a large percentage of the cases this had not been done. There was usually a statement or two about the fee contained in the record, but not enough of the needed information. Secondly, some of the staff do not fill out the forms until the cases are closed. There is still quite a little changeover of cases which were diagnosed and placed on the treatment waiting list before fees were initiated and consequently do not have any fee data recorded. As a result any sample would be too irregular to permit generalizations.

Summary and Conclusions of the Study on the Fee Policy at the Battle Creek Child Guidance Clinic:

The fee policy at the Battle Creek Child Guidance Clinic was initiated July 1, 1960 and has been in operation about eight months. Fee charging was started at the community's request and has operated relatively smoothly. The income realized has amounted to approximately $500.00 per month.

Interviews were conducted with staff members at the Battle Creek Clinic in an attempt to determine their attitudes toward fees. Part of the staff approved and part disapproved, but all felt that the flexible policy they use makes adjusting to charging fees relatively easy.

Both positives and negatives were noted by the staff, with the majority of the staff feeling that charging fees is a move in the right direction. All the staff felt there is a real need for intensive study in a number of areas connected with charging fees, both in their own clinic and in the field in general. Those noted were: (1) With what problem classifications are fees actually therapeutic? (2) What are client attitudes toward paying fees? (3) Do fees have a deterrent effect on intake and treatment? (4) What are the community attitudes toward a public agency charging fees? (5) What are the lower and upper limits of fees, and how can they be standardized? (6) Do fees intensify the client's participation as is commonly supposed? (7) What is the maximum portion of clinic costs that should be covered by fees?

In conclusion, the community, clients, board and staff have accepted the clinic's charging of fees. While there are a number of questions in the staff's minds, and further study is needed to clarify these points,

at present the positives appear to outweigh the negatives and the paying of fees has become a permanent part of agency policy.

CHAPTER VI

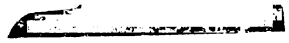
INTAKE PROCEDURES

In this chapter we will examine the intake processes of the four clinics beginning with the initial contact and continuing until a disposition of the case is made. The purpose is to compare the techniques and procedures followed by the four clinics, and to indicate some of the relationships between the philosophy of a clinic and the use of particular procedures.

Included in the discussion of the intake processes are: (1) the taking of the initial referral (2) methods used in screening out applicants (3) functions of the three disciplines in the intake process (4) number and type of interviews included in the process (6) criteria for acceptance and/or rejection of clients for treatment.

Reference is also made to the handling of the treatment waiting lists. Lastly, mention is made of statistical figures which give some indication as to the sources of referrals to the clinics. These figures also compare the types of diagnoses made at the various clinics and the type of service offered.

The data were collected by personal interview with members of each of the three disciplines at the four clinics under study. Supplementary information was obtained from policy statements at the four clinics. Statistical figures were obtained from a Michigan Department



of Mental Health report for the period July 1, 1958 to June 30, 1959. Although all four clinics use the multi-disciplinary approach, they vary rather widely in their intake process.

Initial Referral and Screening:

The Battle Creek Child Guidance Clinic revised its intake procedure in 1958, in an effort to reduce the waiting list. At the present time the clinic attempts to offer appointments to new applicants within or two weeks after the request for service is made. A referral worker (a social worker who usually serves voluntarily for a period of six months and who is responsible for all correspondence with the referral sources and other necessary sources of information) makes the initial decision as to whether the applicant belongs at the clinic. If the case is a re-referral, the original worker usually again assumes responsibility unless this is contra-indicated, the clinic feels it is more effective to have one social worker permanently assigned to intake responsibilities, since outside agencies have more opportunities to become acquainted with him (and vice versa), thereby making communication more efficient.

The intake worker has a list of the staff who will do the screenings i.e. one psychologist and two social workers, and he may assign a case for screening to one of them. He may make this assignment to whoever has an opening or on the basis of who he thinks will be particularly successful with a particular type of case. The referral worker may consult with the Director as to whether a given client should be accepted. On all voluntary referrals, the parents are asked to make the initial call.

At the Flint Child Guidance Clinic, parents are also advised to make the initial call. A secretary takes names, address, and other factual information and does a minimum of screening of cases which obviously do not belong to the clinic. The parent is then advised to call back in approximately four weeks, depending upon the urgency for service. This device is used to screen out those parents who call in a moment of momentarily hightened anxiety and/or who are resistive and who may lack sufficient interest in actually securing help. At the time of the parent's second call, forms are sent to him. Upon their completion and return to the clinic, an appointment is arranged.

This clinic has a half-time intake worker who screens the applications. She may call parents to refer them elsewhere, request permission to obtain more information, or offer an appointment. If there is no reply from the client after the initial call, the application is kept on file for two months and then dropped. Upon re-referral, the procedure is begun anew. The intake worker sees only those referrals whose initial conatct is in person; otherwise the entire procedure is conducted by telephone or correspondence.

The case is next assigned for a diagnostic interview. Ordinarily the case is assigned to a team composed of two disciplines. The intake worker also participates in diagnostic interviews. The intake worker assigns cases according to his own clinical judgement. For example, if the case includes physical illness or a question of deep disturbance, it would be assigned to the team with a psychiatrist; If intelligence is questioned, assignment is made to a team with a psychologist; If family difficulties, the case is assigned to a team with a social worker.

At the Kalamazoo Child Guidance Clinic, as at the other clinics, referral may be made in person, by phone or letter. If referral is made by phone and the client does not make a request for a specific worker, the secretary takes the basic face sheet information. It is the clinic's feeling that the secretary is not as apt to get involved and because of her experience, is adept at explaining the waiting list. However, if she is uncertain regarding a decision, she refers the call to the chief social worker. The secretary then files these applications in chronological order by counties.

Forms are sent to the parents to be completed when it is approaching the time when the client can be accepted for the diagnostic study (with treatment available in the immediate future). Six to eight weeks are allowed for these forms to be returned. These consist of forms to be completed by the parents, physicians, and schools. Appointments are not made until the forms are returned. It is believed that these forms provide helpful information as well as screening out those clients who lack sufficient motivation. If clients do not return the forms, a follow-up letter is mailed to them advising that if they do not respond by a certain time, the clinic will assume they are no longer interested. Appointments for the diagnostic study are made upon return of the forms.

At the Lansing Child Guidance Clinic, as at the others, referral may be by letter but, almost without exception, if someone other than the parent calls, the clinic suggests to the referral source that the parent be advised to call.

A member of the clerical staff talks with the referral source regarding the reason for the referral. The information obtained is then

referred to the chief psychiatric social worker who may contact the parent, other referral source and/or other community agency if permission is granted by the parent. The chief social worker also contacts the initial community referral source after two or three weeks if the parent has not called.

In the case of a "typical" or usual type of referral, she decides as to the approximate time for the diagnostic study. Generally, a diagnostic study is done on each case.

In the more unusual cases the Director is consulted as to appropriate handling. Such cases include those in which there is question as to (1) whether the clinic should consult with the referring agency or whether the regular clinic diagnostic study should be made; (2) Whether the case should be assigned to a social worker for several interviews for clarification of the difficulty so that an appropriate disposition can be made (such as referral to another agency, planning for further clinic service or a series of interviews for consultation); (3) Whether to assign a re-referral to a social worker for a review of the situation. In the latter instance, the case is seen again for a diagnostic study or other planning is made with the psychiatrist. Re-referrals are closed cases on which a complete diagnostic study has been previously done.

The referral is placed on the diagnostic evaluation waiting list and is scheduled according to the problem involved and/or the community concern. A new referral may be seen within a week, two weeks, a month, or perhaps not for a year. Re-referrals are given some priority. Patients referred by community agencies for further study and recommendations are generally scheduled within a month to nine weeks and according to when

the agency reports are recieved by the clinic.

This clinic formerly sent out forms to be completed by the parents and/or referral source during the intake process. However, it is now generally felt that these forms created difficulty and confusion for the clients and resulted in misinformation.

Diagnostic Study:

Among the four clinics there are also variations in the manner in which the diagnostic studies are conducted.

At the Battle Creek Clinic the diagnostic interview generally takes place two or three weeks following the referral. From the initial screening to the end of the diagnostic process usually takes from six to eight weeks.

The initial screening interview is ordinarily completed within one and one-half hours. This is generally true in respect to the other three clinics also. Battle Creek attempts to see both parents for the first screening interview. There are occasions when more than one screening interview is conducted. In this interview the psycho-social history is obtained, the functions of the clinic are interpreted, and the amount of the fee is established if the case is to be accepted for further work.

The psychiatrist (who is hired on a part-time consultant basis) seldom sees the parent. He will see the child if there is a question of brain damage or if the child seems psychotic and may need commitment to a hospital or clinic. The staff member who conducts the screening interview decides as to whether the child should be seen by the psychologist and/or the psychiatrist on the basis of the kind of problem the child presents. If it is felt the child is essentially healthy, the case is not presented

at a diagnostic conference and is dropped as "advice without acceptance".

Battle Creek utilizes forms to be sent to doctors or schools if permission for this is granted by the parents and if the clinic feels this would be helpful in making a diagnosis. Forms are not used for parents, however. It is believed they lengthen the intake process unnecessarily and are generally ineffective.

The case, following the screening interview (s) is reviewed at a diagnostic conference. (Six to eight weeks later) participants at this conference may range from only the director and the worker who did the screening, to the entire staff including one of the part-time psychiatrists. If there is any disagreement on the diagnosis, recommendation, or disposition of the case, the director is responsible for the final decision.

Usually there is agreement by the staff and a staff decision prevails. One of the part-time psychiatrists may or may not be present at the conference and although he may have been requested to make a diagnostic evaluation, he is not necessarily included in the final diagnostic staff conference. At Battle Creek, the Director (a social worker) has been responsible for making the final decision regarding diagnosis.

The criteria used for the selection of treatment cases are: (1) Motivation for change and the willingness by the parents and child to participate in the treatment program; (2) Diagnosis and (3) Treatability of the child. Motivation is one of the primary criteria for acceptance of clientele at the clinic. Examples of diagnoses which would tend to be unaccepted for treatment are: brain damage; mental retardation; psychosis;

primary behavior disorders. A rule of thumb used at the clinic in determining whether a case is to be accepted for treatment is that if a child is unable to function at home or in society, he is unacceptable for treatment.

No priority is given to referrals from a particular area. Occasionally some immediate consultative help is given to the parent or to the referral source.

As previously stated, at the Flint Child Guidance Clinic, a case is assigned to a team composed of two disciplines when it is time for the diagnostic interview. One team, however, has been composed of two social workers. Four to five of these teams function weekly. Team members generally meet together briefly to discuss the particular referral. The parents are seen by the social worker, together or separately, and the child by one of the three disciplines (usually a psychologist or psychiatrist).

Directly afterward the team members meet again to evaluate the situation, make recommendations, and assign for treatment if indicated. In the event that case cannot be disposed of immediately, further planning for staffing or additional diagnostic interviews are arranged. The team member working with the parents then meet again with them for interpretation. Intake studies which do not fit into the team program are seen at other times during the week. Any staff member who has available time may do intake alone, in which case he sees both the parents and the child.

Brain-damaged and mentally retarded children are not seen for diagnosis, and referrals which suggest serious emotional disturbances may be referred directly to an in-patient facility rather than accepted

for intake at the clinic.

More recently the Flint clinic has experimented with a technique which they refer to as Family Unit Diagnosis. This involves interviewing the parent(s) and the referred child simultaneously. This is based on the premise that the family interaction can thus be more readily observed, diagnosis can be more readily made, and it is, of course, a time saving device, in that it replaces several individual interviews with one joint interview. All professional staff members have participated in this technique.

Although in theory any staff member may make the final diagnostic decision, in practice the staff member's supervisor ordinarily participates in this decision. The staff member may also have informal consultations with other clinicians. However, no specific staff member or discipline is responsible for making the final diagnoses.

Not all cases are presented at a diagnostic staff conference. The necessity for such a conference is decided by the staff members involved in the case. Such a conference may be considered necessary when there is disagreement as to diagnosis among the staff members and/or when the shared thinking of staff members would be considered beneficial due to the complexity of the problem. If, following conference, there continues to be disagreement as to the diagnosis, the responsibility is then left to the clinical director. In practice, however, the "majority rules" and/or the opinion of the staff member involved in the case is given more weight.

The criteria used in determining whether a case is to be accepted for treatment include (1) degree of disturbance (2) client's workability

and insight (3) parents ability to use help (4) other resources available to the client and (5) time and availability of staff. Because time and availability of staff are evaluated when the diagnostic disposition is made, the waiting list for treatment is relatively small. If, for example, there is insignificant time or staff available to accept a case for treatment, the next best disposition is made.

Priority for treatment may be given by individual staff members according to their own professional judgement. Priority may also be given to court referrals (as is true at the Battle Creek Clinic) at the time of intake. Emergency cases are considered as those children who are dangerous, or potentially dangerous, to themselves or others.

The Flint clinic uses two forms to be completed prior to the intake interview. One is a form requesting face sheet information and the other is a questionnaire to be completed by each parent asking how they see the problem, etc. It is felt these forms give parents an opportunity to evaluate the problem as each sees it, serve as a test of their motivation for help, and supplement the information obtained in the initial contact.

At the Kalamazoo Child Guidance Clinic the social worker sees the parents for the intake interview and the child is seen concurrently or at a later date by the psychologist. Following this, the social worker and the psychologist confer and if they are able to come to a decision, the social worker makes the recommendations. Psychiatric evaluations are requested when there is a question of a medical problem or a serious psychiatric problem, such as when referral to a residential center may be necessary, or when, according to their clinical judgements, a psychiatric evaluation would be beneficial.

Sometimes the social worker makes the decision alone with psychological tests from other sources. Because diagnosis is considered to be a medical decision, those cases which are not seen by the psychiatrist are left technically undiagnosed.

Workers are assigned to intake primarily according to counties. One worker is assigned to each county with the exception of Kalamazoo County for which all workers take divided responsibility.

It is possible for a client to be accepted for extended diagnostic study, generally up to three appointments. This is to assist in decision making when there is a question as to the nature of problem, treatability, etc.

In addition to the regular intake procedure there is a yearly "screening" week which is used to handle the intake waiting list. The chief social worker reviews the cases ahead of time and decides the one service that appears to be most necessary. For example, she decides by whom the applicant should be seen and what type of evaluation would be most appropriate. At this time, all staff members do three intakes daily and treatment cases are not seen during this period.

The clinic attempts to keep their treatment waiting list at a minimum by not accepting any case for intake unless there is a strong possibility that treatment can be begun in the near future. Cases considered as emergent are these in which the child may endanger himself or others; the court must make an immediate decision; parents are in extreme distress. In such instances, parents may be permitted to come on the date of their application but they are still required to fill out the necessary forms.

Specific problems which would not be considered as acceptable for treatment at the clinic are those of mental retardation (unless accompanied by emotional disturbance) and severe emotional disturbance (such as childhood schizophrenia). Other factors involved in whether the case will be acceptable for treatment are (1) whether there are other available resources, and (2) length of treatment.

At the Lansing Child Guidance Clinic, all diagostic studies include interviews with the parents(s) by the social worker, and psychiatric examination and psychological testing for the child with two exceptions. The psychologist may determine that psychological testing is not necessary due, for example, to the child's young age and/or previous testing has been done by another resource. In the latter case, previous tests may be supplemented by additional testing. The psychologists also see those who come in only for psychological testing e.g. learning difficulties, mental reatrdation, and organicity.

The criteria for considering intakes as emergencies are (1) a child whose problem is so intense that later treatment would become very difficult or impossible e.g. school phobia, child a danger to himself or others, constant depression, colitis. (2) Community emergencies e.g. court must make immediate decision, other family members working with another agency (3) Pre-school children for preventive work. New referrals are generally catgorized as emergency, "ahead" (chronic conditions) and regular.

If parents cancel an intake interview, generally two more opportunities for appointments are given to them. Intakes are referred elsewhere if it is felt the primary problem does not lie within the

function of the clinic. e.g. marital problem.

In this clinic the psychiatrist is responsible for the final diagnosis and makes no diagnosis for which she personally can see no clinical evidence.

Generally, every case is presented for diagnostic conference. Prior to the diagnostic conference, the parents may occasionally be seen more than once for diagnostic interviews e.g. if they are particularly apprehensive about coming to the clinic. Occasionally, also, the psychiatrist may wish to see the child for an additional interview.

The diagnostic study is generally completed within one to four weeks and the case is staffed by the team members involved within one to four weeks later. Parents are seen by the social worker one to two weeks following the conference to interpret the clinic's findings and recommendations. If the child is placed on the treatment waiting list, it may be suggested that he be re-evaluated in several months.

Priorities are used in accepting a child for treatment. The following considerations may influence the decision: intelligence; motivation; problem; degree of suffering; chronicity; social situation; and whether the anxiety is drained off in a psycho-somatic symptom.

This clinic will accept some severely disturbed children e.g. the childhood schizophrenic. The philosophy behind this is two-fold: the need to learn more about the schizophrenic child (research objective) and the desire to provide help to the schizophrenic child.

In the preceding discussion, we have considered the criteria used by the clinics in accepting a case for treatment, the priorities given in respect to the type of case and source of referral, and the methods used

in, making diagnoses and so forth.

Statistics reported by the Michigan Department of Mental Health for the period July 1, 1958 to June 30, 1959 indicate that in this period Battle Creek and Flint had proportionately more referrals from the schools than the other two clinics. Although Lansing had 150 less total referrals than Battle Creek, it had a comparable number of juvenile court referrals (55 and 58 respectively). Flint had proportionately more referrals from private agencies than any of the other clinics. On the other hand, in this same period Kalamazoo had no reported referrals from private agencies. In contrast to this Kalamazoo and Lansing had proportionately more public agency referrals.

The total cases accepted, served, and closed by each clinic in this period were as follows:

	Battle Creek	Flint	Kalamazoo	Lansing
Accepted	445	392	416	295
Served	593	693	580	414
Closed	349	384	361	285

Out of this above total, the following figures are shown in respect to diagnosis:

Mental Deficiency	52	70	19	13
Psychotic	22	1	8	9
Psychoneurotic	68	95	75	110
Situational	32	56	14	80
Essentially Healthy	49	77	14	9
Undiagnosed	20	13	99	10

It will be noted that Lansing where generally all cases are seen for a complete diagnostic study in which all three disciplines participate, had more cases proportionately which were diagnosed as psychoneurotic or situational; where as Battle Creek and Flint had proportionately more than the other two clinics who were diagnosed as essentially healthy and/or mentally deficient. Kalamazoo (where all cases not seen by a psychiatrist are left undiagnosed) had many more in the last catagory.

In a table which states the ages of new and reopened clinic cases, it is interesting to note that Flint had 67 such cases age 1 or under. Battle Creek had 10; Kalamazoo 1; and Lansing, 0. The total seen who were age 4 or under were: Battle Creek 31; Flint 100; Kalamazoo 20; and Lansing 11. Consequently, it appears that Flint had many more pre-school age children than the other clinics.

In conclusion, it is evident that there is considerable difference in the handling of the intake process by the four clinics. In some clinics, specific measures are taken to screen out those who are less motivated or resistive; whereas others reach out more to the resistive client. On the one hand, for example, the Lansing clinic does not require the completion of forms by parents and will schedule more than one intake interview if it is felt the parent has extreme anxieties regarding the acceptance of the child's problem accepting the need for psychiatric help and/or the need for more interpretation of clinic function.

On the other hand, the Flint Clinic generally requires parents to call back several weeks after the initial call and subsequently requires that the parent return written forms in an effort to screen out those parents who call in a moment of hightened anxiety and/or who are

resistive.

Two of the clinics have a full or part-time intake worker while at the others, Kalamazoo and Lansing, workers are assigned intake interviews on a retational basis and/or by county.

There is a rather wide differnce in making determinations of predispositions of cases. Although, of course, all clinics may involve the three disciplines in the intake process, this is not necessarily so. In Battle Creek, for example, the psychiatrists are on a part-time consultative basis.

Only one clinic is experimenting with the method of joint or family interviewing wherein the child and parents are seen simultaneously.

There are variations also in the criteria for the acceptance of cases for treatment. Lansing, for example, is the only clinic which accepts schizophrenic children on a selective basis. According to a policy statement by the Michigan Department of Mental Health, many children who show symptoms of an incipient mental disease or severe personality difficulty can be successfully treated in a child guidance clinic. However, clinics differ in their philosophies as to whom they can successfully treat.

It would seem that future studies might be made to learn more about the client's reaction to the intake process. In this way individual clinics would have a basis on which they could examine and evaluate their intake process. One follow-up study might be made to learn parents' reaction to the clinic following intake and their subsequent acceptance for treatment and/or referral elsewhere. For example, the effectiveness of the clinic's intake process could be measured in trems of

the parents' negative and/or positive attitudes regarding the clinic; whether they feel they were helped in understanding the child's problem, whether they followed through on the clinic referral and what, if any improvement they attribute to their clinic contact.

CHAPTER VII

INTAKE THEORY

As we have shown in the preceeding chapter, the four child guidance clinics under discussion vary, not only in the manner in which they conduct their intake process but also in the type of service they provide and the kind of cases which are accepted for treatment.

The purpose of this chapter is to examine these aspects of the intake process more fully. It includes discussion of the early goals and philosophies of the clinics and the present concepts.

The skills and techniques needed by the therapist in the intake process are discussed, along with the many dynamic factors which need to be considered. Consideration is also given to the methods used in various clinics and reference is made to several follow-up studies which have been done for the purpose of discovering client's attitudes toward the clinic after having been seen at intake.

The Development of Child Guidance Philosophy and Operational Concepts:

The team approach, using the three members of the mental health profession--psychologist, psychiatrist, and the social worker, has been a significant part of the child guidance clinic since its development. As far back as 1909, pioneer mental hygienists felt that treatment of the young would reduce psychosis as well as criminality and other social

disabilities of adulthood. Rather than continuing emphasis on custodial care and the protection of society, it was believed more attention should be given to prevention of emotional disturbance in children and promote greater understanding of the individual.

These hoped-for goals were not fully achieved. Through the years there has been the necessity to examine and re-examine the philosophy and operational concepts of child guidance.

Only a relatively small percentage of emotionally disturbed children are seen at the clinics. In the beginning the courts, schools, and social agencies almost filled the clinic with some of their more difficult cases and the clinic was known as a more autheritarian agency.[1] Much of the professional staff came from backgrounds of state hospitals and much emphasis was placed on diagnosis and manipulative suggestions.

These suggestions were often inadequate and referring agencies disappointed. Cases of mental retardation and organic brain disease were discharged from the responsibility of the clinic.

Gradually the clinic movement modified its aim of preventing psychosis and later criminality which had been primary. It developed the philosophy that the milder disorders of child behavior were deserving of clinic intervention and the clinics dissociated themselves from the more authoritative forces in the community so that they were more free to explore and were less tools of the courts and so forth.

Although the child guidance movement can be traced back to 1909,

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[1]Ross, Alan, The Practice of Clinical Child Psychology, Grune & Straton. New York 1959. pp. 26-32.

clinic organization and technique did not become crystallized until the early 1920s. By that time the influence of Freud, Hall, Meyer and others had led men like Healy, Allen and Stevenson to the recognition that parents play a crucial role in the development of emotional disturbances of children. Consequently, the personalities and motivations of parents, particularly the mother, are now considered in the decision as to whether to accept a child for treatment at the clinic.

Criteria for Acceptance and/or Rejection for Treatment:

According to the literature, clinics now generally screen out the low-grade mentally retarded, children with severe organic brain disorders, and families who are overcome with overwhelming socio-economic pressures or severe marital difficulties which temporarily reduce the possibility of amelioration of the problems through psychotherapy.

Among the four Michigan clinics studied, only one accepts psychotic children for treatment and this is on a selective basis.

Ross[2] mentions eight points which he believes would constitute an ideal treatment case:

(1) The child and both of his parents should be motivated to obtain help.

(2) The child's difficulty should be of such a nature that it results in some subjective discomfort to him so that he is willing to recieve help in alleviating it.

(3) The child and the parent selected for treatment should show good potential to benefit from therapy.

(4) The child's problem should be of a nature which makes it amenable to ego-supportive treatment, based on a positive relationship with an understanding adult.

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[2] Ibid.

(5) The parent, in concurrent treatment, should be able to accept his role in the treatment process and be willing to contribute actively to the child's improvement by recognizing that he himself needs therapy.

(6) The parent in concurrent treatment with the child should be able to progress in therapy at a pace equal to or greater than that of the child.

(7) The family and home situation of the child should not be so unstable and disrupted as to preclude giving him a secure environment in which to try out the healthier responses therapy would enable him to make.

(8) Finally, the family of the "ideal" treatment case should not be so far removed from the cultural milieu of child, therapist, and caseworker as to make it difficult, if not impossible, for them to empathize with the families' value system and reality problems.

Gilbert[3] conducted a study of the probelms for which 2500 children were referred to four of the principal child guidance centers in major metropolitan cities. He found that in clinics the problem with greatest incidence is what he classified as aggressive and antisocial behavior. Emotional instability and anxiety symptoms: passive; withdrawn; asocial behavior; academic difficulties; and hyperactive motor symptoms ranked next, in that order. Significantly, the lowest incidence was for problems involving sexual behavior, a fact which he explained as meaning that parents in our culture are reluctant to admit the presence of sexual maladjustment in children, at least at the first clinic contact.

Functions and Purposes of the Intake Interviews

A. Behavior of Parents in the Initial Interview:

An intake screening should include an investigation of those factors in the circumstances of the referral, the life situation and the

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[3]Gilbert, G. M., "A Survey of Referral Problems in Metropolitan Child Guidance Centers", Journal of Clinical Psychology, Vol. 13, Jan. 1947 pp. 37-42

personalities of the parents which could interfere with receptivity to treatment. Parents who have been pressured into coming to the clinic by the school, court or hospital may arrive in a belligerant mood and defy the clinic to find abnormalities in their children. Such rationalizations and projections may represent insurmountable barriers. Social repurcussions of their children's behavior may bring distressed parents, anxious for relief. They may see the child's behavior as an increasing nuisance. However, indications for clinical treatment may not coincide with the parents' ability to accept such a treatment plan.

As we have noted in the previous chapter, most parents have their first contact with the clinic by telephone or interview. Most clinics require, no matter who makes the initial referral, that the child's parents contact the clinic themselves, thus guaranteeing at least a minimum of involvement on their part.

Often the functions of the clinic are misunderstood, both by the professional person who made the referral and by the parents who establish the contact on their own initiative.

The skill of the therapist and the strength of the client's defenses are factors that determine whether the client can really share his problem with the worker in the intake interview.

During an initial interview the neurotic defenses and the intact adaptive ego functions may enable the "borderline" client to present a relatively conventional neurotic maladjustment. It will only be on subsequent interviews that the other features of the personality would intrude themselves.

Because of a parent's own anxieties in the intake interview, he

or she may be unable to adequately prepare the child for the initial contact. Consequently, often more than one interview may be required for diagnosis and also, so that the parents are better able to prepare the child for contact with the clinic.

The interaction with the parent in the intake interview set the tone for the treatment process. This exploratory role with the client of his difficulties and capacities is the beginning of the therapeutic relationship.

In a study by Blenker, Hunt, and Kogan[4] on the interrelated factors in the initial interview they state:

> We surmise that many of these clients, being new to the agency, were cautious in answering and that they emphasized problems that they thought the agency might be most interested in or that they found least embarrassing to discuss with a total stranger.

B. Role of the Therapist:

Wolberg[5] asserts that the principal objective in the beginning stage of therapy is the establishment of a working relationship. To insure that an adequate working relationship will be established he believes the patient must first be motivated to accept treatment. The therapist must concentrate his efforts around creating the proper incentives in the resistive patient.

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[4]Blenkner, Margaret, J. McV. Hunt, and Kogan, Leonard, "A Study of Interrelated Factors in the Initial Interview with new Clients", Family Service Association of America (New York 1951) p. 63

[5]Wolberg, Lewis R., The Technique of Psychotherapy, Grune & Straton, New York. 1954 p. 195-197

Equally important is the task of clarifying and removing misconceptions about therapy. Thirdly, the therapist needs to convince the patient that he undertands his suffering and that he has the capabilities to help him. The client may expect the therapist to be judgemental or punitive due to his own feelings of guilt and resentment. Fourth, following the unsuccessful completion of the foregoing three steps, the therapist has the task of defining the tentative goals of therapy.

Although the goals of the intake interview have been briefly mentioned previously, Wolberg discusses these in more detail. He lists the primary goals as being: to establish rapport with the patient; to get pertinant information from the patient; to establish a tentative clinical diagnosis; to estimate the tentative dynamics; to determine the tentative etiology; to assay tentatively the assets, strengths, and weaknesses of the patient, actually and latently; to make practical arrangements for therapy; to arrange for essential consultations and psychologic testing.

Hamilton[6] stresses the importance and necessity, in the diagnostic process in child guidance, of obtaining a comprehensive picture of the situation, the person, and the person reacting to his situation, including those earlier experiences which have contributed so much to shaping his character. The question arises often as to the propriety of the making of psychiatric diagnoses by social workers. However, the social worker should have adequate understanding of the significance of terms such as "primary behavior disorder" along with broad classifications of psychoses, psychoneuroses, mental retardation, convulsive disorders

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[6]Hamilton, Gordon, Psychotherapy in Child Guidance, Columbia University Press, New York, 1947. pp. 19-44

and so forth.

In the intake interview, the psycho-social aspects of the client's difficulty must be explored. The willingness of the client to discuss the reality aspects of the problem may well be an indication of his readiness to use help and to work on his problem. It is recognized that the client's application in itself is an indication of motivation but it is essential that the worker must be ready and understanding of other initial attitudes of resistance and defense. The therapist must not reassure, interpret or precipitate too much, nor must he do too much or act too quickly.

Although a patient may directly ask for advice, at the same time he may be defending himself against whatever advice is offered. As Diogenes is credited with saying, "When Thales was asked what was difficult, he said,'To know one's self', and what was easy, 'To advise another'."

Parents often have much ambivalence in asking for psychiatric treatment because of the social stigma which is still often attached to emotional disturbance and because of the resistance they feel to accepting the problem in their child. Also, they may have little actual concept or knowledge of emotional disturbance. One therapist interpreted quickly and briefly to a mother that her child was autistic and for six months, although the child had been accepted for treatment, the mother interpreted the therapist as having said "artistic".

At the Memorial Child Guidance Clinic in Richmond, Virginia, tape recordings were made of intake interviews. Although this research has not yet been completed, it has been discovered that parents remember only that content of the interview which they "want" to remember.

It must be recognized also that the motivations and readiness for help may vary greatly in the parents. When parents are seen together the therapist must necessarily be skilled in recognizing their individual resistances and defenses.

Methods of Intake:

In some clinics motivation is considered of primary importance whereas other clinics reach out more to the resistive client. A case may be deemed inappropriate at any given step in the diagnostic process and in some clinics there appears to be a trend to encourage the disciplines to take more initiative in closing out inappropriate cases before they reach a staffing level.

The activities of the three disciplines over-lap in the intake process in the four clinics studied. Some clinics have a regular intake worker who conducts the initial interview. Other clinics assign responsibility for intake on a rotational basis. The latter is done purposively in that it permits the intake worker, where necessity demands, to continue the case. If for example, a client is seen two or three times, he may be helped within the intake process to overcome acute anxiety before being referred elsewhere.

Although originally the intake interview was conducted by a social worker, this responsibility is now shared in some clinics by other disciplines.

Recently there has been the development of a theory that family diagnosis can offer additional insights into the child's difficulty through the observance of family members within one or several interviews

in the intake process. This may be continued into family therapy. More than fifty years ago, Mary Richmond[7] emphasized the importance of the family as a unit and the importance of the interpersonal relationships within the family matrix.

Some clinics more or less routinely see clients for a total of four to six interviews. During this time it is felt a more accurate diagnosis can be made and/or parents may be offered sufficient supportive help to carry them over to the time that treatment can be offered. This also may eliminate those cases who are carried on waiting lists and subsequently withdraw. This will be discussed later according to the results of several studies on clients who have been seen for one interview. The entire intake process may extend over a relatively short period of several weeks to as much as a year in some clinics.

The process may mean only one interview by the psychologist, social worker, or the psychiatrist. It may mean that both child and parents are seen by a member of each of two disciplines. In some clinics the child is ordinarily seen by both the psychiatrist and the psychologist, the psycho-social material obtained from the parents by the social worker and the parents then seen for interpretation of findings by the psychiatrist.

At the Institute for Juvenile Research, Chicago, Illinois,[8] contact with the majority of patients seen at the clinic is terminated without treatment, although diagnostic procedures have been applied in all

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[7]Richmond, Mary, Social Diagnosis, William Fell Co. Philadelphia, 1917

[8]Browne, Marjorie and Students, "A Report on the Pilot Study of Intake", A review of activities on sixty-eight cases applying for service at I.J.R. during February 1954

instances. The clinic makes an effort to implement its diagnosis in the last contact with the parent, at which time recommendations are made and/or some degree of interpretation may be given.

It has been pointed out that in order for a diagnostic service to be considered "service" the clinical diagnosis has to be implemented to become service or help in behalf of cases.

At the Institute the case may be closed at the discretion of the social worker following the history, or sent to the Scheduling Committee where it is reviewed and further diagnostic procedures are planned. If the case remains open following the social history, the child is then seen for testing by a psychologist, and later on the mother, father and child are seen individually by the psychiatrist. Following the psychiatric interview, the case is scheduled for a diagnostic and service staffing. This conference is attended by the examiners, a senior worker from each discipline of social service, psychology, and psychiatry and a senior psychiatrist who serves as moderator of the staff. At this meeting the case is discussed from all points of view and it is decided what the disposition of the case will be i.e. acceptance or rejection for treatment, or referral to another agency. A case may be accepted for treatment "without question"; "with reservation"; or "prognosis poor but trial treatment indicated". Following this it is sent to a Treatment Committee composed of skilled staff members and this serves as a check on the original diagnostic staffing. Following the Treatment Committee's decision, the case is then ready for the completion interview, at which time it is generally the examining psychiatrist who discusses the findings and recommendations with the parents. If treatment is recommended the

case goes back to the Treatment Committee which assigns the case for treatment in either of the three disciplines. The case is then placed on the waiting list.

In contrast, the Memorial Child Guidance Clinic in Richmond, Virginia makes extensive use of the group method in its intake process. The parents and the child are seen individually by the psychiatrist. Prior to this the parents are seen by a social worker in the initial interview wherein the psycho-social history is obtained. The child may or may not be seen by the psychologist. A decision is then made as to whether the child is to be accepted or rejected for treatment. If accepted for treatment, the parents are then assigned to a group composed of other parents whose children have recently been accepted for treatment. Consequently there may be wide variation among these parents in respect to age, socio-economic status, type of child's problem and so forth. The group meets weekly for a period of six weeks, during which time there is opportunity for discussion and interpretation. Following this the child and his parents are placed on the waiting list for treatment (which consists of group therapy).

Follow-up Studies on Intake Procedure:

There are, of course, many cases, that are referred elsewhere prior to their ever getting to a clinic. Others are referred elsewhere following diagnosis and/or consultation.

In a study by the Bronx Health and Welfare Council[9] it was noted

9"What Can Be Done About Waiting Lists: A Study of Intake and Recording Methods in Bronx Family and Child Guidance Agencies", Committee of Service to Individuals of the Bronx Welfare and Health Council, Bronx, N. Y. 1954 (Unpublished Report)

that because of over-all lack of appropriate resources for referral, no completely satisfactory solution for the problem of who to accept for treatment, when to accept them, and who should be referred, could be found. The Committee on Service to Individuals of the Council stated that:

> "...it is disturbed about the fact that every agency faced with the problem of surplus volume needs to compromise basic values in one way or another. Whether people are turned away from the agency, or too many clients are seen too rarely, or waiting lists of enormous length are built up, the implication is that families whose mental health is impaired already, are permitted to deteriorate further."

Several studies have been made regarding what happens to families who have been seen for a series of diagnostic interviews, accepted for treatment, and then after the waiting period, never returned to the clinic for treatment; those who have been seen at the clinic and referred elsewhere; and those who have been seen only for consultation.

One such study at the Institute for Juvenile Research[10] attempted to appraise whether the clinic met the needs of children who, for varied reasons, were directed elsewhere for treatment.

Most of the parents had been given the recommendations and referrals during personal interviews with them; On the whole, the mothers were willing to discuss how things had gone since they had been seen at the clinic, although less than half of them had actually accepted the referral. Of the group that accepted referral, a large majority reported symptom improvement. Of those who did not follow through, a majority

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[10] Moorhead, Janet, "Redirected Cases: A Follow-Up Study of Cases Referred Elsewhere for Treatment", Smith College Studies in Social Work, Mass. June 1958 pp. 179-209

expressed negative feelings. However, although the majority of the total forty-five cases received some sort of professional help after their clinic contact, it was found that in many cases it was not as a result of the specific clinic referral.

A study at the Albert Einstein College of Medicine[11] inquired into how clients felt after being seen once in an emergency psychiatric clinic, whether they had sought help elsewhere, and the nature of their current adjustment. It was hoped to learn the factors which contributed to the patient's failure to return after the initial visit.

Those patients who had followed through with treatment had been given appointments to return and had presented their problems in such a way that they seemed motivated; their diagnosis substantiated this impression to a large extent. As a result they had described their feelings about the clinic, treatment, and their doctor in positive terms.

Those patients who did not return were a more varied group diagnostically and tended to present their problems in terms of projection and need for concrete services. Over half of the group subsequently sought help elsewhere, some based on clinic referral. Over a third of this group seemed to have misconstrued the recommendations as they were at variance with the case record. It was felt that this may have implied their need to interpret the recommendation in their own way.

A study done at the Jewish Family Service of Philadelphia[12] on one

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[11] Harrison, Harriet, "Follow-Up Study of Patients Seen Once in an Emergency Clinic", Smith College Studies in Social Work, October 1959

[12] Schwartz, Dulcine, "A Study of Eight-Six One In-Person Interview Cases", Smith College Studies in Social Work, Vol. XXIII, October 1952 pp. 1-32

interview cases resulted in the conclusion that factors which seem to influence a client's using referral are the client's decision about the referral, casework considerations of problems other than those for which referral was made and , most important, whether the referral was made formally or informally.

Because there are many more children in need of psychiatric treatment than those who are actually receiving treatment, child guidance clinics have tried to establish intake procedures that will take into account the needs of those clients who, because of the clinic's limited facilities, cannot be accepted for continued treatment. The Madeline Borg Child Guidance Institute of the Jewish Board of Guardians,[13] established a consultation service in an effort to meet this problem. A follow-up study was done in an attempt to learn more regarding the effectiveness and advisability of this service, and to determine how this service was being used by clients. It was concluded that the consultation service seemed to have been used constructively by many clients. A majority reported improvements in the symptoms for which the child had been referred. About forty percent of the clients seen in consultation accepted the referral made, and this percentage of clients also actually received professional help. Cients attitudes toward the clinic seemed to have had no relation to either a constructive or a destructive use of the service. It was felt the study pointed up the need for further considerations to be given to the more highly resistive clients who were not able to use

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[13] Voight, Marilyn, "Follow-Up Study of Client Use of Consultation Service", Smith College Studies in Social Work, Vol. XXVII, October 1956 pp. 74-101

the service constructively.

This study raises several questions. How effective is the intake process in child guidance clinics in screening out those cases which are not considered within the realm of the clinic's function? Is sufficient time being given to make accurate diagnoses, to interpret, and offer consultation?

Although in some clinics the intake process is being shortened, perhaps it needs to lengthened in order to adequately serve the families in the community. Unless we get through the anxieties experienced by parents, they may interpret the recommendations according to their own needs. Not only may they have difficulty in accepting the need for treatment but they may come with much misunderstanding of the clinic and it's function.

Clinics are strained to capacity and it seems more studies could be done regarding the intake procedures of child guidance clinics.

CHAPTER VIII

FAMILY DIAGNOSIS AND TREATMENT

In our investigation of clinical intake and diagnostic practices, and later in exploring treatment techniques of these four clinics, we were intrested to find that atleast two of the clinics are carrying on action research in diagnostic and therapeutic techniques. This chapter will look at these two projects in more detail to share some of the experiences that the Flint and Lansing clinics have had in applying these techniques to the child guidance setting. A general discussion will follow reviewing some of the recent literature on the general use of these techniques, perhaps serving as a guide for other professional persons who may benefit from the use of this auxillary tool but are hesitant to begin without any theoretical knowledge.

Joint interviewing is not a new technique to the field of social work. The traditional home visits which were made frequently required the simultaneous interviewing of two or more family members by one worker. Nor is joint interviewing a new technique to the child guidance clinics. Quite often parents have been seen together for the purposes of interpretation, for the setting of fees, and sometimes the child, too, was included as a participant in these sessions.

However it has been only in recent literature that the process of interaction in the family has been emphasized. Clinicians have been

reminded that healthy individuality in the child is composed of both the component of autonomous development and the component of togetherness with the parents and family.[1] When a child comes to the attention of a clinic because of an emotional disorder, this disturbance is both an expression of the child's own difficulties and a function of his family's disorder.[2]

Clinical experience has demonstrated that most problems referred are disturbances of interrelationships within the family. One might question, then, if the traditional team approach of separate interviews with each parent and the child by different professional staff members might not encourage further breakdown in family relationships.

Recognizing that the fate of each family member is intimately affected by the family group, appropriate intervention in this balance can have significant consequences for each member and the family as a whole.[3]

The Flint Child Guidance Clinic, as described in an earlier chapter, decided to experiment with the technique of joint interviewing used as an auxiliary tool in diagnosis. The project was undertaken for two major reasons. First, this Family Unit Diagnosis may be more economical, decreasing the waiting list and offering more service than was previously possible. Secondly, it would be interesting to determine what advantages and disadvantages this technique might have in completing the clinical

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[1] N. W. Ackerman and M. L. Behrens, "A Study of Family Diagnosis", American Journal of Orthopsychiatry, Vol. 26, No. 1, 1956

[2] Celia B. Mitchell, "Family Interviewing in Family Diagnosis", Social Casework, Vol. 40, No. 7, July 1959

[3] Ibid.

study of the family.

Within a short time it became obvious that joint interviewing was a time saving technique. The traditional diagnostic interview required approximately seven to eight man hours, taking into account time for interviewing, dictation, etc. Using joint interviewing, total man hours for one diagnostic interview averaged between two and three. In addition, the quantity of service offered by the clinic increased to greater proportions than anticipated, as indicated by the following table:

TABLE 4

Rate of Intake Before and After Family Unit Diagnosis at the Flint Child Guidance Clinic

	Average per month 1960	Average Jan. & Feb. 1961	Percent of change
Waiting List	139	100	39% Decrease
Interviews	404	572	41% Increase
New and Reopened Cases	29	55	90% Increase

Of even greater significance was the general agreement of staff members that the quality of service also improved. Not only did this procedure demonstrate to the referred families that the clinic views their problem as a family problem, but it also afforded an opportunity for the treatment plan to be worked out with all family members included and participating.

Staff members felt they were provided with a more accurate reflection of what goes on in the home. Many things are brought out which may not be

brought out, or atleast not for a long period, had family members been separated. For instance, a mother was explaining how she had no control over her youngster and the boy displayed this by going into her purse, jumping up and down on her lap, etc. Though this may be observed in separate interviews, the worker would not have observed the slight grin on father's face while this was going on.

This technique enhances therapeutic use of the diagnostic interview. It affords each family member the opportunity to hear what the other is saying and react to it. One mother was amazed to hear her husband talk so much; she didn't realize he had such strong feelings. When the therapist turns to ask the child how he or she feels about something, the child is often startled and pleasantly surprized to find someone who is understanding, who thinks what the child has to say is important. The therapist, at any time, is able to pick-up on the interaction and use it immediately to help the parents and child see what goes on and gain insight into what they are doing.

This clinic has found that even the cases which seem poorly adaptable to the joint interviewing technique may benefit from this procedure when used appropriately. Flexibility becomes the key concept overcoming most disadvantages. The therapist separates various family members as he sees the need for such, bringing them back together when this seems preferred and most beneficial.

The team concept is still preserved, in fact it operates more effectively in this procedure. Many cases come to a clinic which do not require psychological testing, psychiatric evaluation, or other specialized skills. The family unit diagnosis technique now allows the therapist to

screen out those cases and call upon the special skills of other staff members as the need indicates.

A psychologist at the Lansing Child Guidance Clinic is also evaluating the technique of joint interviewing in an experimental program of family therapy. Dr. Leon Rottersman, in a paper read at staff seminar, states that, "The therapeutic relationship of two or more members of a family being seen by one therapist has served as a check on the accuracy of the therapist's interpretation of dynamics. Seeing two members jointly has increased the accuracy of the information given by the family members and as such their reality orientation..."[5] He suggests that family therapy is economical, enhances the therapeutic process and enhances clarification. He concludes, "Emotional health for the family group as defined by the therapist must constantly remain the therapeutic aim."[6]

In view of the pioneering projects undertaken by these two clinics in Michigan, and in view of the increasing popularity these techniques are gaining throughout the nation, a review of some of the current literature on the subject of joint interviewing may be helpful in evaluating this technique and its application.

Joint Interviewing in Diagnosis

Attempts have been made to integrate social science theory into a framework analytically descriptive of family dynamics. Josselyn focuses

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[5] Leon Rottersman, "Family Therapy in a Child Guidance Clinic", Research Newsletter, Michigan Department of Mental Health, No. 6, March 1961, p. 8

[6] Ibid. p. 8

upon only one facet of the total configuration of the family unit; the family as a psychological unit.[7] She describes the significance of family members to the child's maturation process, pointing out that most consideration has been given to this in the past. The real need is to define the significance of the family structure or unit for the individual. She finds atleast two important functions of the family structure: (1) it provides "emotional atmosphere" and (2) it enhances the maturation process. If this significance becomes clearly defined, the neuroses and psychoses of the family unit rather than of its component parts can then be understood. Such a study of family pathology may clarify what constitutes family health.

Beatman recognizes in the family a three-fold complex of what she terms "individual internal, interactive interpersonal and social cultural."[8] The pattern of these in interaction creates either family disturbance or equilibrium. She suggests that the individual internal pattern develops as each member tries to manipulate the various family relationships into a reservoir for the gratification of his own needs. The caseworker's task is to isolate these family conflicts creating imbalance and producing family pathology.

Meyer points up a conceptual dilemma basic to the problems involved in family diagnosis. While there is an awareness of the existence of family

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[7] Irene M. Josselyn, "The Family as a Psychological Unit", Social Casework, October 1953, Vol. 34, No. 8 pp. 336-342

[8] F. L. Beatman, "Family Interaction: Its Significance for Diagnosis", American Journal of Orthopsychiatry, Vol. 26, No. 1, 1956

interaction, the tools necessary to work with this have not yet been developed.[9] It is generally felt that the process of interaction in the family must be observed within theoretical understanding derived from psychodynamic concepts relating to individual growth and pathology and dynamics of the treatment process.[10]

Ackerman attempts to solve this dilemma.[11] He views family interaction as greater than the sum of the individuals, the forces of which to be understood cannot be handled by concepts of individual psychology alone. There are three levels in understanding interrelations of the individual and family: (1) group dynamics of the family, (2) dynamic process of emotional integration of the individual into family roles, and (3) internal personality organization of the individual. Dimensions of interaction on various levels are evaluated; an extensive diagnostic guide for collection of data necessary to such a system is presented in his book.

Even without solving this dilemma, joint interviewing can be diagnostically enlightening. Simply put, the worker can see how the child responds to what his parents want him to do and the parent has the opportunity to learn through observation how the child may be handled quietly and permissively.[12] Clues can be obtained from such things as

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[9] C. H. Meyer, "Quest for a Broader Base for Family Diagnosis", Social Casework, Vol. 40 No. 7, July 1959, pp. 370-376

[10] C. B. Mitchell and G. Konopka, "Groupwork Techniques in Joint Interviewing", Social Welfare Forum, 1957

[11] Nathan W. Ackerman, The Psychodynamics of Family Life, New York: Basic Books, 1958

[12] Gordon Hamilton, Psychotherapy in Child Guidance, New York: Columbia University, 1947, p. 275

the various individuals' postural charcteristics, tonal quality, disturbances of communication, alliances and scapegoating, and discrepancies between verbalizations and behavior that clearly identify the individual's conflicts, defense patterns, coping techniques, role adaptations, values and strivings.[13]

It is further suggested that by observing the family interaction in diagnostic interviewing the therapist can evaluate how healthy the parent-child relationship may be, and indications of disturbances in relationship can be noted.[14] The health may be evaluated in terms of parental love and affection displayed, that is, sensitivity to the child's needs, intensity of feeling of relationship and acceptance; how the parent helps the child in development of independence; parental protection and support; and parental controls. By raising question and observing the basic warmth of the relationship, perception of the child as a person in his own right, protective functioning, consistancy of reactions, etc., indications of disturbance in parent-child relationship become obvious.

With marital partners, the clinician is better able to determine the degree of involvement of each partner as well as degree of concern, the ability to use the partner to maintain an interest in and to use his concern about mutual interests, interest that is mutually shared and both relate to in coming to the clinic. The nature of the marital interaction

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[13] Op.Cit, C. B. Mitchell.

[14] Fred H. Stone, "A Critical Review of a Current Program in Research into Mother-Child Relationship", Emotional Problems of Early Childhood, Ed. Gerald Caplan. New York: Basic Books, 1955. pp. 95-117

is confronting the clinician.[15]

Diagnostic Indications for Family Treatment

Having completed a diagnostic study of a family seen in a joint session, the decision must be made as to what kind of treatment is necessary and for whom. Criteria for determining that a case should be seen in joint therapy are practically non-existent in the literature. Geist and Gerber suggest five things to look for which indicate that family therapy would be most beneficial.[16] Though they are referring specifically to marital partners, it seems that these may also be applicable in other cases. The individual clinician should evaluate how appropriate they may be for his situation. It is suggested that one of the first indications that joint interviewing treatment would be helpful is when there is a breakdown in verbal communication between family members. Distrust of a family member's actions seems to be a sure indication if any relationship is to be established. When the degree of security of one or more family member's is too slight for them to work individually with the same worker, joint interviewing might be desirable, in treatment. Sometimes there is a lack of focus in individual interviews and many benefits can be reaped from joint sessions. The last two determining factors are suggested only because so little is known at present; namely, the client may request this technique and it seems to be the best method of solving a particular

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[15]Jeanned Geist and Norman Gerber, "Joint Interviewing: A Treatment Technique with Marital Partners", Social Casework, Vol. 41, No. 2 February 1960, pp. 76-83

[16]Ibid, p. 82

problem or when the clinician senses its the treatment method of choice.

If there is question about the accuracy of diagnostic understanding of client to be involved in treatment, or if the caseworker is not comfortable using joint sessions, the clinician should not elect this technique for threatment. The same would be true if the clients are competitive and cannot put this to constructive use.[17]

Role of the Therapist in Joint Treatment

In the past, joint interviewing has rarely been the treatment of choice, except in marital counseling.[18] Now it is being tried in many different settings for numerous types of problems. Still, little has been spelled out about the workers role when see family members simultaneously.

Some have suggested that the therapist plays a major role in limit setting so that no one family member controls the others. The therapist also clarifies distortions and lack of trust in other members present. Universalizing and educational techniques should be emplyed when indicated. Finally the worker must handle transference and counter-transference with skill, always be alert in evaluating such reactions and using them constructively.[19]

Another major task is to focus upon the interaction between the parent and the child. Hamilton suggests that awareness of this psychological involvement and balance on the part of the family is probably the deepest

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[17] Ibid. p. 83

[18] Op. Cit. C. B. Mitchell

[19] Ibid. p. 83

facter in success.[20]

The therapist should also help each member move from projecting the difficulty outside himself to assuming some responsibility for considering his or her role in the family, specially as it relates to the presenting problem.

At times individuals and pairs of family members will be seen separately for a particular purpose. When this occurs, that part which is family-related should be brought back to the family session so the individual and family movement are used as catalytic as well as integrative agents.[21]

Advantages of Joint Interviewing

"All data of social history and other important factors emerge in far less time than in individual interviews." Therefore, it has more immediate and meaningful impact upon the worker as well as the family. In this sense, the diagnostic joint interview becomes therapeutic.[22]

Hamilton proposes that even in the diagnostic session there is more emotional value in observation and experiencing that there is in telling a clinician about something. She feels such sessions help the parents to see the connection between their problem and the child's and "if improvement within themselves is not possible, perhaps it helps them act out their conflicts in different ways."[23]

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[20] Op. Cit. Gorden Hamilton, p. 278

[21] Op. Cit. C. B. Mitchell

[22] Ibid.

[23] Op. Cit. Gorden Hamilton, p. 280

"Working simultaneously with several members cannot help but produce very strong emotional reactions in each person in the group. The immediacy and aliveness of these reactions provide invaluable opportunity to help the client recognize that part of his behavior outside his awareness, and through an awakening to its meaning, gradually to find more mature ways of relating to the people closest to him."[24]

Mitchell too emphasizes that all members share significant joint experiences when seen together in treatment. Trends toward health are energized by the potential corrective influences in the family. Gradually there is a re-establishment of communication which is an important aid to setting a regenerative process in motion. The members seem to become curious about each other and become real persons. Since all are participating, each family member experiences conflict and change; this has more impact than recalling experiences. In addition, as changes occur in communication, motor behavior, affective response, and integration into family roles occur; this is expressed with more impress than would otherwise be possible by any other technique.[25]

Finally at termination, joint interviewing gives focus to the problems which have been worked on, and permits the therapist to summarize and verbalize gains and successful use of casework treatment.[26]

Groupwork Techniques in Joint Interviewing

"The skills and techniques of group work can contribute to joint

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[24] Op. Cit. Leichter

[25] Op. Cit. C. B. Mitchell

[26] Op. Cit. Geist and Gurber

interviewing."[27] The family group is unique from most groups which clinicians, therapists, or social workers deal with, for with the exception of marital partners, the family is not a self-chosen group. Despite this, many of the concepts and techniques used in group work are transferrable to the family situation.

Konopka suggests that the concepts of group formation, subgroups and the process of interaction are meaningful ways of examining and analyzing the family situation. Particularly concepts of changing and ambivalent roles are significant to the family when present-day American society finds the man no longer the sole breadwinner and the woman no longer the sole housekeeper; rather these are tasks shared by both. How a particular family adapts itself and accepts this confused relationship can be most important in understanding the family. Contagion, forms of conflict solving and expectations in regard to self images of family cannot be denied as most valuable diagnostic and therapeutic tells.

Techniques of group work, as distinguished from casework or therapy, require that the therapist assume a different role from individual interviewing. Group interviewing is a more informal activity, which some clinicians who have had no such experience may find uncomfortable. "We are not the only giver (in group interviewing), but must be willing to let others in the group do our job, in fact enhance this task."[28]

Another distinguishing characteristic is that the worker must be willing to accept the informal group situation as an essential, but not

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[27] Op. Cit. Konopka

[28] Ibid.

be seduced by it. This requires skillful use of timing, pauses for relief of tension, or such, but always being cautious not to run away from the problem.

Most important the worker must help members relate to each other instead of predominantly to the worker. This entails discussion leading, and not question and answer games.

Konopka too, points out that the privacy of individual interviews is sometimes needed, so that both methods should be used frequently and as supplements to each other. Finally she warns the clinician not to force family interviews upon family members when they are anxious to keep certain information from other family members. "True and complete confidentiality exists in the individual interview only."[29]

Skills Required

An appreciation of the dynamics of family life and of the significance of social and family role relations is necessary for the clinician to do joint interviewing, as well as skill in using interactional interviewing techniques derived from knowledge of the dynamics of group process (as Konopka suggests above). Neither the individual nor the group can be submerged; rather, these need to be utilized and recognized. The worker must also have a keen sensitivity and enough flexibility in approach to shift from total sessions to particular pairs or individual interviews as perceived from clues.

Mitchell sees joint interviewing as a test of the worker's resolution

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[29] Ibid.

of his own family relationship problems, since family interviewing exposes him to the simultaneous impact of interpersonal conflicts of all family members, and requires him to be "above the battle", yet available to all combatants.

"This type of interviewing process is initially anxiety producing, if only because of newness and multiple demands on the worker."[30]

Summary

Joint interviewing of family members appears to have many advantages and uses for diagnostic and therapeutic purposes. Disadvantages are minimized when this technique is skillfully and flexibly employed. The Flint and Lansing clinics are enthusiastic about the success of their projects and personal satisfaction in exploring this technique. In view of the long waiting lists at most child guidance clinics, as well as other agencies, and in view of the increasing emphasis upon approaching any individual emotional disturbance as a manifestation of a disturbance in intra-familial relationships, family interviewing has many implications for the child guidance setting. Most significant is the experience of these two clinics in discovering that quantity of service is increased with no sacrifice, but rather increased quality of service also.

In relation to the present study, the projects undertaken by the Lansing anf Flint clinics describe and point out one of the differences among these clinics. Continued use of this technique seems likely to affect many other aspects of the clinics also. For instance, intake

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[30] Op. Cit. C. B. Mitchell

procedures, diagnostic and treatment objectives of the clinics, distribution of other services, and perhaps even personnel policies and practices are certain to be directly affected. This may serve to describe the dynamic nature of the clinics.

CHAPTER IX

TREATMENT POLICIES

An integral part of a child guidance clinic is the treatment service for parents and children which it provides. Treatment facilities are directly affected by the intake policies and the staffing patterns. They may also be affected to an extent by the influence of financial sources and other community factors. Intake policies naturally determine who is placed on the treatment waiting list, and fortunately or unfortunately, a certain amount of pressure is placed on each therapist depending on the number of clients on the treatment waiting list. Social workers, psychologists, and psychiatrists come from differing backgrounds of theory, knowledge and skill. These differences in background often influence efforts to form a common treatment policy, and may be the basis for differences within a clinic as well as between clinics.

The Michigan Department of Mental Health, in accordance with its statutory authority, established the Child Guidance Clinic program. The policies within which the clinics operate are mutually agreed upon by the Department and the Clinic Board which represents the community. The purpose of the clinic is to provide a progressive, well-rounded program of mental health services, including not only provisions for the alleviation of mental disorders of children, but also services designed to prevent later mental and emotional disorders. "The community based, psychiatrically oriented mental hygiene clinic is a proven early treatment and preventive

technique."[1] The clinic also contributes to a greater understanding of other children's basic needs.

In this chapter, a comparison was made of the Lansing, Battle Creek, Flint and Kalamazoo Child Guidance Clinics with respect to certain aspects of their treatment policies. The provisions for the prevention and alleviation of mental disorders includes the use of psychotherapy as a method of treatment. Gordon Hamilton states that "the purpose of psychotherapy is to assist the client toward fuller and less distorted satisfactions; toward better integration of himself; toward self-direction and more creative or more comfortable social functioning."[2] This should mean helping the client to find more healthy and normal enjoyments from life and to make a better adaptation to the demands of society in work and play and other dimensions of living.

Various administrative and staff personnel of the four clinics were interviewed in an effort to learn their particular practices with regard to treatment. The interviews were concerned with the three disciplines and their participation in treatment, factors influencing client priority on the treatment waiting list, and the therapists' treatment orientation. Also of concern were some of the considerations involved in the assignment of cases, what constituted "emergency" cases and how were they handled. Such questions as the following were asked: What is the frequency of treatment interviews? what methods of treatment

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[1]State Department of Mental Health, Michigan Child Guidance Clinics: Program and Policy Statement, (Lansing, Michigan 1956) p. 8

[2]Gordon Hamilton, Psychotherapy in Child Guidance, (New York: Columbia University Press, 1947) pp.15-16

are available? what has been the experience of the clinic with group treatment? how were treatment conferences scheduled? and what criteria are used with regard to the termination of treatment?

The information which follows in this chapter reflects a summation of statements offered by those who were interviewed. In some instances, the answers were brief but they indicate a few of the differences and similarities in the administration of the four clinics. No attempt was made to measure validity of these descriptive features against the actual practice of the clinic; however, one may assume they tend to reflect agency practice as seen by key personnel.

Treatment Orientation and Participation in Treatment Activities:

All four clinics are psychiatrically oriented, having teams of professional workers chosen from the disciplines of psychiatry, psychiatric social work and clinical psychology. The Battle Creek clinic however, provides with only limited psychiatric time which is on a consultative basis. Unavailability of psychiatric personnel has made a necessary compromise.

The treatment in the clinics is usually described as psychoanalytically and dynamically oriented. Therapy uses various combinations of expressive or release techniques, re-education, insight and support, which are directed toward self-resterative forces in the personality. Treatment is also assisted by other available resources in the community, such as the court and Visiting Teachers (School Social Workers), and the general range of available community social services.

All three professional disciplines are responsible for treatment

in all but the Battle Creek clinic. At this agency, the consulting psychiatrist is not responsible for treatment. The number of cases on the treatment waiting list of all clinics varies from one clinic to another and includes only those cases which have been accepted as treatment candidates following the intake process.

Waiting List Priority and Emergencies:

In most instances, the clinics will remove cases from the treatment waiting list in the order in which they were assigned. However, there are times when a particular situation will receive priority and one case will be accepted ahead of another. The method of assigning cases, certain kinds of problems, and situations which are thought to be urgent are factors which may give a case priority. It is difficult to differentiate between agencies and other criteria for granting priority. However, some cases are accepted for treatment as soon as possible while others, if not accepted immediately, are still selected in advance of their place on the list.

There are times when a child should be seen immediately if the therapeutic experience is to be of maximum benefit. However, it is sometimes difficult to determine which case needs prompt attention and which case can wait, and if so, how long. Cooper defines an emergency as follows:

> "A psychiatric emergency is a situation in which a person may represent a danger to himself or others; it must also be understood in terms of whether immediate therapeutic intervention is necessary. The need to extend such immediate help often conflicts with the mounting waiting list of the clinic, and with efforts to keep this within manageable proportions.

> However, although delay in all cases is undesirable, some patients can tolerate this for less time than others. In some cases, the cost of delay is unestimable.[3]

The criteria for the selection of "urgent" cases are difficult to determine; however, Cooper provides some suggestions which might be compared to clinic practices. One consideration is symptoms arising out of a new life crisis which will develop into damaging patterns of behavior. Another is the child who displays new symptoms which, given immediate treatment, will shorten treatment considerably.

Priority is also given in cases where there are signs of sudden and sharp regressing, indicating the situation is urgent, as in clients whose defenses are in the process of shifting, making them amenable to treatment at that point. The kinds of questions which are included in such criteria are: the complaints becoming increasingly wide-spread? Are there supportive influences in the environment outside of the agency? Is the client dangerous to himself or others? These are some questions and considerations which may be helpful in judging emergencies.[4]

Battle Creek:

The Battle Creek Clinic seems to consider some of these factors, although not all of them, which Cooper speaks of when determining priorities. At the diagnostic conference, for example, each case may be given a number from one to four. In this case, a number #1 would be given preference over a number 4. The factors considered in making this

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[3]Shirley Cooper, "Emergencies in a Psychiatric Clinic", Social Casework, Vol. XLI, No. 3 (March 1960), p. 139

[4]Ibid., pp. 137-38

judgement are the severity of the problem, treatability, and motivation. Thus, a psychoneurotic individual with a high degree of anxiousness would be given priority over a long standing neurotic character disorder. An attempt is made to see children when treatment would be most effective. The prognosis of the child is determined to some extent by the above factors and this is also considered. As is described in an earlier chapter, the intake process begins immediately with all clients at the time of the parents' initial call, therefore the clinic does not feel that it has any emergencies except those referred from the court. Because of not having full-time psychiatrist, the clinic does not feel it is able to assume responsibility for cases with homocidal or suicidal tendencies. These cases are referred elsewhere, either to the court or to an in-patient institution.

Emergency cases which are referred by the court have top priority for diagnostic purposes only, and will be seen within a five day period. Such a case might be a child whose symptoms include setting fires etc. However, these cases are encountered infrequently. The court does not refer cases for treatment purposes because of their knowledge of the treatment waiting list.

Community and parental pressure does not in any way give priority to a child or permit a case to be accepted for treatment ahead of someone else on the list. There is no particular priority given to any source of referral, other than from the court, as was just mentioned.

Lansing:

For the most part, Lansing seems to agree with Cooper in judging a

priority case since priority is given to the child on the treatment waiting list who is in an acute state of suffering and cannot be helped by some other plan. Priority cases are those whose symptoms include colitis, school phobia, anxiety neurosis, and those children who cannot be tolerated in school. These factors, plus a favorable age of perhaps between six and twelve, give the case a priority on the waiting list, but do not necessarily mean that the case will be accepted immediately for treatment. Other factors given to describe emergency cases were those clients whose symptoms included psychotic decompensation, acute onset, suicidal tendencies, and deviant sex experiences.

Flint:

In the light of Cooper's discussion, the Flint clinic may give consideration to the timing of treatment for a particular child or the acute onset of symptoms but would also stress the equality of each case. Priority is given only to those cases defined as emergencies or those individuals who are dangerous or potentially dangerous to themselves, family members or others in the community. Otherwise, cases are accepted for treatment in consecutive order, depending on the date they were placed on the list.

Kalamazoo:

It would appear that Kalamazoo would generally agree with Lansing in judging an emergency or giving priority to a particular client. Here the treatment waiting list is kept to a minimum because cases are not accepted for intake until there is a strong possibility of their being

followed up with treatment in the near future, should this be the recommendation. Cases are given priority when they are considered an emergency. The chief factor which describes a case as an emergency and gives it priority is the type of problem. Examples of symptoms which would place a child in the emergency category are: exclusion from school because of acting out behavior; endangering themselves and/or others; parents who are in extreme distress; and in some instances, when a child has been known to run away from home frequently. Often a case referred by the court, in which an immediate decision must be made, will also be given top priority for treatment.

Assignment of Cases:

There are certain factors which are taken into consideration when assigning cases to the various staff personnel. Although Lansing does not mention these particular factors, it would seem that all clinics give consideration to the availability and skills of the practitioner. It is generally agreed that the once-accepted division of labor in which the psychiatrist treated the child and the social worker the parent never became the standard practice of a child guidance clinic in Michigan, nor was a sharp distinction ever made as to which disciplines engaged in direct treatment.[5]

Most of the clinics consider the sex, availability, personal interest, skill and experience of the professional practitioner in assigning cases. The Lansing administration considers the anticipated length of

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[5]Hamilton, Op. Cit., p. 7

treatment in assigning cases to the practitioner, (student practitioners are assigned short-term cases) and balancing the practitioner's case load (with respect to the variety of different types of cases).

Frequency of Treatment Interviews and Methods of Treatment:

The usual frequency of treatment interviews which has been found to be successful in most clinics is on the average of once per week; however, Kalamazoo prefers to schedule treatment interviews on the average of once every two weeks which enables each clinician to have larger caseloads. In all clinics, nevertheless, this is subject to alteration depending on the needs of the client as seen by the individual clinic. For instance, in Lansing a schizophrenic child was seen daily for hourly individual treatment interviews. In Battle Creek, occasionally with fairly healthy individuals, a more directive and educational approach will be used by the therapist and the client will be seen on the average of every two or three weeks. It is a common practice in all of the clinics for the frequency of treatment interviews to decrease as the client approaches termination.

All of the clinics provide individual therapy which includes play therapy. Three of the clinics provide some form of group therapy. Under the direction of the psychiatrist, drugs are available for therapeutic purposes when the psychiatrist feels that such a prescription is in the best interest of the client. This therapeutic device is available in all the clinics and is used, for the most part, with brain-damaged children.

Group Therapy as a Method of Treatment:

All of the clinics are now or have been provided with some form of

group therapy. Social workers are performing it in the majority of clinics; however, all three disciplines are conducting groups although not necessarily all in the same clinic. All group therapists are required to posses a knowledge of the dynamics of group behavior. The group therapist is usually responsible for the selection of the group members through consultation with other staff members. Group therapy seems to offer a unique experience for some clients and produced effective results which may not have been attained in individual therapy.

In Battle Creek, group therapy is administered bt psychiatric social workers who have a knowledge of the dynamics of group process and experience. One of the purposes for instigating group treatment was to provide a different medium for psychiatric help, as it was realized that some clients do respond better to group therapy than to individual therapy. Selection of clients for group therapy is influenced by the need for some homogeneity or common core which will facilitate mutual relatedness between the group members. In 1960 two groups of mothers at the Battle Creek clinic were in group therapy sessions once a week and one group of young boys also met once a week. These clients were not seen individually during the time they were in the group. However, other members of the family could have been seen on an individual basis during that time.

In Flint, group therapy may be practiced by clinicians in any of the three disciplines, provided that he or she had a basic interest in group therapy, satisfactory length of experience in individual therapy, and some knowledge of the dynamics of the group process. Groups are selected on the basis of similarity of problem, age, sex, degree of pathology and ability to use the group experience. However, the evaluation

of these criteria are left to the discretion of the group therapist. The goal is similar to that for individual therapy. In general, that goal is improved social functioning between parents and children. Currently, two groups are being conducted on a weekly basis. The first group consists of parent couples who are being seen for a predetermined number of sessions. The other group is providing a more intensive therapy to a group of mothers. The clinic has also conducted group therapy by all three disciplines with boys between the ages of six and ten, and between the ages of eleven and seventeen. Group members are seen individually when it appears necessary or beneficial, depending on the needs of the individual. Sometimes the child is seen individually while one or both parents are in a group, or vice versa. Individual therapy is always available if desired, by the group members.

Group therapy is not presently being conducted in Kalamazoo. However, their psychiatrist did at one time form a group of mothers for this purpose. In that instance, many of the mothers were also seen individually. The clinic did not feel that it could replace individual treatment, and they have not as yet continued with this method of treatment.

Lansing has had previous experience with group therapy for parents of schizophrenic children. The psychiatrist conducted this group, and more recently has worked with a group of teen-age girls who were social isolates. At present, a psychiatric social worker is using the group method with mothers of pre-school children. Again, consideration is given to the experience and training of the therapist before the practitioner is selected to use this method. One of the clinic psychologists is also doing family therapy, defined as the treatment of two or more family members by

one therapist. The family members may be seen jointly or separately.

Treatment Conferences:

Treatment conferences are held when the need for these arise as judged by individual therapists. The conferences are usually not scheduled on a regular basis. The conference is attended by the therapist and the supervisor and/or administrator, and occasionally the entire staff may attend. The usual considerations at a conference are therapeutic techniques, further diagnosis, and decisions for termination.

In both the Kalamazoo and Battle Creek clinics, conferences occur as the need is felt by the individual therapist. They might also be scheduled as a result of a supervisory conference. During these conferences, such things are discussed as further diagnosis, questions pertaining to termination, and therapy techniques.

Treatment conferences in Flint are scheduled on a regular basis each week for one hour and a half. Individual therapists are responsible for selecting a case, the management of which would benefit from such a conference. The cases are then placed on the schedule in consecutive order. It is believed that each treatment case should be scheduled for a treatment conference at least once every six months for purposes of discussing particular technique, critical issues, termination, or cases which have a particular learning value.

Lansing schedules staff conferences on treatment cases attended only by those involved in the treatment and the agency director or administrative assistant. The clinic believes that these conferences should be scheduled in a somewhat flexible manner.

Termination Practices and Criteria:

The decision for termination is usually arrived at through consultation with another therapist, who frequently is the supervisor or administrator. Some of these factors which are felt to be important in considering termination of a client are his peer and parental relationships, symptoms, intellectual functioning, capacity to deal with interpersonal conflicts, and ability to test reality. These same factors will be used later to form the criteria which will be used in the next chapter to study termination practices at the Battle Creek Clinic.

With regard to termination, Battle Creek felt that this decision has usually been left up to the clinician and his supervisor. The criteria for termination for all the clinics are considered to be the degree of symptom removal; the altering of pathological or conflicting defenses; when possible, the establishment of the equilibrium within the psychic structure; improved object relationships; and some assurance that these alterations would continue beyond termination. In more general terms, the practitioners terminated their relationships with clients when there was assurance of more effective social functioning and when the client illustrated his capacity to cope with internal personality conflicts. Some of the staff members felt that there should be definite time limitations placed on treatment and were opposed to carrying a case in treatment for over two years. The client may always feel free to contact the clinic; however, treatment time is not always readily available due to the ongoing treatment waiting list.

In Flint the individual therapist will generally make the decision for termination of case; however, in some cases the administrator or a

staff conference would influence this decision. The criteria for making such a decision are usually based on the progress an individual has made in functioning comfortably within limits acceptable to society. As in all clinics, the client is helped to understand that he may return to therapy should he desire to do so, which may consist of a telephone call or actual return to treatment.

A decision for termination in Kalamazoo, is reached through the consultation of one practitioner with another and the mutual consent of the client. Following one or two years of treatment, serious consideration is given to the client's use of treatment and the possibility of redefining goals with an aim toward termination.

Lansing makes the decision for termination through the consultation of the therapist and the director with the consent of the client. This clinic is opposed to arbitrarily terminating a treatment relationship because of the pressures from the treatment waiting list.

Summary:

It should be noted that in any comparison of child guidance clinics, the individualized local setting will have a tendency to influence agency practices, and that no attempt has been made to evaluate the effectiveness of these practices. With this in mind, the following similarities and differences have been observed.

All four clinics were found to be psychiatrically oriented in psychoanalytic psychology with the three professional disciplines of social work, psychology and psychiatry being responsible for treatment of both parents and children except in Battle Creek where the psychiatrist is

not responsible for treatment.

Skill, sex, and availability of the therapist comprise factors which Battle Creek, Lansing and Kalamazoo consider in the assignment of cases. Battle Creek and Flint view the personal interests of clinicians as factors in assignments, whereas Lansing and Kalamazoo would also consider balancing the case load as to various kinds of problems. Lansing takes cognizance of the length of treatment when assigning cases to student practitioners; however although not specified, it is probable that the other clinics also follow this practice.

While all three disciplines participate in group therapy, it is administered by psychiatric social workers in Battle Creek, by a social worker and psychologist in Lansing, and by all three disciplines in Flint. The particular discipline does not necessarily govern the selection of the group therapist. Other factors such as availability, skill, experience and interest are considered in arriving at such a decision.

Some difficulty arises in differentiating between cases which are given priority and not considered emergencies, and emergency cases which are given priority. In clinics where a full-time psychiatrist is available priority is given to clients exhibiting suicidal tendencies, because medical supervision is immediately available. A child who is considered intolerable by school authorities is given priority in both Lansing and Kalamazoo, which may indicate the degree of pressure exerted by the school on these clinics, or the responsibility felt by the clinic.

A factor to which both Lansing and Battle Creek would agree as influencing priority is the type of problem. Lansing also considers the child's age as a criterion. Battle Creek would generally take clients in

the consecutive date of original referral for treatment. However, when the problem is considered to be intolerable and other agencies, such as the school, are exerting pressure, a priority may be given. In some instances where a problem is not too ingrained, the parents may be taken into treatment immediately with an aim toward short-term treatment.

Individual, group and drug therapy is administered by all clinics with the exception of Kalamazoo, which does not have a group therapy program at the present time.

Selection of clients for group therapy involves clients with similar problems, age, and sex, and the ability to use group experience. This selection is usually the responsibility of the group therapist, although it is often done with consultation with other staff members.

Battle Creek does not see group members on an individual basis; however, this is left to the choice of the individual at Flint. In both instances, other members of the family may also be seen on an individual basis.

With respect to frequency of individual treatment, Kalamazoo usually schedules bi-monthly treatment interviews while the other clinics schedule their interviews on a weekly basis.

Practices vary widely in the four clinics in the scheduling of, and participation in, staff treatment conferences. While Flint schedules conferences on a regular weekly one and one-half hour basis, at the other extreme Battle Creek holds conferences depending on the therapist's needs or at the instigation of the supervisor. The frequency of treatment conferences in Lansing, Battle Creek, and Kalamazoo is dependent upon the need for same; however, in Lansing only those involved in the treatment

for a specific case attend the conference, along with the administrator or administrative assistant.

No specific procedure in regard to termination is followed in any of the four clinics. The therapist and supervisor usually decide on termination at Battle Creek although sometimes the psychiatrist and staff are consulted, and occasionally a therapist alone will terminate. At Kalamazoo, the therapist will consult with another therapist, and with the consent of the client, will terminate the treatment. Lansing requires consultation with the director by the therapist, and with client consent, will terminate the treatment.

The therapist alone will terminate, although sometimes consultation will be sought with the administrator or the staff in Flint.

As discussed in the next chapter, criteria for termination of treatment are nebulous and often arbitrary. It is therefore understandable that one would encounter variations in reviewing the criteria among the four clinics. For example, Battle Creek considers the degree of symptom removal, the altering of pathological defenses, the balance of psychic forces, the assurance of sustained improvement, capacity to master internal conflicts, improved object relationships, and the assurance of better social functioning. Flint specifies only improved social functioning, while Kalamazoo and Lansing consider symptom removal, capacity to handle internal and external conflicts, and improvement in social relationships.

Conclusions and recommendations:

Individual personality factors of the therapist are given primary concern in assigning cases for treatment. This would seem to reflect

the autonomy of the individual workers as opposed to the more routinized procedures prevailing in many large bureaucratic social agencies.

This study seems to point out the great time gap between intake diagnostic services and treatment services, largely due to the number awaiting treatment. This is conflict with the professional goals of social work, psychology and psychiatry.

The clinics agree on broad criteria for termination but at closer range, we can only assume there are undoubtedly numerous factors entering into each decision for termination.

On the basis of this study, and the data collected, it would seem that further study toward establishment of standardized criteria for emergencies and priorities would be of value as they now seem somewhat arbitrary.

There seems to be room for further study in the area of selection of members for group therapy.

In the area of treatment conferences, there is need for more knowledge or a possible re-evaluation of the timing, value, purpose, and need of this medium for consultation with the client and the clinic.

CHAPTER X

TERMINATION

In the preceding chapter brief mention was made of the way in which the decision for termination of treatment clients was arrived at in the four clinics. A few suggestions were given as to the criteria which determine termination. Consideration is given to such factors as the degree of symptom removal and assurance of better social functioning. In some instances pressures from the waiting list influenced termination. It is obvious that a clinic's philosophy and practice regarding termination greatly influence the effectiveness of the overall service of the clinic and are directly responsible for the number of clients who will be seen over a period of time. In most instances, the individual therapist is in the best position to evaluate the treatment experience and to give consideration to the possibility of terminating. How does he come to this conclusion and why at this particular point in treatment? Is this an arbitrary decision or based primarily on the therapist's knowledge, skill and experience? Answers to these questions are not readily available but an attempt will be made to discuss this important phase of the clinic operation and make some suggestions regarding criteria for termination. A review of the literature offers some theoretical as well as practical suggestions and a brief study of case records gives some empirical evidence as to what factors are important in considering termination.

The disposition of treatment cases in a child guidance clinic may take one of three forms, which are: patient withdrawal from clinic service; clinic termination with referral for further service to another community resource; or clinic termination without making referral. This paper deals for the most part with the latter form, which is defined by the Department of Mental Health Child Guidance Clinic Statistical Manual (effective July 1, 1958). The manual indicates that the clinic may terminate without making a referral when one of four possibilities exists: (1) further care not indicated; (2) further care indicated - additional clinic service needed but not available; (3) further care indicated - community resources other than this clinic needed but not available; and (4) further care indicated - community resource other than this clinic needed and available but patient or family not ready.[1]

The concern of this chapter centers around the first possibility; that is, "further care is not indicated." We can assume that this means termination of treatment. In an effort to know "what" we are "terminating", it might be well to define treatment as any form of short-term or long-term psychotherapy. Psychotherapy as defined by Wolberg is:

> a form of treatment for problems of an emotional nature in which a trained person deliberately establishes a professional relationship with a patient with the object of removing, modifying, or retarding existing symptoms, of mediating disturbed patterns of behavior, and of promoting positive personality growth and development.[2]

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[1] Michigan Department of Mental Health, Child Guidance Clinic Statistical Manual (effective July 1, 1958).

[2] Lewis Wolberg, The Technique of Psychotherapy, (New York: Grune & Stratton, 1954), p. 3

It is realized that there is controversy inherent in attempts to define the treatment being carried on in a child guidance clinic. The majority of staff at the Battle Creek Clinic agree to the above definition as representing their practice. An attempt will be made to establish criteria for the termination of treatment clients.

The plan toward termination begins with the first interview since it is within the beginning phases of treatment that goals are established and the accomplishment of these goals leads to termination. The establishment of goals necessitates a practical point of view on the part of the therapist, taking cognisance of the client's limitations and resources. Evaluating the accomplishment of goals by the therapist comprises one of the most difficult phases of treatment, primarily because of the lack of effective standardized measurements.

Wolberg suggests that theoretically, and in a broad sense, the effects of treatment are never-ending because the constructive growth potential it helps to set in motion can continue throughout one's life. But from a practical point of view, it becomes necessary to set up certain goals which can be measured in an effort to determine where to discontinue treatment. Goals must be used by every therapist if any degree of success or failure is to be measured by the treatment effort. These goals may not necessarily be the goals of the patient, society, or the "ideal" objectives of mental health. The goal of the therapist might be described as the achievement by the patient of more effective functioning within the limitations of his existing motivations, his ego resources, and the reality situation. This would allow for the expediency of selecting modified goals, such as those aspects of the problem which the client can

effectively handle in the present treatment situation. Of course, judgements of "success" in reaching desired goals are a matter ofdefinition and may be viewed differently from the standpoints of the patient, society, and the therapist.[3]

The question has often arisen of whether or not one should terminate treatment when the client stops "hurting" or when he reaches that point in emotional growth where he "ought" to be, in the judgement of the therapist.

However incomplete this simple statement of the problem is, it does point to two distinct goals, which upon completion would more than likely bring about varying times for termination. It is quite probable that there are many therapists who terminate somewhere between these two arbitrary goals, depending upon their own philosophies and external factors beyond their control.

It is generally agreed that therapy attempts to enable the client to deal more effectively with his internal and/or external problems. The therapist might at best work toward symptom removal, or toward more tolerance of his symptoms, which without help might grow in severity and further handicap the patient. However, it is not always easy to know when the client has shown much movement, nor to what degree movement has occurred. The client might say he "feels" better and may invite termination whereas in reality his daily adjustment patterns may still reflect unresolved difficulties with which he is not emotionally prepared to grapple.

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[3] Ibid., Welberg, pp. 551-56

Termination in Psychoanalysis:

Of all the disciplines, the psychoanalysts have shown the greatest concern regarding criteria for termination. The factors whith which they are concerned include a lessening of superego dictates where such is desired and a greater fulfillment and satisfaction of needs, a realistic appraisal of, and improved, object relationships, and redirection of energies through socially approved means of sublimation.

The analysts provide an intensive form of psychotherapy and obviously, the duration of treatment is longer than in the average child guidance clinic, however, they also appropriate consideration to the limitations of each client. As with other disciplines, subjective judgements are used in defining accomplishment of goals.

Menninger speaks of criteria for termination which include the self-estimate which a client consciously develops and the effect of one's self estimate on relationships with others. He suggests that the superego takes on a "new look" which brings about "a sense of greater freedom, a capacity for joy in life, a cessation of various compulsive activities and a diminution of the tendency to depression." One would also look for maturation and a lessening of ambivalent feelings through the improvement of relationships with parents, off-spring, spouse, siblings, or peers. A lessening of their infantile wishes and needs will enable the client to assume a greater appreciation for the needs of others or object relationships. An improved marital adjustment can be seen as the love object becomes an end rather than a means to an end, and "things" become means rather than ends. Improvement may also be measured by one's greater ability for sublimation through work, play and thinking. It may

mean greater interest and satisfaction from play with a minimum of guilt feelings connected with it. The reverse may be true, but in any case, one looks for a better balance which is both satisfying and effective for the client. During treatment, guilt and anxiety aroused by unresolved unconscious conflicts may be diminshed. In other words, one looks for more appropriate feelings attached to the client's reality. The transference situation also plays a part in the criteria for termination. The client will see the therapist more for what he is than as a mother, father, brother, sister, or spouse. The magic omnipotence of the therapist diminshes and is replaced with increased feelings of objectivity. Termination may be less a period of sadness than a period of joy since the client may feel more free, stronger and more independent and confident that he has passed the 'test'. It should be seen as a beginning rather than an end.[4]

Annie Reich points out that Freud made it rather obvious in his published works as to what the conditions for termination of the analysis are.

> "The patient has to have lost all his symptoms, inhibitions, anxieties, all his repressions have to be undone. This implies, as is mentioned elsewhere in Freud's writings, that the blank spots caused by infantile amnesia have to be filled out, the childhood history has to be reconstructed. As a means to this aim, the transference has to be resolved. The therapeutic result which we desire is expressed best in Freud's own words: 'Where Id was, Ego should be'
> "These results, of course, we are not always able to achieve. The violent intensity of instinctual demands or too severe pathology and weakness of the ego frustrate our efforts."[5]

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[4] Karl Menninger, Theory of Psychoanalytic Technique, (New York: Basic Books, Inc., 1958), pp. 155-73

[5] Annie Reich, "On the Termination of Analysis," International Journal of Psychoanalysis, Vol. XXXI, 1950, p. 179

> "As for the time being, there is no possibility of control or verification, (regarding criteria) all statements about truly terminated analyses are, of necessity, subjectively coloured and therefore not absolutely reliable."[6]

From selected articles in the International Journal of Psychoanalysis 1950, one could arrive at the following criteria which are based on the client's capabilities:

1) Capacity for self-awareness of unconscious mental processes.

2) Capacity to move smoothly in the memory from the past to the present and back again, i.e. the removal of infantile amnesia, which includes a facing and working through of the Oedipus complex.

3) The capacity for heterosexual genital satisfaction.

4) The capacity to tolerate libidinal frustrations and privation without regressive defenses, and without anxiety.

5) The capacity to work and to endure employment.

6) The capacity to tolerate the aggressive impulses in the self and others without losing object love in its full sense and without guilt.

7) "The capacity to mourn."[7]

8) The capacity to diminish persecutory and depressive anxieties.

With regard to the foregoing, it is believed that the point of view of the psychoanalyst has a place in this discussion since the practice of psychotherapy by social workers is based on Sigmund Freud's

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[6] Michael Balint, "On the Termination of Analysis", International Journal of Psychoanalysis, Vol. XXXI, 1950, pp. 196-99

[7] John Rickman, "On the Criteria for the Termination of an Analysis", International Journal of Psychoanalysis, Vol. XXXI, 1950, p. 194

theory and technique of psychoanalysis. It has not been uncommon in the years since Freud for practitioners to look to the psychoanalysts for deeper understanding of human behavior and further techniques to promote positive personality growth.

When it is felt treatment is reaching the terminal period, the therapist might well ask himself some difficult although pertinent questions regarding the advisability of termination. Has the client gained "maximum" benefit from treatment? Are countertransference elements influencing termination planning, such as a vacation date, negative feelings for the client, or "disappointment" over the lack of rapid "success"? Are the therapist's personal feelings prohibiting termination, such as personal gratification from the relationship, the difficulty of starting a new case, or having expectations which are beyond the client's capacities, and being unable to modify the goals? Countertransference is frequently present in any treatment relationship and will be controlled in varying degrees, depending on the client and the problems which he presents. The degree to which countertransference is controlled will also have an effect on the difficulties of termination from the therapist's point of view. Psychological retesting has been frequently used by the Menninger Clinic as an aid in the decision for termination, but this in itself of course is not sufficient as a criterian.[8]

Termination in Social Work:

Social workers have long been perplexed in evaluating the factors involved in termination, because of the lack of standardized criteria.

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[8] Op. Cit., Menninger, pp. 163, 175-76

This is brought out clearly in reviewing the literature and may be largely due to the varying functions among the different agencies. These differences affect the establishment of goals, as well as the fact that all social workers are not trained as psychotherapists. Thus, a child welfare worker has different goals and expectations from those of a psychiatric social worker in a child guidance clinic.

Hamilton states that the treatment should have defined and distinct goals and should not drift along with vague gratifications. Termination should follow the completion of those goals which have been within reason to offer or expect. However, the measurement of success and failure is still in its infancy. Hopefully, with the development of research projects and other devices, we will some day be able to make informed qualitative judgements as to termination.[9]

It is not uncommon for therapy to end prior to the therapist's vacation in the summer. In many other cases, the therapist claims that both he and the client "will just know" when therapy should terminate because it seems to wear itself out. Obviously, this could be judged as only an intuitive formulation rather than a theoretical criterian.

Clarice Platt, in apaper read at the Child Guidance Clinic meeting in 1951, stated that the purpose of the child guidance clinic will affect decisions regarding the point at which termination must be considered. The criteria for termination of children would be somewhat different from adults in that the growth potential of the child is, to a certain extent,

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[9] Gordon Hamilton, Theory and Practice of Social Casework, (New York: Columbia University Press, 1951), pp. 79-82

dependent on the restrictions and limitations of the parents' motivations and ego resources, as well as the reality of the home situation. Whenever possible, termination with children would also include the parents in the process. The reality of available parental support in the home makes the termination for the child less painful and less time consuming. Recognizing that termination is a part of the total treatment, termination can then be utilized in the process.[10]

Agency functions or purpose and the practical consideration of pressure on the clinic from treatment waiting lists attach additional factors which must be considered in establishing the criteria for termination.[11] Although these factors may be rationalized on the part of many clinics, they must be faced realistically, since the community rather than an individual has assumed the responsibility for providing this service. The helping professions of social work, psychology and psychiatry have not as yet been able to agree on a criterian for termination which can be reasonably measured, and it is understandable that the community should want the greatest number served in the shortest time. This problem is not so evident in private practice.

In considering termination, the therapist might look for a child less tense or anxious who is better organized or better able to accept limitations. He may be seen by the parent as having better relationships with peers and siblings or functioning better in school. They may find

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[10] Clarice Platt, "Termination Planning in a Child Guidance Clinic", Journal of Psychiatric Social Work, American Association of Psychiatric Social Workers, Vol. XXI, No. 3, (1952) p. 34

[11] Ibid, p. 35

the child is more affectionate at home, more independent, less demanding and restless, and better able to concentrate.[12] However, these are all subjective judgements on the part of the therapist or perhaps the parents. Because of the limitations in communicating with children, the criteria for termination may be somewhat more difficult to ascertain than with adults. Disabling symptoms may be removed, modified, or inhibited. However, one is not certain that a more effective balance has been established within the psychic structure of the individual to master internal and external problems.

A standardized measurement of a client against acceptable criteria for termination has not yet been established, and the professions, at best, can only rely on subjective, intuitive appraisal, as well as offering some security to the therapist's uncertainties.

Clarice Platt is of the opinion that "it is unusual to find formalized evaluation by team members of the strengths and readiness of the client to separate from the helping relationship of the clinic. It seems to occur more often when there is distress about failure than when a child is improved and ready for termination of treatment".[13] She felt that informal evaluations between workers in terms of readiness for termination included such things as adaptive efficiency, reduction or disappearance of disabling habits and conditions, and verbalized attitudes or understanding on the part of the client. Other considerations of concern include the function of the agency, availability and use of agency service, and pressure from the treatment waiting list.

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[12] Ibid. p. 36

[13] Ibid. p. 35

Termination is the logical outcome of psychotherapy with any given client since therapy is a means to an end, rather than an end in itself. As a client finds greater gratification in the roles he or she performs in society, there is greater appreciation for independence from the therapist. In the case of a mother and child in treatment, there is a greater sense of physical and emotional well-being toward the final stages of treatment. The child responds to the mother's new and different interest in her with better use of his(her) capacities. When both are relatively free from anxiety and symptoms, they are able to review the changes with considerable gratification. The separation from the therapist is usually a smooth process and a natural oneresulting from the efforts on the part of both the therapist and the client.[14]

When motivation for treatment and anxiety have been sufficiently diminished through success in finding approved forms of gratification and the use of innate abilities to handle conflictual problems, it seems the client usually thinks of termination. As an example of this, when a couple in joint treatment seemed to be feeling more comfortable together and positive about their marriage, the therapist felt it appropriate to terminate treatment.[15]

It would seem that length of treatment has a great deal to do with termination. However, there has been no consensus as to what an average

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[14] Ilona Reetas, "Casework Treatment of Mothers in Behalf of Their Children", Social Casework, Vol. XLI, No. 2, (February 1960) p. 75

[15] Joanne Geist and Norman M. Gerber, "Joint Interviewing: A Treatment Technique with Marital Partners", Social Casework, Vol. XLI, No. 2 (February 1960), pp. 76-83

length of treatment should be. The three month period advocated by Otto Rank has not been shown to work out successfully. On the other hand, treatment for a period of ten years or more is not practical for clients in a child guidance clinic. Length may be determined on the basis of either the number of contacts or the number of weeks, months, or years between the first and last contact. In the opinion of Ralph E. Walton, Administrative Assistant, Michigan Department of Mental Health, a review should be made of any case which has had fifty or more contacts and serious consideration given to termination. However, he felt that length of treatment cannot form a rigid criterion for termination.

A great deal has been reported in the literature regarding short term treatment (defined by Walton as ten contacts or less), which has proven to be successful in the majority of instances in reaching limited goals and removal of some of the more obvious symptoms. Usually, this has been accomplished through direct interpretation and advice. In one such instance, the author reported that basic changes in personality structure could not be attempted or affected in so brief a program. However, a six-month follow-up investigation indicated that in almost all instances of significant improvement these gains were sustained.[16]

In the example mentioned above, a series of five interviews over an eleven-week period for supportive psychotherapy were scheduled at predetermined intervals. The criterion for termination in such a circumstance is obviously not a problem and with the ever-increasing need for psychiatric services and with the limited treatment facilities

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[16] Anita Gilbert, "An Experiment in Brief Treatment of Parents", Social Work, Vol. V, No. 4, (October 1960) pp. 91-97

available, short term treatment offers one answer to the problem. However, clients who did not respond to such a program would need to be accepted for longer term, sustained psychotherapy.

While there has been very little research in this area of establishing criteria for termination of treatment, it would be unfair not to include the work of J. McV. Hunt in establishing criteria for movement. In his attempt to formulate a dependable measure of the effects of casework, Hunt devised the following movement scale where changes were likely to be looked for by the caseworker.

(1) Changes in adaptive ability or efficiency. This category included such items as changed ability to get along with other people, changed efficiency in running a home or in performing a job or in school, and new skills of any sort.

(2) Changes in disabling habits and conditions. This category included such items as changes in attitudes, personality traits, and behavior inimical to good social relations, changes in delinquent tendencies, and changes in the level of anxiety, in basic conflicts of motivation, and in health.

(3) Changes in attitude or understanding as evidenced from the client's verbalization. This category included such items as accepting counsel, changes in attitudes toward self and others as shown in what the client says, and discernment of relationships between present behavior and feelings and events in the client's personal past.

(4) Changes in the environmental situation. This category included such items as changes in living quarters, clothes, and furnishings, changes in the behavior of other people toward the individual, and changes resulting from child placement or the transfer of a psychotic from the home to a hospital.[17]

It is interesting to note how closely this list of changes resembles

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[17] J. McV. Hunt, "Measuring Movement in Casework", Social Casework, Vol. XXIX, No. 9 (November 1948), p. 346.
J. McV. Hunt and Leonard S. Kogan, Measuring Results in Social Casework, (New York: Family Service Association of America, Inc., 1940) p. 41

the list of capacities arrived at during the symposium on the criteria for the termination of analysis in 1950.[18]

The measurement scale was also found to be useful by Clarice Platt in her attempt to evaluate termination practices at the Kalamazoo Child Guidance Clinic.[19]

It seems to become apparent at this point that establishing the criteria for termination is a difficult problem, whether it be by an analyst, child psychiatrist, clinical psychologist, or a psychiatric social worker. It has been suggested that there are many personality factors which should be considered. These factors are centered around the effectiveness of a client's overall behavior. However, in most instances, the "effectiveness" of the client is determined through subjective judgements on the part of the therapist.

It was found that consideration should also be given to the function and purpose of the agency in planning for termination. This is especially true when the agenct has a responsibility to the community for providing services in accordance with community expectations. Limitations in the availability of a therapist's time must also be considered. There may be personal feelings on the part of the therapist which are influencing the decision for termination. Limitations in the home and environmental situation; in the attitudes and motivations of parents, etc., determine the prognosis for further improvement and therefore are factors in deciding when to terminate treatment. Thus, it is seen that there are many

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[18] Ibid. p. 5

[19] Ibid. p. 8

external factors which influence the decision for termination other than the client's personality factors.

It would seem natural that practical goals must be stressed which would include all of the above factors where applicable. The necessity for the therapist to possess sufficient skill, knowledge and understanding is paramount in evaluating the achievemnet of these goals, since this is usually a matter of subjective, intuitive appraisal on the part of the therapist. Perhaps with further development of research projects in this area, more informed qualitative judgements can be made.

In the light of the above theoretical discussion and review of the literature on the subject of termination , it was felt that even limited empirical evidence would be valuable in determining and substantiating some of the factors considered in termination. With this in mind, a small sample of closed treatment cases were reviewed at the Battle Creek Child Guidance Clinic.

A Selected Study on the Criteria for Termination:

The purpose of this brief study was to find out why and under what circumstances clients were terminated from treatment on the basis that further care was not indicated. What factors are present in the client's circumstances which would influence the clinic to reach this decision? Since disposition of cases also includes those which withdraw and those which are referred to other social casework agencies, it was necessary to determine the status of change in these clients as well. Should some clients, who withdrew or were referred, actually have been terminated by the clinic according to their criteria for termination? No attempt is

made to find out the client's reasons for withdrawing; however, some suggestions are given in some instances as to why a client was referred to another agency.

The study consisted of reviewing twenty-seven case records with particular attention being given to the closing notes in each record. The cases selected for study included all those cases which were closed by the Battle Creek clinic during the period from May 1, 1959 through August 31, 1959. These cases had all gone through the formal process of diagnosis and treatment prior to closing. As the case was evaluated by the examiner, a determination was made as to status of change in each child at the time of the closing note.

The criteria used in determining the status of client change included those factors which were felt to be important by clinic practitioners in making a decision for termination. In reviewing the literature, these same factors are seen as being important in considering termination by many other therapists. The examiner compiled and expanded these factors to form the criteria which were used to place the children into one of three catagories.

For lack of better terminology, classifications of 'improved', 'partially improved' and 'unimproved' were used to catagorize the children. This was done because a standardized method of catagorizing an individual following treatment was not available which would indicate the degree to which an individual illustrated "total" emotional maturity ("total" refers in a broad sense, to the six factors in the criteria). No attempt was made to measure the effectiveness or success of the treatment experience. However, an attempt was made to look for certain strengths of a child at

the time of termination which might indicate some of the factors considered when a case was terminated. It is assumed that there may have been other factors, such as the therapist's vacation, which were not considered.

The status of client change was measured against the following criteria:

1) Symptom removal - included the modification and/or alteration of pathological defenses, and the strengthening of constructive ego defenses.

2) Intellectual functioning - included the reduction of depressive anxieties and tension states, improved capacity for coping with such maturational tasks as work and school, and capacity for self-awareness.

3) Self image - included a healthier and improved super ego identification, an improved ability to have fun through socially approved forms of gratification, and improved sexual adjustment.

4) Relationships with parents or parent without surrogates - included the capacity to tolerate aggressive impulses without losing love objects and without guilt.

5) Peer relationships - included the ability to move effectively, deal with one's own feelings and the feelings of others, and observe changes in the behavior of other people toward the individual.

6) Capacity to deal with interpersonal conflicts - included the discernment of relationships between present behavior and feelings and events in the client's personal past, and improved capacity for reality testing.

One of the problems encountered in making an analysis of this rather small sample was the limitations of the closing notes in some cases. Fortunately, however, it was sometimes possible to speak directly with the clinician responsible for the closing when further information was needed. It was realized that the subjective judgements on the part of the therapists were complicated by a further judgement on the part of this writer in evaluating the degree of change. In all instances, it was the child who was measured againstthe criteria for termination, rather than the parents.

Another problem presented itself when in some cases, only the parents were treated and only subjective statements on the part of these parents could be used in evaluating change of these children who were not seen in treatment.

Finally, it was not always possible to determine all of the reasons for termination, but onlt those indicating client change, since not all the practitioners had continued employment at the clinic at the time the study was done. They were therefore not available for consultation. For that reason, it was not possible to have the individual therapist evaluate the possible change which might have been present at the time of the termination, whether it was because of client withdrawal, referral to another agency or clinic termination on the basis of further care not indicated.

The six factors or areas mentioned above are factors which, for the purpose of this study, depict emotional maturity and indicate the status of client change. With this in mind the examiner classified each child represented in the twenty-seven cases into one of the three catagories 'improved', 'partially improved', or 'unimproved'. In order to make this general classification, it was necessary to catagorize a child in each of the six areas which would then illustrate his overall status of change.

The leniency which was used in placing the children in one of the three catagories may be questioned; however, in considering the limitations of 'ideal' goal achievement, it was felt that rigid judgements could not be employed. Therefore, a classification of 'improved' was used to describe a child who met this qualification in at least four of the above areas and

at least 'partially improved' in the remaining two areas in the judgement of the examiner.

A classification of 'partially improved' was used to describe a child who met this qualification in at least three of these areas, or 'improved' in at least two areas in the judgement of the examiner.

Any child who was found to have revealed less change, in the judgement of the examiner, than described above was classified as 'unimproved'.

The three classifications divided the twenty-seven children into the following groups: eleven 'improved', eight 'partially improved', and eight 'unimproved'.

Of the eleven children who had improved: eight cases had been terminated by the clinic as requiring no further care; two were referred elsewhere, one to the school and one to a social casework agency; and one case had withdrawn from clinic service by reason of moving.

Of the total twenty-seven children, only nine had been terminated by the clinic as not in need of further care. This would seem to indicate that in at least eight of these cases, the clinic was correct in terminating by their standards since these children were placed in the 'improved' classification. Of course, it is not known whether or not these cases could have been terminated earlier. Only one of these children was found to the 'partially improved' in one area, which was parental relationship, and he was 'improved' in the other five areas. The lone child who was terminated by the clinic and not found to be 'improved' will be discussed later.

In measuring these eleven children who 'improved' against said

criteria for termination, the examiner recorded only 'partially improved' in three instances in the area of parental relationships. In the area of ability to deal with interpersonal conflicts, 'partially improved' was recorded in two instances, and in the area of symptom removal and self image, 'partially improved' was recorded for one each.

This might indicate that since children of maladjusted parents have difficulty improving parental relationships even with therapy, they can find gratification and improve in other areas; however, in one instance, this was also associated with 'partially improved' in dealing with interpersonal conflicts. The degree of therapeutic success with these parents is not known.

In view of the 'improved' classification in the two cases which were referred, it would be well to offer some explanation as to why the case was not terminated instead of referred. One case involved an adolescent girl where 'partially improved' was recorded in four areas. Because of a difficult family situation, she was prepared and referred to the court for placement in a boarding home after twenty-eight clinic contacts; the second case involved a pre-adolescent boy where 'partially improved' was recorded in the area of dealing with interpersonal conflicts, while he was found to be 'improved' in the other five areas. It is not known why this case was referred to the school after thirteen clinic contacts, although in some instances a case will be referred for further supportive help with the Visiting Teacher. As for as the adolescent boy who withdrew, it is not known why the clinic did not terminate since the examiner records 'partially improved' in the area of parental relationships while 'improved' in the other five areas. Perhaps

the clinic should have terminated prior to the time the client moved, which occured after thirty-five contacts.

However, this may also point to the leniency used on the part of the examiner in placing this child in an 'improved' classification. As long as there is any area of difficulty, the therapist may feel the goals of therapy may not have been accomplished and continued treatment is warranted. On the other hand, a 'practical' goal for children would necessitate that consideration be given to the limitations of parents.

The average number of contacts for these eleven children was forty-two, with the least number being nine and the greatest being one hundred and eight contacts.

'Partially Improved':

Of the eight cases which were recorded to have 'partially improved', one child had been terminated by the clinic as requiring no further care; two were referred elsewhere, one to the school and one to a social casework agency; and five cases had withdrawn from clinic service for reasons other than moving, death or illness, such as the parents' resistance or lack of further interest.

In measuring these eight cases against the criteria for termination, the examiner recorded four instances of 'unimproved' in the area of dealing with interpersonal conflicts, three instances of 'unimproved' in both the areas of intellectual functioning and self image, while there were two instances of 'unimproved' in the area of relationship with peers and one in the area of symptom removal.

In this group of children, their major difficulty was seen in the

area of handling interpersonal conflicts. Three of these same children also had difficulty in intellectual functioning and two of them had difficulty in establishing a healthy self image. This may indicate a correlation between intellectual functioning and capacity to deal with interpersonal conflicts. One of these children was referred to a social casework agency, and two of them were withdrawn from treatment by the parents. Of those who withdrew, the records suggested that the parents withdrew prematurely after the symptoms of their children seemed to diminish.

In regard to the child who was terminated by the clinic, it was found that he was 'improved' in areas of symptom removal and parental relationships, but 'unimproved' in the other areas. This may have been a premature termination on the part of the clinic. However, the judgement of the examiner could have been in error since the closing note was somewhat incomplete and only the parent was treated.

In the two cases which were referred, it is difficult to know why continued service was not provided by the clinic once the case had been accepted for treatment. Occasionally, however, the attainment of limited goals is attempted during which time the client is prepared for referral to another community resource. One of the cases referred involved an eleven-year old girl who came from a sordid home situation. After fifteen contacts with the parents, the clinic felt that it had little more to offer the family and a referral was made to the Visiting Teacher at the child's school. The child had made only very marginal gains during the family's four month contact with the clinic.

The reason for not terminating the five cases which withdrew seems

apparent, although it may also mean that a reappraisal of goals is needed and lowering of one's expectations with some families.

'Unimproved':

In the final group reported as 'unimproved' cases, it was found that four of these were referred to social casework agencies; three withdrew from clinic service also for reasons other than moving, death or illness; such as lack of parental interest; and one case was terminated by the clinic because there was no service available, although it was felt that additional clinic service needed.

In regard to the referral cases, it was found that one seven year old was referred to a boarding school and preparation was attempted with the parents. Another seven year old was referred to M.C.A.S. and preparation was planned with the parents. A sixteen year old adolescent girl was referred to the adolescent unit of NPI at Ann Arbor and preparation was planned with the mother. In the case remaining, it was recommended by the clinic that a fourteen year old adolescent girl be placed in Vista Maria with planning toward this goal accomplished with the parents.

Of the three cases which withdrew, no comment is needed, but an explanation should be given for the termination mentioned above which was a result of no available service. The case was accepted for treatment; however, at that point, the client's mother was no longer interested. It would seem that this case should be classified as a withdrawal rather than a clinic termination.

The average number of contacts for this final group of eight cases was seven, with the least number of contacts being one, and the greatest, twenty-two.

There may be question why some of these cases were included as having gone through the formal process of diagnosis and treatment. The only explanation which can be offered is that once a case has been accepted for treatment and appointments scheduled, it becomes necessary to place them in the diagnosis and treatment classification, regardless of whether or not they continue treatment.

An additional finding of the study revealed that in twelve cases, only the parents were accepted for treatment. Of these twelve cases, two children were found to be 'improved', six 'partially improved', and four 'unimproved'. This may indicate a tendency for less therapeutic results when only the parent is in treatment. Of course, such a tendency would need further documentation before any definite conclusions could be drawn.

Conclusions:

This brief study seems to illustrate that on the basis of the nine children who were terminated as not in need of further service, the decision for termination was made with due consideration given to certain criteria. The factors considered in termination were suggested in the preceding chapter by the Battle Creek clinic practitioners. These same factors were compiled and edited to form the criteria used in the study which included symptom removal, intellectual functioning, self image, peer and parental relationships and capacity to deal with interpersonal conflicts.

Eight of the nine children met the criteria which would make them terminable while the remaining case may have been terminated prematurely.

Of the eight children who were referred for further service elsewhere, two of them met the criteria which would make them terminable.

However, in the one case, there was sufficient reason to believe that fulfilling the total child's needs was not within the function of the clinic. It was therefore necessary to rely on another community resource. Some suggestions were given as to why a case is referred rather than continue treatment in instances where the case partially met the criteria necessaryfor termination. The most general reason for referring all of these cases was that their needs could better be fulfilled by another agency and the function of the clinic included preparing the child and the family for the referral, and only very limited goals were attainable or attempted.

Of the nine cases which withdrew only one met the criteria for termination. Five of these children partially met the criteria and perhaps some of them should have been terminated. It may indicate that the goal of the therapist is not always in agreement with that of the client. On the other hand, it is recognized that the clinic emphasizes diagnostic services and perhaps in some instances, treatment is used to further perform the diagnostic service, especially in those cases which are referred.

The study revealed that when these childen were terminated by the clinic, they most frequently met the criteria for termination. However, in those cases which were referred or withdrawn, they might also have met or partially met the criteria for termination. When this happened, we often saw that factors might be present other than those which were presented in the criteria for termination; i.e. certain client needs which are not within the function of the agency to fulfill.

Recommendations:

It is recommended that at the time of termination, a note should be entred in the client's case record which would include information regarding the reasons for termination, the client's condition at termination, the areas of improvement, the client's attitude toward the therapist, the final diagnosis and recommendations made to the client. Possibly, a form such as shown in Appendix would be useful.[20]

It is further recommended that research continue in its efforts to adequately standardize a set of criteria for termination which will give direction and scope to psychotherapy in the various agencies where it is performed. Standardized methods of reporting statistics based on reliable criteria for movement would inhance their meaning and offer considerable help in interpreting therapy to lay persons.

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[20] Op. Cit. Welberg, pp. 565 and 821

CHAPTER XI

THE ROLE OF THE CLINICS IN THEIR COMMUNITIES

The previous chapters of this study have been concerned with internal aspects of the child guidance clinics, discussing various administrative policies, procedures and clinical practices. This chapter will focus upon some of the external aspects of the Battle Creek, Flint, Kalamazoo and Lansing clinics, investigating the role of clinics in their communities.

This chapter will include discussion of the similarities and differences among these four clinics relating to three major questions about community relations: (1) How do the clinics carry out the specific functions of "community services" as defined by the Michigan Department of Mental Health policies? These include activities of general public education, training for professional groups, participation in community planning and conferences with other agencies; (2) How does each clinic perceive its role in offering the various clinical services to the community? Here, we are interested in whether the clinics see themselves as emphasizing the same services, as best serving the same type of cases, as serving the same kind of clientele and distributing their services proportionately throughout the service area; (3) How does each clinic interpret its purpose and functions to the community? This refers to the activities involved in communication and the cultivation of citizen interest.

For purposes of this study, the community is defined as the geographical area which each clinic serves. The Battle Creek community includes Calhoun and Branch counties. The Flint community consists of Genesee, Shiawassee and Lapeer counties; Kalamazoo community consists of Kalamazoo, St. Joseph, Cass, Van Buren, Allegan and Barry counties. Finally, the Lansing community includes Ingham, Eaton, Clinton, and Livingston counties.

To obtain the information, selected professional personnel at each clinic were interviewed. They were requested to give responses to questions according to how they perceived the clinic functioning in these relationships. Therefore, when we speak of a clinic participating in various activities or such, we are referring to how the professionals interviewed at that clinic perceived the performance of the entire clinic staff. In cases where staff members of a given clinic indicated different opinions or attitudes, these will be pointed out.

Community Services

"Community Services" has been spelled out as one of the specific objectives or functions of child guidance clinics, along with diagnosis, treatment, training of professional staff and research. These services have been defined by Mr. Ralph Walton of the Michigan Department of Mental Health in terms of three types of activities.[1] The first is consultation services where the child is not seen by the clinic, but

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[1]Ralph E. Walton, "Clinic Objectives and Distribution of Staff Time", Paper presented at meeting of Association of Michigan Child Guidance Clinic Boards. Detroit: March 25, 1955. p. 3

advice is given to workers of other agencies on matters presented by them to assist in planning an appropriate program to be carried on by those agencies. The second activity is education of the lay public as to the meaning of childhood behavior problems, the steps which are necessary in child care to prevent maladjustment when possible, and means and resources for treatment that are indicated if maladjustments do occur. The third activity is education on child growth and development to help parents and others in better understanding the normal processes of child behavior from infancy to adulthood.

Admittedly "Community Services" includes several less already defined areas of service to the community. In the personal interviews conducted, we asked a general question about the kinds of community relations engaged in by the clinic. We did not expect those responding toinclude all the activities engaged in by each clinic, but rather we felt that the activities which would be mentioned might reflect what the staff perceived as being the clinic's attitude, emphasis and/or actual practice of community services. Other questions asked were who participates in community education at your clinic, who delegates these responsibilities and to whom, and what do you see as the clinic's role in offering community services.

Of the four clinics, Flint and Kalamazoo seemed to place greater emphasis upon community services based upon the greater number of activities mentioned and the detail in which these services were defined. In all four clinics, speeches, lectures, and other presentations were reported along with consultation and training services to other agencies. Flint, Kalamazoo and Lansing listed additional activities of promoting new

resources and facilities in the community and participating in other civic, professional and social organizations, but even here Flint and Kalamazoo went a step further in spelling these out.

At Battle Creek, community mental health education is undertaken by the staff, with approximately fifty presentations annually before parent groups, service clubs, church and teacher groups. The clinic participates in training programs for social workers and visiting teachers, in an effort to raise the level of professional skills in the service of children. A well known speaker is procured annually for the clinic's annual meeting which brings together around 200 persons from the community to hear various mental health problems discussed. The Lansing clinic actively participates in giving lectures to groups; seminars and consultations with other agencies; TV and radio presentations. One staff member has been active with the local chapter of the Michigan Association for Mentally Disturbed Children in raising funds and promoting a plan for a resident facility in the area. In Flint, along with educational classes and study groups, initiating and promoting new resources as needed, and consultative services to established agencies, the staff is represented on the board of directors of the Michigan Welfare League, a committee of the Jewish Community Council, the Council of Social Agencies and other civic and professional organizations. Two staff members were instrumental in promoting the local organization of parents and friends of retarded children. Though a great deal is done informally, the staff also participates in regularly scheduled consultative and training services to: an institution for the mentally ill, a psychological clinic of a nearby university, Big Brothers, Big Sisters and local court workers. This

clinic also works closely with the schools, making its staff available one afternoon each week for consultation on both clinic and non-clinic cases, visiting the various schools upon request or initiating such conferences. At Kalamazoo, visiting teacher or school conferences are arranged on mutual cases. Clinic tours to educate along the lines of mental health are given to various groups student nurses, and psychology classes. A lecture series, similar to an on-going workshop, is offered to persons working in a nearby residential setting. Consultaion services, weekly or bi-weekly, are offered to the social service department of the court. The Kalamazoo staff is represented in the local association for retarded children and the parents' association for emotionally disturbed children. The clinic had an active part in planning and setting up the program of classes for hyperactive children. Consultation and participation in community planning, such as the monthly Case Coordinating Committee meetings, are part of the program.

Though at all four clinics the director is responsible for community services and usually delegates such activities to his staff, Battle Creek and Lansing indicate that the director provides the greater number of these activities, while at Flint and Kalamazoo the staff is expected to share equally in these services. Battle Creek estimates that the director engages in two-thirds of all such activities while the rest of the staff participates in one-third. Although these duties are rotated flexibly at Lansing, the director is most often called upon. In Flint, the administrative director screens and assigns requests for speeches and other appearances by clinic staff, and though no staff member is forced, all are expected to participate in some way, utilizing whatever talents

he may have in educating the community. Kalamazoo assigns staff members to specific counties of its service area to do liaison work with visits to agencies, schools, etc.

In defining the clinic's role in offering community services, Lansing sees an obligation to educate the community in terms of preventive psychiatry, and a responsibility in cooperating with other community agencies in defining clinic services. Flint's major role is broadly defined as mental health education. Battle Creek feels a responsibility of prevention, giving lectures to other organizations, consulting with other agencies and involving interested people from other agencies in clinical cases. Kalamazoo finds the clinic's role in offering community services is not clearly defined. This clinic functions around demand rather than definition which would probably mean handling only children who need a psychiatric setting. The clinic is oriented to needs and not philosophy. It takes on more cases because other agencies do not have enough staff with training and the clinic plays "stop-gap". The many local sources of financial contributions may well indicate the emphasis placed upon community services by the Kalamazoo clinic.

It is interesting to note that in Battle Creek and Lansing, where the director seems to fulfill most of the community services, fewer activities are spelled out by those interviewed; in Flint and Kalamazoo, where these functions are shared among all staff, those interviewed listed more activities.

Comparing the data from our interviews with the statistics in the following table it would not appear that this holds true in actual practice:

TABLE 5

Community Services of Child Guidance Clinics
July 1, 1958 - June 30, 1959*

	Battle Creek	Flint	Kalamazoo	Lansing
General Public Education**	106	112	90	160
Training for Professional groups**	8	227	19	3
Participation in Community planning**	30	183	118	124
Conferences with other agencies/	173	696	167	69

* Michigan Department of Mental Health, Statistical Report.
** No. of presentations.
/ No. of cases discussed.

From this table it is apparent that the volume of community service is lowest in Battle Creek. Flint has about double to the Battle Creek volume os service in this area and the other two clinics are in between. These differences may be accounted for by varying procedures used in tabulating the statistics for report by each clinic; however, it is suggested that many other factors may be involved. Remembering that our data were based upon the perception of selected personnel, we would speculate that in these clinics where the director performs most of the community services, other staff members perceive the role of the clinic in offering these services as a less active one.

Now that we have investigated each of the clinical functions of diagnosis, treatment, and community services, all of which relate directly to clients or other community resources, let us turn our attention

to how the clinics are alike and how they differ in distributing these services to the community.

Services Most Emphasized

One of the differences we expected to find among clinics was that in the actual distribution of services one clinic may emphasize treatment or prevention through consultation services. However, the data from our interviews indicated that these four clinics place greatest emphasis upon diagnostic services to clientele. The Lansing clinic suggests that diagnostic studies are necessarily given the most emphasis since the clinic begins with diagnosis prior to referral elsewhere, placement on the treatment waiting list, or any other section, planning or case disposition. Kalamazoo reminds us that treatment cannot be effective unless the diagnostic evaluation is sound. Flint describes another factor of community pressure to emphasize diagnostic services, estimating that in comparing diagnostic and treatment services, 60% are diagnostic. Battle Creek estimates that two-thirds of its services are diagnostic.

This emphasis upon diagnostic services by these four clinics is substantiated by the following table:

TABLE 6

Final Service Classification of Child Guidance Clinic Cases Closed, July 1, 1958 - June 30, 1959

	Battle Creek	Flint	Kalamazoo	Lansing
Diagnosis	241	215	181	236
Diagnosis and Treatment	51	84	128	49
Psychological Testing	56	85	51	-
Unknown	1		1	
Total	349	384	361	285

The figures of the preceding table were obtained from the Michigan Department of Mental Health Statistical Report.

While there was general agreement among the clinics on this point, our data suggested a tendency for professional persons to differ according to discipline in responding to what services are emphasized most. The social workers at three of the clinics tended to report a balance of services, stating that no one service is emphasized while another is essentially non-existent; diagnosis and treatment are both important and it is difficult to place greater emphasis upon one; there is a need for both kinds of service. The psychologists and psychiatrist did not hesitate to emphasize diagnosis.

Cases Best Served

Of the four clinics, each had a different criteria in determining the type of case best served by the clinic. Battle Creek described cases best served in terms of diagnostic classification, namely, neurotic first, then less severe charcter disorders. Qualifying that it is difficult to determine the type of case best served, the Flint clinic, too, finds that generally cases best served appear to be psychoneurotics. Further caution is mentioned that any such breakdown by diagnostic catageries become artificial, for cases are perceived as individuals and not as diagnostic entities. Sometimes a staff member becomes interested in cases which look hopeless, such as severe acting out problems, sexual problems, and the like. It is difficult to determine the value of this service. Though such cases, frequently termed not amenable to treatment by others, may not be progessing as well as less complex or less intense

cases, the value of this service may be as great if not greater. Kalamazoo adds that the classification of treatment cases may not be accurate because less serious cases are not seen by the psychiatrist and so remain undiagnosed. Based on the great number of referrals by parents, it appears that parents are being served best. Children best able to benefit at the Lansing clinic are determined by the type of problem; adequacy of intelligence; motivation of family and prognosis. This may be the young child who is just beginning to show signs of pathological development which would continue to grow in the absence of therapeutic intervention.

From this, differences noted among the clinics seem to be related to defining and selecting criteria for dertermining the value of case service. The Battle Creek, Flint and Lansing Clinics considered the criteria of diagnostic classifications, each stating the clinic is best able to serve clients classified as neurotics. The Kalamazoo clinic referred to the nature of clientele, stating that parents are best served. There was general agreement in the hope that each case is served equally well, within the scope and limitations of the clinic and the client's ability to use services.

Distribution of Services

The Battle Creek, Lansing and Flint clinics take no measures to insure an intake caseload which is representative of all persons living within the service area. However in Flint, specific workers do provide consultative and supervisory services, working closely with counties outside that in which the main office is located. When it becomes known that a particular area desires service and is being neglected, some attempt

is made to alleviate this situation. It is pointed out that these attempts to each out to the entire service area are not made for the purpose of obtaining representation, but to provide services to all who so desire. Differing from the other three clinics, Kalamazoo has designed measures to represent each county in its service area. From the total number of referrals from each county the previous year, and the contributions received from that county, a ratio is determined by the clinic board as to the proportionate number of children to be accepted for intake from any one county during the following year.

Nature of Clientele

Among these four clinics, clientele receiving most service range from the upper-lower class client to those in the upper class. Lansing and Battle Creek reported upper-lower to upper-middle socio-economic status as charcteristic of their clientele, while Flint defined a narrow range of lower-middle to middle class and Kalamazoo reported those receiving most service included upper as well as the middle class. Two of the clinics, Flint and Lansing, described both extremes, the wealthiest and the poorest, as segments of the community not being reached; whereas Battle Creek and Kalamazoo pointed out that it was the lower-lower class, the deprived who were not being served by the clinic. Battle Creek suggests that these are cases in which environmental problems are severe; the so-called hard-core families. Multiple problem families are accepted by the Kalamazoo clinic, however they do not usually seek service. It is suggested that severe deprivation makes these cases untreatable from the scope of the child guidance clinic. Neverthless , there is a need for more

reaching out to such cases. Flint suggests that the lower class sometimes lacks incentive and nothing is done by outside sources to stimulate awareness of the problem; when such cases do contact the clinic the porblem usually has become so serious that the clinic cannot handle it. It is further speculated that the American society as a whole is more punitive in dealing with lower class problems so that local authorities work with these people through corrections while the same probelms presented by other socio-economic classes would be referred to the clinic. Since the upper-class may hide problems, seek private services, or such, the child guidance clinics seem best to fill the needs of and be established for the middle class.

Another factor pointed out by three clinics as affecting those who receive services is geographical distance from the clinic. Those who live closest receive most service, and those who live farther away from the clinic are being reached less often. One explanation of this may be that the county housing the clinic is more populated and therefore more requests come from the nearby area. Kalamazoo was the only clinic to omit this factor. There was one area which was not being reached by Kalamazoo, but that area seems unbale to utilize clinic services at this time because of environmental factors and not because of distance from the clinic proper. Perhaps Kalamazoo's procedure of county representation during intake eliminates distance from the clinic as a factor interfering with availability of services to the client.

When we consider possible explanations about why certain people come to the clinic for services while others needing the same kind of service do not, we must also evaluate the effectiveness of the clinic in

educating the public as to its purposes and functions.

Agency Interpretation

"Though social agencies differ in many ways, almost all share one tantalizing problem in common. They have never succeeded in making the public really understand them".[2] Clear understanding of the clinics' aims and possibilities and careful cooperation by parents and referral sources are essential for an effective child guidance program. This section would discuss the role of the clinic in community activities related to interpretation of the child guidance program.

The importance of this task was emphasized for the Michigan program in recommendations made to clinic boards outlined in the program and policy statement, 1956:

> The greatest existing problems in the clinics are those of not being able to meet the demands for service in the communities, and especially, quickly serving emergency cases while there is a long waiting list of referred children. The clinic board and staff members should help the communities to understand that there are three main functions of the clinic staff: First, diagnosing the various problems presented by the children referred; second, treating such children as the clinic decides may be helped; and third, learning something from the study and treatment of those children that will help the clinic staff in consulting with the schools, parents, courts, physicians and others in dealing with other children.[3]

Though the clinic boards act as liaison body between the community and the clinic, having a responsibility of public interpretation and

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[2] Harold P. Levy, Public Relations for Social Agencies, New York: Harper and Brothers, 1956 p. 3

[3] Michigan Department of Mental Health, Michigan Child Guidance Clinics, Program and Policy Statement, Lansing. 1956 p. 20

education, the staff has a professional obligation to share this responsibility and actively participate in such acticities. Viola Paradise points out that a report of the personnel committee of the Family Service Association of America specifically describes the public relations qualificatiens and responsibilities of casework personnel, and she further suggests that along with all various ways the public is informed, "all interpretation stems back to the worker."

Questiens were asked at these four clinics relating to the kinds of publicity and interpretive activities the clinics participated in as well as the procedures and methods used to inform the public about making referrals to the clinic.

In educating the community as to the clinics' purpose and functions, all four clinics participate in speaking to various groups or organizations throughout the area, distributing brochures, pamphlets, andother written material, reporting pertinent contents of board meetings, and encouraging newspaper publicity. Distinguishing characteristics include open houses from time to time at Kalamazoo and Battle Creek, television and radio presentations at Lansing, and a bi-monthly newsletter recently initiated in Flint which is distributed to interested persons, agencies, institutions and othet groups. The Flint clinic has in the past trained lay leaders to meet the demands of "one night stand" speeches.

Of the four clinics, Battle Creek, Lansing and Flint advise the community that referrals to the clinic may be made by any responsible person in the ferm of a letter, telephone call, or personal visit; but in each case the parenst of the child referred must also call. Kalamazoo advised the community about the procedure for referring cases in a

similar manner, with the exception that the parents are not required to call. Even though these four clinics are well established in each community, it is necessary to make a continuous effort to keep community sources informed of these procedures and to report changes when necessary. Attempts are made to improve or alter this referral process when it appears that the existing procedure is troublesome to a particular source.

Summary

There are essentially no differences among these four clinics in three of the areas explored. All place greatest emphasis upon offering diagnostic services to clients, all express similar attitudes in advising the public how to make referrals to the clinic and these clinics educate the community as to their purpose and function through similar activities. Generally these clinics feel they are mostly serving a middle class clientele and are not reaching either extreme of the socio-economic scale as well as those living further away from the clinic offices. The caseload carried is not representative of the clinic's geographic area and measures are not taken to accomplish this. It is usually the clinical director who assumes responsibility for the community services program, but other staff members play an active role in offering similar services of educational speeches, lectures, classes and consultation.

Differences appear to be more subtle. One clinic does carry a caseload representative of counties in the service area. It is suggested that types of cases best served, community services engaged in, and those receiving most service may also be areas of difference, but more substantial data, along with criteria for measuring these characteristics are

necessary to make such comparisons. Further expleration and analysis of responses made by the various disciplines may help to reveal the nature of dissimilarities which might exist, or be inferred.

CHAPTER XII

SUMMARY AND CONCLUSIONS

The purpose of this exploratory study has been to compare the philosophies and practices of the Battle Creek, Flint, Kalamazoo and Lansing Child Guidance Clinics. The data on which the findings are based were collected primarily through interviews with key personnel at the various clinics and reflect their philosophies and attitudes. The specific areas involved in making the comparisons were: staffing patterns, intake procedures, treatment policies, financial resources, and activities in community relations. An effort was made to point out differences as well as similarities which might illustrate certain patterns affecting the overall functioning of the clinic. A number of selected problems in clinic practice were followed up utilizing both a review of pertinent literature and illustrative material drawn from one or another of the clinics.

As might have been anticipated, there is broad consensus in the general philosophies of these clinics, and many similarities in their overall functioning. Each of the persons interviewed felt that his clinic was a community agency specializing in diagnostic, treatment and consultative services in relation to emotional and personality problems of children.

The major emphasis in each clinic was seen as providing diagnostic services. Each operates within an orthopsychiatric framework. Thus, all the clinics have available the services of psychiatry, psychology, and social

work. With a few exceptions, which will be pointed out later, clinic staff usually assumed that the psychologist is responsible for the psychological testing of children and that the psychiatrist carried major responsibility for the diagnosis of children with the help of social and psychological background information obtained by the social worker. The clinics all have formalized intake procedures which usually include the referral telephone call, the screening and diagnostic interviews, and the diagnostic conference. Services are available to all minors below the age of 18 whose parents must be residents of the counties which are served by the particular clinic. Since the number of cases accepted for treatment in each of the clinics is continually greater than the number which can be treated at any one time, cases are placed on the treatment waiting list. The parents will be seen for an interpretive interview, at which time the diagnostic findings are reviewed with the parents. At the same time, suggestions are offered for handling the problem. The criteria for determining which cases are accepted for treatment vary to some extent from one clinic to another, but it is the consensus that the less severely disturbed cases, such as the psychoneuroties, coming from the well motivated families are preferred as treatment candidates. They are usually accepted for treatment from the treatment waiting list in consecutive order whenever possible. The different clinics made various exceptions to this rule, depending upon the nature of the problem and where they feel the greatest responsibility lies in providing services to the community. The largest percentage of clients served, in proportion to population, are those within relatively close proximity to each clinic.

Within the clinics, the assignment of cases is usually made on the

basis of the sex, interests, and availability of the therapists. Individual, group and drug therapy are or have been used by all the clinics, and all three disciplines are usually responsible for the treatment of both children and parents. Except for one clinic, all see most clients on a weekly basis. The administration of drugs for therapeutic purposes is solely the responsibility of the psychiatrists. Social workers are doing group therapy in all of the clinics which offer it at the present time, and in two of the clinics the groups are also led by the psychologists. In some instances, the psychiatrist may be involved in this method of treatment. The usual criteria include the type of problem, sex, age, and ability to benefit from the experience.

Treatment conferences are usually scheduled as the need arises and may be initiated by the individual therapists. In one clinic, they are scheduled regularly on a weekly basis. In all clinics, the clinic administrator is usually present and at times the conference is open to staff members not directly concerned with the case. The purpose of the conference is usually to discuss further diagnosis, questions pertaining to termination, and therapy techniques.

Decisions for termination of treatment usually involve the therapist and another staff member, who may or may not be the supervisor or administrative director. The criteria for termination usually include some form of improved social functioning.

Each of the clinics is financed through state and local funds. Sources of local funds may include the county, public schools, community chest, foundations, and others. With the exception of one of the clinics which was studied, the combined local funds are usually slightly greater

than the state funds. A wide financial base is usually preferred by all clinics with many sources contributing from the local community.

Community relations is an important function of a clinic. Although not a primary function, it is vital since the clinic is a service of and for the community. All clinics are responsible to a board of directors as well as the Department of Mental Health and are dependent on local funds for a good share of their operations. The interpretation of clinic service to the community is a continuing practice and is done through public presentations, bulletins, newsletters, individual interviews and other means.

The differences among the four clinics were sometimes quite obvious but often they were of a much more subtle nature. No claim is made in this study that all of the more subtle differences were identified or thoroughly examined; however, an effort was made to point out certain observable patterns and to speculate how they may affect the overall functioning of the clinic.

For instance, reviewing the Battle Creek clinic in these five areas suggests that staffing patterns may be related to intake and diagnosis, and treatment. Battle Creek employs its psychiatrists on a part-time consultative basis with their primary purpose being the diagnosis of a majority of the children and participation in most of the diagnostic and treatment conferences. This fact alone seems to give social workers and psychologists more responsibility and authority to make decisions. It means that in some instances, a psychiatrist will not have seen the child and sole responsibility for disposition at intake will be left up to the other two disciplines. Policies and decisions are usually arrived at

by consensus of the entire staff rather than by one person. Social workers alone participate in group therapy and the directorship of the clinic is held by a social worker.

Intake services for families begin immediately with the intake referral call and are completed within four to six weeks. This brief processing period, then, eliminates the need for maintaining a priority list for "emergency" cases. Cases with homicidal or suicidal tendencies are immediately seen by the clinic and then referred to the court or to an in-patient treatment center. Group members may or may not be seen for individual treatment interviews. Occasionally, the decision for termination will be made by an individual therapist without consultation.

The social worker-director must assume much clinical as well as administrative responsibility in the processes of intake diagnosis and treatment. In diagnosis this means that the director moderates at conferences, and that although the psychiatrist's opinion may be given greater weight, in cases of controversy, the director makes the final decision.

How the clinic perceives its role in the community may be related to intake, diagnosis and treatment. The Battle Creek clinic feels there is little pressure from community resources and sees itself as fairly autonomous in deciding which cases deserve priority, which services to emphasize, etc. The setting of fees at this clinic accounts for differences noted in intake and it affects financing and budgeting, since monies are not obtained from either chests or schools.

The Flint clinic shows a pattern of staff members working with some degree of independence. The staff is included or consulted in the

formulation of many clinical policies and other decisions. This pattern of worker independence and flexibility is observed also in the fact that all disciplines participate in diagnosis of adults and children, and all carry a treatment load of both adults and children. Perhaps it is this kind of staffing patterns and attitudes which creates an atmosphere that encourages and allows experimentation, such as family unit interviewing during intake. These personnel practices may also account for more flexible policy regarding priority of cases and assignment of cases for treatment, and for mutual staff participation in various services and therapies offered by the clinic.

Kalamazoo's pattern of community relations seems consistent with the four other aspects studied, namely staffing patterns, intake, treatment and financing. The speech therapist was added to the staff in order to handle problems in this area as well beginning where the community sees the problem. Emphasizing community relations seems related to the greater number of financial sources this clinic draws upon, and this in turn may explain Kalamazoo's attempt to represent each county proportionately on its caseload. Emphasis on community relations may also be related to clinic policy of seeing cases in treatment bi-weekly; for by doing this more people of the community can be served.

The Lansing clinic attempts to follow the goals set up by the American Association of Psychiatric Clinics for Children and emphasizes the traditional team approach. These personnel practices seem to determine much of what is done and how it is done at the clinic. In the traditional team, the psychiatrist is usually director, responsible for clinical decisions. As pointed out, in Lansing generally each case is presented

fer diagnostic staff cenference and although all disciplines participate, the director is responsible fer final diagnosis. Further the director and her assistant assign cases fer treatment to the other staff members. The director also carries out most activities in community relations.

Of the four clinics, Lansing and Kalamazoo follow the more traditional approach and have a more authoritarian line of administration. Deviation from this approach would seem to reflect the differences from the other two clinics.

In evaluating this study, it must be remembered that most of the material was obtained by interviewing selected although key staff members at each clinic. If other staff members were interviewed, the responses may have been different.

Secondly, the interview schedule used consisted primarily of open-ended questions. Since this was an exploratory project, this approach seemed most useful. Therefore, using this schedule as an outline and using the findings stated in the study, a more systematic, structured interview might be designed fer further research of this kind.

Naturally, interviewers' bias is always a hazard when personal face-to-face interviewing is done. This may be particularly true in the present study, since each student interviewed staff at the clinic where he was completing field placement. This was necessary because of time, expense and other practical considerations. Since participants in this group project reviewed and criticized each others findings, it is hoped this bias is overcome, or atleast reduced.

It should be realized that these agencies do not operate on a 'status que' basis, but rather they are dynamic agencies with a progressive

attitude toward the improvement of methods and practices.

From this study, generalizations about differences and similarities cannot be made for all child guidance clinics. Rather, it is hoped that this review may be used as a foundation for further research which will eventually lead to such generalizations.

APPENDIX A

TERMINAL NOTE

1. Name of Patient: _____

2. Date of Initial Interview: _____

3. Date of Terminal Interview: _____

4. Total Number of Sessions: _____

5. Reason for Termination: ( ) Planned termination
( ) Withdrawal by patient (explain)

6. Condition at Discharge:

( ) a. Recovered: Asymptomatic with good insight
( ) b. Markedly Improved:
( ) Asymptomatic with insight
( ) Asymptomatic with no insight
( ) c. Moderately Improved:
( ) Partial reduction of symptoms with good insight
( ) Partial reduction of symptoms with some insight
( ) d. Slightly Improved: Partial reduction of symptoms with little or no insight
( ) e. Unimproved
( ) f. Worse (Describe)

7. Areas of Improvement: (Use back of sheet, if necessary)

a. Symptoms:

b. Adjustment to Environment: (work, community, etc.)

c. Physical Functions: (appetite, sleep, sex, etc.)

d. Relations with People:

8. Patient's Attitude Toward Therapist at Discharge: (Use back of sheet, if necessary)
( ) friendly ( ) indifferent ( ) unfriendly

9. Would patient object to a follow-up letter inquiring about progress?
( ) Yes ( ) No

10. Recommendations to Patient at Discharge: (if any)

11. Diagnosis at Discharge:
12. Additional Comments (use back of sheet):

APPENDIX B

INTERVIEW SCHEDULE

1. Title and discipline of director and staff.

2. Why, how, and by whom, was this composition determined? What are the similar and distinctive functions of each discipline?

3. What is the clinic's intake procedure? How are clients accepted for intake? How is intake work assigned and to whom? Who sees various family members and what order are they seen? Does intake include the diagnostic study? What are the criteria for acceptance of cases for treatment vs. referral to another agency?

   Which of the following administer intake process:
   Psychiatrist
   Psychologist
   Social Worker

   Intake procedure includes one, more, or all of the following:

   a. Screening device — Fill out form:_____
      Call back period:_____
      Other:_____
   b. Social worker sees: Parent_____ Child_____
      Psychiatrist sees: Parent_____ Child_____
      Psychologist sees: Parent_____ Child_____
   c. Intake process includes:
      1. intake interview with child____ father__ mother___
      2. interviews with child____ father__ mother___
      specify other work
   d. Intake assignments determined by the following:
      Rotation among the staff _____
      Whoever has time open _____
      According to area of referral _____
      According to type of problem _____

4. Which of the following participate in diagnosis: Psychiatrist _____ Psychologist_____ Social Worker_____ Other_____. Who makes the final diagnostic decision? Is every case presented to a diagnostic staff?

5. Do you have a treatment waiting list and is there any priority? What are the criteria for determining emergency cases? Are they given special preference? Is there priority given to referrals from county, school, court, etc.?

6. Who does treatment and how are cases assigned? Is anticipated length

of treatment a factor in acceptance of a case for treatment? How? How often are clients seen in treatment? What is the reasoning behind this decision?

What kinds of therapies are available?

If there is group therapy, who does it? How is the group selected? What are the aims of group work? Qualifications of group therapist? What relationship between individual and group therapy?

Are there staff conferences for cases in treatment? routine_____ spontaneous_____ as needed_____? How is the above decided? What and who determines which family members will be treated?

7. How is termination decided? Client_____ therapist_____ administrator_____? What criteria are used in agency terminations? Who decides and how is the decision made?

8. For what reasons would you refer cases from this clinic to another? What community resources do you use most in referring cases?

9. Which services do you think are given most emphasis? What type of cases do you feel you best serve? Is anything done to keep representation from various parts of the community?

When in the community do you think you are serving most? What do you see as the clinic's role in offering community services? How do you advise the community to make referrals? What is your procedure in educating the community as to your purpose and function? Who participates in community education? What kinds of community relations are engaged in? Who delegates these responsibilities and to whom? What parts of the community are you not reaching?

APPENDIX C

FACE SHEET

Childs Name _____ Address _____

Fathers Name _____ Mothers Name _____

Address _____ Phone _____ Address _____ Phone _____

Occupation _____ Occupation _____

Income: Father $ _____ Comments:

Mother $ _____

Gross Total $ _____

Less 20% Approx.
Taxes & Sec. Sec. $ _____

Net Weekly Income $ _____

Special Expenses $ _____

$ _____

$ _____

Adjusted Net Income $ _____

Number in Family _____

	Amount	Date Fee Set	Date fee to begin
Intake Fee (partial)	$ _____	_____	_____
Intake Fee (Full)	$ _____	_____	_____
Weekly fee for treatment	$ _____	_____	_____

****

Fee Changes	Amount	Period Covered	Reason
	$ _____	_____	_____
	$ _____	_____	_____
	$ _____	_____	_____
	$ _____	_____	_____

FACE SHEET (continued)

Worker: Child	Diag.	Rx	Rx
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Bill To: _____

Anticipated method of payment:

Monthly Biweekly Weekly Billing

APPENDIX D

Proposed Fee Scale
Battle Creek Child Guidance Clinic

Net Weekly Income	Number in Family						
	2	3	4	5	6	7	over 7
$0 - $45	none	none	none	none	none	none	none
$46 - $50	$1.00	....	....	....	....	....	....
$51 - $60	$2.00	$1.0	....	....	....	....	....
$61 - $70	$3.00	$2.0	$1.0	....	....	....	....
$71 - $80	$4.00	$3.0	$2.0	$1.0	....	....	....
$81 - $90	$5.00	$4.0	$3.0	$2.0	$1.0	....	....
$91 - $100	$6.00	$5.0	$4.0	$3.0	$2.0	$1.00	....
$101 - $110	$7.00	$6.0	$5.0	$4.0	$3.0	$2.00	$1.00
$110 - $120	$8.00	$7.0	$6.0	$5.0	$4.0	$3.00	$2.00
$121 - $130	$9.00	$8.0	$7.0	$6.0	$5.0	$4.00	$3.00
$131 - $140	$10.00	$9.0	$8.0	$7.0	$6.0	$5.00	$4.00
$141 - $150	$11.00	$10	$9.0	$8.0	$7.0	$6.00	$5.00
$151 - $160	$12.00	$11	$10	$9.0	$8.0	$7.00	$6.00
$161 - $170	$13.00	$12	$11	$10	$9.0	$8.00	$7.00
$171 - $180		$13	$12	$11	$10	$9.00	$8.00
$181 - $190			$13	$12	$11	$10.00	$9.00
$191 - $200				$13	$12	$11.00	$10.00
$201 - $210					$13	$12.00	$11.00
$211 - $220						$13.00	$12.00
$221 - $230							$13.00

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