A NEW CONCEPT IN CRISIS INTERVENTION: II

THE DROP-IN GROUP IN A CHILD GUIDANCE CLINIC

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This presentation is the second annual report[1] of a five year, research and demonstration project titled "Open-End, Drop-In Group, Child Guidance Project" funded jointly by the San Fernando Valley Child Guidance Clinic, the National Institute of Mental Health,[2] and the Los Angeles County Mental Health Department and the State of California Department of Mental Hygiene under the Short-Doyle Program. The study is designed to evaluate the application of crisis intervention techniques, immediately available in a group format to the problems met in a child guidance clinic. Patients may either "drop in" or may call and receive a screening appointment within one or two days. At this time, the parent, or the child if he is a teenager, can explore the appropriateness for the presenting problem of short-term, supportive or crisis oriented, group therapy with a staff member. If the child is less than 12 or 13 years of age (not in junior-or senior-high school) he also may be seen but only after the parents are seen. If the problem is appropriate the child (if in junior-or senior-high school) and/or his parents are referred to the Drop-In Group for further, immediate help.

The initial screening evaluates the problem in terms only of the immediate needs--whether the problem is appropriate to the Drop-In Group, whether the problem is appropriate for further study at the Clinic or whether the patient and/or his family should be referred elsewhere for help. The screening interview is conducted with one family or one family member (one or both parents and/or child). Several interviews may be necessary to make the necessary evaluation. Usually one interview suffices

and we try to keep the interviews brief and to the point of the evaluation--about 30 minutes.

The Drop-In Group is open-ended (patients may start or terminate but the group continues) and is problem centered. To encourage use of treatment when it is needed and to avoid lessening motivation by delay, the patient may attend the Drop-In Group ad lib when the group therapist feels that it is important to recommend for or against a particular schedule. Drop-In Group for parents meets three times a week, for teenaged children twice a week and the patient may come to each session or less often. Pre-teenaged groups have not yet been established[3] but the younger child may be seen individually, if necessary. Although there is no limit to the number of times a person can be seen we try to discourage the evolution of long-term, "uncovering", group therapy by requiring the therapist to review each case after a stipulated number of interviews[4] with his supervisor. If the supervisor approves, the therapist may ask the Drop-In Group Coordinator to extend the number of interviews.

Because of the frequency of Drop-In Group meetings, the considerable demand of the group on the therapist, problems of staff logistics and other reasons, it was not possible to assign the same therapist for all Drop-In Group meetings. However, the same day each week is generally covered by the same therapist. If the therapist is ill or must be away for some reason another therapist will substitute. The group is constant, the therapist may or may not be. This situation leads to one patient often being seen by more than one therapist. The problems and some

solutions were presented in the previous report, will be touched on further in this paper and will be elaborated on in more detail in later publications.

Since this project is both complex and unique it presented many problems, some answers and stimulated or generated a few new studies. Because it is unique it is necessary to repeat some of our earlier observations to make the present remarks clear. We shall try to fill in the necessary data without unnecessary duplication in this report.

During the course of the second year of the project our observations lead us to explore changes in two areas; the nature of patients accepted in the Drop-In Group and the question of using a very liberal attitude about fees in order not to disturb motivation.

Originally the target population included children with psychologic problems whom we expected would respond to short term, group counselling for the child, himself, and/or his parents.[5] However, in the past year we found that more "types" of patients than we originally assumed could be helped were, in fact, aided by the group format. We also frequently offered brief, individual counselling which allowed a significant saving in professional and administrative time over previous forms of service. We often used the Drop-In Group to further evaluation of the patient's immediate need and avoided a more lengthy formal evaluation which might determine, for example, that the primary need was marriage counselling or psychotherapy for one or both parents instead of or prior to the child's need for psychotherapy. In such instances, we also used the group

to help the parent(s) recognize their own needs and come to a clearer definition of the problem. Similar clarification of problem and need in the Drop-In Group was used to aid patients who were uncertain what help they wanted and those whose motivation was uncertain. Some patients who could not accept the need for psychotherapy, on referral, were able to resolve their uncertainty in the group. This was especially true if a significant reason for rejecting or hesitating about psychotherapy reflected a fear of narcissistic injury by admitting need for help.

Since many more patients than we originally expected to be helped were helped we began to orient our thinking around the question of which patients should not be included rather than those whoch should be included. Contra-indications were seldom seen and this, along with a number of other observations strongly suggested that all patients might benefit from being referred to the Drop-In Group as an initial service.

One of the reasons leading us to consider referring all patients to the Drop-In Group grew out of our observation that there was a surprisingly high rate of failure to follow through on patients who were accepted for treatment in the Drop-In Service as well as those placed on our waiting lists for more definitive treatment, the former by not returning and the latter by not accepting treatment when offered it at a later date. Many of the patients who failed to accept treatment after six months to a year on a waiting list seemed to feel that the delay accounted for their lack of interest. However, this explanation was not valid for those who were offered immediate help in the Drop-In Group.

We, therefore, looked at two sets of data to develop an hypothesis to answer the question posed by this observation; the nature of the presenting problems of the patients and the nature of referral by the staff. Preliminary scrutiny of the patient data did not offer any leads but preliminary evaluation of those staff members with the highest follow through failure was quite suggestive. Those staff members whose referrals to the Drop-In Group were followed up least well were also the same ones who stated in staff conferences their feeling that short-term counselling is a second best or even second rate therapy. We postulated that their patients perceived the referral to the Drop-In Group as a delay and/or rejection and therefore, reacted just as if they had been placed on a waiting list. One means to cope with this problem would be to refer all patients to the Drop-In Group which would then be used for several new functions in addition to those for which it had heretofore been used; namely, an extended evaluation or screening and an added aid to help tide the patient over acute problems until more definitive treatment could be offered. This should be able to overcome any staff feeling that the Drop-In Group was second best and also would allow us to evaluate the use of the Drop-In Group for a larger variety of patients.

Therefore, we recently began to offer all applicants the use of the Drop-In Group as an initial clinical service unless the patient seriously objects or we feel that this service could harm him or he would harm the group. This procedure serves several purposes in addition to those for which the Drop-In Group has been used:

1. It offers immediate and interim supportive assistance.
2. It amplifies the diagnostic information obtained in the brief screening.

3. It further explores the types of patients who can benefit from short-term, group counselling.
4. It explores (and hopefully strengthens) motivation in marginally motivated families.
5. It weeds out the drop-outs at an earlier stage allowing us to:
   a. Attempt to explore and support motivation further and earlier than if we place on a waiting list.
   b. It saves administrative time of maintaining and servicing a waiting list composed of patients who at best do not accept and at worse fail individual diagnostic appointments.

Although we have made some modifications in the project which may influence some of the factors contributing to follow-through failure we are still quite concerned with other aspects of the problem and are examining patient data more intensively. These data include the nature of the presenting symptoms, precipitating factors, duration of illness, reasons for referral, demographic and other factors for leads to indicate common factors in these patients. We also are studying the screening methods of the high follow-through and high follow-through failure staff members for empirical leads.

Our second major change in the conduct of the service grew out of some of our observations of patient and staff reactions to the Drop-In fee structure. Initially, in order to increase motivation to make use of the Drop-In services, we planned to remove as many obstacles to obtaining help as possible. One approach, of course, was to eliminate any wait. Another was to charge no fees for initial screenings nor for teenagers attendance

at the Drop-In Group meetings and to allow parents to elect whether and what fee to pay. We have not seen any great amount of guilt mobilized by this procedure although a few patients have elected to pay unnecessarily high fees. However, guilt over non-payment or an expectation that the service was of low worth because of low fees could have been present and might have been overlooked because the nature of the service did not allow us to tap those transference affects. It is also possible that this consideration supported the attitudes of those staff members who relate to the Drop-In Group on a second-best form of treatment. We do know that the average fees paid fell quite short of the ability-to-pay scale which is accepted readily for other Clinic services. One month Drop-In fees averaged under $.90 a visit in contrast to much higher fees in our own and other comparable clinics ($2-5). In order to test whether fees are a deterrant to seeking service we plan to institute a fee program more consonant with that of the other Clinic services after the first of the year. This change should also give more information about client reaction to the fee schedule since many patients will have had experience under both programs.

Another function of the Drop-In Service on which we will report is our continued attempt to refine data collection, storage and retrieval methods. We have continued experimenting with a check list format and the following series of form (See Figures 1, 2, & 3) shows the evolution of our screening forms from the earliest to the most current.

INSERT FIGURES 1, 2 & 3 ABOUT HERE

Although staff consensus is that we lose some of the "flavor" or "color" of a narrative clinical statement, the check list allows for prompt and

easy review of records when the patient drops in for a subsequent visit. The more subtle inferences are included in a brief, narrative amplification appended to the end of the check list. We have also found it necessary to develop a manual for orienting new staff members to the check list but we expect that the forms will become familiar enough to do away with the manual after a short period of practice. (See Appendix B for manual)

In order to retrieve groups of data for investigative purposes, we plan ultimately to use an electronic data storage and retrieval system such as the IBM system. Until such time as we are able to institute such a program we have developed a much more simple, manual, punch card, sorting system which can be operated by the large staff of lay-volunteers which are available to the Clinic. We have developed a training program for the volunteers and have developed a manual of instructions for punching the cards (see Appendic C). A "mock-up" of a card ready for punching is presented in Figures 4 & 5. Using these cards will allow us to explore the inter-relation

Insert Figures 4 and 5 about here.

of many patient and therapist variables and will give us the necessary background on which to develop a more elaborate data library.

We have been fairly successful in designing a useful recording instrument for the screening interviews but as yet have not been able to evolve a similar instrument for the treatment interviews. We hope to have accomplished this in time for our third report on the Drop-In Service.

Our success in "streamlining" the recording as well as the conduct of the screening interview was one instrumental factor in developing another Clinic project, the training of Case Aides who now perform most of the functions

of the screening interviews. The Case Aides are another group of volunteer women who undergo a one year training program at the Clinic. At the end of the didactic part of their training they begin to do the screenings under supervision of a professional staff person after first observing the staff person doing screenings. The Case Aides perform other Clinic functions, also under professional supervision but since the Case Aide training program was described in another publication (1) we will not go into detail here. Ten Case Aides started with the Clinic in December, 1965. One dropped out due to illness. One was employed by the Clinic and eight continue to contribute one to $1\frac{1}{2}$ days a week each. In December, 1966, we started our second group of 12 Case Aide Trainees.

Although at this writing it is too early in the history of the Drop-In Project to report patient-response data, our follow-up questionnaire to discharged patients has already revealed a significant problem in that a large percent of patients and parents who had been referred elsewhere because their initial referral to our Clinic was not appropriate were quite dissatisfied and felt that we had not offered any help. Many such patients did not carry out the referral recommendation and this lead us to consider using patient advocates in our middle-class clinic population as we and others do in the clinics' lower economic classes. We are now training a group of non-professional, case-aides whom we will assign to the function. In addition to using patient advocates, we have become aware of the need to structure referrals as a positive recommendation (not, "we are unable to help you..." but rather, "you will get more appropriate help at...but if you have any trouble please let us know".) and to give more comprehensive explanations as to why the referral is necessary. We

also must change our philosophy from making a referral to exploring the needs for and purpose of the referral with the patient. This is especially important since a patient will readily understand that his physician can not help him with his psychiatric problems but often they do not appreciate that we are not an all purpose psychiatric clinic and are, therefore, limited from offering some forms of psychiatric and case-work services.

As suggested above, reaction of professional staff continues to be a somewhat troublesome area but one which is responding to experience and education. Overt staff resistance to the project has disappeared but latent resistance appears in many guises. We assume that the resistance reflects a reluctance to change from older and still more secure methods of operation as well as a continued tendency to perceive dynamic or "psychoanalytic" therapy as of a higher status than problem centered therapy. That these explanations do not account fully for the staff resistance is suggested by the fact that it has not responded as well as could be expected to the considerable enthusiasm with which the Drop-In Service was accepted by senior persons and psychoanalysts on our own staff and in the community. Inspection of records revealed that the staff who had most difficulty to use the Drop-In format were those who tended to some degree to use psychoanalytic theory in an intellectual manner in their psychotherapy, i.e., they protected themselves from counter-transference anxieties by intellectualizing about "psychoanalytic interpretations". Since the Drop-In format requires a more intensive and active involvement of staff, this type of therapist would necessarily feel less comfortable. Further support for this hypothesis came from one therapist who spontaneously reported that as he felt the demands for involvement increase in the Drop-In service he became more rigid and stereotyped in

his responses which problem he also encounters in intensive, expressive psychotherapy.

Some other ways in which these resistances manifest themselves are by:

1. Failing to use forms properly or not using them at all.
2. Persistently misinterpreting the requirement to review each case with their supervisors after "X" visits, which procedure was devised as a means to check counter-transference problems and over-identification with the patient which might lead the Drop-In Group to become ongoing, closed, group therapy. Instead they relieve themselves of responsibility and guilt by telling patients that the "policy", "project", director, etc., will not permit more than "X" visits, although they need not and are asked not to set any time limit with the patient.
3. Some children who could use the Drop-In Group are denied admission as a result of the therapist's over-identification with the patient and feeling that this is only supportive. Frequent rationalizations are that the patient needs more help or that he will disturb or be disturbed by the group or that he will become disillusioned by the superficial nature of the group.

In general, however, the core staff in the Drop-In Group Project are committed to an objective evaluation and their evaluation to date is that it does serve a useful service to most clients for whom it is predicted to be helpful and also to many others.

Some indication of the impact of this program on the child guidance clinic community can be seen in the fact that clinics throughout the United States, Canada, and one in Prague, Czechoslovakia, have expressed an interest in

the Drop-In Service and many have developed similar projects of their own. We also have added a second Drop-In Service to our satellite clinic in a low-income, minority ethnic neighborhood. A partial list of other

INSERT TABLE 1 ABOUT HERE

clinics which have expressed an interest in our Clinic are presented in Table 1.

Summary:

We have presented a report of the second year of operation of a new approach to child guidance clinic services and have outlined the project and discussed our findings in regard to the kinds of patients able to be benefitted; to problems of failure to make use of the service and the contribution of both staff and patient variables to this problem; the relevance of fees to motivation; methods of data collection, storage and retrieval; staff reaction to the project and the development of several new projects as a serendipitous effect.

IHW:sm/12-14-66

INTAKE SUMMARY

Therapist_____ Name_____

Date_____ Person Interviewed_____

REASON FOR APPLICATION AT THIS TIME:

PRESUMPTIVE PRECIPITATING FACTORS: (To what does parent or child attribute his difficulties)

SIGNIFICANT DEVELOPMENTAL OR BACKGROUND FACTORS:

IMPRESSIONS OF: PARENTS.

FAMILY SITUATION

CHILD

INTAKE SUMMARY Cont.

SUITABILITY FOR GROUP: PARENTS

CHILD

RESPONSES TO PRELIMINARY SUGGESTIONS AND RECOMMENDATIONS:

PARENTS.

CHILD.

POSSIBLE GOALS, DISPOSITION:

INCOME, FEE:

SCREENING SUMMARY

Therapist_____ Child's name _____

Date _____ Person interviewed_____

Record the following information where pertinent:

Reason for application at this time - for each item checked, indicate with whom and whether at school, home, in peer activity or elsewhere.

I.	At School, with whom	At Home, with whom	With Peers, with whom	Elsewhere, with whom
Over affect'nte	☐_____	☐_____	☐_____	☐_____
Hyperactive	☐_____	☐_____	☐_____	☐_____
Rebellious	☐_____	☐_____	☐_____	☐_____
Withdrawn	☐_____	☐_____	☐_____	☐_____
Aggressive	☐_____	☐_____	☐_____	☐_____
Inattentive	☐_____	☐_____	☐_____	☐_____
Other	☐_____	☐_____	☐_____	☐_____

What?_____

IA. Present Stress. Nature of complaint. Where appropriate, describe & identify person involved:

- ☐ Change of school
- ☐ School pressure for help
- ☐ School phobia
- ☐ Anti-social behavior
- ☐ Physical illness
- ☐ Recent death
- ☐ Birth of sibling
- ☐ Recent separation
- ☐ Recent divorce
- ☐ Recent marriage
- ☐ Home moved
- ☐ Pt. frustrated dependency needs
- ☐ Parent's " " "
- ☐ Other What:_____

Neurotic Symptoms

- ☐ Enuresis
- ☐ Soiling
- ☐ Nervous mannerisms
- ☐ Other
  What _____
- ☐ Anti-social behavior
  List:_____
- ☐ Suicidal
- ☐ Other
  What_____

resumptive Precipitating Factors - to what does parent or child attribute difficulty?

ignificant Developmental or Background Factors:

thnic Origin_____ Religion_____

Impressions of:
Parents:

Family Situation:

Child:

Disposition:

	Fa	Mo	Pt	Oth
A. Drop-In Group				
B. Cl. Wtg. List				
C. Screening				
D. Emer. Diag. Eval.				
E. Referral Out				
F. Pending				
G. No Refer. closed				

See Item # 8 below

Reason for disposition B thru G.

Interviewees response to Disposition: Reason:

Accept Accept & reserve Reject

Recommended focus and goals - DIG only.

	Fa	Mo	Pt	Ot
Clarify areas of concern				
Identify needs				
Gratify needs				
Mobilize affect (help parents/child feel emotion).				
Support strengths				
Resol. of crisis				
Catharsis (Discharge)				
Other; What				

Please explain recommendation and identify crisis and the resolution desired.

come_____ DIG Fee_____ Registration Fee_____

ate letters sent to _____ M.D. _____ School _____ Other (Specify)

SCREENING SUMMARY

Date _____ M F - N C S O Child's Name _____ Age _____

Interviewer _____ Interviewee _____

Income _____ DIG Fee _____ Registration Fee _____

Date letter sent to _____ M.D. _____ School _____ Other _____ Specify

1a. PRESENTING & RELATED PROBLEMS

1b. SUMMARY - Check appropriate boxes

home	schl	peer	AGE OF Onset	Disap.

Immature
Hyperactive
Sht.attn.span
Inattentive
Demanding
Bossy
Fighting
Argumentative
Doesn't Obey
Withdrawn
Underachiever
Stealing
Truancy
Sex actg. out
Jealousy
Other - what?

Neurotic Symptoms

Enuresis
Soiling
Fire Setg.
Obs.compl.
Accid.prone
Nail biting
Lying
Anxiety
Depression
Suicidal
Nightmares
Obesity
Tic
Stuttering
Phobias -
Schl.phobia
Psy-som.
Other

AGE OF Onset	Disap.	Specify

2a. PRECIPITATING FACTORS - Indicate whether seen by P.C.I. and if related to coming to Clinic or present illness.

SUMMARY - Indicate by date and by whom perceived. If item relates to why patient comes to the Clinic, insert the number "1" in the box; if it relates to the precipitants of the present illness, insert "2"; if both, insert "3".

	P	C	I
Home moved			
Chg. school			
Pressr. help by			
☐sch.☐probation			
☐M.D.☐other			
Just learned of service			
Accum.fam.stress			
Accum. stress in pt.			
Symptoms worse			
Par.inabil.cope w/new beh.			
Financial stress			
Chg. income			
Chg. soc. status			
Phys. illness			
Birth of sibling			
Incest			

Date	P	C	I
Recent death			
Marital difficulty			
Separation			
Divorce			
Marriage (who?)			
Pt.frustr.dep.needs			
Par. frustr. dep. needs			
Peer influences			
Sibling influence			
Proj. par. impulses			
Paternal rejection			
Maternal rejection			
Paternal pressure			
Maternal pressure			
Other fam. stress			
Other chg. fam. comp.			

FACTORS SIGNIFICANT TO DEVELOPMENT OF PRESENT ILLNESS.

A. Narrative

B. Summary

	Ages	
Preg. unwanted P		Hyperactive
Preg. unwanted M		Mat.intol.of act
Diff. delivery		Pat.intol.of act
Birth injury		Marital probs.
Excessive need		Divorce
Major illness		Proj.par.impls.
Sickly		Retardation
Mat. rejection		☐recog.☐unrecog.
Pat. rejection		☐mental☐physical
Mat. illness or inj.		☐developmental
Pat. illness or inj.		Mat.seductiveness
Mat. absence		Pat.seductiveness
Pat. absence		Sibl.seductiveness
Freq. siblings		Compet.stim by M
Sibl.illness or inj.		Compet.stim by F
Phys. limitations		Compet. stim. by sib.

Ages	
	Unrec. precocious.
	Compet. from M
	Compet. from F
	Compet. from sibl.
	Overprotection
	Mat. hostility
	Pat. hostility
	Sibl. hostility
	Situat. intol-activ.
	Mat. presr. to perform
	Pat. presr. to perform
	Mat. strictness
	Pat. strictness
	Other _____

DO NOT WRITE IN BINDING MARGIN

DO NOT WRITE IN BINDING MARGIN

4. INTERVIEW PARTICIPATION

A. Narrative.

B. Interviewee's assignment of Primary Responsibility for P.I. Check columns labeled L (little), M (moderate), or C (considerable) if interviewer agrees.

	L	M	C
M			
F			
P			
O			
I			

C. Interviewee's Assumption of Changes Necessary.
Comments:

☐ Patient ☐ Other
☐ Spouse ☐ Self
☐ Sibling ☐ Family

D. Hopefulness: ☐Hopeless ☐Low ☐Moderate ☐High ☐Excessive

E. GENERAL - Indicate who by putting M, F, or P in box.

☐ Neat	☐ Unkempt	☐ Attractive	☐ Unattractive
☐ Talkative	☐ Changing sub.	☐ Cheerful	☐ Disruptive
☐ Quiet	☐ Follows sub.	☐ Depressed	☐ Hyperactive
☐ Interruptive	☐ Attentive	☐ Anxious	☐ Domineering
☐ Aloof	☐ Disinterested	☐ Angry	☐ Oppositional
☐ Evasive	☐ Compliant	☐ Passive Agg.	☐ Distraught
☐ Coy	☐ Pleasant	☐ Fearful	☐ Other (what

5. DISPOSITION

M	F	P	O	
				Intake Waiting List
				Screening
				Emergency Screening
				Referral out
				Pending
				Closed
				Drop-In Group

Give reason for disposition.

DIG Focus and Goals
Identify and specify where indicated.

M	F	P	O	
				Clarify concern
				Identify needs
				Gratify needs
				Mobilize affect
				Support strength
				Resolution of crisis
				Catharsis
				Education
				Diagnostic
				Other, what?

ason for inclusion in D.I.G.:

] Routine ☐ Crisis reaction ☐ Crisis anticipation ☐ Exacerbation
] Anticipated exacerbation ☐ Need for support ☐ Explore motivation

RESPONSE TO RECOMMENDATION:

☐ Accept ☐ Accept with reserve ☐ Reject

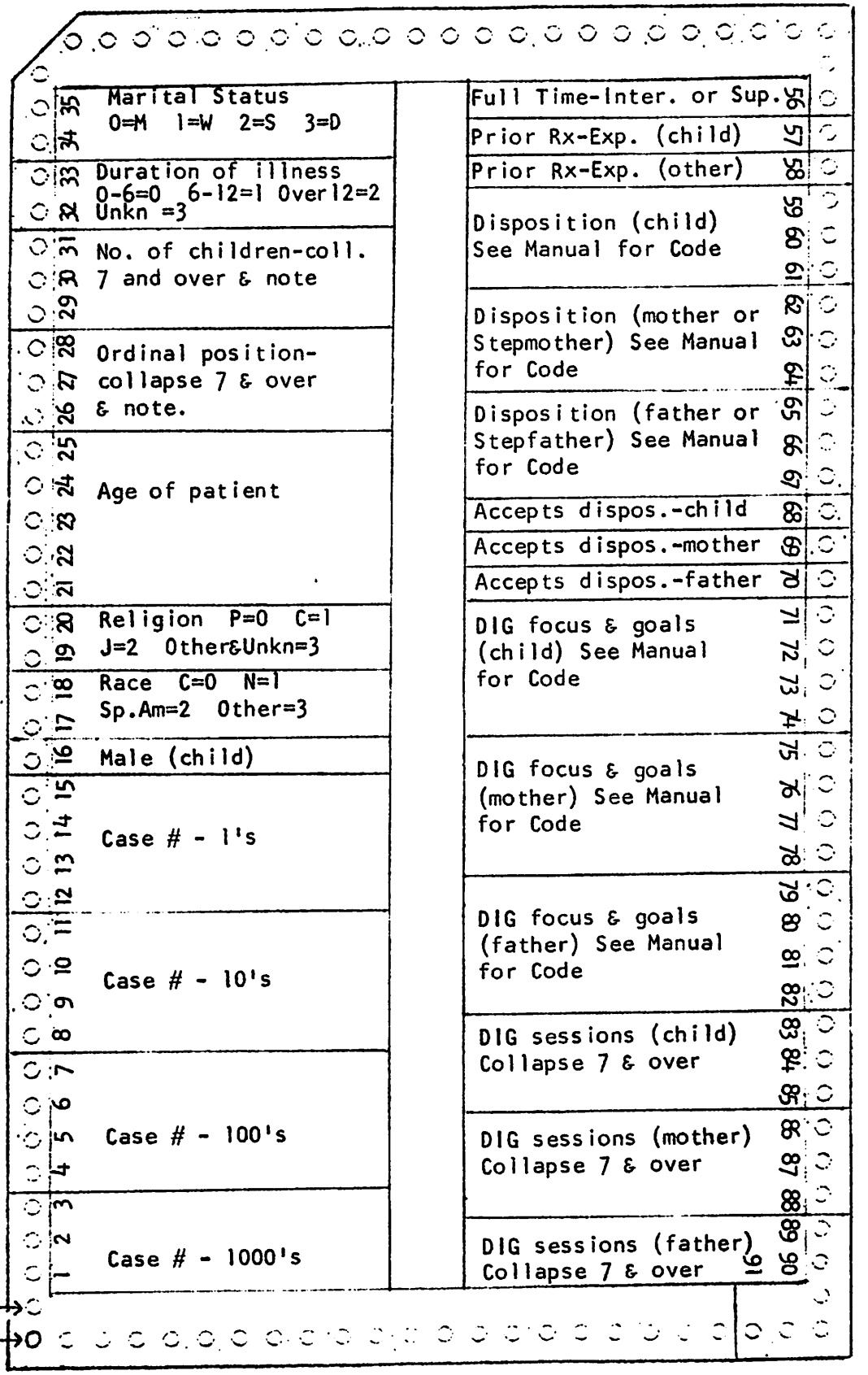
PROVISIONAL DIAGNOSIS (only if child seen) _____

WHAT WOULD YOUR RECOMMENDATIONS HAVE BEEN IF WE WERE NOT REFERRING ALL PATIENTS TO THE DROP-IN SERVICE AT THIS TIME?

ADDITIONAL NARRATIVE (if needed).

DO NOT WRITE IN BINDING MARGIN

CARD NUMBER 1



0 - Pacoima Case

00 - Presence of unusual events not included in research data but of significance such as mixed ethnic back ground, parent convicted of felony, formerly very wealthy family, etc.

FIGURE NO. 4

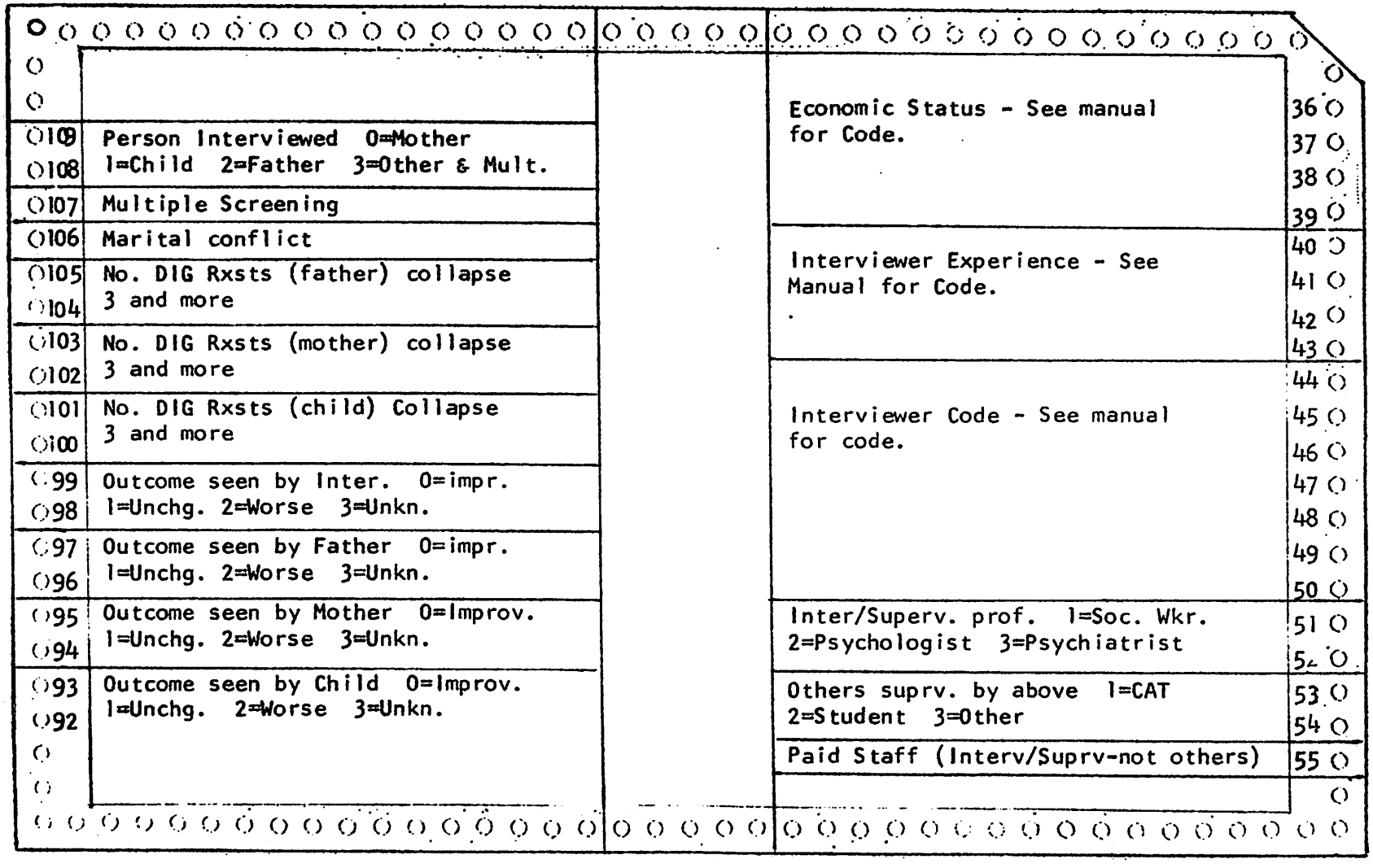


FIGURE NO. 4 Cont.

CARD NUMBER 2

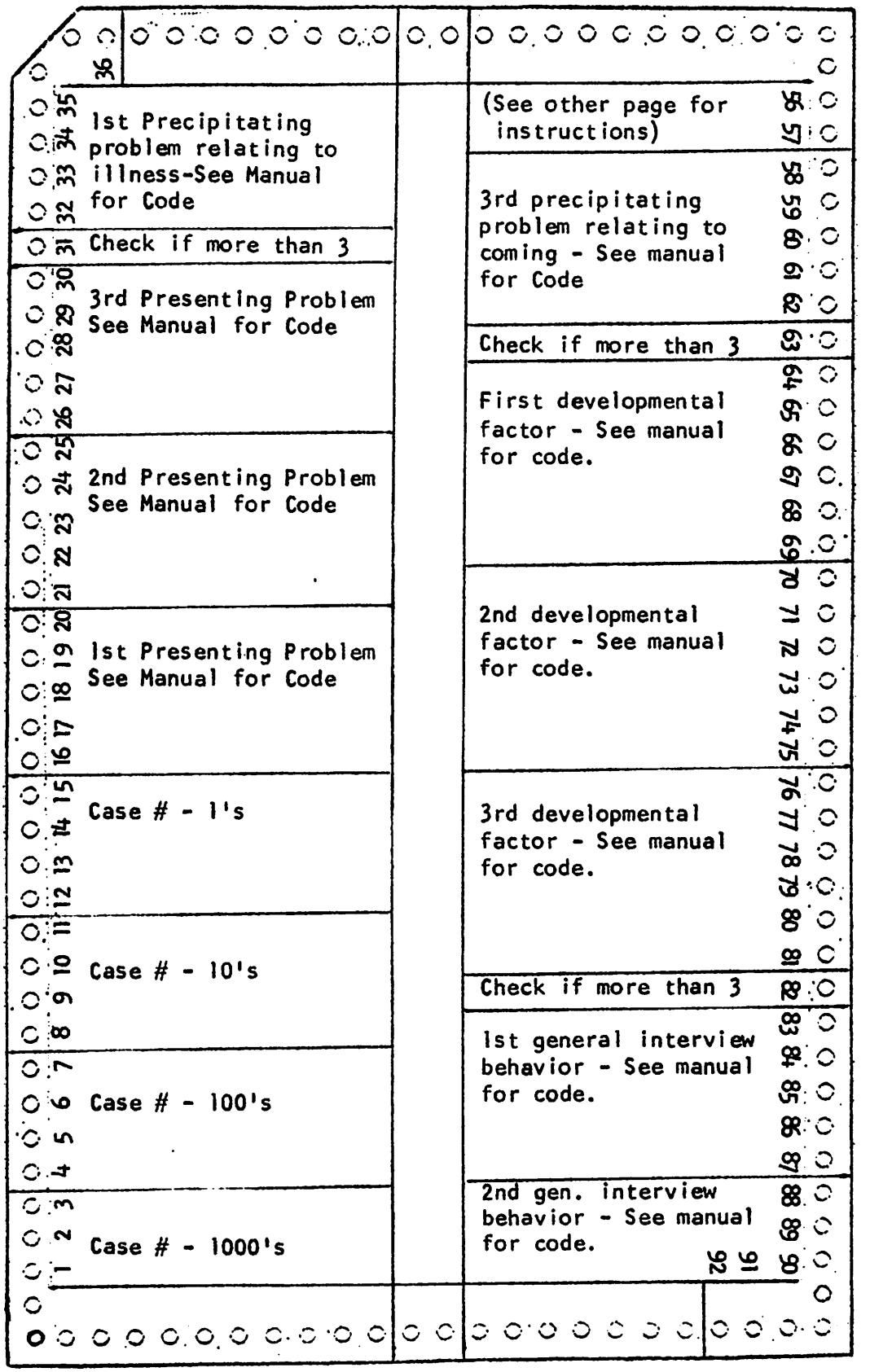


FIGURE NO. 5

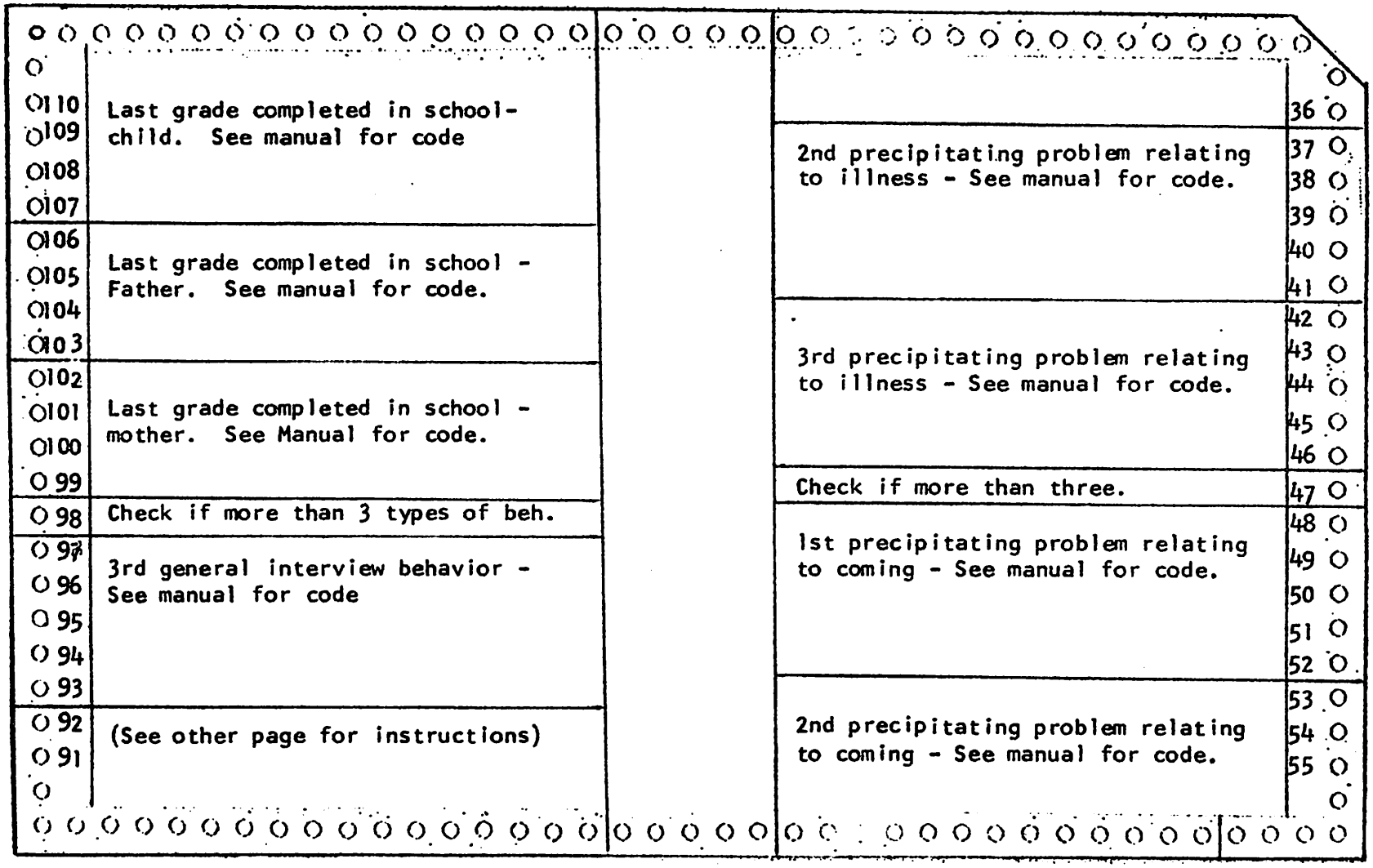


FIGURE NO. 5 Cont.

CARD NUMBER 2 Cont.

APPENDIX A

Notes on Drop-In Group Meeting

The following remarks are summaries of pre-planning meetings of Mr. Barricklow and myself as well as my recollection and my notes from meetings on Tuesdays January 12 and 19, 1965. The topic covers criteria of acceptability and referral.

Two over-riding comments are made which apply to all acceptable patients.

1. all children who are acceptable to the Drop-In Group must be able to make use of the service either directly or to their parents in the short time allotted. Such use must be expected to be more effective than another available service.

2. if more definitive help is needed and/or is available following acceptance of the patient to the Drop-In Group, the service would also include referral for the available service.

Nine categories of children would be acceptable to the group under these above, two overriding categories. They will be listed alphabetically to set them apart from the first two.

A. Teen-age children suffering from acute or recent changes of behavior related to current life or other "superficial" situations.

B. Parents of teen-age children and those of other ages suffering from acute or recent changes of behavior related to current life or other "superficial" situations.

C. Teen-age children who anticipate the possibility of some problem in adjusting to a new life situation.

D. Parents of teen-age or other children who anticipate the possibility of some problem in their child's adjustment to a new life situation.

E. Children who anticipate the possibility of some problem of adjustment to an anticipated change in a life situation or other new life situations.

F. Parents of teen-age children or younger children who fulfill the criteria of Group 5.

G. Any acute exacerbation or anticipated exacerbation of an existing or chronic emotional problem presented by a teen-age child or the parent of any child through teenage which is paradigmatic to any of the first six items.

H. Children who are suffering from acute or chronic emotional problems for which there is clinical evidence to indicate the possibility of

being helped within the limits of the situation even though a cure or major resolution would not be expected.

I. Acute or chronic emotional problems presented by teen-age children or parents of children of teen-age where motivation is marginal and in which there is reason to believe that the child or his parents could be expected to consolidate the conception of the problem and resolve doubts about the motivation within the scope of the project.

Exclusion from the project would be simply stated as applying to all children who could not meet one of the above nine criteria as subsumed under the two overriding criteria. Examples could, but would not necessarily nor regularly, include most long standing symptoms, chronic psychosis or borderline state and mental retardation per se. Even in these three diagnostic categories it would be conceivable that numbers of children might be found who would meet the acceptability criteria and could be included.

I. Hyman Wailand, M.D.

IHW:lb

January 20, 1965

SCREENING SUMMARY MANUAL

Note that in the Screening Summary, most items have a narrative as well as check list form. The narrative is only to be used to amplify on or specify about check list items where necessary and to include data that are not covered in the check list.

In general, the presenting problem refers to those complaints that the patient or his family describe spontaneously or in response to question as contributing to their concern about the child. Precipitating factors relate, as also stressed below, to two aspects: one, the reason the patient elects to come to the Clinic at this time; and two, recent events that have precipitated the appearance of currently disturbing symptoms. Developmental history, on the other hand, relates to all events in the family or the previous life of the child that have contributed to the development (in contrast to precipitation) of the neurosis. The mere presence of an event in the life of the family (example - moving from one community to another) does not necessarily imply that this move is related to either precipitation or causation of the neurosis. This must be determined by the interviewer on the basis of the total clinical picture.

General Instructions

At top of page "Date" = date of interview. Child's Name = child-patient. MF-NCSO = male/female-Negro, Caucasian, Spanish surname, other.(Circle appropriate initial). Circle "S" only if child lives in Spanish-American culture. If "O" is circled, identify (e.g. Japanese, Indian). Write in if parent(s) are of different race.

Interviewer = person conducting interview.

Interviewee = person interviewed.

Income = total family income. Indicate if per month or per year. If accurate information not available ask parent to estimate.

DIG fee - Drop-In group fee.

Date letter sent to _____M.D.= requests date information request was sent to child-patient's physician. _____School = ditto re school. _____other - ditto re other source of information.

1a. PRESENTING AND RELATED PROBLEM
General complaints about patient as stated by interviewee. Under "1a" write in only pertinent facts which cannot be covered under 1b.

1b. SUMMARY
Check appropriate boxes and give ages of onset and disappearance for each item checked. Home, self and peer refer to where item occurs and more than one can be checked. Age of onset and disappearance should be inserted to nearest approximation and if unknown write "unk". If still present insert "pres" in "Disap" box.

"Specify" column allows describing e.g. type of phobia or psychosomatic symptom, etc. If symptoms were always present, write "birth" in "onset" column.

Most terms are self-explanatory (s.e.) and for others there are brief definitions or examples of the neurotic symptoms listed:

Immature -	s.e.
Hyperactive -	More active than normal - needs to be on the go.
Sht. att. span -	Short attention span - looses interest quickly.
Inattentive -	s.e.
Demanding -	s.e.
Bossy -	s.e.
Fighting -	s.e.
Argumentative -	s.e.
Doesn't Obey -	s.e.
Withdrawn -	Remains by self - does not play with others.
Underachiever -	Not achieving up to ability in skills and tasks.
Stealing -	s.e.
Truancy -	From school or run away from home
Sex actg. out -	Sexual promiscuity or other inappropriate sexual behavior
Jealousy -	s.e.
Other - what? -	s.e.
Enuresis -	Bed wetting
Soiling -	Loss of bowel control--not necessarily constant
Fire stg. -	Intentional
Obs. compl. -	Obsessive compulsive - repetitive and meaningless actions
Accid. prone -	frequent accidents. which pt. feels compelled to
Nail biting -	s.e. execute
Lying -	s.e.
Anxiety -	Severe episodic uneasiness
Depression -	Excessive sadness.
Suicidal -	Threatened or attempted.
Nightmares -	s.e.
Obesity -	Overweight
Tic -	Twitching movements of eyes, face, shoulders, etc.
Stuttering -	s.e.
Phobias -	Specific fears (e.g. of dogs)
Schl. phobia -	Fearful of going to school.
Psy-som.	Psychosomatic - (e.g. asthma, ulcer, & other physical illnesses
Other -	s.e. w/emotional causes.

2a. PRECIPITATING FACTORS - Specific reason or reasons for seeking Clinic help now. and precipitants of present illness.
NOTE: P means parent, C means child, I means Interviewer.

2b. SUMMARY - Follow directions. Definitions follow.

Definitions

Home moved -	s.e.
Chg. School -	s.e.
Pressr.help by -	Outside pressure for help
Just learned of service -	s.e.
Accum. fam. stress -	Repeated small family problems-straw that broke camel's back.
Accum.stress in pt. -	Repeated small problems for patient
Symptoms worse -	s.e.
Par.inabil.cope w/new beh.-	Parents not able to cope with new behavior of patient.
Financial stress -	With or without change in income
Chg. income -	With or without financial stress
Chg. social status -	Upward or downward social change
Phys. illness -	Patient's illness
Birth of sibling -	s.e.
Incest -	Sexual behavior or acts between parent and child or between siblings.
Recent death -	In family or close associates
Marital difficulty -	s.e.
Separation -	s.e.
Divorce -	s.e.
Marriage (who?) -	s.e.
Pt. frustr. dep. needs -	Something has happened to cause patient to lose gratification of needs to be dependent.
Par. frustr. dep. needs -	ibid. re: parents needs (e.g. father becomes ill and mother can no longer receive support)
Peer influences -	Peers cause patient to come for help or cause patient to develop presenting symptoms.
Sibling influences -	ibid. siblings
Proj. par. impulses -	Parents expect patient to do what they are tempted (consciously or unconsciously) to do.
Paternal rejection -	s.e.
Maternal rejection -	s.e.
Paternal pressure -	Push child beyond his ability.
Maternal pressure -	Push child beyond his ability.
Other family stress -	s.e.
Other chang. fam. comp. -	e.g. brother leaves for college.

3. FACTORS SIGNIFICANT TO DEVELOPMENT OF PRESENT ILLNESS.

A. Narrative - In this section we are most interested in causative influences--in Section 2 we are interested only in precipitating factors. State factors in child's development which might have some bearing on present illness; i.e. difficult birth, premature, etc. Remember, write in only what cannot be marked under 3b.

3b. SUMMARY
This will be the interviewer's interpretation.

Definitions

Preg. unwanted P -	P = by father
Preg. unwanted M -	M = by mother
Diff. delivery -	Difficult delivery of patient at birth
Birth injury -	s.e.
Excessive need -	Problems stem, in part, from pt. needing more of some gratification than he can normally expect to obtain.
Major illness -	s.e.
Sickly -	s.e.
Maternal Rejection -	s.e.
Paternal Rejection -	s.e.
Mat. illness or inj. -	s.e.
Pat. illness or inj. -	s.e.
Maternal absence -	s.e.
Paternal absence -	s.e.
Freq. siblings -	s.e.
Sibl. illness or inj. -	s.e. (e.g. guilt because of)
Phys. limitations -	Due to illness or defect
Hyperactive -	Constitutional
Mat. intol. of act -	Mother not able to tolerate normal activity.
Pat. intol. of act -	Father " " " " "
Marital Problems -	s.e.
Divorce -	s.e.
Proj. par. impls. -	Parents expect patient to do what they are tempted (consciously or unconsciously) to do.
Retardation -	s.e.
Mat. seductiveness -	Unnecessary stimulation by parent--father wrestling with teenaged daughter - Son sleeping in bed with mother.
Pat. seductiveness -	" " " " " "
Sibl. seductiveness -	" " " " " "
Compet. stim by M -	Mother pushes child to compete excessively.
Compet. stim by F -	Father pushes child to compete excessively.
Compet. stim by sib. -	Siblings push child to compete excessively.
Unrec. precocious. -	s.e.
Compet. from M -	Mother competes with patient.
Compet. from F -	Father competes with patient.
Compet. from sibl. -	Siblings compete with patient.
Overprotection -	s.e.
Mat. hostility -	s.e.
Pat. hostility -	s.e.
Sibl. hostility -	s.e.
Situat. intol-activ. -	e.g.: can't play because apartment too small.
Mat. pressr. to perform -	Mother pushes child to perform beyond capacity.
Pat. pressr. to perform -	Father pushes child to perform beyond capacity.
Mat. strictness -	s.e.
Pat. strictness -	s.e.
Other -	s.e.

4. INTERVIEW PARTICIPATION - Interviewer's impressions of interviewee.

   A. Narrative. General comments to elaborate on or not covered in check lists.

   B. Check box to indicate that person whom interviewee feels is most responsible for present illness - M (mother), F (father), P (child patient). Interviewer checks I (Interviewer) if he agrees.

   C. That person whom the interviewee feels must change in order to resolve the presenting problem.

   D. How hopeful is interviewee for improvement.

   E. All items s.e.

5. DISPOSITION

   First box refers to disposition of each family member (mother, father, child patient, other). Second column indicates goals for Drop-In Group therapist.

   Reason for inclusion in D.I.G.

   1. s.e. 2. Becuase of crisis in family. 3. Expected.Crisis. 4. Problem suddenly worse. 5. s.e. 6. To support person in problem solving. 7. To assess person's desires for help.

6. RESPONSE TO RECOMMENDATION.

   s.e.

7. PROVISIONAL DIAGNOSIS (only if child seen) - Use standard APA nomenclature.

8. WHAT WOULD YOUR RECOMMENDATIONS.....ETC. - To elaborate on or for items not covered above.

APPENDIX C

MANUAL FOR RESEARCH AIDE TECHNICIANS

Except for numerals, a punch always indicates the presence of the item in question: i.e. punching for "male", item #16, means that the child is male, a boy. Numeralled items, i.e. those with 1-2-4 etc., are used to indicate code numbers, ages, etc. Except for the case number (q.v., infra) the particular number is designated by punching that combination of numbers which total the code number desired. Always start with the largest number in the designator which is less than the desired code number. Then use the next largest number which is less than the difference between the code number and the first number used. Continue thusly until the code number is represented by the combined totals. Designator numbers are selected so that any code number up to the highest needed can be obtained.

Example: To indicate the therapist code number, #85, we note that the punch card holes 44, 45, 46, 47, 48, 49, 50 are assigned designator value of 1, 2, 4, 8, 16, 32, 64 respectively.

The largest value less than 85 is 64, leaving a difference of (85-64)=21. We punch hole #50 (for 64) and note that the designator 16 is the largest under 21 leaving a difference of (21-16)=5. Therefore, we punch hole #48 (for 16) and in like manner punch holes #46 and #44 for 4+1=5. We now have completed the code number 85 and can verify it as follows:

#50 = 64
#48 = 16
#46 = 4
#44 = 1

Total 85

The reason we use this somewhat complicated method is that it allows us to represent large numbers in a relatively small number of spaces. Thus, the seven spaces used for the interviewer code allows us to use any code number from "0" through "127". You will find the procedure to become much easier after some practice.

Case Number:

The Case Numbers are coded somewhat differently to reduce the amount of computation which would be required to represent large numbers. Thus, we have broken down the case numbers into four separate digits each of which represents 1000's, 100's, 10's, & 1's respectively. We have allowed for up to seven in the 1000's and nine in the 100's, 10's, and 1's to enable us to record case numbers up through 7999. To punch for case number 3079 we first note that there are three 1000's, "0" 100's, seven 10's, and nine 1's. Holes #1, 2 & 3 are assigned values of 1, 2 & 4 so we punch holes 2 & 1 for values 2+1 or 3(1000's). Holes 4-7 represent the hundreds and we punch none since our case number has no 100's. To designate the seven 10's in 3079 we note that the 10's are represented by values of 1, 2, 4 & 8 on holes 8-11 and therefore, punch hole #10(4), 9(2) and #8(1) -- 4+2+1=7. Similarly for the 1's we punch 15(8) and 12(1) to show "9".

Multiple Screenings:

Punch one card for each. & punch "00".

Card Codes

See sample cards for location of code numbers.

Note 1: Always write explanatory data on your punch cards when necessary.

2: Whenever instructions say to collapse numbers over a certain amount (e.g. collapse if more than seven children) this means only that you use the number to indicate that number or more (in the case of the number of children you would use seven to indicate seven, eight, nine etc). When you collapse numbers always write in the actual number.

3: Whenever writing notes place the code number of the item referred to on the left of your comment. Thus, to indicate that there are more than seven children in the family your note would read:

(29-31--Ten children)

CARD NUMBER 1

00 Presence of unusual events not included in research data but of significance such as mixed ethnic background, parent convicted of felony, formerly very wealthy family, etc.

0 Pacoima case

1-3 Case # 1000's ----- 1, 2, 4

4-7 Case # 100's ----- 1, 2, 4, 8

8-11 Case # 10's ----- 1, 2, 4, 8

12-15 Case # 1's ----- 1, 2, 4, 8

16 Male (child)

17-18 Race - Code

Caucasian = 0 (no punch)
Negro = 1 (punch - 17)
Span.Am. = 2 (punch - 18)
Other = 3 (punch 17 & 18)

19-20 Religion - Code

Protestant = 0 - no punch
Catholic = 1 - punch 19
Jewish = 2 - punch 20
Other & Unknown = 3 - punch 19 & 20 and make note

21-25 Age of patient - 1, 2, 4, 8, 16

26-28 Ordinal position-collapse seven & over & note 1, 2, 4

29-31 Number children-collapse seven & over & note 1, 2, 4

32-33 Duration of illness - Code

0 to 6 months	0 - no punch
6 to 12 months	1 - punch 32
Over 12 months (collapse)	2 - punch 33
Unknown	3 - punch 32 & 33

34-35 Marital Status of Parents - Code

Married = 0 - no punch
Widowed = 1 - punch 34
Separated = 2 - punch 35
Divorced = 3 - punch 34 & 35 and make note

36-39 Economic Status - Use codes 1, 2, 4, 8

Code Number	Monthly Income
1	0 -- $ 349
2	350 -- 399
3	400 -- 449
4	450 -- 499
5	500 -- 549
6	550 -- 599
7	600 -- 649
8	650 -- 699
9	700 -- 749
10	750 -- 799
11	800 -- 899
12	900 -- 1000
13	1000 - 1199
14	1200 - 1499
15	1500 -

No punch -- unknown

40-43 Interviewer experience - Code is first two numbers of interviewers code (e.g. 45-97). Using 1, 2, 4, 8 designate by punching according to following code.

40, 41, 42	= 1	64-66	= 9
43-45	= 2	67-69	= 10
46-48	= 3	70-72	= 11
49-51	= 4	73-75	= 12
52-54	= 5	76-78	= 13
55-57	= 6	79-81	= 14
58-61	= 7	Before 40	= 15 *
61-63	= 8	Unknown	= no punch **

*The designator number or 1st two digits of the interviewer code will be "XX".

**The designator number or first two digits of the interviewer code will be "00".

44-50 Interviewer Code (last one, two or three digits = one number) 1-2-4-8-16-32-64

51-52 Interviewer's profession or supervisor's profession 1 = Social Worker 2 = Psychologist 3 = Psychiatrist 1-2

53-54 Others supervised by above 1 = CAT 2=Student 3=Other 1-2

55 Paid staff (Interviewer or supervisor -- not "others...")

56 Full Time (Interviewer or supervisor -- not "others...")

57 Prior Rx --Exper. (child)

58 Prior Rx - Exper. (other)

59-61 Disposition (child)
62-64 Disposition (mother or stepmother)
65-67 Disposition (father or stepfather)

1 = Intake Waiting List
2 = Referral Out
3 = Closed
4 = Drop-In Group
5 = Screening or Emergency Screening & another, specify
6 = Pending or pending & another - specify
7 = Other & multiple - specify

1, 2, 4

68 Accepts disposition (child)

69 Accepts disposition (mother)

70 Accepts disposition (father)

71-74 DIG Focus & goals (child)
75-78 DIG Focus & goals (mother)
79-82 DIG Focus & goals (father)

1 = Clarify concern
2 = Identify needs
3 = Gratify needs
4 = Mobilize affect
5 = Support strength
6 = Resolution of crisis
7 = Catharsis
8 = Education
9 = Diagnostic
10 = Other, & multiple, specify

1, 2, 4, 8

83-85 DIG sessions (child) Collapse 7 & > 1, 2, 4

86-88 DIG sessions (mother) Collapse 7 & > 1, 2, 4

89-91 DIG sessions (father) Collapse 7 & > 1, 2, 4

12-1-66

92-93	Outcome seen by child 0 = improved 1 = Unchanged 2 = Worse 3 = Unkn.	1-2
94-95	Outcome seen by mother 0 = improved 1 = Unchanged 2 = Worse 3 = Unkn.	1-2
96-97	Outcome seen by father 0 = improved 1 = Unchanged 2 = Worse 3 = Unkn.	1-2
98-99	Outcome seen by Interviewer 0 = improved 1 = Unchanged 2 = Worse 3 = Unkn.	1-2
100-101	No. DIG Rxsts (child) Collapse 3 & more	1-2
102-103	No. DIG Rxsts (mother) collapse 3 & more	1-2
104-105	No. DIG Rxsts (father) collapse 3 & more	1-2
106	Marital conflict	
107	Multiple Screening	
108-109	Person interviewed - 0 = Mother 2 = Father 1 = Child 3 = Other & multiple, specify	1-2

IHW:sm/12-9-66

CARD NUMBER 2

Punch lower left hand corner to indicate Card #2.

1-3	Case # 1000's	1, 2, 4
4-7	Case # 100's	1, 2, 4, 8
8-11	Case # 10's	1, 2, 4, 8
12-15	Case # 1's	1, 2, 4, 8
16-20	First Presenting Problem (See Code List below)	1, 2, 4, 8, 16
21-25	Second Presenting Problem (See Code List below)	1, 2, 4, 8, 16
26-30	Third Presenting Problem (See Code List below)	1, 2, 4, 8, 16
31	Check if more than three presenting problems and note the additional numbers from list.	

Presenting Problems Code List

1-Immature	17-Soiling
2-Hyperactive	18-Fire Setting
3-Sht. attn span	19-Obs. compl.
4-Inattentive	20-Accident prone
5-Demanding	21-Nail Biting
6-Bossy	22-Lying
7-Fighting	23-Anxiety
8-Argumentative	24-Depression
9-Doesn't Obey	25-Suicidal
10-Withdrawn	26-Nightmares
11-Underachiever	27-Obesity
12-Stealing	28-Tic
13-Truancy	29-Stuttering
14-Sex actg. out	30-Phobias & Schl. Phobia
15-Jealousy	31-Psy-som. note what.
16-Enuresis	No punch = other, what?

32-36	First Precipitating problem relating to illness (See Code List below)	1, 2, 4, 8, 16
37-41	Second precipitating problem relating to illness (See Code List below)	1, 2, 4, 8, 16
42-46	Third precipitating problem relating to illness (See Code List below)	1, 2, 4, 8, 16
47	Check if more than three precipitating problems and note the additional numbers from list.	

48-52	First precipitating problem relating to coming (See Code List below)	1, 2, 4, 8, 16
53-57	Second precipitating problem relating to coming (See Code List below)	1, 2, 4, 8, 16
58-62	Third precipitating problem relating to coming (See Code List below)	1, 2, 4, 8, 16
63	Check if more than three precipitating problems and note additional numbers from list.	

Precipitating Problems Code List

1-Home moved
2-Chg. school
3-Pressr. help
4-Just learned of service
5-Accum. fam. stress
6-Accum. stress in pt.
7-Symptoms worse
8-Par. inabil. cope w/new beh.
9-Financial stress
10-Chg, income
11-Chg. social status
12-Phys. illness
13-Birth of sibling
14-Incest
15-Recent death
16-Marital difficulty
17-Separation
18-Divorce
19-Marriage (who?)
20-Pt. frustr. dep. needs
21-Par. frustr. dep. needs
22-Peer influences
23-Sibling influence
24-Prog. par. impulses
25-Paternal rejection
26-Maternal rejection
27-Paternal pressr.
28-Maternal pressr.
29-Other fam. stress- Note
30-Other chg. fam. comp.-Note
31-Other-Note

64-69	First developmental factor	1, 2, 4, 8, 16, 32
70-75	Second developmental factor	1, 2, 4, 8, 16, 32
76-81	Third developmental factor	1, 2, 4, 8, 16, 32
82	Punch if more than three developmental factors and note extra numbers from list.	

Developmental Factors Code List

1-Preg. unwanted F
2-Preg. unwanted M
3-Diff. delivery
4-Birth injury
5-Excessive need
6-Major illness
7-Sickly
8-Mat. rejection
9-Pat. rejection
10-Mat. illness or inj.
11-Pat. illness or inj.
12-Mat. absence
13-Pat. absence
14-Freq. siblings
15-Sibl. illness or inj.
16-Phys. limitations
17-Hyperactive
18-Mat. intol.of act.
19-Pat. intol. of act.
20-Marital probs.
21-Divorce
22-Proj.par.impls.
23-Retardation-Mental
24-Retardation-Phys.
25-Retardation-Dev.
26-Mat.seductiveness
27-Pat.seductiveness
28-Sibl.seductiveness
29-Compet.stim by M
30-Compet.stim by F
31-Compet. stim by sib.
32-Unrec. precocious.
33-Compet. from M
34-Compet. from F
35-Compet. from sibling
36-Overprotection
37-Mat. hostility
38-Pat. hostility
39-Sibl. hostility
40-Situat. intol-activ.
41-Mat. pressr. to perform
42-Pat. pressr. to perform
43-Mat. strictness
44-Pat. strictness
45-Other

83-87 First general interview behavior 1, 2, 4, 8, 16
(See Code List below)

88-92 Second general interview behavior 1, 2, 4, 8, 16
(See Code List below)

93-97 Third general interview behavior 1, 2, 4, 8, 16
(See Code List below)

98 Check if more than three and note additional code numbers from list

General Interview Behavior Code List

1-Neat	15-Attractive
2-Talkative	16-Cheerful
3-Quiet	17-Depressed
4-Interruptive	18-Anxious
5-Aloof	19-Angry
6-Evasive	20-Passive Agg.
7-Coy	21-Fearful
8-Unkempt	22-Unattractive
9-Chg. sub.	23-Disruptive
10-Follows sub.	24-Hyperactive
11-Attentive	25-Domineering
12-Disinterested	26-Oppositional
13-Compliant	27-Distraught
14-Pleasant	28-Other (what?)

99-102 Last grade completed in school - Mother 1, 2, 4, 8
(See code list below)

103-106 Last grade completed in school - Father 1, 2, 4, 8
(See code list below)

Code

0 = 8	7 = 2 yrs. coll.
1 = 8th	8 = 3 yrs. coll.
2 = 9th	9 = Grad. school
3 = 10th	10 = Post grad. work
4 = 11th	11 = Master's level
5 = 12th	12 = Doctorate
6 = 1 yr. coll.	

107-110 Last grade completed in school - Child 1, 2, 4, 8

Code

0 = Kindergarten	7 = 7th grade
1 = 1st grade	8 = 8th grade
2 = 2nd grade	9 = 9th grade
3 = 3rd grade	10 = 10th grade
4 = 4th grade	11 = 11th grade
5 = 5th grade	12 = 12th grade
6 = 6th grade	

TABLE NO. 1

Partial List of Clinics Expressing an Interest to Develop a Drop-In Service

1. Prague Child Psychiatry Clinic, Prague, Czechoslovakia * +
2. Tillamook Child Guidance Clinic, Tillamook, Oregon +
3. San Diego Child Guidance Clinic, San Diego, California +
4. USC, Department of Child Psychiatry, Los Angeles, Calif. * +
5. Whittier Child Guidance Clinic, Whittier, Calif. * +
6. PTA Child Guidance Clinic, Los Angeles, Calif. * +
7. Washington County Guidance Center, West Bend, Wisconsin
8. Westminster Neighborhood Association, Inc., Watts, California +
9. Luthern Children's Friend Society, Wauwatosa, Wisconsin
10. Seattle Atlantic Street Center, Seattle, Washington

* Those clinics which have or plan to start a Drop-In Service.

+ Those clinics whose staff have visited our Clinic or whom our staff members have visited.

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1. Howard, Stephen J., Ph.D. "Case-Aide Training Program". Newsletter, Section on Clinical Child Psychology, Division of Clinical Psychology, American Psychological Association, Vol. V, No. 2, May, 1966.
2. Weiland, I. Hyman, M.D., & Levine, Jules, ACSW. "A New Concept in Crisis Intervention: The Drop-In Group in a Child Guidance Clinic". Presented at Annual Meeting, American Orthopsychiatric Association, April, 1966.

FOOTNOTES

1. The first report has been presented previously and will soon be published.
2. Grant Number 5 R11-MH01480
3. These younger children have not been provided with a drop-in group for several reasons:
   a. Teenaged children constitute a larger percent of our referrals.
   b. Younger children can more readily be helped by working with their parents.
   c. Logistics of staff supply forced us to choose one or another group for Drop-In.
   d. We have not developed adequate techniques for rapidly engaging young children in problem centered therapy. We are currently exploring the use of a semi-structured, projective, puppet play situation using blank, plastic, finger puppets on which the child may draw a face with a crayon and erase it with a tissue. Each child may use from one to several puppets.
4. Currently six for each family member.
5. The list of situations we felt would be appropriate are attached as Appendix A.