BRIEF SERVICE IN A CHILD GUIDANCE CLINIC:
A PRELIMINARY SURVEY

A Descriptive Study Based on Child Guidance Clinic Cases, Burnaby, 1954-57

by

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ABSTRACT

The main purpose of this study is to survey a sampling of brief service cases in a child guidance clinic in an effort to discover why these cases could be treated on a brief or short-term basis.

Because of the need to help more people in a given length of time and the limited agency staff and high case loads, it is very desirable that treatment on a brief service basis be expanded if it can be done without sacrificing good casework practice.

Making use of the transcribed notes made during the Clinic Diagnostic Conferences, the presenting problems, diagnoses, number of contacts and person to whom service was given were tabulated for each of 62 cases which were designated by the Clinic as brief service cases.

It was found that there is no formalized definition of brief service at the Clinic and the giving of brief service does not appear to be a planned part of the general program. The data assembled from the diagnostic conference notes indicate that there has been no organized effort to delineate properly what a brief service case is.

Because of the success of well organized brief service programs in other agencies, it is suggested that such a program should be planned for at the Clinic and some of the steps in organizing such a program are suggested.
ACKNOWLEDGMENTS

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It is a pleasure to express my gratitude to Mr. Adrian Marriage for his helpful criticism and suggestions and to Miss Muriel Cunliffe and Dr. Leonard Marsh of the faculty of the School of Social Work.

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Chapter 1

THE CONCEPT OF BRIEF SERVICE

The common desire to help shorten human suffering coupled with the very practical problems of growing case loads, and the resultant long waiting periods for clients, has produced among social workers a great interest in the possibilities of "brief services" as a means of helping more people in a given period of time. Pressures on agencies to provide more services have been mounting as people become aware of the sources of help available within the community. Shortages of trained personnel and lack of facilities to meet the increasing case loads has forced existing agencies to face the problem of finding ways to meet the growing demands of people who need help. Many agencies desiring to be more readily available to the community and to cut down the long waiting lists have begun experimenting with shorter forms of services. This does not seem to be a regressive trend to the time when casework services were brief owing to the still undeveloped methods, but is seen as a positive response to the economic necessity of treating as many people as possible who need help.

In considering any method by which casework services can be shortened, one must constantly consider the question: are there ways of giving effective help in shorter periods of time without sacrificing basic social work principles and quality of service? Historically, social casework practice has been influenced by psychoanalytic concepts. The practitioners of psychoanalytic therapy very early gave up the idea of
brief analysis when it appeared that the results were disappointing, and it became common practice for an analysis to extend over a two or three-year period. Casework, under the influence of psychoanalysis, tended to follow the same pattern and long-term treatment was emphasized. The focus of teaching and practice in casework has for years stressed the value of long-term treatment.

Some analysts, however, have in recent years been experimenting with modified techniques that will encourage early improvement and shorten the span of treatment. Alexander and French\(^1\) openly advocate shorter methods. These authors have questioned certain traditional psychoanalytic dogmas: 1) that the depth of therapy is necessarily proportionate to the frequency of the interviews and the length of treatment, and 2) that the results achieved by a small number of interviews are superficial and temporary while those of the classical or standard analysis are more stable and lasting. They conclude that brief therapy if based on full diagnostic understanding of the patient and the problems, can meet the full therapeutic needs of the individual.

To the previously posed question whether effective casework help can be given in shorter periods of time without sacrificing quality of service, it can be seen, as a result of brief casework experiments, that there are indications that brief casework has intrinsic value regardless of the staff and time available. Thus, emulation of traditional psychoanalytic concepts

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may have inhibited to some extent the development of the idea of brief services in some social agencies.

The Constructive Use of Time Limits

Melitta Schmideberg from her study of short-term treatment concluded that, "short therapy as I have practiced it is not so much a technique of 'brief' or 'abbreviated' treatments as it is a flexible method that frequently accelerates treatment."¹ She observed in her work with parents that when they had hopes of early improvement they worried less and were better able to put up with their children's difficulties. Their tolerance and hopefulness in turn had a beneficial effect on the children and made for further progress. "One is often surprised how quickly a child improves when parents gain new hope."²

Many clients at intake indicate that they want to help with a specific situation or problem. They want the help to be given quickly and effectively for various reasons: it may be difficult for them to get to the agency because of the distance and travel time involved, an emergency may exist for which they want immediate help, they may fear getting involved in long-term treatment which is costly and exposes them to an intense relationship with the worker, or they may feel perfectly capable of dealing with the problem themselves if a little help is given at the

²Adler, Alexandra, Guiding Human Misfits, New York, 1948.
right time. There is little doubt that a client's relief at being told that the counseling service will be brief is frequently a manifestation of resistance. However, instead of interpreting this to the client as resistance, the caseworker can attempt to use it constructively as an ego strength. Theoretically the attempt would be made to transfer the ego energy which at first is being used as a defense (i.e., for resistance) to an assertion of independence and a determination to overcome the personal difficulty. In other words the resistance to long-term treatment could be utilized in making a success of brief counseling with the focus being on the healthy aspects of the personality rather than on its impairments.

Thus there are many indications that the pressure of time can be a force that helps the client come to grips with his problem more readily and is an incentive for more rapid movement. Knowing that his contacts will be brief he will have to sort out more quickly the peripheral from the vital needs. Within a few interviews he can evaluate with his worker whether he should have continuing treatment or whether he can carry on by himself.

For the worker a time limitation may help him evaluate progress in a more conscious and focused manner. It may serve to sharpen diagnostic judgment and therapeutic skill. Furthermore it may prevent fostering undue dependence in certain dependent individuals since he will release them from treatment as soon as they can function unaided.

In functional casework, time is one of the primary instruments of the helping process. Length and frequency of interviews and "end-setting"

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1 For a discussion of resistance on the part of parents coming to the clinic, Kennedy, Ramona, Initial Resistance of Parents to Casework Services in a Child Guidance Setting, M.S.W. Theses, University of British Columbia, 1957.
are carefully planned. To the functionalist the concept of time "represents to the individual the most final of limits, about which he can do nothing, and it may be said to be the most fearful aspect of his existence."

"Within these two limits in time (birth and death), the present moment is all that is available to the human being. It cannot be grasped, held, repeated, or postponed; but can only be used, (that is, lived) and allowed to pass. It is upon this universal reality of the meaning of time to the individual human being that functional casework bases its use of time in the helping process, with its emphasis upon the present moment and the present relationship, and its dynamic use of that relationship."¹

Although he may not hold to time limits as strictly as the functionalists, the "diagnostic" caseworker also makes use of time therapeutically. Interviews are planned ahead to suit the convenience of both client and worker, and the client is expected to keep his appointments. Usually there is an understanding as to the approximate length of time the treatment will continue. The termination of interviewing contacts comes not as an abrupt ending but rather as a natural step taken by the client when he recognizes his readiness to be on his own.

Time is of fundamental importance in many types of casework. For example, in casework with the unmarried mother the nature of the problem sets time limits within which at least a minimum amount of planning must be made and carried out by worker and client.

Some Examples of Agency Use of Brief Services

Some agencies, because of the nature of their work, have had extensive experience with brief contact cases. The Traveler's Aid has a well established program that might serve as a model of what can be done to help clients in one or two interviews. Miss Townsend¹ says the opportunities for a "sensitive caseworker to give effective help to this never ending stream of human beings in difficulties are tremendous..... it is possible to render fundamental help in one interview or in a few. Dramatic changes do occur overnight." She emphasizes the importance of having a highly skilled caseworker as the key to successful brief service.

Community Information Centers are agencies where the rule is brief service. Here the caseworker's job is to give information about resources the client asks for, to help him find the resources he really needs, to help him decide whether he is ready to use the help available, and to move on. All this must be done in less than one hour. Dorothy Eklund reporting on the experiences of the Minneapolis Community Information Center points out the advantages of short contact interviewing by saying that the caseworker's awareness of the time "sharpens his skills - he must help the client make a beginning, help him to get to what can be done, and help him bring the interview to an end. One might call this a creative use of time limits."²

Family agencies are currently giving considerable attention to determining what valid services can be given in one interview or in a limited number, and what special skills are needed to do this. A significant study

¹ Townsend, Gladys E., "Short-Term Casework with Clients Under Stress", Social Casework, Nov. 1953, pp. 392-398
² Eklund, Dorothy, "Short-Contact Services in an Information and Referral Center", Social Casework, 1951, p. 432.
of brief services conducted by the Family Service Association of America (hereafter called FSAA), has served to raise many questions concerning these services and to stimulate further research. The trend toward the increasing proportion of brief service cases in family agencies was first dealt with in a report entitled Short Contact Cases in Family Service Agencies, based on a study of brief service cases closed during March, 1948 for 64 member agencies. As a result of this study FSAA suggested that individual family agencies examine their cases in order to achieve an understanding of short contact cases. Any case closed with not more than one "in person" interview since its latest opening, regardless of telephone calls or correspondence is classified as "brief service."

Some of the questions raised were why were so many of the cases short-contact cases? Were these clients receiving a valid service within a brief time or was the family agency failing them? Should these clients have continued with the agency for further service?

Dorothy Thomas made a follow-up study of brief services in a family service agency at Washington, D.C., and found that there were valid reasons for short-contact cases and their increase in the past five years if they were determined by a careful diagnosis made at intake. She suggested that the intake procedure, since it is in fact a diagnostic service, could be more correctly and usefully described by the term "information, consultation, intake and referral service."

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1 Shyne, Ann W. Short Contact Cases in Family Service Agencies, F.S.A.A. New York, 1948 (mimeographed)
2 Thomas, Dorothy V., "The Relationship Between Diagnostic Service and Short Contact Cases," Social Casework, 1951, p. 74.
Using the FSAA survey as a starting point, the Jewish Family Service of New York made a study of its own short-term cases. In this agency a short-term was defined as "all activity up to and including one planned intake appointment - which meant all telephone calls, letters, and unplanned reception interviews included in the contact, with a planned interview as maximum activity." One finding of this investigation was that the use of the term "short-term case" was confusing and deceptive. Grouped under this description was a wide variety of situations having as the only thing in common their shortness of contact.

There are other implications in this investigation, the most important being the need for professional re-thinking of the characteristics of brief services in a family agency setting. Family agencies had traditionally looked upon brief services with apprehension, considering them as abortive long-term cases and as somehow second-class. Caseworkers tended to put their greatest effort into the long-term cases and felt guilty at giving what they might think of as less than the full treatment to clients. This has been so even though the long-term cases are in the minority. (In some family service agencies 50 to 60 per cent of the cases are brief services) The Frings study suggested that short-term cases should be looked upon as neither better nor worse than extended services but as different in the demands they made on casework skills. Furthermore, the Frings study pointed up the need for training to provide caseworkers

2 Have caseworkers tended to rationalize their passive acceptance of the client's lack of movement by calling it going "at the clients pace", instead of sharpening their skills and methods to helping the client in a shorter period of time?
with the necessary skills for giving brief services.

In all the social agencies examined there seemed to be general agreement on three main categories of positive and legitimate services that could be given in short contacts, i.e., referrals, information-giving and brief counseling.

Referral means preparing the client for other sources of help. Effective referral can be of therapeutic value to the client and demands the same skills essential in any good casework. Information-giving involves such things as advising parents on characteristics of normal child development, interpreting clinic findings and suggesting educational plans for children. Since the simplest request for information may be based on parental anxiety, even the briefest contacts can call forth all the skill at the caseworker’s command. Brief counseling usually means giving help on a specific problem.
Chapter II

DEVELOPMENT OF BRIEF SERVICES AT THE PROVINCIAL
CHILD GUIDANCE CLINIC

The Provincial Child Guidance Clinic of British Columbia was established to prevent mental illness, delinquency and other forms of dependency and disturbance in society. It carries out its function by offering guidance services for children and parents by providing community education services. Diagnosis and treatment within the agency is a collaborative effort using the skills of several professions. The team approach is used in the program and the basic team is composed of a psychiatrist, social worker, psychologist and public health nurse.

Intake interviews are conducted by a social worker. When sufficient data is acquired, usually in one or two interviews, an intake conference is held at which the clinic teams come to a decision about the disposition of the case. If the decision is to accept the case for diagnostic study, a planning conference is held at which various members of the team are assigned to the case. Diagnostic interviews are scheduled, followed by a diagnostic conference at which the thinking of the various disciplines is pooled and a treatment plan is evolved.

Most of the treatment given by the clinic at the present time is casework treatment. In 1951 Glover, in his study of interviewing methods

at the clinic said, "It became recognized that social workers in most instances could take over individual treatment within the clinic so long as the knowledge and experience of a more specialized person was available through consultation. In the years 1948 and 1951 a study of 141 private cases showed that the burden of treatment was carried almost entirely by social workers." In theory any department of the clinic might be directly involved in treatment, but in practice the time of the workers in the other departments is almost entirely taken up with diagnostic and consultative services, leaving them little opportunity for direct treatment of children and their parents.

The "New System"

The social work department at the Child Guidance Clinic is composed of two sections: 1) Intake, Diagnostic and Brief Service and 2) Continued Service. The evolution of these two distinct services has come about gradually within the past five years (since 1952) and became well established and structured during the last two years. It was an internal development and some of the other departments in the clinic were not very much aware of this development. All workers at one time did all types of work: Intake, duty work^1 and continued or long-term treatment, although some attempts were made at specialization. It became obvious that this was not proving satisfactory, mainly because of the long waiting periods between application and intake study. Dissatisfaction with the ever-increasing number of names on

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1 One social worker is always on duty to take phone calls and answer inquiries regarding the services of the clinic.
the waiting list led to discussions in staff meetings of ways to cope with the situation, and these discussions are continuing. For example, the staff meeting minutes of September 8, 1953 contained this reference: "Discussion by Intake Committee of changing and enlarging intake procedure - mainly towards Intake and Brief Service Section - general agreement in thinking on it is that Intake will include the team as a whole and will involve the intake worker bringing the client and the case to the point of what we can now think of as full clinic examination and diagnostic conference."

The Clinic intake committee was very much interested in improving intake procedures but the changes seem to have taken place not as a result of any particular study made by this committee, but as a trial and error attempt by the staff as a whole in its striving to cut down the waiting period.

The first change came with the appointment of one worker to be responsible for intake interviews. Following the intake interview the case awaited until a worker was assigned to work up the social history for the diagnostic conference, and to carry the case for treatment if so decided by the team. It soon became apparent that a single intake worker was not meeting the need, so the question arose of adding two or three more. The thinking of the committee expanded gradually to seeing these workers carrying the

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1 Coming to the clinic often represents for clients a state of urgency for they are seeking help as a last resort. When help is not readily forthcoming and they have to take their turn on the waiting list, they become disappointed and frequently withdraw from the clinic. Warde Laidman found in his study, *Premature Withdrawal From Treatment in a Child Guidance Clinic*, M.S.W. Thesis, University of British Columbia 1957, that dissatisfaction with the long waiting period was one of the main reasons clients gave for discontinuing treatment after diagnostic conference.
case to the diagnostic conference. A further development occurred when the idea of dividing the social work department into two sections emerged.

The "new system" of dividing the social work department into two sections came into operation gradually and very informally and was in operation sometime in the summer of 1954. It was referred to by workers in the clinic as the "new system" and essentially it involved dividing the social work staff into the "Intake, Diagnostic and Brief Service Section", and the "Continued Service Section." However, the idea of "Brief Service" was always subordinate as one of the reasons for establishing the new system, and there was no systematic attempt to define brief service nor were any criteria set up for making use of brief service.

The change-over to the new system was not particularly revolutionary. Intake workers continued with their long-term treatment cases until they were closed. Those in the continued service section likewise carried on their intake cases until they were closed or reassigned.

Defining Brief Services at the Provincial Child Guidance Clinic

As has been indicated, no official definition of brief services has as yet been formulated by the clinic. Those cases which are not put on the waiting list following diagnostic conference but are serviced by the intake section, are categorized by some workers at the clinic as brief services.

In 1954 an attempt was made in staff meetings to define brief service. At one meeting a worker defined a brief service case as one in which formulated casework service following a careful diagnostic study was given, but which never extended to more than three interviews. At a staff meeting held in February 1954, the suggestion was made that the staff statistics
committee prepare a definition of brief service. However, at this writing, no formal definition of brief service has yet been prepared and it should be mentioned that no one at the clinic seems to use the definition of "No more than three interviews" when they speak of brief service.

In current practice those cases which are designated as brief services have been to diagnostic conference where the team decides on a suitable treatment plan. If brief service is the plan, the client may be seen from one, or "several interviews" up to any number during the following six-month period. The length of time or number of interviews apparently does not determine the definition of brief service.

The basis for the team's decision to recommend brief service is not stated in the conference notes, except very occasionally. One can assume that the team bases its decision on clinical judgment. It is one aim of this study to try to discover some of the unarticulated criteria that are used in making this judgment.

The term, "brief service", seems to have many connotations at the clinic. It is used to refer to services given after diagnostic conference, such as referrals to other community resources, giving of general information to parents, or brief counseling. It has been used to describe services given at the initial application, referral to another resource or to further diagnostic study. In fact at each of three major decision points in the procedures at the clinic (duty-call, intake conference, and diagnostic conference) various plans may be recommended and what could be called brief

1 The following is an example of what is meant by brief counseling and is taken from the social worker's notes made at diagnostic conference: "It was felt that the parents could be helped in a brief service in accepting this child's limitations and encouraging them to give her support and reassurance rather than pressuring her further."
services relative to each phase can be identified.

Brief service is a term frequently used by workers at the clinic when they mean limited goals such as the relief of a specific symptom with no particular reference to limited time. However, a limited goal of modification of some one area may take a long time and an unlimited goal of resolving many problems may take a very short time.

One worker at the clinic thinks of brief services as being limited in both time and aims and defines such services as "Those cases closed after one or two interviews. This implies ... a very limited goal of a concrete nature; limited clarification, specific environmental help, or possibly supportive help around making a specific decision or finding an appropriate resource which is reasonably acceptable to the client."

"Short-term" treatment is a term which is beginning to be used at the clinic. It seems to describe a category of treatment separate and apart from that described by the term "brief service." It is used to indicate those cases which are more than brief service but are not referred on to the continued service section. The implication of short-term treatment seems to be that goals are limited to help in a fairly specific area which is all that is needed or desired. The goal would not be any fundamental change but would be confined to strengthening capacities, or motivating client and family action, or possibly testing and evaluating responsiveness to help."

There is a group of miscellaneous services given by the clinic which frequently involves casework help but which is not at the present time categorized as either brief service or short-term treatment. The term used to describe these services is "accidental services." These services almost
never involve more than one interview. They consist of giving information about resources, referring parents to literature on child problems, helping a referral to withdraw, or directing the referral to a more appropriate resource. "Accidental" as applied to these cases is an unfortunate term inasmuch as the services given constitute a planned and important helping process for the client and real casework skill on the part of the caseworker. Preferably they should be described by a term that gives recognition to their true nature.

Summary

The idea of brief service first emerged when the clinic was seeking ways of cutting down the long waiting period and set up the two sections as one method of accomplishing the task. The idea of brief services has always been subordinate to the desire to shorten the waiting period and there has been no systematic attempt to define it in relationship to the other clinic services. Each worker has his own definition of brief service and there is a wide variety in the definitions as to length of time, number of interviews, limited goals, and whether brief services and short-term treatment mean the same thing. In other words, the term brief service is used at the clinic to describe anything other than continued service. The idea is still evolving and not generally agreed upon definition has yet been crystallized.

In view of the need for brief services in order to cut down the ever-expanding waiting list, and in view of the apparent success of brief services in other agencies, and the present lack of concerted effort to define and develop brief services at the clinic, some of the characteristics of what might be called brief services at the clinic will now be examined.
Chapter III

ANALYSIS OF "BRIEF SERVICE" CASES AT THE CHILD GUIDANCE CLINIC

Scope of the Study

In selecting the cases categorized by the clinic team as "brief service", the period covered is from November 1954 to January 1, 1957. This period of time was chosen because the sources of information for analyzing the cases are the notes transcribed at the diagnostic conferences. The Clinic first began keeping a separate file of these notes when the "new system" was instituted during the summer of 1954.

These cases were designated as brief service cases by the Clinic itself. As has been previously indicated, there does not seem to exist at the clinic any formalized, clear-cut definition of what constitutes brief services, and there is among different workers an interchange of terminology applied to similar types of cases, all of which have characteristics of "briefness" or "short-term". Furthermore, different workers seem to use different criteria in labeling a case "brief" or "short-term". However, there seemed to be general agreement at the clinic, for one reason or another, that the cases chosen are brief service cases.

A total of 65 brief service cases were presented by the clinic for study. This total was reduced to 62 when it was found that two of the 65 cases were given treatment by a psychiatrist and in one case by a public health nurse. The remaining 62 cases were carried by social workers and hence are within the scope of this study.
In diagnostic conference notes use, no attempt was made to infer from them the process by which the clinic team came to the decision to allocate certain cases to brief services. Instead the notes were used as sources of data about the kinds of problems and services found in those cases designated as brief services, in order to discover whether they had common characteristics.

Limitations of the Sample

It should be pointed out that the 62 cases represent only about 50 per cent of all brief service cases carried during the period of time under consideration. The reason for this, according to the clinic staff, is that the diagnostic conference notes were frequently not duplicated when they were being transcribed. The alternative to basing the study on these duplicated diagnostic conference notes would be to search all case records for the period and separate out all brief service cases. This would involve examining approximately 1000 case records which the lack of time makes prohibitive. The 50 per cent random sampling of brief service cases constitutes a statistically valid sample as a basis for formulating certain conclusions regarding all brief service cases handled during this period.

Another difficulty arose from the inadequacies of the notes made at the diagnostic conferences. The clinic has a "Suggested Format for Diagnostic Conference Notes" but in many cases the suggested format was not followed, or followed only in part. Yet one of the purposes of using the format is specifically stated in the format itself to be that of research.

A question might be raised concerning the usefulness of the diagnostic conference notes for research purposes. The alternative would seem to be using the full case records which are very voluminous. Sorting out
pertinent information from them would therefore be extremely time con-
ssuming.

In order to make better use of staff time spent in recording and
studying case records, the clinic might consider a revision of its methods
of record keeping. An excellent method of streamlining the procedures has
been developed and put in practice at the Harms-Beth David Hospital Clinic
in New York. 1

Findings

The 62 cases have been studied in an effort to ascertain what common
characteristics, if any, are found which would cause them to be categorized
as brief services and to see if an analysis of the cases reveals any dis-
tinct patterns as to:

1) What brings these people to the clinic (presenting problems).

2) Diagnosis - the clinic findings as reported by team members,
    not a social or psychiatric diagnosis.

3) Length of contacts (number of interviews).

4) Purpose of casework treatment.

Apparently there is no formal classification of presenting problems in
general use in the clinic at this time. There is a list that has limited use,
but it was decided not to use this list because the classification of present-
ing problems seemed to make use of diagnostic judgment in assigning a par-
ticular problem to a particular category. For example, the main general
classifications in the list in "Primary Behavior Disorders". Under this head-
ing are four sub-groups: Habit Disorders, Personality Disorders, Neurotic

1 Harms, Ernest, "The Short-Term Adjustment Clinic of Beth David Hospital
Disorders and Conduct Disorders. Under each is a list of specific problems. Aggressiveness is classed as a Personality Disorder. As a presenting problem, aggressiveness may or may not be a personality disorder. Definitely labeling it as such calls for diagnostic judgment.

This list is discussed because it indicates the difficulty of making any kind of classification of presenting problems. Several classifications were attempted, but none of them seemed to have any particular value or significance, therefore the decision was made to arrange the presenting problems in a purely semantic grouping, ranging from concrete observable facts to very broad generalizations.¹

The tabulation of presenting problems of the 62 cases of brief services (Table 1) seems to have no particular significance for this study. All that is known is that the list of problems in Table 1 constitutes the presenting problems of the cases which were designated brief service cases. In order to determine whether any particular type of presenting problem is of significance in assigning a case to brief service, it would be necessary to tabulate the presenting problems in a sampling of all cases accepted by the clinic for diagnosis and treatment and then see if there is a correlation between any particular type of presenting problem and the assignment of the cases in which these problems occur to brief services.

The descriptive phrases used in Table 2, showing the diagnoses, are taken from the diagnostic conferences notes in each case. Of the 62 cases, no diagnosis was reported in 8 cases.

¹ The grouping used is adapted from that used in a study of 500 cases at the Los Angeles Child Guidance Clinic, Los Angeles, California, see: Anderson, F. D. and Dean, Helen C., Some Aspects of Child Guidance Clinic Intake Policy and Practice, Public Health Monograph No. 42, United States Government Printing Office, 1956, pp. 15-16.
Table 1. Classification of Presenting Problems in Brief Service Cases in the Clinic.

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Group 1: Concrete Conduct - Observable Facts</strong></td>
<td>25</td>
</tr>
<tr>
<td>Speech defect or speech problem</td>
<td>7</td>
</tr>
<tr>
<td>Lies</td>
<td>4</td>
</tr>
<tr>
<td>Enuresis</td>
<td>3</td>
</tr>
<tr>
<td>Soils clothing</td>
<td>3</td>
</tr>
<tr>
<td>Steals</td>
<td>2</td>
</tr>
<tr>
<td>Pulls own hair</td>
<td>11</td>
</tr>
<tr>
<td>Hits own face</td>
<td>1</td>
</tr>
<tr>
<td>Tears clothing</td>
<td>1</td>
</tr>
<tr>
<td>Whines</td>
<td>1</td>
</tr>
<tr>
<td>Sucks thumb</td>
<td>1</td>
</tr>
<tr>
<td>Truant</td>
<td>1</td>
</tr>
<tr>
<td><strong>Group 2: Concrete, Observable Behavior</strong></td>
<td>10</td>
</tr>
<tr>
<td>Destructive</td>
<td>3</td>
</tr>
<tr>
<td>Poor application in school</td>
<td>2</td>
</tr>
<tr>
<td>Aggressive</td>
<td>2</td>
</tr>
<tr>
<td>Fearful of mother</td>
<td>1</td>
</tr>
<tr>
<td>Prefers to play with younger children</td>
<td>1</td>
</tr>
<tr>
<td>Hard to discipline</td>
<td>1</td>
</tr>
<tr>
<td><strong>Group 3: Behavior described by Abstractions and Generalities - Interpretation Enters In</strong></td>
<td>24</td>
</tr>
<tr>
<td>Stubborn</td>
<td>4</td>
</tr>
<tr>
<td>Does not get along with siblings</td>
<td>4</td>
</tr>
<tr>
<td>Maladjusted in school</td>
<td>4</td>
</tr>
<tr>
<td>Negativistic</td>
<td>2</td>
</tr>
<tr>
<td>Feels unloved</td>
<td>2</td>
</tr>
<tr>
<td>Disobedient</td>
<td>2</td>
</tr>
<tr>
<td>Domineering</td>
<td>1</td>
</tr>
<tr>
<td>Spoiled</td>
<td>1</td>
</tr>
<tr>
<td>Uncooperative</td>
<td>1</td>
</tr>
<tr>
<td>Temperamental behavior</td>
<td>1</td>
</tr>
<tr>
<td>Lack of confidence in own ability</td>
<td>1</td>
</tr>
<tr>
<td>Irresponsible</td>
<td>1</td>
</tr>
<tr>
<td><strong>Group 4: Very Broad Generalizations</strong></td>
<td>17</td>
</tr>
<tr>
<td>Nervous</td>
<td>2</td>
</tr>
<tr>
<td>Emotional immaturity</td>
<td>2</td>
</tr>
<tr>
<td>Parent-child conflict</td>
<td>1</td>
</tr>
<tr>
<td>Mental retardation</td>
<td>10</td>
</tr>
<tr>
<td>Hyperactive</td>
<td>1</td>
</tr>
<tr>
<td>Poor muscle coordination</td>
<td>1</td>
</tr>
<tr>
<td>Child asked for vocational counseling</td>
<td>1</td>
</tr>
<tr>
<td>Child neglect</td>
<td>1</td>
</tr>
<tr>
<td>Not stated</td>
<td>21</td>
</tr>
<tr>
<td><strong>Total (62 cases)</strong></td>
<td>99</td>
</tr>
<tr>
<td>Diagnosis</td>
<td>Number Times diagnosis used</td>
</tr>
<tr>
<td>------------------------------------</td>
<td>----------------------------</td>
</tr>
<tr>
<td>1. Mentally deficient or retarded</td>
<td>22</td>
</tr>
<tr>
<td>2. Parent-child relationship problem</td>
<td>22</td>
</tr>
<tr>
<td>3. Mother's personality problem</td>
<td>2</td>
</tr>
<tr>
<td>4. Physical problem of child</td>
<td>2</td>
</tr>
<tr>
<td>5. Speech defect</td>
<td>2</td>
</tr>
<tr>
<td>6. Hostile and negativistic</td>
<td>1</td>
</tr>
<tr>
<td>7. Schizophrenic</td>
<td>1</td>
</tr>
<tr>
<td>8. Sibling rivalry</td>
<td>1</td>
</tr>
<tr>
<td>9. No problems</td>
<td>1</td>
</tr>
<tr>
<td>10. Not stated</td>
<td>8</td>
</tr>
</tbody>
</table>

Total (62 cases) 62

Source: Clinical findings as recorded in diagnostic conference notes.
Thirty-five per cent of the cases were diagnosed as mental deficiency, and would naturally be brief cases since it is not within the function of the clinic to treat mental deficiency. The procedure in these cases is to interpret the clinic findings to the parents and refer them to other community resources.

Another 35 per cent, Items 2, 3, and 4, constitute problems in child-parent relationship, the type of case naturally expected to be found in a child guidance clinic.

Fourteen of the cases have a miscellaneous diagnosis, there was no problem found in one case,¹ and no diagnosis was given for approximately 12 per cent of the cases.

In Table 3, Length of Treatment, a combination of Items 3, 6, 7, and 8, shows that 25 per cent of the cases were of short duration insofar as number of interviews is concerned. It is true that with the exception of about six cases, the exact number of interviews is not stated but in 25 per cent of the cases the information in the conference notes indicates that there would be only a "few" interviews at the most and in most cases this seemed to mean not more than three or four.

In a third of the cases there is no indication, one way or the other, as to length of treatment but from the character of the cases involved, it could be inferred that the number of interviews would not exceed three or four.

¹ In this case the presenting problem was stealing. The conclusion reached at diagnostic conference was that the stealing was "an expression of a phase" and would correct itself in time and therefore no treatment for either parents or child was considered (by the psychiatrist) as necessary.
Table 3. **Length of Contacts in Brief Service Cases at the Child Guidance Clinic**

<table>
<thead>
<tr>
<th>Length of Contacts</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Brief Service</td>
<td>22</td>
</tr>
<tr>
<td>2. Not stated</td>
<td>21</td>
</tr>
<tr>
<td>3. Probably one interview only</td>
<td>13</td>
</tr>
<tr>
<td>4. Six months</td>
<td>2</td>
</tr>
<tr>
<td>5. No treatment</td>
<td>1</td>
</tr>
<tr>
<td>6. One telephone contact only</td>
<td>1</td>
</tr>
<tr>
<td>7. Two interviews</td>
<td>1</td>
</tr>
<tr>
<td>8. &quot;Several&quot; interviews</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>

Source: Diagnostic Conference notes.
It is not possible to determine the exact number of interviews meant by the first item "brief service". For example, the notes on one case state, "brief service to mother. If mother doesn't respond to short-term casework treatment, case should be put on waiting list." The notes on a second case state, "Brief service with mother to assess permanency of her present improvement and to help her seek treatment should anxiety states continue." Another say, "Brief casework services to parents by intake worker to give mother support and to encourage spontaneity and relaxation in handling child." A fourth one notes, "Supportive casework to be made available to the mother on a brief service basis, tentatively to the end of the school term. Psychologist to continue vocational counseling with child during the time."

In the examples given, which are typical of the group, there is no way to determine how many interviews were intended. It would appear that many of the cases referred for "brief service" are referred for further diagnostic study.

With more complete information it would be very desirable to establish whether there is any correlation between length of service and presenting problems, diagnosis and purpose of treatment.

Table 4, Purpose of Casework Treatment, involves classifications of treatment which are explained as follows:

1. Advice and guidance given in terms of environmental manipulation within the context of the caseworker's knowledge of the particular parent-child relationship.

Examples of advice and guidance are: helping the parents find community resources to care for a mentally retarded child, suggesting medical supervision or speech therapy, and interpreting the child to school personnel.
2. **Clarification** of the child's emotional needs, as understood by the caseworker, and of the parent's response to these needs, and the interrelationship of the two.

Clarification might mean a suggesting of appropriate toys for the child; helping the parents take pressure off child; helping parents accept the child's limitations; helping ease tension between parents; giving information of normal growth and development; advice to parents on handling a specific problem, e.g. child's stealing. The way this is handled is summed up by one worker in her description of the plan of treatment, "Brief service to parents to present clinical findings which are essentially reassuring; but gearing interpretation in such a way as to answer parent's underlying anxiety rather than offer mere surface reassurance."

3. **Listening**, e.g. giving the opportunity for catharsis to occur and the pressure of feelings to be relieved.

4. **Interpretation** of acting out by parent on the child; of connections between feelings at the threshold of parent's awareness; and of distortions in the relationship of parent to child.\(^1\)

The results shown in Table 4 seem to indicate that in the majority of brief service cases the purpose of treatment is, almost without exception, either to give advice and guidance or clarification. In 54 per cent of the cases advice and guidance was given and in 37 per cent clarification was used.

Although it is likely that listening and catharsis occurred in most of the cases, instances where it was the only method of treatment occur in only 3 per cent of the cases. There are no examples where interpretation as defined here was the purpose of treatment.

In 93 percent of the brief service cases, as shown on Table 5, treatment was given to a parent or parents; in only 2 per cent was treatment given to the child only, and in 2 per cent treatment was to both parent and child.

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\(^1\) This classification of casework techniques has been adapted from that of Dorothea McClure and Harvey Schrier, "Preventive Counseling with Parents of Young Children," *Social Work*, April 1956, p. 70
Table 4. Purpose of Casework Treatment in Brief Service Cases at Child Guidance Clinic.

<table>
<thead>
<tr>
<th>Purpose of Treatment</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Advice and guidance</td>
<td>34</td>
</tr>
<tr>
<td>2. Clarification</td>
<td>23</td>
</tr>
<tr>
<td>3. Listening</td>
<td>2</td>
</tr>
<tr>
<td>4. Interpretation</td>
<td>-</td>
</tr>
<tr>
<td>5. No treatment</td>
<td>2</td>
</tr>
<tr>
<td>6. No clear indication</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>
Table 5. **Person to Whom Service was Given**

<table>
<thead>
<tr>
<th>To whom service given</th>
<th>Number of Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Parent or parents</td>
<td>58</td>
</tr>
<tr>
<td>2. Family doctor</td>
<td>2</td>
</tr>
<tr>
<td>3. Child</td>
<td>1</td>
</tr>
<tr>
<td>4. Parent and child</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>62</strong></td>
</tr>
</tbody>
</table>
In 3 per cent of the cases interpretation of clinic results was given to a family doctor.

The possible significance of the results obtained from the survey of the 62 brief service cases will next be considered.
Chapter IV

CONCLUSIONS

In attempting to draw conclusions from the data previously given, a dilemma presents itself. Some general characteristics of a "brief service" case at the Provincial Child Guidance Clinic seem to be fairly distinguishable. A clinic case would usually be classed as a brief service if a parent or parents only are seen by the caseworker for a "few" interviews and the purpose of treatment is to give advice and guidance and perhaps clarification. Yet it is necessary to say that these general characteristics only seem to be fairly distinguishable because the data upon which the conclusion is based are incomplete. For example, in many cases the inference appears to be that there was a limited number of interviews but no clear indication as to whether this meant one interview, three or four or a dozen.

In considering the significance of the presenting problems (Table 1) it can be said that caseworkers are aware that the presenting problem is not necessarily the real problem which motivated the client to request help. No attempt has been made in this study to correlate the presenting problems with the clinic team diagnoses, but such a study would be valuable. It appears doubtful that any reliance should be placed on presenting problems with the exception of medical cases, as criteria for assigning cases to either brief service or continued service. Diagnostic judgment should always be the means by which such assignments are made.
It would appear from the data in Table 2 that in general the cases which diagnosis reveals have a serious pathology are not considered suitable brief service cases. However, a tabulation of the diagnosis in a sampling of continued service cases would have to be made as a basis for comparison. Such a tabulation is not within the scope of this study.

No definite conclusion could be made regarding the length of treatment, expressed in numbers of interviews.

The two definite conclusions to be drawn from the data examined are 1) that in the brief service cases the purpose of treatment is to give advice and guidance and to provide clarification, and 2) that interviews are held almost exclusively with a parent or parents. Thus some general characteristics of brief service cases at the clinic are clear-cut but the question of duration of treatment is not clearly defined nor are the diagnoses.

As has already been stated, brief service can be a valuable technique as a recognized method of treatment in certain selected cases because:

1) More help can be available to more people in a given period of time, and

2) brief service has intrinsic value.

Therefore it is suggested that brief service should be definitely planned for as an important part of the clinic program.

In planning a brief service program it would be necessary first to define brief service. To aid in the formulation of such a definition a study should be made of the continued service cases in order to compare the characteristics of the two types of services.

If a decision were made to institute a planned brief service program at the clinic and a definition of what constitutes brief services were agreed
upon, criteria for assigning cases to brief service should be set up.

McClure and Schrier¹ suggest the following criteria.

A. The Criteria for selecting the type of problem treatable by brief service:

1. Of recent onset
2. Not chronic
3. Not multiple
4. Not yet internalized
5. Not yet a behavior disorder
6. Age-adequate (i.e. a problem to be expected at the particular age.)

B. Criteria for selecting the parent-child relationship usually considered treatable on a short-term basis:

1. Temporary imbalance.
2. Potentially gratifying relationship.

C. Criteria for selecting parental characteristics which would lend themselves to treatment on a "brief service" basis:

1. Relatively intact egofunction (e.g. perception, reality-testing, judgment)
2. Ability to learn relatively intact.
3. Ability to focus on a specific problem.

If brief services become a planned part of the clinic program, all cases at intake should be carefully screened for possible assignment to brief service so that as many as possible can be treated in this manner but also to make sure that cases which need continued service are not mistakenly assigned to brief service. In making the assignment great objectivity and skill are necessary on the part of those making the recommendation. A second look may reveal many cases which at first glance may appear to be continued service cases which could successfully be treated on a brief service basis. However,

¹ op. cit.
the desire to treat as many people as possible who need help shouldn't lead to decisions for assignment based on expediency alone which would result in sacrificing good treatment practice.

The success of the brief service program will depend upon the skill of the caseworkers who give the treatment. Brief service is not second-class service but requires the very highest kind of skillful practice.

If a recognized and planned program of brief services is instituted, a careful check of results should be made to be sure mistakes are not being made in assigning certain cases to brief services. Follow-up studies of brief service cases should be made to determine how many of the cases, if any, return to the clinic or go to other agencies for continued service.

*
APPENDIX A

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