ABSTRACT
                Described is an infant consultation service which
provides preventive psychiatric intervention to the families of young
children, training of professionals and paraprofessionals, and a
research component. Reviewed are clinic experiences leading to the
program and the underlying theory which stresses integration of
familial and individual development. Described are varieties of
counseling services offered such as group meetings for parents,
intensive guidance in the mother-child relationship, and group
meetings for both parents and children. It is noted that volunteer
professional social workers needed training in areas such as
understanding of family interactions and dynamic processes. Also
explained is the training program for paraprofessionals, most of whom
were selected from parents who had successfully completed a
therapeutic program. It is reported that the previous patients
experienced emotional difficulties during the training program and
were not utilized as paraprofessionals. Aspects of the research
component are considered including followup interviews of clients.
Program evaluation is given to indicate that the Infant Consultation
Service has led to 52 percent of cases receiving additional services
suggesting that the service provides early intervention which may
well prevent more serious problems later. (DB)

Preventative Interventions For The Very Yo

An Infant Consultation Service Interweaves Service, Trai.

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Having decided, in 1970, to establish a small counseling service
for parents of infants and toddlers, we soon discovered that we
were into something more complex than we had expected. In the
first section of this paper we will review those complexities
both through some brief history and in relation to some of our
theorizing. In the later sections we will discuss specific func-
tions of the service, issues of training and, finally, assessment
and research.

Looking Backward

The idea of a counseling service for parents of infants and
toddlers flowed naturally from long experience (14 years) with
a therapeutic nursery school in our child psychiatry department.
Most of our staff had learned a great deal about disturbances
in very young children and their parents, as well as about the
dynamics of family life at that developmental phase. Having

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We found that these family interviews could be very productive.
Also, through that medium we had an opportunity for directly
observing how subtle but powerful and long-lasting, mutually
maladaptive transactions between certain parents and their very
young children evolve.

An important department-wide activity became the weekly demon-
stration interviews in which most of the staff observed the
chief of the department interview families with preschool child-
ren. These interviews, observed through the one-way window,
were (and continue to be) followed by intensive discussion of
what had been seen and listened to by everyone. Many of these
interviews were videotaped so there was opportunity for those
with special interest to review the interviews more than once.
Those on the staff with interest in the problems of parents
and very young children developed special clinical acumen in
this area. Refinement of diagnostic thinking about the prob-
lems in this phase of development, and therapeutic techniques
for helping parents through a brief series of family interviews
evolved.

Alongside of our experiences with preschoolers in the therapeutic
nursery school and in family group interviews, was our coinci-
dental interest in group therapy. Many staff members became
impressed with the effectiveness of dynamic group process for
helping troubled parents. We observed that group sharing of
problems and anxieties common to parenting has a relieving
impact on most parents. We believe, however, that for

sharing to be meaningful beyond immediate emotional ventilation,
sensitive and wise leadership based upon clinical knowledge
about early family experience is essential.

Just a little more history. Anticipating changes in our clinical
programs that we thought might arrive with the development of a
community mental health center, our department had experimented
with the use of brief, time-limited group approaches with parents
of children of all ages. The service had taken shape in which
families applying for help were offered an initial family inter-
view, followed by six parents group meetings, followed by a follow-
up family or parent meeting. This format became a reliable one
as a basis for providing first phase help. We found in follow-up
evaluations[3] that a surprising number of parents felt this brief
series of clinical contacts had been very helpful to them even
though the behavioral symptoms in their children had not neces-
sarily ended. Their own objectivity and tolerance as parents
seemed to have grown as a result of the group experiences.

Theory

We will briefly outline some of the theory that integrates our
project. Clinical work with children requires a developmental
frame of reference. Because of the ways in which we have worked
with parents and children our theoretical perspective has come to
include the notion of familial development in addition to and
interlaced with individual development. This notion, which places
the individual child's development in the context of an evolving
or changing family system adds considerable complexity to clinical
thinking. One way in which we have come to think about the family

derives from sociologic theory about social systems and the concept
of resistance to change. Some of us have found it useful to view
any family as a system undergoing a constant series of develop-
mental changes. Most developmental changes in families evolve
fairly smoothly and constructively. Some meet enormous resistance,
a perspective introduced in an earlier paper by Brown.[4] Using the
notion of resistance to change in a family system, one can try to
discern how troubles and clinical symptoms result from failure to
master normal developmental stresses and changes evolving in the
life of the family. Extending this just a little further, we note
that resistance to developmental change might arise from various
sources. An example illustrates this. A mother finds it difficult
to let her baby crawl on the floor. This, then, is a mother's
resistance to spontaneous individual developmental change in her
baby. The mother's failure to facilitate normal developmental pro-
gress in her child may very quickly contaminate the normal develop-
ment of the whole family unit. The child is blocked from experi-
ences which foster the development of competencies and facilitate
its evolution as an emerging autonomous little person. The mother
herself, in avoiding the anxiety her child's new behavior chal-
lenges her to face, fails to move forward in her role function and
in her individual maturing as a mother. Coincidentally the father
also fails to make progress in his role as parent responding to an
energetic, curious, exploratory, little child. In a sense, every-
one stops growing and we would say that in accepting this in each
other the family as a system is resisting normal change. These

events may become nuclei for subsequent pathologic relating in the family and for individual disturbances in the children.

Left out of this example are the infinite number of possible causative factors that may have produced mother's resistance to her child's development. These may include not only her own psychodynamics, but her husband's, the nature of the marital relationship, and purely environmental issues as well - - the dwelling they live in, the presence of danger, physical limitations, etc. All this alludes to more than we can review in this presentation. The main point, in summary, is that the theoretical framework that guides our work with parents of very young children takes very seriously the issues of intrafamilial dynamics and mutual adaptation as well as the view of families as evolving systems. We believe that this kind of theoretical formulation keeps us open to pragmatic approaches to each family problem and prevents over-investment in traditional approaches when they are not applicable. It is especially useful for organizing our approach to preventive mental health.

Early prevention requires, in our estimation, and holistic view of development. The measures we as clinicians can use for early prevention include purely educative guidance for parents, along with psychodynamic therapeutic interventions, group process, and environmental alterations. Recommending appropriately for the latter requires that we engage in a vital way with other child care and nursery school settings, community agencies and with currents in the surrounding social system. If our thinking includes a focus upon the resistances to and interferences with developmental change in families, we may be able also to more clearly define what kinds of helpers need to be

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trained and what kinds of social agencies are needed for meeting particular kinds of failures.

Functions Of The Infant And Toddler Counseling Service For Parents

We have already described the basic service model of family and parent group interviews. We began our service by publicizing it through established channels. We notified all of the pediatric attending staff of the medical center. A sizeable number of pediatricians showed interest but in fact, relatively few of them referred parents to the service. A newspaper article about a research project in our department called the "Parenting Project" produced numerous phone calls from young parents who were attracted by the idea of a research program for "normal families." We learned from these experiences to emphasize the theme of normalcy in our publicity and also to look for referral elsewhere than from pediatric sources.

Usually the group meetings are attended by mothers. Fathers participation varies considerably.

At the end of six group meetings, certain parents have elected to go through another series of six. Some husbands have accepted referral to a series of married couples group meetings which are limited to six sessions. Other families have been referred into another service in our department in which 5 or 6 families, including the child, meet together weekly for 12 sessions. These "family education workshops" are lead by educational therapists from our nursery school. A number of mothers in the groups have been seen to need a period of

intensive guidance in the mother-child relationship. We refer

them into still another service in which mother and toddler or

infant are seen together for   series of sessions. In ummary,

the parent groups provide a central clinical process leading to

the desired constructive changes or to a clarification of the

parent's and child's problems. On this basis a family can spin

off into other, differentiated services as they seem indicated.

Our objectives in the group process are the following:

1. To encourage the sharing of problems and the search for
   solutions to those problems among group members.

2. To stimulate an approach to problem-solving that involves
   an examination of one's own and one's children's behavior
   in order to discover the meaning in it.

3. To invite some self-examination and awareness of childhood
   as significant in determining present relationships within
   the family.

The problems introduced by parents in the groups include:

1. Ordinary parental worries about eating, sleeping, walking,
   talking, toileting, and socializing, problems with siblings.

2. Major concerns about such items as rejection of food, feces
   withholding, failure to verbalize, resistance to sleeping,
   aggressivity, and poor frustration tolerance.

3. Marital tensions; conflicts with grandparents (in-laws);
   maternal post partum depression; maternal feelings of
   isolation and communication problems with pediatricians.

Issues Of Training

We referred earlier to "complexities" in the development of
the service and to "issues of training." We will discuss
the issues of training in two sections: A. Training of
Professional Social Work Volunteers and B. Training of
Paraprofessionals.

A. Training Of Professionals (Volunteers)

Soon after the service began it became clear that the avail-
able Child Psychiatry staff time was not sufficient to meet
the program's needs. A call for volunteers from non-working
mental health professionals who were known to the initiator
of the project (Helen Reid) was successful. A number of capa-
ble individuals, most of them holding Master's degrees in
psychiatric social work, offered from one half to one day per
week. None, however, had more than minimal experience in
clinical work with very young children and parents. The
volunteering professionals were mostly mothers of preschool
or early school children who had taken leave from their careers
as social workers because of maternity. The length of their
professional inactivity varied, and the area of their speciali-
zation in the field of social work was diverse. They all
showed a marked interest in a project dealing with families of
young children. We speculate that a common motivation for
involvement in this particular project comes from an interest
in understanding and being helpful to clients in a similar
phase of parenthood.

A brief initial operating period pointed out that most of the professionals were not familiar with the information involved in early family interventions, namely, knowledge of a) family interaction, b) the psychology of early childhood development, and c) brief intervention techniques. Thus, a phase of training was necessary to equip them with the basic specialized theoretical and factual knowledge, and technical intervention tools.

The training schedule established included the following traditional steps:

1. Demonstration by an expert family therapist of interviews of families including children under 3 years of age, as a basis for discussion of technical problems and understanding of family dynamics.

2. Series of lectures and discussions on early child development given by an experienced educational therapist.

3. Group supervision of brief family and group interventions conducted by the volunteer social work staff.

The results of this training program have not been rigorously controlled or quantified, although first steps in this direction will be described later in the paper. At this point, descriptive evaluation only is presented. On the whole, it appears that the professional staff gained skills and confidence in the type of interventions required by the service, and are now functioning within delineated objectives of the project. Nevertheless

qualitative differences among workers remain, and the gain from a relatively extensive period of training at times appears minimal. Two particular deficiencies should be stressed: a) inadequate understanding of family inter- actions and underlying dynamic processes often is evidenced, and b) mechanisms of unconscious identification of the thera- pist with one member of the family group, usually the patient- child, led to distortions of interaction.

These essential restrictions to the success of training may involve several factors. First, it is reasonable to question whether therapeutic abilities can be taught by conventional means, such as the ones described above, observations, classes, supervision, or whether attention should be given to a differ- ent type of training, involving a personal therapeutic experi- ence. Second, it is possible that the particular character- istics of this group of social workers, namely their situation as mothers of young children, constituted a negative factor in handling problems encountered by young families by over- facilitating processes of unconscious identification. Our experience does let us conclude that prior traditional social work training associated with earning the academic Master's degree, does not provide an adequate foundation for special- ized work involving families of very young children.

B.   Training Program For The Paraprofessional Staff
The paraprofessionals were chosen as candidates for the

specialized training program from parents of former patients
in the Section of Child Psychiatry's therapeutic nursery
school. The selection criteria were: a) successful outcome
of the therapeutic intervention for themselves and their family,
b) desire to return the services received in the clinic to the
community, c) interest in entering the field of the helping
professions and in furthering their own formal education programs.
It was felt that former patients of the clinic whose treatment
involving problems with a pre-school child had a successful
outcome, could be particularly appropriate candidates for train-
ing as counselors for families of young children.

Secondly, it seemed that a group of successful former patients
would constitute an exploratory sample for the innovative imple-
mentation of a non-traditional form of training, combining in
the same setting personal therapy and training of therapeutic
skills.

Thus the hypotheses underlying the training of paraprofessionals
were: a) former patients having successfully benefited by the
treatment program in the clinic would be effective counselors
in handling family problems, b) training including both a thera-
peutic and supervisory experience would be more effective than
the traditional social work training.

Description Of The Paraprofessional Group
During the first year of operation, the paraprofessional group
included eight members: Six female members were former mothers

of patients in the clinic and had received intensive and pro-
longed treatment for themselves and their families. All of
them had one child who had been placed in the therapeutic
nursery school and each mother had received individual treat-
ment. Two members, one male and one female had not been
patients of the clinic, and did not present a severe family
disturbance. Both were and are still undergoing individual
therapy. Both had been involved in individual psychotherapy
for a period of time, and their psychotherapy was an ongoing
experience as they participated in the other training and super-
visory aspects of the program described below.

The group was organized as a therapy group in which the members
could openly present their internal difficulties as well as
explore their interrelationships. One important variation from
a traditional group therapy was the addition of a training
component. Each member was asked in turn to present a problem
while the others acted as therapists. Two professional staff
members functioned as supervising psychotherapists, intervening
on two levels - therapeutically when the problems of the group
were not handled effectively by the trainees, and didactically
when the supervisor judged that examination and discussion of
issues just illustrated, could effectively help the group members
acquire therapeutic skills.

A flexible academic program was devised and included supervised
observation of short-term mothers and couples groups, course on
child development and participation as co-therapists with a

trained social worker in the handling of a short-term family
or group intervention.

Outcome Of The Group

Quantitative measures of process and outcome are being devised,
in part based on data elicited by experimental procedures applied
as pre-tests to this group. However the results of the first
year of operation are here presented and discussed descriptively.

The main outcome was a gradual elimination of the six former
clinic patients as members of the group and exclusion of four
of them from the paraprofessional program. Two women dropped
out during the first few months by mutual decision of the thera-
pists and themselves, and the remainder at the end of the year.
The two members who were not connected with the clinic remain
active members of the group, now in the process of reorganiza-
tion. The difficulties presented by the former patients were
in two areas:

1. The experience of training through psychotherapy appeared
to produce a disintegrative personality process in the six
former patients. The manifestations appeared to be intolerable
anxiety or depression and/or heightened primitive mechanisms of
defense. In the two members who were not former patients, a
process of progressive insight of intrapsychic mechanisms and
integration appears to have taken place and is still in pro-
gress.

2. Although there is still insufficient perspective and

experience of the effectiveness of the paraprofessionals in
brief family and group interventions as co-therapists, it
appears that the former patients manifested great difficulty
in handling that function. A phenomenon of unconscious identi-
fication with the child against the mother as a recipient of
the projected "malignant" mother-part of themselves seemed to
occur, thus impeding the therapeutic exchange.

An attempt at understanding the factors contributing to this
striking, unexpected outcome follows:

1. Training through psychotherapy involves a duality of roles.
On the one hand, the trainee is a patient in the group, but
on the other hand, he is also required to act as a therapist.
This duality seems to induce a complicated relationship with
the professional therapist, particularly in making a distinct-
ion between transference reactions and reality. This inherent
ambiguity of the therapeutic training group might require the
capacity to maintain a relatively intact observing ego function.
It can be hypothesized that patients, like the members of this
group who have presented severe disturbances manifested in early
pathology in their child, do not possess a sufficiently organized
personality to sustain the ambiguity of this experience.

2. The step from the status of former patient to the role of
therapist might constitute a most difficult reversal of roles.
The experience described above points out that former patients,
in spite of an apparent recovery and the achievement of an

adequate level of parenting function, might undergo a pro-
found regression when functioning as a trainee in a therapy
group and/or a co-therapist of parents' groups.

Only tentative indications can be derived from the limited
data from the two paraprofessionals who were not clinic
patients. They seemed to be able to use the therapeutic
training effectively, both to further their self-understanding
and understanding of their group's interactional processes,
and to apply such insight for a better grasp of the parent-
client. Their work as co-therapists manifested qualities of
accurate empathy and non-possessive understanding of the client.
A great deal more experience is needed, however, to evaluate the
positive aspects of this type of training, and compare the results
with the outcome of a more traditional approach to the teaching
of psychotherapeutic skills. The group is in the process of
reorganization based on the knowledge acquired in the first year
of operation.

Our training experiences to date suggest:
1. Selection of paraprofessionals for training in a therapeutic
group should be done with caution. Former patients who had
presented serious personal difficulties do not, despite the
good results of their own therapy, appear to be promising
candidates.
2. Insufficient data is available to support or invalidate the
effectiveness of the non-traditional form of training through

psychotherapy. This method proved unsuccessful in the present
sample, but this failure seems related to the particular com-
position of the group. The positive experience with two non-
clinic patients and a positive trend emerging with some new
members added in the last three months indicates the possible
effectiveness of the technique for teaching psychotherapy.

3. Currently in the mental health field, budgetary consider-
ations and a philosophical preference for emphasizing as basic-
ally helpful, the presence of an interested human combine to
encourage increased use of paraprofessionals in clinical work.[5]
However, the relationship between types of training of para-
professionals and their effectiveness as therapists remains
insufficiently studied. Thus we have added to the questions
noted earlier in this paper, an interest in identifying dimen-
sions of the ICS experience perceived as most helpful for clients,
and an interest in tracing how participation in the training
program relates to changes in the paraprofessional therapists'
ability to deliver these helpful experiences.

Research Perspectives
The inclusion of a formal research component in a new clinical
service and training program represents an extension of the method
of self-observation and shared commentary illustrated by the
weekly demonstration interview described earlier. We have had
a continuing interest in assessing empirically what we do, in
our training programs[1] and in our programs for serving clients[3].

The formal research aspects builds on the foundation idea
of research, a commitment to observation and careful recording
of observations. The formal research endeavor simply adds the
further responsibility for explicitly relating the methodologi-
cal operations and precedures to the ideas (programs) one seeks
to evaluate and assuring that the methods of observation and
data recording can be shared in a way which permits replicabil-
ity by others, and a basis for judging the reliability of the
data.

Let us now look at some of the questions generated by the ICS
and how we are proceeding with research to help answer those
questions.

The theory and practice of clinical service we have described,
puts the person of the clinician in a central role. The clin-
ician's formal knowledge, but certainly and importantly the
perceptions and feelings experienced as the interviews flow
along, provide the basis for on-the-spot decisions about how
to respond. What is the response set a person brings into the
clinical endeavor? Does clinical training and studied experi-
ence uniquely alter the well learned "basic disposition" so
that a person, as clinician, can make available to another
person, as client, some new idea or sense of emotional worth
they can assimilate into themselves and take away for construct-
ive use.

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We approach measuring this by asking our trainees to partic-
ipate vicariously in a real ICS family interview. A video
tape interview done by the senior staff member developing
the ICS program (Helen Reid) was video taped. The tape was
shown to both professional and paraprofessional trainees (by
now 26 have taken the precedure). At various points the tape
was stopped and the observer was asked to respond to questions
which could reveal their understanding of the parents, the
child, the interactions between clients, the purpose of the
clinician, how they themselves could feel it was appropriate
to respond, etc. Sample questions to which the clients wrote
open-ended responses were: a) In making her comment, what do
you think the interviewer's intent was? b) If you were the
interviewer, what would be your thinking about whether (and
how) to intervene at this point? c) Imagine you are the inter-
viewer. What feelings and thoughts might you be having about
the parents' relationship to each other? d) How would you
describe the emotional mood and feelings of the father? etc.

As a first step to using this material empirically, we asked
the interviewing clinician to use herself as a standard and
read and "score" the protocols of each of the 26 respondents.
Because the procedure was being developed while people were
already in training, we do not have, for the people being
discussed in this paper, a neat set of protocols based on
administrations of the precedure before any training (or ICS

experience took place) then followed by later readministra-
tions to ascertain changes. If, as working hypothesis, we
assume that the procedure taps, to some degree, a person's
intrinsic sensitivity, perceptual-cognitive bias, and so
forth, we might be able to use even these first collections
of data to help understand why some of our first paraprofes-
sional trainees decided by themselves, or had to be asked to
leave the clinical phases of the program.

As Figure 1 illustrates, there is a large range of scores on
the procedure from 34 to 110. Clearly the procedure, involving

- -

Insert Figure 1 about here

- -

future clinical interviewers as "vicarious interviewers,"
reflects unique tendencies and appears to be a promising
relevant method for establishing differences between individ-
uals. We note that 3 of the 6 paraprofessionals, who were
former patients, indeed did score at the very lowest end of
the distributions of scores. Considering that 6 of the partic-
ipants out of a total of 26 were asked to leave, we can say
that this group was highly over-represented in the lowest quar-
tile of scores, and under-represented (there were none) in the
highest quartile. Although we do not have the satisfaction of
a "blind" judgment, there is reassuring support for the belief

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FIGURE 1

Congruance of Perception and Uncerstanding
of a Videotaped I.C.S. Family Interview

Code

● = Former clinic patient

0 = Other paraprofessional

M = M.S.W. returning to field

S = Clinic staff member

X = Senior clinician who did the video
interview and scored all protocols -
the "Standard"

Scores of 26 Subjects

Range	34-110
Lowest quartile	34-42
Median	65-5
Highest quartile:	83-110

PERSONS

CONGRUANCE SCORE
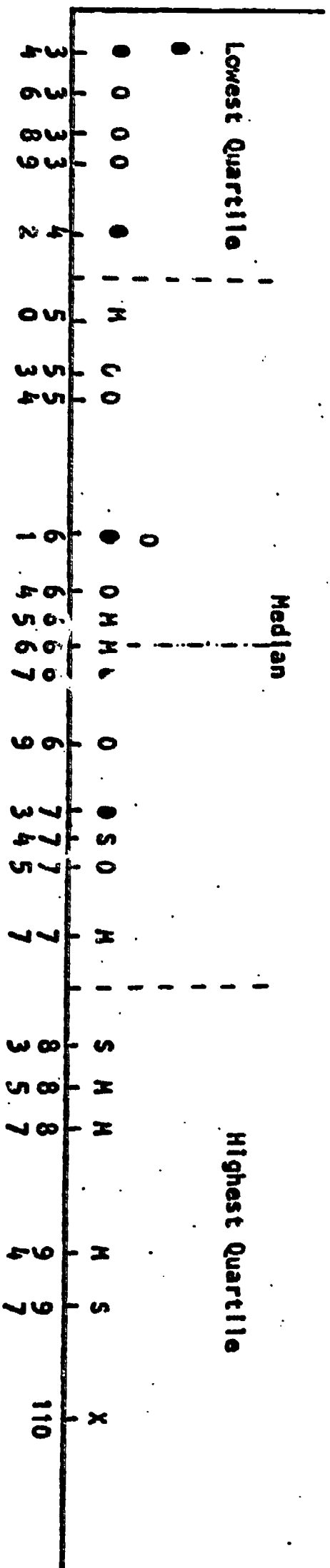
Lowest Quartile   Median   Highest Quartile

that whoever is hiring our own department staff knows what
he or she is doing. We have earlier emphasized the fact
that Masters level social workers did not have an adequate
backgound, on that basis alone, for making competent brief
interventions for problems of families and young children.
Nevertheless, schools training professional social workers
could also take some satisfaction from the distribution of
M's reported in Figure 1. The MSW background does appear
to facilitate focusing on the important issues of a clinical
transaction. Given the number in a sample, we can only
report the observations in Figure 1 as a trend. Application
of the appropriate statistical test (Kolmogrov-Smirnov one
sample test) yielded a D of .25 which was not statistically
significant.[7]

We have established that a standard procedure for sampling
how trainees observe and conceptualize might well indeed
serve as a discriminating indicator of the effect of training.
By applying this procedure before training and after training
to our next group of paraprofessional and social worker ICS
volunteers, we will also be able to assess the degree to which
a formal professional academic background might be necessary
for the kind of brief clinical work our service chooses to do.

In the first year of operation of our program, 86 families had
at least one face-to-face contact. Since the Infant Consulta-
tion Service was conceived as a preventative endeavor, and the

publicity emphasized our availability to families of young

children, it is of interest to note that one-fourth of the

children with reference to whom these 86 families contacted

the ICS were less than 18 months of age, and only 9 of the

86 were older than age 4.

The basic service model, noted above, called for a family

interview, a series of 6 group meetings of mothers, and a

follow-up family interview. In the free exploration of our

program, many variations from this theme occurred. For

example, some families had a series of family interviews.

For other families, the group was a Couples Group experience.

Some families immediately asked for and were judged to be

ready to benefit from an additional series of 6 group meetings

(sometimes both a Couples Group and a Mothers Group experi-

ence being involved). Despite all of these variations, we

decided as a first effort in follow-up, to ask the therapists

who had run the initial Infant Consultation Service group to

evaluate whether they judged the families they had served to

have gotten maximal, neutral, or negative results from the pro-

cedure. These categories were defined as follows:

I. Would you say they had gotten much benefit from their ICS

experience (i.e., improvement, problems and worries resolved,

questions clarified, symptoms alleviated, etc.). In short, a

very positive, good result.

II. Would you say their ICS participation had not provided
any significant new perspective or strength to help them
move ahead (i.e., although they may have had an interesting
experience, their initial concern, problems, symptoms, etc.
were essentially not significantly better, but neither were
they necessarily worse). In short, a moderately positive or
neutral outcome.

III. Their ICS participation had been an unhelpful experi-
ence (they seem, if anything, more confused with respect to
their initial questions or worries, the problems they des-
cribed at the end of the service seemed to be more severe
or weigh on them more heavily than those described initially,
the symptoms concerning them seemed, in quantity or severity,
perhaps to have gotten worse). In short, a negative outcome.

The therapists, as judges, were asked before making their
ratings to establish a frame of reference by thinking of all
the families they had personally worked with, and also of
other ICS families they had heard discussed which had been
worked with by other therapists. They then were urged to
keep in mind that the probable range of outcomes should be
assumed to involve approximately 25% highly successful out-
comes, 50% in category II and, 25% in category III. It was
the researcher's initial expectation that some 20 families
in the two extreme categories would be identified, assigned
to follow-up interviewers (paraprofessionals now in training

who had not had contact with those families) and we would then have an "experiment" in which clients' own perceptions could be related to the groups defined by the original therapist. To our surprise, despite the "normal curve" of outcomes we alluded to, our therapists found only 5 cases they could identify as fitting III - - the negative outcome. Of course, the definitions of the three categories was such that a substantive base was available which logically would permit the therapists to deviate in judging their particular cases from what was presented as a probable overall distribution. As we shall see, the clients end up agreeing with the therapists.

We then designed a follow-up interview which explored via a telephone call the clients' recall of the experience, and evaluated outcome by means of 3 clusters of questions dealing with: 1) the area of the child's symptoms (improving?, new symptoms appearing since ICS?, old symptoms reoccuring?), 2) a parent cluster in which parents could indicate how they now worked together and what happened to mother (the informant) or her spouse's personality, and 3) a "referral" cluster in which their interest in returning to the service or making it known to friends was tapped.

Since only 5 catagory III cases were found, we ended up using the number of catagory I cases (22) as the definer of sample size, and selected at random 17 category II (neutral outcome)

cases, as well as the 5 category II cases to represent the
other group. By using 5 different telephone interviewers,
each of whom did a small number of cases, systematic follow-
up interviewer bias was adequately delimited. Each follow-
up interviewer received a like number of category I and
category II (or III) cases, not knowing which was which.
Our follow-up sample was reduced by 7 when a sixth parapro-
fessional interviewer had to withdraw from the study, and
at the last moment couldn't be replaced. In addition, we
discovered how highly mobile our young population is. Three
of the five category III cases, three of the 16 category II
cases, and five of the 22 category I cases had moved, and no
forwarding telephone number could be ascertained. An addi-
tional two category I cases were located but not available - -
one mother having gotten seriously ill and being in the process
of brain surgery, while another family had moved from Califor-
nia to Florida.

We thus ended up being able to follow up 13 cases judged by
the original therapists as highly successful and 12 cases
judged by the original therapists as having a neutral, or
(2 of these cases) negative outcome. The follow-up interval
for the successful cases ranged from 2 to 10 months since
the end of the basic (first) ICS service with a median interval
of 8 months. For the less successful group, the follow-up
range was from 5 to 20 months, with the median interval 9.5
months. Overall we succeeded in following up 78% of the cases,

a little better than the usual experience in this kind of
research effort. In discussing the results of this follow-
up we wish to underline that many of the families were,
indeed, "spun off" into additional services   8 of the 13
category I cases had subsequent service (some of it contin-
uing at the point of the follow-up). 5 of the 12 category
II-III cases (actually none of the category III cases received
additional service) had further work done in the clinic.
Although the trend indicates that more category I cases sought
and were offered additional service than was true for cate-
gory II-III, the discrepancy in proportions is not significant
when tested statistically (Chi square = .92, probability$>$ .30).
We'll return however to the implications of this trend in our
comments below.

First let us turn to Table I. Based on the phone follow-up

- -

                    Insert Table I about here

- -

interviews, the outcome for the clients of the service were
categorized as very positive, moderately positive, or negative.
It is important to note that moderately positive means just
that, and is not a "neutral" category as was the case for the
judgments asked for the ICS therapist. Thus in Table I we
can compare the degree of outcome described by the client in

TABLE 1

Therapists and Clients (Mothers) View of the I.C.S.

Therapists Judgment*	Therapy outcome based on follow-up interviews		
	Very Positive	Moderately Positive	Negative
I N = 13	4 (30.8%)	7 (54.8%)	2 (15.4%)
II or III+ N=12	5 (42%)	4 (33%)	3 (25%)
Total N=25	9 (36%)	11 (44%)	5 (20%)

*I = Much benefit. Problems and worries resolved, questions clarified symptoms alleviated.

II = Participation had not provided any significant new perspective or strength. They may have had an interesting experience. Their initial concerns were not significantly better. In short, a moderately positive or neutral outcome.

III = I.C.S. an unhelpful experience. If anything they seemed more confused, symptoms seemed worse—a negative outcome.

+ Two of the total of 5 cases judged III were successfully contacted. Both mothers described very positive outcomes.

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relationship to a successful versus non-successful categori-
zation based on therapist judgments. It is of interest to
note that only 20% of our cases can be viewed, from the clients'
point of view, as having not gotten something of worth from
the ICS. 36% of the cases felt that the outcomes were very
positive and their comments in the interview gave substantia-
ting anecdotes for their judgments. Likewise, the 11 cases
(44%) who had moderately positive outcomes in the sense of
their own personal reactions, or what they saw happen to
their child, did provide substantiating comments to support
their judgments. (All phone interviewers were asked to fill
out a form assessing various dimensions of communication on
the basis of which the reliability of the phone interview
could be judged. Overwhelmingly the data was considered to
be adequately reliable). Comparing the category I and cate-
gory II-III outcomes, we note that 85% of the category I
respondents (all the phone interview respondents were mothers)
reported positive outcomes and 75% of the category II-III
mothers felt they had positive outcomes. Thus both our
"unsuccessful" and "successful" groups reported satisfaction
well above the "two-thirds of people who get well anyway"
argument of critics of psychotherapy (See Dr. Frank's [6] recent
reexamination of this and other issues pertinent to "The
Bewildering World of Psychotherapy".)

It is interesting to note that the two cases judged to be

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unsuccessful on follow-up reported great gain, and this with
some enthusiasm.

We will now consider the conditions leading to certain thera-
peutic results being considered very positive by the client,
while these same clients were judged to have had only neutral
or even negative outcomes by the therapist. We reviewed
these cases in comparison with the descriptions of the ICS
experience of clients judged very successful by the therapists,
but whose follow-up protocols led another judge (a trained
clinician) to categorize them as having had negative, or at
best moderate outcomes. Comparison of these protocols suggested
an interesting dynamic operative in clinicians.

Some of the clients established relationships in which they
readily and openly acknowledged their gratitude, the dependence
and the high value they placed on the support given to them,
particularly by the therapists, and sometimes also by the group
of mothers with whom they worked. Many of these cases had
entered into ongoing therapeutic relationships. However, on the
basis of the follow-up protocols no substantial change in either
the mother's personality or the child's originally presented
problem had actually taken place. Rather, the client seemed to
be saying "I need you" and was willing openly to share "ma erial"
revealing this need. It appears that this eager relating and
offering of problems influenced the therapists into believing
these clients were making good use of the ICS.

It is important to underline the probable fact that many of
these mothers (and other of the cases judged on the basis of
follow-up to have positive outcomes might have indeed have
gotten something of substantial value from the service which
helped to accept their dilemmas, problems and anxieties as
their own. With some of these families we felt signigicant
preventative work was accomplished. Thus, there were a few
cases where parents strong needs to defend against their own
inadequacy led to an intense need to use externalizing defenses,
attributing exaggerated pathology to their child. Often this
was seen to happen even where the child described appeared to
be essentially normal. Given group support, some interpretive
understanding, a better working relationship with the spouse,
and the offering of further services as needed, some of these
mothers began to separate their needs from the pressures they
experienced in relation to the child. Indeed these young child-
ren often did generate "normal" pressures as they went through
developmental phases involving temper tantrums, nightmares, "no"
saying, some picky eating, etc. It appeared that the service
helped the parents (mothers particularly) step back, exempt
their child from the pathological role and rather accept their
own frustrations, impatience or fatigue as legitimate and their
own. This left the child free to experience the phase he was
in and then "flow on" in what the follow-up revealed to be a

pattern of normal development.

Feeling potentially competent and able to help, seeing a comprehensible principle rather than being overwhelmed by what was initially perceived to be incomprehensible, helped a mother see herself as a resource even if initially she was bothered or puzzled by the child's behavior. Parents sense of confidence was bolstered, and they could go on, not being too bothered and work with the problems their children had, especially when a better working relationship with the spouse had occurred, and sometimes because a good feeling now existed about being related to a service (remembered as potentially available when needed, or actually still being used). The conclusion that a child may indeed remain mildly symptomatic, or be in a phase where his behavior makes him difficult to live with, without the child or parents requiring therapeutic work, supports the similar conclusion reached in our previous follow-up study of the effects of brief service in our out-patient clinic. Here the families initially sought service, concerned about problems with older children or adolescents. (Byars, et al, 1972). This conclusion is also in line with Frank's (1972) recent comments on the role of "demoralization" as a determinant of the need for professional help.

As we continue with the Infant Consultation Service, informa-tion from our research fed back to the training staff, and to the participants who are asked to judge their own work as it proceeds, promises to refine our judgment about the need for and the timing for offering further service. Certainly as

viewed in the perspective of this first sample of research
data, we can say that the Infant Consultation Service can,
in brief span, exert a constructive direct effect on some
families; that relevant case finding (52% of our cases went
on to additional service) does occur when working with
families of very young children, thus supporting our hope
that the ICS can provide early intervention which might well
prevent later more serious problems; and that there is a
possibility that clinicians has a bias to perceive as resis-
tance the readiness of some clients to leave the service
after a brief exposure, when the clients themselves can point
to substantial positive outcomes they experienced in their brief
contact.

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