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The Handbook of Clinic Practice

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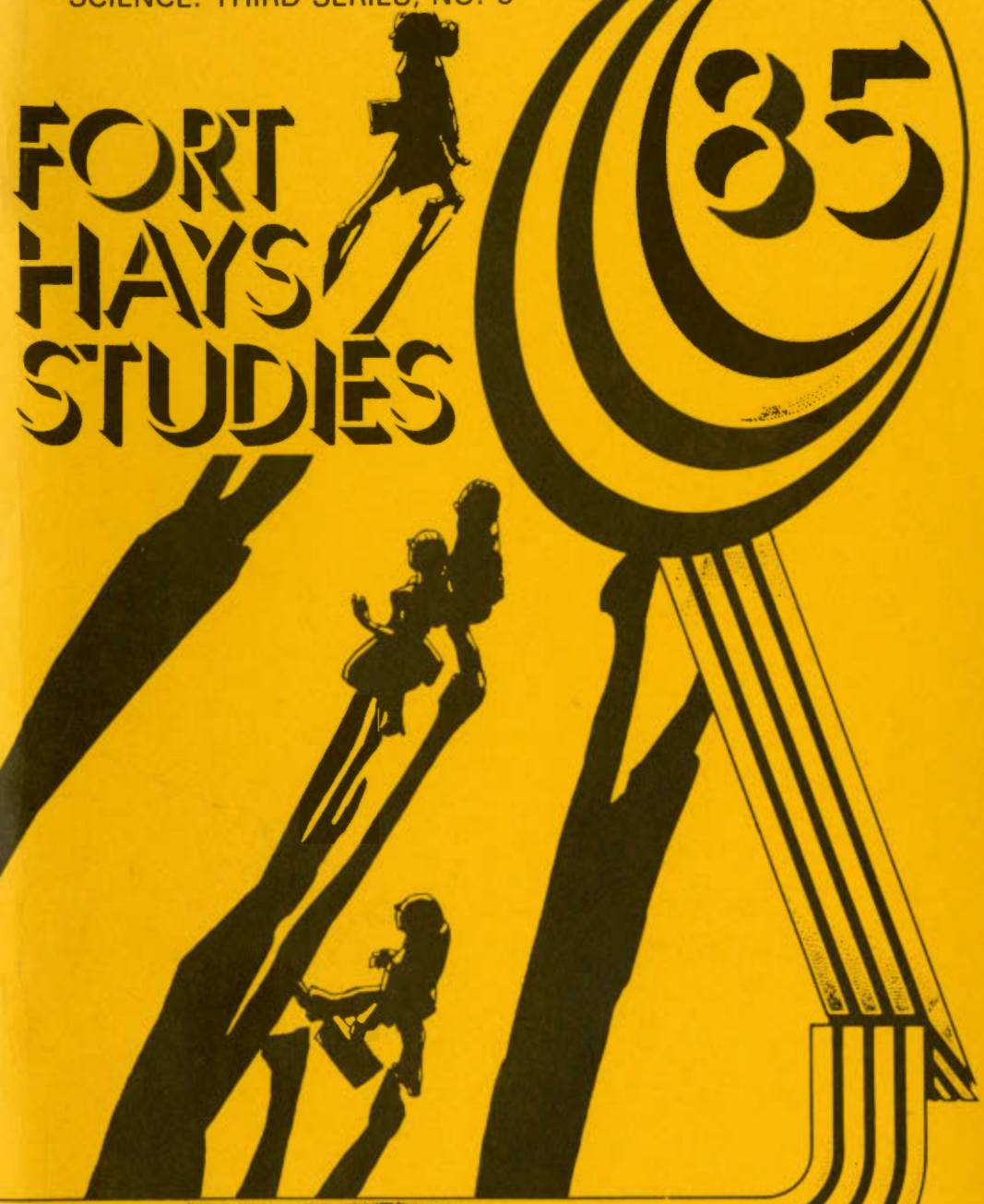

THE HANDBOOK OF CLINIC PRACTICE

By

George A. Kelly

with editorial comments and arrangement by
Thomas T. Jackson, Paul F. Zelhart, and Robert P. Markley

FORT HAYS STATE UNIVERSITY
Museum of the High Plains

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Hays, Kansas

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PREFACE

When George A. Kelly completed his Ph.D. in the Spring of 1931, jobs were scarce. As part of his employment search he registered with a placement agency in Chicago. The agency referred him to a small, public college in the western half of his home state—Fort Hays Kansas State College.

Fort Hays Kansas State College was 29 years old when Dr. Kelly, accompanied by his bride (Gladys), arrived for the Fall semester. The school enrollment was at an all time high (655 students). President Clarence Rarick was busily developing federally funded student recruitment and support programs that would enable the instituion to survive the Depression and Dust Bowl years. Survival was not assured, however. The precariousness of the situation was reflected in changes in faculty salaries. Early discussions of a salary for Dr. Kelly had involved a figure of $2500 for the nine month term. When he arrived he found his salary had been trimmed to $2400. Over the next five years further salary reductions would reduce Dr. Kelly's salary, along with those of other faculty, to 75 percent of the 1931 base figure. Student enrollment also fell in 1932, but President Rarick's programs to recruit qualified but impoverished students began to work. Enrollment increased steadily from 1933 until World War II.

George Kelly brought a varied educational background to his first academic post. In 1926 he had received his first bachelor's degree from Park College after earlier study at Friends University. He received his master's degree in Sociology in 1928 from the University of Kansas, and then he took additional coursework in Sociology that summer semester at the University of Minnesota. After a stint as a teacher, Dr. Kelly received his second bachelor's degree (in Education) upon the completion of a year of study abroad at the University of Edinburgh (1930). His doctorate in Psychology was granted after only one year of study at the University of Iowa. So, in terms of his academic coursework, Dr. Kelly had the greatest amount of training in sociology and education and a lesser amount of experience in psychology. In clinical psychology, the area in which he would make his greatest contribution, his formal training was meager.

Dr. Kelly's involvement with clinical psychology at Fort Hays Kansas State College began in the Fall semester of 1931. As Dr. Kelly recounts in an article orginally published in 1937 in the college magazine, *Aerend*, a twelve year old boy was referred to the Psychology Department for evaluation of school related problems. The evaluation became a laboratory exercise for Dr. Kelly's class in Adolescent Psychology. It was apparently a powerful and positive experience for Dr. Kelly and his students. By the Spring semester of 1932 the Psychological Clinic had been established. It would grow in terms of the variety of services offered until Dr. Kelly's departure for military service in World War II. By 1935 the value of the services offered were so well recognized that the Clinic was funded directly through an act of the state legislature. Throughout the pre-war history of the Clinic Dr. Kelly and his students were the only staff members. Remembering Dr. Kelly's limited formal training in clinical psychology, it is clear that the practices and procedures of the clinic were the products of a mutual learning experience for both teacher and student.

The Handbook of Clinic Practice is a major surviving document that shows Dr. Kelly's early development as a clinician. With Mrs. Kelly's permission, it is being published for the first time through the Fort Hays Studies series. The *Handbook*

began as a guide for bachelor and master level students working in the Clinic. Although it was written and rewritten numerous times, it was always in draft form and used as a teaching aid. Two versions have been found. The earlier one (Circa, 1936) was found in the basement of Forsyth Library (Fort Hays State University) in 1981. A later version (1941) is in the possession of Mrs. Kelly. Dr. Kelly began a revision of the *Handbook* for publication after World War II, but abandoned the project (Landfield, 1981). Dr. Kelly also mentions the *Handbook* as the precursor to his major work *The Psychology of Personal Constructs* (Kelly, 1955). The 1936 version of the *Handbook* is the one to be published.

To understand the content of the *Handbook* one must understand the functions of the Clinic. The services of the Clinic on campus included evaluation and therapy for psychological disorders, vocational counselling, speech therapy, academic counselling, and skill training. Both adults and children were seen on campus. The traveling clinics primarily offered diagnostic and consultation services for school children. The progress of those served was followed by mail.

An interesting feature of the *Handbook* is the "Rules". The "Rules" are admonitions for the students working in the clinic. Included within them is a nearly complete set of ethical standards that are congruent with current ehtical standards of the American Psychological Association (APA) (Cleanthous, Zelhart, Jackson, & Markley, 1982). Dr. Kelly's "Rules" were written about ten years before the APA began work in this area. The APA ethical standards were not adopted until the early 1950's.

The orientation of the therapeutic approaches used, as revealed in the *Handbook*, is also interesting. While the campus clinic used psychotherapeutic methods that were Freudian, the traveling clinics and vocational counselling projects reflect Dr. Kelly's background in sociology. The diagnostic evaluation instruments employed emphasized the environmental contributions to pathology and rehabilitation.

The *Handbook* also reveals that the training demands upon students were particularly rigorous. Students were required to be able to administer many of the major psychodiagnostic tests from memory. Highly detailed and demanding schedules were kept both on campus and on the road. As a result, in the traveling clinics 12 clients per day were evaluated by Dr. Kelly and four or five of his student assistants. The public demand for the clinics became so great that Dr. Kelly and his "team" traveled over the whole state of Kansas in the late 1930s (Kelly, 1937). These clinics are an early model for the delivery of school psychology services in rural areas.

An outgrowth of the traveling clinics was that a satellite system of four or five "permanent" branch clinics throughout Kansas was established in the period 1936-1937. Taken together, these activities are similar in structure and operation to the community mental health center model that was adopted nationally 30 years later. In the 1930s however, these were new, bold and ambitious activities. Running such a system with bachelor and master level students must have required equal measures of organizational ability and grit.

Many of Dr. Kelly's students who stood the dual test of the curriculum and the clinics went on to careers of importance in Psychology. Several had distinguished academic careers at major universities.

Dr. Kelly left Fort Hays in 1943 to join the Navy. After the war he would serve on the faculty of the University of Maryland, and later developed and directed the nationally recognized clinical psychology training program at Ohio State Univer-

sity. At the end of his life, in 1967, he held an endowed chair of theoretical psychology at Brandis University.

Since his death, Dr. Kelly's theory of Personal Construct Psychology has gained in recognition. As a result, his place in the history of American Psychology is as yet not fully determined. It is clear at this time, however, that he is one of the most influential personality theorists of this century. He was a major contributor of methods and standards for the training of clinical psychologists and he was a man whose personal characteristics inspired accomplishment in others.

As previously mentioned, the *Handbook of Clinic Practice* was a major teaching tool for Dr. Kelly during his years at Fort Hays Kansas State College. It represents his early position regarding behavior in a clinical setting, and also provides a glimpse of the immense variety and scope of Dr. Kelly's talents.

Since very little information has been available concerning the early years of Kelly's career, it was decided to print the *Handbook* (1936 edition) in its entirety. The Editors believe scholars of Dr. Kelly will appreciate this foundation piece.

The readers of the *Handbook* must remember that it was used as a teaching tool and Dr. Kelly did not intend that it "stand on its own" outside the context of the clinic and classroom. In order to provide greater clarity to the organization of the *Handbook*, the Editors have: (1) made minor changes in the numbering of the paragraphs and rules, (2) rearranged the placement of the numbers of the forms,(3) made minor format changes, such as margins, spacing, etc., and (4) added a Table of Contents. The pages that have lettered pages (e.g., i, ix, etc.) denote material that has been added by the Editors. The numbered pages present the material developed by Dr. Kelly.

References

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The Editors thank Marnie Arnhold and the Fort Hays State University Printing and Duplicating Department for their assistance in preparing this *Handbook*.

KELLY'S RULES

RULE 1: Every applicant for psychological service possesses a psychological constitution. This constitution may legitimately be investigated by the clinic without incurring responsibility for nonpsychological diagnosis.

RULE 2: The psychological clinic should never assume responsibility beyond that which is delegated to it.

RULE 3: No practice under false pretenses.

RULE 4: Clinical psychology is distinguished from those disciplines which deal with organic or physiological problems on the one hand and those which deal with social and religious problems on the other.

RULE 5: Each case must be treated as an unique entity.

RULE 6: Every clinician is himself a case.

RULE 7: Reassurance should not be indiscriminately offered: it closes the case and compromises the diagnosis.

RULE 8: Delicate questions should be asked in such a way as to encourage affirmative answers.

RULE 9: The clinician must never show surprise, disapproval, or reassurance either by word, expression or gesture, no matter how morbid or unusual the information given him.

RULE 10: The psychometrist should not report the results of an intelligence test to the case or his parents unless directed to do so by the clinic authority.

RULE 11: Only the patient can effect a cure.

RULE 12: The patient's diagnosis is synonymous with the cure.

RULE 13: Improvement is in proportion to the insight which the patient acquires into the true nature of his difficulty.

RULE 14: All recommendations should be written in duplicate, addressed to some individual, and signed by the authorized diagnostic clinician.

RULE 15: The patient should be informed of the diagnosis as soon as it is completed.

RULE 16: Every conference carried out under the auspices of the clinic must be reported in detail.

RULE 17: Clinic records must not be seen by unauthorized persons.

RULE 18: There must be a plan held in reserve for every conference.

RULE 19: Call for the deliver cases under fourteen until certain that they will come and go promptly alone.

RULE 20: Appointments must be specific as to the time and place.

RULE 21: Allow ten minutes for case to appear for apointment. If the appointment is not kept, discover the cause and make another appointment as soon as possible.

RULE 22: Make instructions definite and distinguish clearly between suggestions and instructions.

RULE 23: The clinician must control his case. One failing to do so will result in his immediate discharge from the clinic.

RULE 24: A clinician should never give any indication of emotion, surprise, disapproval or mirth during a conference unless such an indication is definitely a part of the planned therapeutic procedure.

RULE 25: The clinician must not under any condition confide in the patient.
RULE 26: Important facts are being revealed every moment of a conference.
RULE 27: Avoid physical contact with the patient.
RULE 28: Do not permit the patient to become too depressed in any one conference.
RULE 29: Do not concur in the patient's opinion on personal or controversial matters.
RULE 30: Treat the case.
RULE 31: The conference begins with the seating of the clinician.
RULE 32: A failure may be reoriented but never escaped.
RULE 33: Terminate the therapeutic series on the second conference after transference is resolved, unless a complete new series is to be undertaken.
RULE 34: Use reassurance liberally in the last conference of a therapeutic series.

LOCATION OF RULES

LOCATION OF FORMS AND TABLES

THE HANDBOOK OF CLINIC PRACTICE

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George A. Kelly
Fort Hays Kansas State College
(1936)

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I. SCOPE OF PRACTICE

1. **Cases admitted:** All cases applying to a psychological clinic for services are normally eligible for such services. It has been the custom in some quarters to discourage the registration of cases in which some pathology other than psychopathology is suspected. This is not justifiable.

RULE 1: EVERY APPLICANT FOR PSYCHOLOGICAL SERVICE POSSESSES A PSYCHOLOGICAL CONSTITUTION. THIS CONSTITUTION MAY LEGITIMATELY BE INVESTIGATED BY THE CLINIC WITHOUT INCURRING RESPONSIBILITY FOR NONPSYCHOLOGICAL DIAGNOSIS.

The psychological anamnesia should be so arranged and interpreted that other pathologies may be suspected and the case referred to the proper agencies for their diagnosis and treatment. This, however, should not be construed as a professional responsibility of the clinic.

2. **Cases not admitted:** The psychological clinic should never undertake responsibility for any case which is not committed to the clinic for diagnosis and treatment. Parents, teachers, physicians, and others who confer with the psychologist about cases but who do not present the cases must be made to understand that the responsibility is entirely theirs. Recommendations in such instances must be limited to the general rules of mental hygiene which may be applied safely in any case by any layman.

RULE 2: THE PSYCHOLOGICAL CLINIC SHOULD NEVER ASSUME RESPONSIBILITY BEYOND THAT WHICH IS DELEGATED TO IT.

No case should be administered therapy unless it has been specifically requested by himself or by those who present the case. Application for psychological diagnosis should not be construed as application for therapy.

No case should be administered therapy unless upon entering the clinic he has been made to understand as clearly as he is capable of understanding the purpose for which the clinical examination is being made and the general functions of a psychological clinic. The practice of admitting cases under false pretenses is never justified even under the most extenuating circumstances.

RULE 3: NO PRACTICE UNDER FALSE PRETENSES.

3. **Relation to medicine:** There is only one tenable position in distinguishing the field of psychology from the field of medicine: psychology deals with the psychological and medicine with the physiological. Any disregard for this boundary by either discipline must be considered a usurpation of responsibility. This distinction is otherwise known as the distinction between the functional and the organic.

4. **Relation to psychiatry:** Psychiatry is commonly known as a branch of medicine which deals with mental disorders. Many psychiatrists are trainees both in psychopatholgy and in the related organic pathologies. Strictly speaking, psychiatry is not necessarily a branch of medical practice. Psychiatry overlaps clinical psychology to the extent that it deals with functional or psychological

problems. The attitude of clinical psychologists toward the practice of psychotherapy by psychiatrists should be based upon a consideration of the preparation of the individual practitioners. This preparation should include basic studies as described in a later section of this handbook. The attitude of clinical psychologists toward the practice of organic therapies by psychiatrists should be that of one discipline toward another.

5. **Relation to law:** There have been a few instances when the position of the clinical psychologist as a recipient of confidential information has created delicate legal situations. The clinical psychologist must maintain an attitude of helpfulness in all legal matters. Information, however, which is received in confidence by a psychologist acting in a professional capacity must be kept in confidence. Written records must be kept and guarded accordingly.

6. **Relation to religion:** The clinical psychologist must recognize as belonging to religion all matters of right and wrong. When a therapeutic recommendation of a psychologist conflicts with the patient's conscience the psychologist should point out the consequences involved and, if possible, make alternative recommendations (e.g., when a psychologist recommends social dancing to a patient who holds scruples against this form of recreation, the attitude of the patient must be respected.)

7. **Relation to education:** Clinical psychology in its broadest sense is an educative function. If there is a distinction it is that clinical psychology places primary emphasis upon the individual aim of education. Education is thought by some to be more properly a socializing process.

RULE 4: CLINICAL PSYCHOLOGY IS DISTINGUISHED FROM THOSE DISCIPLINES WHICH DEAL WITH ORGANIC OR PSYSIOLOGICAL PROBLEMS ON THE ONE HAND AND THOSE WHICH DEAL WITH SOCIAL AND RELIGIOUS PROBLEMS ON THE OTHER.

8. **Future of clinical psychology:** Somewhat more than half of the hospital beds in this country are being occupied by patients with diagnosed mental illness. When this fact is considered together with the fact that psychotherapy usually requires more time on the part of the clinician than does physiotherapy and with the fact that there is still considerable reticence on the part of patients in seeking psychotherapy it can be seen that an adequately organized profession for dealing with these disorders must be provided on a large scale. Such a profession must be organized as an integral unit and not as a subsidiary of another profession.

II. QUALIFICATIONS OF CLINICIANS

1. **Intelligence:** Psychological treatment differs in certain fundamental respects from medical treatment. One of these respects is in its greater dependence upon the indirect therapies and the accompanying necessity of discovering specific etiologies. Each case possesses a unique syndrome and constellation of causative factors which usually must be thoroughly understood by the clinician. In the solution of such novel problems there is no substitute for native mental acquity.

RULE 5: EACH CASE MUST BE TREATED AS A UNIQUE ENTITY.

2. **Mental health:** A clinician must be prepared to shoulder vicariously a great many difficult personal problems. If he is in a poor state of mental health himself or has only lately recovered from such a state he may be overtaxed. Every clinician before completing his training must undergo a psychological diagnosis and, if so advised, must accept psychotherapy.

RULE 6: EVERY CLINICIAN IS HIMSELF A CASE.

3. **Training:** The curriculum for clinicians should include the following subjects in addition to a specialized clinical psychology.

experimental psychology	genetic psychology
differential psychology	statistics and measurements
educational psychology	social psychology
systematic psychology	history of psychology
comparative psychology	physiological psychology
abnormal psychology	physiology
anatomy	sociology
social pathology	criminology
educational methods	

All clinicians should plan to complete doctorate study and must have made definite provisions for masters study at the beginning of their preparation.

4. **Attitude toward work:** The responsibility of a clinician toward his case transcends all other responsibilities. Illness, study, vacations and all personal matters must be considered secondary. A psychological problem is generally more important than a problem of bodily health and the clinician can scarcely feel his responsibility too deeply. Individuals who are unwilling to assume this attitude should not attempt to become clinical psychologists.

III. THE ANAMNESIS

1. **Registration** (Form 1.1): Every case must be registered and all addresses recorded accurately so that the case may be followed by correspondence (see Form 1.1). The questions are to be answered by the person who registers the case and who wishes to have recommendations regarding its treatment. Below the starred line the clinician records the place or town at which the case is seen, the date on which the case was first seen, the auspices under which the clinical service was rendered, his own name, and the number of the case in the local clinic. Under Psychometrics the recommended tests are listed. The blanks for memoranda may be used by any clinician in calling special attention of any other clinician to some point.

All available supplementary information such as reports of other clinics, medical reports, health reports and social workers histories' are part of the clinic's permanent file. After a clinician has made recommendations regarding a case he should enter a preliminary diagnosis in the blanks provided.

During an oral registration it is a common experience to have the registrant or patient ask questions concerning the probable diagnosis or concerning the efficacy of corrective measures which have been used. A parent will ask, "Do you think my child is feebleminded"? Instead of reassuring the parent the clinician should say, "Of course that is possible. Our examination will cover that point and if we should

discover that he is feebleminded we shall tell you so quite frankly." If parents or patients are reassured at the time of registration it places the psychologist in an embarrassing position if an unfavorable diagnosis must be reported. Such reassurance also encourages the withholding of valuable but morbid information which otherwise might be volunteered.

RULE 7: REASSURANCE SHOULD NOT BE INDISCRIMINATELY OFFERED: IT CLOSES THE CASE AND COMPROMISES THE DIAGNOSIS.

2. **Appointments** (Form 1.21): When the anamnesis requires several appointments scattered over a period of time informants should be given a written schedule of appointments. Clinicians should always be careful to make appointments clear and definite. Extension clinics require a careful listing of appointments. Form 1.21 is to be filled from the registration in advance of an extension clinic. One copy is to be sent to the sponsor so that he may arrange to have all clients appear for their appointments, the other becomes a permanent record of the extension clinic's enrollment. On the form, C1 refers to case 1, P3 refers to parent 3, T6 refers to teacher 6, and F8 refers to friend 8. Names should be entered in the blanks.

3. **Schedule** (Forms 1.51, 1.52): This form enables a clinician to see at a glance the schedule of his day's work. The schedule is arranged so that no two clinicians need be using the same apparatus at the same time; it permits the psychologist to check all conferences, and it provides for group tests to be administrated by the supervisor without conflict with the clinicians. If a guidance conference is to be substituted for an individual psychometric and a physiological examination, the clinician will find at least fifty minutes of consecutive time available. If a parent has two children in a clinic he is registered as P1 and P2, or P4 and P5, etc. The schedule is arranged so that the parent may have double and usual conference time with the same clinician.

4. **Education** (Form 2): Form 2 is designed to be filled out by the clinician in conference with the case's classroom teacher. With some instruction the teacher may fill in Items 1-8, and 13 himself. As with the other forms, the clinician should attempt to secure answers for as many items as possible if the proper conferee is not available.

All information which the clinician considers significant to the diagnosis should be plainly encircled. Thus the psychologist, in making his first perusal of the form, may look for encircled material only.

In item 1 "age" refers to age of case at the time he entered the grade, "repeat" is to be encircled if that grade was repeated once. In Item 2 the x's under "dislike-like" comprise a profile. If the subject listed spelling and the child dislikes it slightly the clinician should encircle the x just to the left of the large middle X in the profile. The large X is to be encircled if there is a normal amount of traits. "Remedies" refer to remedies attempted. In Item 4 a number of vocational subjects are listed and may be encircled when taught. Other vocational subjects taught may be listed in the blanks. In Item 7 the initials and names are requested so that the clinic may seek the cooperation of these individuals if such cooperation appears to be necessary in the treatment of the case. In Item 10 "conference" should be encircled if the teacher has had a conference with the case's parents

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC

Form 1.1
Registration

Name of case — Mailing address

Name of parent or guardian — Mailing address

Name of superintendent or principal — Mailing address

Name of most interested classroom teacher — Mailing address

Name of person filling out this form — Relation to case — Mailing address

1. Upon what problems do you wish the Clinic to advise you?
2. When were these problems first noticed?
3. Under what conditions did these problems appear?
4. What corrective measures have been taken?
5. What changes have come with treatment or the passing of time?
6. Under what conditions are the problems most noticeable?
7. Under what conditions are the problems least noticeable?

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Place — Date — Auspices — Clinician — No.

Psychometrics: 1 2 3
4 5 6 7

(Picture)

Memoranda:

Diagnosis: 1 2 3
(Final) 1 2 3

Follow-up: Person	Sent form no.	Date	Recd. Reply Date	Conf. date	Clin.

Town _____ Auspices _____ Date _____

Appointment hours are hectographed immediately below the names of those whom the clinic wished to see. When one of the case's conferences may be eliminated the earlier arrival hour is stricken out. All individuals should be informed in advance of the date of the clinic and the exact hours of their appointments.

C1	P1	T1	F1
_____:	_____:	_____:	
Arrive 7:50 or 8:30	Arrival 8:00	Arrive 7:50	
Finish 11:10	Finish 12:10	Finish 9:20	
		Tchrs' conf 5-6	
C2	P2	T2	F2
_____:	_____:	_____:	
Arrive 9:40 or 10:30	Arrive 10:05	Arrive 10:50	
Finish 2:30	Finish 3:20	Finish 12:25	
		Tchrs' conf 5-6	
C3	P3	T3	F3
_____:	_____:	_____:	
Arrive 10:30	Arrive 3:10	Arrive 1:50	
Finish 4:40	Finish 5:05	Finish 3:40	
		Tchrs' conf 5-6	
C4	P4	T4	F4
_____:	_____:	_____:	
Arrive 7:50-8:30	Arrive 7:50	Arrive 8:20	
Finish 11:30	Finish 12:25	Finish 9:50	
		Tchrs' conf 5-6	
C5	P5	T5	F5
_____:	_____:	_____:	
Arrive 9:50 or 10:50	Arrive 10:20	Arrive 10:05	
Finish 2:40	Finish 2:55	Finish 10:55	
		Tchrs' conf 5-6	
C6	P6	T6	F6
_____:	_____:	_____:	
Arrive 10:40 to 1:20	Arrive 3:00	Arrive 1:50	
Finish 4:40	Finish 5:05	Finish 2:30	
		Tchrs' conf 5-6	
C7 _____:	P7 _____:	T7 _____:	F7
Arrive 7:50 or 8:50	Arrive 7:50	Arrive 8:20	
Finish 11:30	Finish 11:55	Finish 9:00	
		Tchrs' conf 5-6	
C8 _____:	P8 _____:	T8 _____:	F8
Arrive 9:40	Arrive 8:33	Arrive 9:05	
F nish 2:40	Finish 2:55	Finish 10:00	
		Tchrs' conf 5-6	
C9 _____:	P9 _____:	T9 _____:	F9
Arrive 1:20	Arrive 1:20	Arrive 11:00	
Finish 4:40	Finish 5:00	Finish 12:25	
		Tchrs' conf 5-6	
C10 _____:	P10 _____:	T10 _____:	F10
Arrive 10:30	Arrive 2:45	Arrive 11:30	
Finish 4:20	Finish 4:45	Finish 12:25	
		Tchrs' conf 5-6	

Psychologist	Clinician I	Clinician II	Clinician III	Supervisor
8:00	General	T1	P4	P7	1.2.3.4.5.6.7.8.9.10
05	confer-				.o.o. .o.o. .o.o.o.
10	ence				.o.o. .o.o. .o.o.o.
15		P1			.o.o. .o.o. .o.o.o.
20					.o.o. .o.o. .o.o.o.
25					.o.o. .o.o. .o.o.o.
30			T4	[illegible]7	.o.o. .o.o. .o.o.o.
35					.o.o. .o.o. .o.o.o.
40	P7				.o.o. .o.o. .o.o.o.
45		C1 Test	C4 Person-	P8	x.o.o.x.o.o. .o.o.o.
50	T7		ality		x.o.o.x.o.o. .o.o.o.
55					x.o.o.x.o.o. .o.o.o.
9:00	C7				x.o.o.x.o.o.x.o.o.o.
05					x.o.o.x.o.o.x.o.o.o.
10	T1				x.o.o.x.o.o. .o.o.o.
15			C4 Test	T8	x.o.o.x.o.o. .o.o.o.
20	P1				x.o.o.x.o.o. .o.o.o.
25		C1 Physic-			x.o.o.x.o.o. .o.o.o.
30	P4	logical		C7 Person-	x.o.o.x.o.o.x.o.o.o.
35				ality	x. .o.x.o.o.x.o.o.o.
40	T4				x. .o.x.o.o.x.o.o.o.
45		C1 Person-			x. .o.x.o.o.x.o.o.o.
50	T8	ality			x. .o.x.o.o.x. .o.o.
55			C4 Physio-		x. .o.x.o.o.x. .o.o.
10:00	P8		logical	C7 Test	x. .o.x. .o.x. .o.o.
05					x. .o.x. .o.x. .o.o.
10	C8				x. .o.x. .o.x.x.o.o.
15		P2	T5		. . .o. . .o.x.x.o.o.
20	C1				x. .o. . .o.x. .o.o.
25					x. .o. . .o.x. .o.o.
30	C4		P5		. . .o.x. .o.x. .o. .
35					. . .o.x. .o.x. .o. .
40	T5			C7 Physic-	. . . . . .x. .o. .
45		C2 Test		logical	. .x. . . . .x. .o. .
50	T2				. .x. . . . .x. .o. .
55					. .x. . . . .x. .o. .
11:00	P2		C5 Physio-	C8 Person-	. .x. . . . .x.x.o. .
05			logical	ality	. .x. . .x. . .x.o. .
10	T9				. .x. . .x. . .x.o. .
15					. .x. . .x. . .x.o. .
20			C5 Test		. .x. . .x. . .x.o. .
25		C2 Physio-			. .x. . .x. . .x.o. .
30	Staff	logical		Staff 7	.T10
35	1,4,7				
40					
45		Staff 1		P7 Report	.C10 Test
50					
55				C8 Physio-	
12:00		P1 Report	Staff 4	logical	....
05					
10		T2			
15	T10		P4 Report	T9	
20					

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC Form 1.52
Afternoon

Psychologist	Clinician I	Clinician II	Clinician III	Supervisor
1:30. P9	C2 Personality	C5 Personality	C8 Test	1.2.3.4.5.6.7.8.9.10.
35.				o.x. .o.x. .o.x. . .
40. C9				o.x. .o.x. .o.x.x. .
45.				o.x. .o.x. .o.x.x. .
50 P5				o.x. .o.x. .o.x.x. .
55.				o.x. .o.x. .o.x.x. .
2:00. C5	T3	T6		o. . .o.x. .o.x. . .
05.				
10. C2			P9	o.x. .o. . .o. . . .
15.	C3 Test	C6 Physiological		o.x.x.o. .x.o. . . .
20. T6				o. .x.o. .x.o. . . .
25.				o. .x.o. .x.o. . . .
30. Staff				o. .x.o. .x.o. . . .
35. 2,5.8		Staff 5		o. .x.o. . .o. . . .
40.			Staff 8	C10 Physiological
45.				
50.		P5 Report		
55.	Staff 2		P8 Report	
3:00.		C6 Test		P10
05.			C9 Personality	
10. P6	Report			
15.				
20. P3	C3 Physiological			
25.				
30. T3				C10 Personality
35.			C9 Physiological	
40. C6	PP3	P6		
45.				
50. C3				
55.			C9 Test	
4:00. P10				Draft recommendations.
05.				
10. C10	C3 Personality	C6 Personality		
15.				
20. Staff				Staff 10
25. 3,6.				
30. 9,10				
35.			Staff 9	P10 Report
40.	Staff 3	Staff 6		
45.				Pack
50.			P9 Report	
55.	P3 Report	P6 Report		
5:00				
05.				
10.				
15.				
20.				
25.				
30.				
35.				
40.	T E A C H E R S' C O N F E R E N C E			
45.				
50.				
55.				
6:00				
05.				

Case _____ Informant _____ Relation _____ Clinician _____ Date _____

1. History

Grade	Age	Year	Repeat	School	Teacher	Superintendent	Ave Mark
Preschool							F D C B A
I							F D C B A
II							F D C B A
III							F D C B A
IV							F D C B A
V							F D C B A
VI							F D C B A
VII							F D C B A
VIII							F D C B A
IX							F D C B A
X							F D C B A
XI							F D C B A
XII							F D C B A

2. Recently studied subjects — Dislike-marks — Difficulties — Remedies

1. _____ xxxxxxxxxx F D C B A _____
2. _____ xxxxxxxxxx F D C B A _____
3. _____ xxxxxxxxxx F D C B A _____
4. _____ xxxxxxxxxx F D C B A _____
5. _____ xxxxxxxxxx F D C B A _____
6. _____ xxxxxxxxxx F D C B A _____
7. _____ xxxxxxxxxx F D C B A _____

3. Vocation: case's aim _____ School's aim _____
4. Vocational subjects taught: 1 _____ 2 _____
   domestic-science domestic-art mechanics agriculture economics craft typing stenography book-keeping carpentry animal-husbandry crops market
5. Advocational interests of case: _____
   studies music projects dramatics societies companions parties dances movies gangs athletics mechanics pets collections domestic-interests
6. Avocational training of case by school: music dancing art sewing dramatics social-usage athletics current-events excursions organizations reading debate oratory declamation
7. Present sponsors of avocational training: (give initials and names)
   1 _____ 2 _____ 3 _____
8. Further schooling: no. yrs expected ____ obstacles _____
9. Absences: ____ Mo. ill work truant unknown remedies
10. Parental cooperation: x x X x x conference insight pressure instab critic
11. Behavior problems in last month: Measures taken Reaction of case
    1. _____ _____ _____
    2. _____ _____ _____
    3. _____ _____ _____
    4. _____ _____ _____
    5. _____ _____ _____
12. Member of what organization: 1 _____ pres off 2 _____ pres off
    3 _____ pres off 4 _____ pres off 5 _____ pres off
13. Attitudes

Dependent-Independent	x x X x x	Rebellious-Cooperative	x x X x x
Lazy-Industrious	x x X x x	Tired-Energetic	x x X x x
Quiet-Noisy	x x X x x	Relaxed-Restless	x x X x x
Disinterested-Interested	x x X x x	Distracted-Calm	x x X x x
Quiet-Talkative	x x X x x	Cries easily-Mature	x x X x x
Interests narrow-broad	x x X x x	Follower-Leader	x x X x x
Quarrelsome-Friendly	x x X x x	Unpopular-Popular	x x X x x

14. Rapport: x x x X x x x

regarding his progress, "insight" is for parent's insight into case, "pressure" for parental pressure on case of success, "instab" for emotional instability of parents, and "critic" for critical attitude on part of parents. In Item 12 "pres" is for a presidency and "off" is for any other official position. Item 13 is a personality profile, and Item 14 refers to the rapport between clinician and conferee during the taking of the educational history.

If the case is not in school as much of the educational history as possible should be obtained from whatever sources are available.

5. **Sociology** (Form 3): Forms 3, 4 and 5 are designed to be filled out by the clinician in conference with the parent. No part can be filled satisfactorily by the parent himself. The clinician should say at the outset, "There are a great many questions which we always ask before giving any advice concerning a child. Let's work rapidly and get all the information before us that we can."

It is the practice in some quarters to make the case history interview as casual and conversational as possible, making no notes during the conversation. An opposite point of view is much more desirable; cases who present themselves in a clinic have already become serious about their problems and in general appreciate a thorough and business-like procedure. The blank should be filled at the time each answer is given. No time should be wasted.

RULE 8: DELICATE QUESTIONS SHOULD BE ASKED IN SUCH A WAY AS TO ENCOURAGE AFFIRMATIVE ANSWERS.

RULE 9: THE CLINICIAN MUST NEVER SHOW SURPRISE, DISAPPROVAL, OR REASSURANCE EITHER BY WORD, EXPRESSION OR GESTURE, NO MATTER HOW MORBID OR UNUSUAL THE INFORMATION GIVEN HIM.

It will be noticed that in the present (1936-37) edition, forms 3, 4, 5, 6, and 8 carry an analysis table in the margin. In Form 3 this table permits the clinician to scan for encircled items which bear upon vocational orientation, recreational orientation, personal orientation, school orientation, community orientation, friends, household, security, absorption of personality, independence, possessions, and control, respectively. If an item, such as Item 2, principally throws light upon the case's community orientation an x is to be found opposite that item and under "Com Or." If it also throws light upon friends and personal orientation o's will be found under "Friends" and "Pers Or". When the clinician records information which appears to be clinically significant he should encircle it and all of the o's and x's which appear in the same row in the analysis table.

Items 1-4 and 6 do not require names. Individuals may be identified by their relationships to the case, their sex and approximate age. In Item 6 intimacy should be indicated as specifically as possible. Terms such as "playmate," "dates," "kissing," "sexual intercourse" should be used. In Item 18 the abbreviations are to be interpreted as follows, "mus" music, "dan" dancing, "voc" vocational training. In Item 21 "shr" is for shared and "own" is for very own or unshared belongings. Item 24 refers to the usual method of spending evenings; Item 25 refers to literature in the home suitable for the child. Item 27 calls for indicating those who help the case in his school work, and whether such help was requested by the school. Abbreviations in Item 30 are as follows: "sep" separated sexes for undressing, "mod" extremely modest attitude, "fea" fearful of undressing, "sex" sexual

gestures, and "help" required for undressing. In Item 31 abbreviations are as follow · "rstls" restless, "indf" indifferent, "deprs" depresses, "exalt" exalted, "brood" brooding, and "susp" suspicious.

6. **Development** (Form 4): The developmental history blank is designed so that it can be filled during a conference with the parent. When the case is an adult the information is difficult to obtain and the clinician may have to consult several sources in addition to the case. All sources should be indicated at the head of the form.

The same general rules which apply to the taking of the sociologic history also apply to the taking of the developmental history.

There will be greater difficulty in keeping the conversation under control. Sometimes a parent will stop the clinician in the midst of the citation of problems and say, "My child has had none of those things." In this, the clinician must explain that few children have had many of the problems but that it is very important to know what problems have been met.

In Forms 4 and 8, terms which represent pathologies are capitalized.

In Item 1 abbreviations are for mother's age at the time of birth, period of pregnancy in months, malnutrition, use of alcohol, narcotics, and hard work during pregnancy. The question regarding malnutrition is best asked as follows, "Did you get all the kinds of foods you needed during your pregnancy?" The question regarding narcotics may be asked, "Did you require narcotics during pregnancy?" The abbreviations may be encircled.

In Item 2 the complete expressions are delivery period in hours, delivery without physician, delivery at home, breech case, instruments used, birth injury, breathing difficulty and cyanosis.

Item 3 gives a check on early growth with weights at various ages as the parent remembers them.

Item 4 the terms refer to unusual conditions of the nose and throat, mouth, breathing, ear, eyes, and infections.

In Item 5 "sev" is for unusually severe.

Item 6 "temp" is for maximum temperature and "No-md" is for no physician in attendance. In Item 7 the blanks are for the age of the appearance of the first tooth in months, weaning from breast, weaning from bottle, difficulty in weaning, achievement of bowel control, bladder control, age of sitting up, walking, talking, dressing self, lacing shoes, use of spoon, cup, age of reaching puberty in years. Item 8 gives the number of medical calls a year, dental calls, and administration of medicine in a month. In Item 9 the total hours of sleep in 24 hours is recorded, together with the norm.

Sometimes children are allowed to sleep with their parents; occasionally after the regular practice has been discontinued. In such a case the clinician should be sure to obtain the information because of its bearing upon absorption of the personality. Particularly should regular or occasional sleeping with the parent of the opposite sex be recorded. Item 10 calls for bowel movements a day, urinations a day, washing of hands and face a day, and baths a week. In Item 12 encircle or write in the nature of the sex questions asked by case. Abbreviations are for asking where babies come from, questions regarding puberty of self and others, questions on sex differences, and questions of marriage. The clinician may indicate the nature of the answer by encircling the appropriate abbreviation on the next line:

complete answer, reference to a book (get the name of the book), answer more complete than needed, inhibited attitude on part of parent, "doctor brings babies", "stork brings babies", "answer postponed", "God sends babies".

Items 13-28 refer to special problems exhibited by the case during his life: the ages at which they appeared and the corrective measure attempted. Abbreviations are as follows: 14-night mares, 17-temper tantrums, 20-thumb sucking, tongue sucking, 22-table manners, 23-peculiar food preferences and aversions, 27-strephosymbolia, 28-peculiar mannerisms.

7. **Family** (Form 5): The family history is frequently difficult to fill because parents sometimes are unable to see its bearing upon the case. Another explanation may well be made before the form is attempted, the clinician saying that it is necessary to know the child's family as if he were a member of it in order to make helpful recommendations.

In this form names are not required, individuals being identified by order of birth and relation to case. The last of abbreviations at the top of the form permit the rapid recording of the family record in a small space. The items at the top of the columns indicate the order in which information should be recorded. Material important to the diagnosis should always be encircled. Item 6 refers to separations of parents for several months. Item 8 refers to the case. Item 11 abbreviations are for: retiring from active community participation, anxiety, projections, escape, irritability, excesses such as drunkenness, dependent attitude, and attitude of disillusionment. Item 12 abbreviations are for: religious denomination, attendances a month, active church participation, saying grace at table, religious because of felt need for comfort, because of family custom, and because of felt need for community status. Item 13 abbreviations are for: supervision of case's companions, use of car prohibited, card playing prohibited. Sunday playing prohibited, smoking prohibited, dancing prohibited, attendance at parties prohibited, and drinking prohibited. Item 15 abbreviations are for: definite division of labor in the family, community of interest among members of the family, overt expression of affection between members of family, and strong tendency of members of family to protect each other. Items 8-17 may sometimes be filled without asking direct questions depending upon inference from the earlier part of the interview.

Forms 3, 4, and 5 should be mastered completely enough so that they can be all filled in a period of thirty minutes. The beginner will find this no easy task as he will realize after he has spent some ninety minutes in his first trial. A question should be asked as soon as the answer to the previous question has been given: the clinician recording an answer, while the next question is being answered. This requires a good attention span, habitual phrasing of memorized questions, and an ability to appear interested in what the person is saying even though writing information on the form. It also requires thorough familiarity with the system of abbreviations appearing in the forms and customarily used for recording information.

8. **Physiology** (Form 6): The object of the physiological examination is to throw additional light upon the psychological diagnosis, not to attempt a medical diagnosis. From the physiological examination the clinician may conclude that an additional medical examination is necessary although he can never permit his

Case | Informant | Relation | Clinician | Date | Number

For attitudes give ages, sexes, & relations of person
male - m punished by - pun love - lov
Female - f fight - fgt protect - prt
nagged by - nag quarrel - qrl inseparable - insp

Voc Or	Recr Or	Pers Or	Sch Or	Com Or	Friends	House	Security	Absorb	Indep	Possess	Control		
.	.	o	.	, .	.	x	o	, o	o	.	o	1.	Household: 1.....2.....
.	.	o	.	, .	.	x	o	, o	o	.	o		3.....4.....5.....
.	.	o	.	, .		x	o	, o	o	.	o		6.....7.....8.....
.	.	o	.	, .	.	x	o	, o	o	.	o		9.....10.....11.....
.	.	o	.	, x	o	.	.	, .	.	.	o	2.	Adult Neighbors:.....1.....2.....
.	.	o	.	, x	o	.	.	, .	.	.	o		3.....4.....5.....
.	.	o	.	, x	o	.	.	, .	.	.	o		6.....7.....8.....
.	.	.	x	, .	.	.	.	, o	o	.	o	3.	Teachers: I.....II.....
.	.	.	x	, .	.	.	.	, o	o	.	o		III.....IV.....V.....
.	.	.	x	, .	.	.	.	, o	o	.	o		VI.....VII.....VIII.....
.	.	.	x	, .	.	.	.	, o	o	.	o		HS 1.....2.....3.....
.	.	.	x	, .	.	.	.	, o	o	.	o		4.....5.....6.....
.	o	.	.	, .	x	o	.	, o	o	.	.	4.	Companions: 1-2 yrs.....2-5.....
.	o	.	.	, .	x		.	, o	o	.	.		5-9.....9-14.....14-19.....
.	o	.	.	, .	x		.	, o	o	.	.		Present: 1.....2.....
.	o	.	.	, .	x		.	, o	o	.	.		3.....4.....5.....
.	o	.	.	, .	x		.	, o	o	.	.		Younger Older Boys Girls Noisy Quiet Wander Rough
.	o	.	.	, .	x		.	, o	o	.	.	5.	Groups: (Indicate official positions) 1.....
.	o	.	.	, .	x	o	.	, o	o	.	.		2.....3.....
.	.	o	.	, .	x		o	, o	o	.	.	6.	Loves: Age, Age of other, terminates by, intimacy
.	.	o	.	, .	x		o	, o	o	.	.		1.....
.	.	o	.	, .	x		o	, o	o	.	.		2.....
.	.	o	.	, .	x		o	, o	o	.	.		3.....
.	.	o	.	, .	o	o	o	, x	o	.	o	7.	Manner of expressing affection: help hug lap kiss
.	.	o	.	, .	o	o	o	, o	x	.	o	8.	Dominates.....
.	.	o	.	, .	o	o	o	, o	o	.	x	9.	Dominated by.....
.	.	o	.	, o		.	o	, o	o	o	x	10.	Escapades.....measures.....
.	.	o	.	, .	o	o	o	, o	o	.	x	11.	Punished by.....for..reaction.....
.	.	o	.	, o	o	o	o	, o	o	.	x	12.	Criticised by...for..reaction.....
.	.	o	.	, .	.	.	o	, o	o	.	x	13.	Taboos.....reaction.....
.	x	.	.	, o	.	.	o	, .	.	.	.	14.	Trips.....1.....2.....3.....
x	.	.	.	, .	.	o	o	, x	o	.	o	15.	Parents' Ambitions for Case:.....
x	.	.	.	, .	.	.	o	, o	o	.	.	16.	Case's ambitions:.....fulfilled.....
x	o	o	.	, .	.	.	o	, .	o	.	.	17.	Talents:.....
x	o	o	.	, .	.	.	o	, o	o	.	o	18.	Special training: mus art dan sew voc.....
o	.	.	.	, .	.	.	o	, o	x	o	o	19.	Spending money: $____ ____mo, earn how.....
x	.	.	.	, .	.	.	o	, o	o	o	o	20.	Job:.....found own fire.....
.	o	o	.	, .	.	o	o	, o	x	x	o	21.	Belongings: shr.....own.....
.	o	o	.	, .	.	.	o	, o	o	x	.	22.	Pets.....collections.....
o	x	o	.	, .	.	.	o	, o	o	o	.	23.	Hobbies.....
o	x	o	.	, .	.	.	o	, o	o	.	o	24.	Evenings.....
o	x	o	o	, .	.	.	o	, o	o	,	o	25.	Literature.....read.....
.	x	.	.	, .	.	.	.	, .	.	.	.	26.	Movies: _____per mo Sports:.....
o	.	o	x	, x	o	o	o	, o	o	.	o	27.	Help in school work: moth fath sis bro request.....
o	o	o	x	, .	.	o	o	, o	o	.	o	28.	Absences to work:.....Kind of work.....
.	.	.	.	, .	.	o	o	, o	x	.	o	29.	Bedfellow: .....Room-mate.....
.	.	.	.	, .	.	o	o	, o	x	.	o	30.	Undressing: sep mod fea open sex help.....
.	.	x	.	, .	.	.	o	, o	o	.	.	31.	Moods: rstls indf deprs exalt brood susp moody .....
.	.	.	.	, .	.	.	.	, .	.	.	.	32.	Rapport: x x X x x

Injury	Constitution	Care	Training	Maturation	Stability	Tension	Status Social Or.	Assertion	Motor	Indep-Absoro
0	X	0	.,0	0	.	.,.	.	.	.
X	0	0	.,0	0	.	.,.	.	.	.
.	0	0	.,X	0	.	.,.	.	.	.
0	X	0	.,.	.	.	.,.	.	0	.
X	0	0	.,.	0	.	.,.	.	0	.
0	X	0	.,0	0	.	.,.	.	0	0
0	X	0	.,0	0	.	.,.	.	0	0
0	X	0	.,0	0	.	.,.	.	0	0
0	X	0	.,0	0	.	.,.	.	0	0
0	X	0	.,0	0	.	.,.	.	0	0
0	X	0	.,0	0	.	.,.	.	0	0
0	0	0	0,X	.	.	.,.	.	0	0
0	0	0	0,X	.	.	.,.	.	0	0
0	0	0	0,X	.	.	.,.	.	0	0
0	0	X	.,.	0	.	.,.	.	0	0
.	0	X	0,0	0	0	.,.	0	0	.
.	.	.	0,.	.	.	.,.	.	.	X
.	0	0	X,0	.	.	.,.	.	0	0
.	0	X	0,.	0	.	.,.	.	0	.
.	.	0	X,.	.	0	.,.	.	.	0
.	.	0	X,.	.	0	.,.	.	.	0
.	.	.	.,.	.	.	.,.	.	.	.
.	.	.	.,.	0	X	0,	.	.	0
.	0	0	0,.	0	0	0,	.	.	X
.	.	.	0,.	0	0	0,	0	X	.
.	.	.	0,.	0	0	0,	0	X	0
.	.	.	0,.	0	0	0,	0	X	0
.	.	.	0,.	0	0	X,	0	0	.
.	.	.	0,.	0	.	0,	0	X	.
.	0	0	0,X	.	.	.,.	0	0	0
.	0	0	.,0	0	0	0,	0	0	X
.	.	.	0,0	.	.	0,	0	X	0
.	0	0	X,0	0	.	0,	.	0	0
.	0	0	0,0	0	0	0,	0	0	X
.	.	.	X,0	0	0	0,	.	0	0
.	.	.	0,0	.	0	.,	0	.	X
.	.	.	0,0	.	.	.,	0	.	X
.	.	.	0,0	.	.	.,	0	,	X

Case _____ Informant _____ Relation _____

Clinician _____ Date _____ Number _____

1. Birth: :Date___ m-age__ pd__ mc MAL ALC MAR WK
2. Deliver: __hrs. ALON HOME BRCH INST INJ BIRTH CY
3. Weight: birth ___,___,at___,___,___,at___,___,___.
4. Condition: NOSE THROAT MOUTH-BREATH EAR EYES INF.
5. Injuries: AGE KIND SEV, AGE KIND SEV.
6. Diseases: AGE DURATION SEVERITY TEMP TIME NO-MD.
   a. _____ ___ _____ _____ ___ ___ _____
   b. _____ ___ _____ _____ ___ ___ _____
   c. _____ ___ _____ _____ ___ ___ _____
   d. _____ ___ _____ _____ ___ ___ _____
   e. _____ ___ _____ _____ ___ ___ _____
   CONVULSIONS EPILEPSY RICKETS SCARLET TYPHOID
7. Maturation: tooth___mo, breast___mo, bottle___DIFF
   Bwl___mo, Bldr___mo, Sit___mo, Wlk___mo, Tlk___mo.
   Drs___mo, Lace___mo, Spn___mo, Cup___mo, Pub___mo.
8. Medication: m-d___/yr, dent__/yr, Medicine___/mo.
9. Sleep: retire___rise___reg nap___hrs. tot___nrm___
   Age stop nap___since sleeping with parent_____
10. Toilet: bwl___/ dy urn___/wsh___/dy bth___/ wk
11. Diet: reg fam mlk frt f-veg meat grs hot cdy var
12. Sex Instruction: Ouest: baby puberty sex marriage
    Ans: ans BOOK EXCESS INNB DR STORK POSTPONE GOD

PROBLEM	AGE	MEASURES TAKEN
13. NERVOUS RESTLESS WORRY PHOBIA	___	_____
14. SLEEPLESS SLEEP-WALK NIGHT MA	___	_____
15. TIMID SHY SECLUSIVE EXHIBITION	___	_____
16. STUBBORN RUDE NAG DISOBEDIENT	___	_____
17. T-T CRY QUARREL FIGHT JEALOUS	___	_____
18. RUN-AWAY TRUANT QUIT-SCHOOL	___	_____
19. SELFISH STEAL BOAST LIE SWEAR	___	_____
20. SMOKE DRINK THUMB-SUCK TONGUE	___	_____
21. SADISM MASOCHISM NAIL-BITE	___	_____
22. FIRES DESTRUCTION TABLE-MNRS	___	_____
23. CONSTIPATION ENURESIS FOODS	___	_____
24. VOMIT FAINT HEADACHE EXHAUST	___	_____
25. MASTURBATION SEX IRREGULARITY	___	_____
26. STUTTER ARTICULATION LEFT-HAND	___	_____
27. APHASIA MIRROR-WRITE STREPHO-	___	_____
28. TIC POSTURE CHOREA GAIT MANNER	___	_____

RAPPORT x x x X x x x

Case	Informant	Relation	Clinician	Date
Male.....m	Married.....mar	Deafness.....df	Epilepsy.....epl	
Female.....f	Divorced.....dvr	Speech defect....sp	Genius.....g	
Died.....d	Separated.....sep	Sinistrality.....si	Feebleminded..fm	
Foreign born....B	Miscarriage.....mag	Nervousness.....n	Insanity.....ins	
White.....W	Illegitimate.....ilg	Headaches.....h	Narcotism....nrc	
Negro.....N	Poverty.....pvt	Convulsions.....cv	Alcoholism...alc	
Mixed blood.....M	Suicide.....sui	Paralysis.....prl	Criminality..crm	
Consanguinity...C	Blindness.....bl	Tuberculosis.....tb	Delinquency..dlq	

Encircle parents' Parentheses in Item 3 and child's in Item 4.

PATERNAL	Sex	Death	Age	Cause	Disease	Marital	Children	Econom	Social	School	MATERNAL	Sex	Death	Age	Cause	Disease	Marital	Children	Econom	Social	School
1. Grand											1. Grand										
2. Grand											2. Grand										
3. Parent, uncles and aunts											3. Parents, uncles and aunts										
(1)											(1)										
(2)											(2)										
(3)											(3)										
(4)											(4)										
(5)											(5)										
(6)											(6)										
(7)											(7)										
(8)											(8)										
(9)											(9)										
(10)											(10)										

4. Case and siblings. Indicate step-siblings.

(1)					(6)				
(2)					(7)				
(3)					(8)				
(4)					(9)				
(5)					(10)				

5. Occupations of parents since birth of case.

	Occupation	Location	Time	Occupation	Location	Time
(1)	_____	_____	_____	_____	_____	_____.
(2)	_____	_____	_____	_____	_____	_____.
(3)	_____	_____	_____	_____	_____	_____.
(4)	_____	_____	_____	_____	_____	_____.

6. Separation: ___mo. in ___because _____, ___mo. in ___ because _____
___mo. in ___because _____, ___mo. in because _____.
7. Remarriage: _____ Dates _____.
8. Tension: Intra-_____ Overt known to case _____.
Extra-school Church Neighbor Organization Arrest Lawsuit Overt Known
9. Economic Status: Ample Secure Uncertain Debt Temporarily-low WPA Relief
10. Inadequate for: Food Shelter Clothing Education Entertainment Medicine.
11. Reaction of parents: Retir Ans Proj Esc Irrit Excess Depend Disillus
12. Religious Denom_____ Att_____mo. Active Grace Cust Comf Status
13. Taboos: Supr-comp Car Cards Sunday Smoke Dance Party Drink
14. Control: Patriarchal Matriarchal Democratic Anarchical
15. Integration: Divis-labor Com-interest_____ Affection Protection.
16. Language: _____ Recreation_____ Literature_____.
17. Rapport x x x X x x x

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC

Form 6
Physiology

Case _____ Age _____ Sex _____ Clinician _____ Date _____ Number _____

Name _____

Dictation _____

Vision	Audition	Other sens	Nutrition	Elimination	Infection	Endocrin	Calcium	Anatomy	Ventilation	Cardi-motor	Motor		
.	1	2	.	.	.	.	.	.	.	.	.	1.	Akoasm 2. Anesthesia
.	.	.	1	2	.	.	1	.	.	.	.	3.	Paraly_____Conv. 4. Chronic enuresis
.	.	.	.	½	.	.	.	.	.	.	.	5.	Chronic diarrhea 6. Chronic constipation
.	.	.	.	½	.	.	.	.	.	.	.	7.	Bowel move hr._____t.___ 8. Nausea anorexia allergy
.	.	.	.	.	.	.	.	1	.	.	2	9.	Menses age__per._____ 10. Vertigo
½	.	.	½	½	½	.	.	.	.	.	½	11.	Headaches front vert. bitemp. occip. tender.
½	.	.	½	½	½	.	.	.	.	.	½	12.	Headaches time_____occasion_____hypochon.
.	.	.	.	½	½	.	.	.	½	½	½	13.	Other pains time_____occasion_____hypochon.
.	.	.	.	.	.	.	.	.	.	.	½	14.	Voice mono. nasal thick harsh trem. stut. art.
.	.	.	.	.	.	.	.	.	.	.	½	15.	Breathing trem. abt-init. lon-exp int-insp,
.	.	.	.	.	½	.	.	½	.	.	.	16.	Feet dirty infected odorous malformed_____
.	.	.	2	.	.	2	.	2	.	.	½	17.	Pat. reflex L____ R____ 18. Weight_____lbs.
.	.	.	½	.	.	½	.	½	.	.	½	19.	Height_____inches 20. Norm____lbs. %_____
.	.	.	½	.	½	.	½	½	.	.	.	21.	Teeth stained dirty Hutchinson's irregular soft
.	.	.	½	.	½	.	½	½	.	.	.	T.	U. 6 5 4 3 2 1 1 2 3 4 5 6 d - decay
.	.	.	½	.	½	.	½	½	.	.	.	T.	L, 6 5 4 3 2 1 1 2 3 4 5 6 o - out
.	.	.	½	.	½	.	½	½	.	.	.	P.	U, W 7 6 5 4 3 2 1 1 2 3 4 5 6 7 W L - loose
.	.	.	½	.	½	.	½	½	.	.	.	P.	L. W 7 6 5 4 3 2 1 1 2 3 4 5 6 7 W
.	.	.	½	.	2	.	.	.	.	.	.	22.	Gums enlarged inf. 23. Mouth inf. mal._____
.	.	.	.	.	1	.	.	2	.	.	.	24.	Tonsils lrg. inf. 25. Palate cft. c-uv. hare
.	.	.	½	.	.	.	.	½	.	.	.	26.	Tongue coat macro micro fis trem tie f-tie hem
.	.	.	.	.	.	.	.	½	.	.	.	27.	Locution undershot over-mal. malf-jaw.
.	.	.	.	.	½	.	.	½	.	.	.	28.	Skull exct. mucus micro-macro-hydro-mongol.
.	.	.	½	½	.	.	.	.	.	.	.	29.	Scalp dirty inf. 30. Ears dirty inf malfor.
.	.	.	.	½	.	.	.	.	.	.	.	31.	Hair coarse dry soft bald thin thick color_____
.	.	.	½	½	.	.	.	.	.	.	.	32.	Skin dry moist dirty inf. color_____birthm_____
.	.	.	1	2	.	.	.	.	.	.	.	33.	Cerv. lymph nodes 34. Thyroid enlarged
.	.	.	.	2	.	½	.	.	.	.	.	35.	Thorax abnormality 36. Abdomen pdnt flat arc
.	.	.	½	.	½	.	.	.	.	.	.	37.	Rib rosettes 38. Scaphoid tendency
.	.	.	.	.	½	½	.	.	.	.	.	39.	Body spins torso-leg_____pyknic asthenic athl.
.	.	.	.	.	1	½	.	.	.	.	.	40.	Bowlegs knock-knees 41. Posture_____
.	.	.	½	.	1	.	1	.	.	.	.	42.	Fat sub-cut_____ 43. Mal-nut. sympt.
.	.	.	.	.	2	.	½	.	.	.	.	44.	Hernia atro. asym. 45. Enlarged bones perspir.
.	.	.	.	.	.	.	½	.	.	.	.	46.	Atonicity grip L 1__2__3__R 1__2__3__kg.
.	.	.	.	.	.	.	.	.	.	.	½	47.	Handedness L R 48. Pupil ref.___coor.___
.	.	.	2	2	2	2	.	.	.	2	1	49.	Methodist Episcopal 50. Temperature_____F
.	.	.	.	.	.	.	.	.	.	½	.	51.	Blood pres. S D 52. Pulse rate 1__2__
.	.	.	.	.	.	.	.	2	.	½		53.	Breath rate 1__2__ 54. Pulse irregularity_____
.	.	.	.	.	.	.	.	.	.	½		55.	Toe stand_____sec. 56. Fatigue complaint.
½	.	.	.	.	2	2	.	2	.	.	1	57.	Strabismus ver. c p 58. Eye color__inf. prot.
.	.	.	.	.	.	.	.	.	1	.	2	59.	Cough adn. asth. sin. 60. Space perception_____
.	.	.	.	.	.	2	.	.	.	.	½	61.	Tremor fing. intent. 62. Nails dry soft bitten
.	.	½	.	.	.	.	.	.	.	.	.	63.	Olfaction Gustation__pain (area)_____
1	.	2	.	.	.	.	.	.	.	.	.	64.	Color RG BY tot agn 65. Astereognosis kinesthesis
.	.	.	.	.	.	.	.	2	.	.	½	66.	Romberg long. trans. 67. Line walk L C R ataxia
2	1	.	.	.	.	.	.	.	.	.	.	68.	Audition L___R___ 69. Vision L____R_____
½	.	.	.	.	.	.	.	.	.	.	.	70.	Astigmatism L 0 30 60 90 120 150
Rapport			x	x	X	x	x						R 0 30 60 90 120 150

recommendation to indicate that such an examination is not necessary or that the findings of such an examination would be positive. None of the information obtained on the physiological form may be put into the psychological recommendations to the case or others: for instance, if the eye examination shows that a child possesses less than 10/20 vision in each eye the psychologist can only recommend an eye examination, never say that the child needs glasses.

The items of the examination are arranged in the order in which they are to be administered. The physiological equipment should be arranged as follows: The physiologist's case should be placed on a table at the light end of a room at least twenty feet long. One side, or the back should face the distant end of the room. The physiologist should have a chair facing the front of the physiologist's case. The chair for the subject should face the physiologist's chair and the scales should be placed in front of it. The steel rule should be used to measure off twenty feet from the case with marks on the floor every four feet: then the rule is to be tacked to the wall back of the physiologist. All other material should be left in the case except when in actual use.

When the subject enters the room he is asked to write his name and a dictated passage, then to remove his shoes. While he is removing them he is asked questions on Items 1-12. Items 14-16 may be filled from observaton. Item 17 is checked next and while the results are being recorded the subject is asked to weigh himself. The clinician checks the weight and while recording it asks the subject to stand with his back against the steel rule. Height is checked by holding the right angle of the age-height-weight norm card against the rule above the subject's head. If the subject removes his shoes quickly some of the Items 1-13 may be postponed until after Item 19 and filled while the subject is replacing his shoes. The physiologist should be able to check Items 21-27 after one careful observation of the mouth. If he does so he will save considerable time in the examination. Items 28-45 should be filled at one time.

On Items 52 and 53 the first part is to be filled and then the subject told to step on and off a chair to a count of four. The counting should be spaced at about one second intervals and the subject required to mount the chair eight times. The pulse and breathing rate are counted immediately and simultaneously for fifteen seconds and the results multiplied by four to augment the value to rate a minute. Item 56 is checked immediately after Item 55. Item 60 is checked by holding a pencil about twenty inches in front of the subject and asking him to extend his arm horizontally at one side then rapidly touch the point of the pencil with the index finger. Space perception is a test with both arms separately and with both eyes open. Item 61 is tested by having the subject hold a sheet of paper on the tips of his fingers. Olfaction is tested by asking the subject to recognize the odor of peppermint oil. If necessary the subject may be given the vial of water and the vial of peppermint oil and asked to tell which one smells better. Pain is tested with an algesiometer fully loaded for adults and half loaded for children six years of age. Tests are made on the back of both hands with the eyes diverted, also on the back of the neck, on the back of the shoulder and on the calf of the leg. The subject is asked if the point is sharp or dull. Color blindness is checked with the Ishihara test, astereognosis by having the subject close his eyes and distinguish a ball and cube held in either hand, and kinesthesis by distinguishing between a nine gram weight and a fifteen gram weight of the same size. For children below nine years of age the regular Stanford-Binet Block test should be used. The line walk is

carried out by directing the subject to walk to the twenty foot mark at the opposite end of the room with his eyes closed and his hands over his eyes. When he arrives at the mark his vision is tested for each eye separately, the light on the letters of symbols. The physiologist must be careful to hold the astigmatic chart at a level with the subject's eyes and perpendicular to his line of sight. Audition is tested with each ear separately, the subject facing the side and holding his hand over the far ear. He is asked to count a series of clicks of the acoumeter or to say "tick" each time he hears the acoumeter.

The analysis table in the margin of the form contains three symbols, 1, 2, and ½. 1 indicates that the left hand item in that row is involved, 2 indicates that the right hand item is involved and ½ indicates that both are involved.

Abbreviations are as follows by items: 3, paralysis with a note as to location, recent convulsions, or seizures; 7, time of usual bowel movements, frequency a day; 9, age of puberty; length of menstrual cycle; 11, frontal, vertical, bitemporal, occipital, excessive tenderness; 12-13, hypochondrical attitude toward headaches and pains; 14, monotone, focal tremor, abrupt initiation of sound, long expirations, interrupted inspirations; 17, patellar reflex; 20, percent under or over weight (use plus and minus); 21, temporary and permanent teeth; and upper and lower; 22-24, infected, malformed, excessively large; 25, cleft palate, cleft uvula, hair lip; 26, tongue coated, large, small, fissured, tremor, tie, functional tongue tie, hemiatrophy; 27, overshot, malocution, malformed jaw; 28, skull exotosis, mucus patches, microcephaly, macrocephaly, hydrocephaly, mongoloid; 29, ears malformed; 32, birthmarks (usually significant only if conspicuous); 33, enlarged cervical lymph nodes; 36, abdomen pendant, **arc de cercle;** 39, torso leg ratio (approximate), athletic; 42, sub-cutaneous fat locations; 43, symtoms of malnutrition; 44, atrophies, asymmetries; 45, excessive perspirations; 46, left and right hand three trials on hand dynamometer; 48, pupillary reflex, coordinated (reflex in nonstimulated eye); 49, speech; 51, systolic, diastolic; 57, vertical, central, peripheral; 58, protruding eyes; 59, adenoids, asthma, sinus conjestion; 61, finger tremor, intention tremor; 64, red-green blindness, blue-yellow, total, agnosia (does not know color); 66, longitudinal, transverse; 67, left, center, right; 70, numbers refer to degrees of angle at which lines seem darkest.

The clincian should master the physiological form sufficiently well to enable him to administer it in an average time of twenty minutes. He should be able to set up the equipment in three minutes.

9. **Psychometry** (Forms 7.1, 7.2, 7.3): Advanced clinicians qualifying in psychometry must complete the following preparation:

Test	Number of Practice Administrations	Degree of Proficiency
Stanford-Binet	20	without manual or blank
Herring-Binet	10	with manual and blank
Pintner-Paterson	15	with blank only
Gasell	3 throughout entire scale	with blank only

Test	Number of Practice Administrations	Degree of Proficiency
Pintner Non-Language Mental	3	with manual
Detroit First Grade Intelligence	2	with manual
Detroit Primary Intelligence	2	with manual
Henmon-Nelson Mental Ability 3-8	1	with manual
Henmon-Nelson Mental Ability 7-12	1	with manual
Modern School Achievement	1	with manual
Pintner Achievement	1	with manual
Iowa High School Content	1	with manual
Monroe Reading Aptitude	3	with manual
Gray Oral Reading	2 of each set	with manual
Nelson-Denny Silent Reading for Senior High Schools and Colleges	1	with manual
Nelson Silent Reading 5-8	1	with manual
Kelly Speech and Reading Scale	10	with blank only
Clapp-Young Arithmetic	1	with manual
Nelson English	1	with manual
Stenquist Mechanical Aptitude I	1	with manual
Stenquist Mechanical Aptitude II	1	with manual
Pressy X-O	3	with manual

Binet tests and the speech and reading examination must be given in strict privacy. The Pintner-Paterson may be given in a room with other people who are not observing the case. The group tests may be given in a room with other people provided there is no disturbance.

A case should not be tested more than three hours in one day. The basic test for any case is the intelligence test. Cases in which there are suspected social inhibitions should be given a group test. Those who have educational difficulties in subjects involving reading difficulty should have a performance test.

Unless starred tests are specified, the longer form of the Stanford-Binet Scale should be given. Tests in the selected group of the Durrel scale for non-readers are underlined. If a reading disability is suspected the M.A. on the Durrell Scale should be computed and compared with the other. Parts of tests completed should be encircled, the numbers of completed tests should be encircled and the year numerals of complete year levels should be encircled. C.A. and M.A. should be given in months. Test materials must be kept in the box when not actually in use so that the subject will not be distracted. The lid of the box must be kept up in such a way as to obscure the materials not in use. The form should be kept out of sight as much as possible. Children under eight should be asked if they need to go to the toilet before starting the examination.

Unless otherwise specified Group E (entire test) of the Herring-Binet Scale should be given. The Herring revision is preferred for use in extension clinics when time is short. When records are to be compared with those of other clinics the Stanford revision is preferred.

In each item the first number is the number of the test, the second is the score in Group A which qualifies the subject for taking the test. For instance, -9 in Test 5 indicates that if the subject made a score of 9 or less in Group A he is to take Test 5.

Case _____ Examiner _____ Date _____ Testing Time _____ Number _____

Sex _____ Age _____ Date of birth _____/_____/_____ C A _____ M A _____ School _____ Parents name _____ Parents Address _____

#III * Body/nose-eyes-mouth-hair
*2 Objects/ key-1¢-knife-watch-pencil
*3 Pictures/Dutch-canoe-postoffice
4 Give sex
5 Give last name
*6 Repeat/I have-The dog-In summer
A Repeat digits/642-352-837

#IV.*1 Compare lines/1 2 3 (4 5 6)
2 Forms/ 1 2 3 4 5 6 7 8 9 10
*3 Counting four pennies
*4 Copying square (use back)
*5 Comprehension/sleepy-cold-hungry
6 Digits/4739-2854-7261
A Repeat/ The boy's-train- we are

#V.*1 Weights (3 & 15) /a - b - c
*2 Colors/red-yellow-blue-green
*3 Aesthetic comparison/a - b - c
4 Definitions/chair-horse-fork
doll-pencil-table
5 Patience/a - b - c
*6 Three commissions/ key-door-box
A Give age

#VI. *1 Right & left/hand-ear-eye
*2 Missing parts/ a - b - c - d
*3 Thirteen pennies
*4 Comprehension/rain-fire-train
5 Coins/5¢-1¢-25¢-10¢
6 Repeat/time-vacation-walk
A Forenoon and afternoon

#VII.*1 Fingers/one-other-both
2 Pictures/Dutch-canoe-postoffice
3 Digits/31759-42835-98176
4 Bow knot/t___double-single
*5 Differences/fly-stone-wood
*6 Copy diamond/a - b - c (use back)
A1 Days of week/t___checks a-b-c
A2 Digits bkws/283-427-958

#VIII.*1 Ball and field/inf-sup
*2 Count bkws/t___e___
*3 Comprehension/
broken-late-hits
*4 Likenesses/wood-apple-iron-ship
5 Define/ballon
tiger-football-
soldier
6 Vocabulary/1st___
2nd___
A1 Coins/1-25-10 $1-50
A2 Dictation

#IX.*1 Date/day of wk. mo. day of mo.
*2 Weights/a - b - c
3 Make change/(4 10)-(12 15)-(4 25)
*4 Digits bkws/6528-4937-9629
*5 Make sentence/boy-work-deserts
6 Rhymes/day___mill___spring_____
A1 Months/t___checks a - b - c
A2 Stamps/t___

#X.*1 Vocabulary/1st___2nd___
*2 Absurdity/hill-cars-body-48 rider
3 Designs/ A___B___(use back)
4 Reading and report/t___e___mems
*5 Comprehend/opinion-begin-actions
*6 Words/½___1___1½___2___2½___3___t___
A1 Digits/374859-521746
A2 Repeat/apple-halfboast-summer
A3 Healy-Fernald puzzle a/t

#XII.*1 Vocabulary/1st___2nd___
2 Definitions/pity-revenge-charity
envy-justice
3 Ball and field/inf.-sup.
*4 Dissected sentences/a - b - c
*5 Fables/a___b___c___d___e___t___
*6 Digits bkws/31979-69482-52961
*7 Pictures/Dutch-canoe-post.-colon.
*8 Like-snake-book-wool-knife-rose

#XIV.*1 Vocabulary/1st___2nd___
2 Induction/ans.-rule(give XVIII 1st)
*3 Pres. & king/accession-tenure-pow.
*4 Questions/man-death-bicycle
*5 Arithmetic reasoning/50-20-35¢
6 Clock/6:22-8:08-2:46
A Digits/2183439-9728475

#XVI.*1 Vocabulary/1st___2nd___
*2 Fables/a___b___c___d___e___t___
3 Differences/laziness-evolution-
poverty-character
*4 Boxes/ (2 1)-(2 2)-(3 3)-(4 4)
*5 Digits bkws/471952-583294-752638
6 code/t___e___
A1 Repeat/Walter-yesterday
A2 Physical relations/cannon-
rish-rifle

#XVIII.*1 Vocabulary/1st___2nd___
2 Paper cutting test
*3 Digits/72534896-49853762-83795482
*4 Thought/a-b (record verbatum)
*5 Digits bkws/4162593-3826475-
/83795482
6 Ingenuity/3 & 5 get 7-5 & 7 get 9

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC

Form 7.2
Herring-Binet

Case _____ Clinician _____ Date _____ Testing time _____ Number _____

Sex _____ Date birth _____ C A _____ M A _____ School _____ Parent's name _____ Parent's address _____

GROUP A

1. Pictures/ 1 2 3 4 — 12 ( )
2. Number series/ a b c d e f g h — 8 ( )
3. Thought/ — 13 ( )
4. Digit bkws/ 1 2 3 4 5 6 7 8 9 — 9 ( )

M A _____ GROUP A TOTAL _____
Tests 1-4

GROUP B

5.-9 Body/ knee-finger-ear-foot — 4 ( )
6.-9 Syllables/want-winter-bed — 3 ( )
7.-15 Size/ 1 2 3 — 3 ( )
8.-19 Aesthetic comp./ 1 2 3 4 — 4 ( )
9.-25 Colors/black-grey-white — 3 ( )
10.-41 Situations/lost-lessons buy-eat-failed-good — 6 ( )
11. Read & report/score - 2 — 9 ( )
12.6- Define/obedience-hope-pride-culture-hostility severity-prejudice — 7 ( )
13.22- Read & report/score - 2 — 6 ( )

M A _____ GROUP B TOTAL _____
Tests 1-15

GROUP C

14.-29 Situations/empty-ocean dropping-muddy-autos — 5 ( )
15.-31 Absurdities/$5-friends-$100-thief-Smith-25¢ 1 & 2-lights — 8 ( )
16.-31 Make sentences/hen-play-money-ball — 4 ( )
17.-37 Rhymes/ball-map-bad-rim — 4 ( )
18.-37 Similarities/wheel-sling ink-star-cloud-stone — 6 ( )
19.6- Proverbs/canoe-fire-mild-Rome-woods — 5 ( )
20.10- Read & report/score -2 — 7 ( )
21.10-Mixed sentences/ 1 2 3 (o n e m i n u t e) — 3 ( )
22.22-Problem reading/1 2 3 — 6 ( )

M A _____ GROUP C TOTAL _____
Tests 1-22

GROUP D

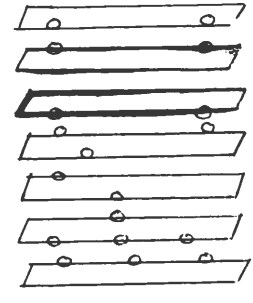
23.-25 Syllables/ school-snowballs-add-ice — 4( )
24.31 Directions/ 1 2 3 — 3 ( )
25.-31 Directions/ 1 2 3 4 — 4 ( )
26.-31 Similarities/baseball-rain-wood-bed — 4 ( )
27. Generalization/ — 5 ( )
28.10- Comprehension/ — 3 ( )
29.19- Sentence completion/5. 5 (two minutes) — 5 ( )
30.10- Problem reading/ (two minutes) — 5 ( )

M A _____ GROUP D TOTAL
Tests 1-30

GROUP E

31.-9 Name objects/nail-button-safety pin-hair pin-string — 5 ( )
32.-15 Firm comparison/score-2 — 5 ( )
33.-29 Commissions/ — 4 ( )
34. News route/

start-



Score — 6 ( )

35. Digits forward/ — 10 ( )
36.10-Syllables/ 1 2 3 — 3 ( )
37.10-Roast/ ½-1½-3-3½ — 5 ( )
38.10-Code/letters -2 (five minutes) — 6 ( )

M A _____ GROUP E TOTAL _____
Tests 1-38

YEAR-MONTH EQUIVALENTS FOR CONVENIENCE IN COMPUTING CHRONOLOGICAL AGE
1-12, 2-24, 3-36, 4-48, 5-60, 6-72, 7-84, 8-96, 9-108, 10-120, 11-132, 12-144, 13-156, 14-168, 15-180, 16 and over-192

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC

Form 7.3
Pintner-Paterson

Case _____ Clinician _____ Date _____

Testing time _____ Date of birth _____ Age _____ C A _____ M A _____ Grade _____ Requested by _____

			4	5	6	7	8	9	10	11	12	13	14	15	A
		T	160--91--76--58--48--44--39---------32												
1.	Mare	E	11---4----------2												
2.	Senguin (3)	T	43--29--25--21--19---------15----------12												
		T	300-224-145-131-106--90--84--62												
3.	Five Figure	E	31--18--11---78----------4												
		T	300-283-115--93------63--5--42												
4.	Two Figure	E	45--39--20--17--------14---------11												
		T	300-279-164------127--98---------·--83												
5.	Casuist	E	30--14-------11---7----------5												
		T	300-289-122------88---------85--59												
6.	Triangle	E	36--30--17-------13--------10---6												
		T	300-173-------140--83---------48--38												
7.	Diagonal	E	40--21--------16--10--------5												
		T	300----257---144---95--77--65												
8.	Healy A	M	100----50--38--31--26--20												
9.	Manikin	S	2----------3--------4---------5												
10.	Profile	T	300-236----------311-189												
11.	Ship	S	1---7---9--15--17--17--18----------19												
12.	Picture	S	5--43--99-178-271-327-366-396-410												
		(T)													
13.	Substitution	(E)	600------384-248-194-163-142-122-118-109												
14.	Adaptation	S	1---2---3------4----------5												
15.	Cube	S	1---2---3---4-----5----------6----------7---8												

4---5---6---7---8---9---10---11--12--13--14--15--A

Picture Completion. (Part scores)
1 2 3 4 5 6 7 8 9 10

The notation 9- would indicate that if he made a score of 9 or more in Group A he is to take the test. When the score in Group A exceeds this qualifying range full credit is given without administering the test. The number just before the blank indicates the maximum score on that test.

In form 7.3 the upper row of figures opposite each test refers to time in seconds and the lower row either to moves or errors. The score made is indicated by a check mark interpolated approximately between the two adjacent standarized scores. Scores better than the best standardized are indicated by drawing a line out to the right-hand margin. Ordinarily, it is not necessary to compute the mental age; the concentration of check marks indicates that value as closely as the discriminative power of the test justifies.

The Pintner-Paterson materials should be packed in their cases in the reverse order to that in which they are used. The subject should not see the top of any form board until he is ready to take the test. The method is to turn the form board upside down on a piece of cardboard to remove the blocks, then turn it on its edge with the back toward the subject, arrange the pieces using the board as a shield, give the instructions, drop the board toward the subject, and start the stop-watch.

RULE 10: THE PSYCHOMETRIST SHOULD NOT REPORT THE RESULTS OF AN INTELLIGENCE TEST TO THE CASE OR HIS PARENTS UNLESS DIRECTED TO DO SO BY THE CLINIC AUTHORITY.

10. **Speech and Reading** (Form 7.5): The diagnosis of the symbolic functions requires a special examination covering both physiological and psychological aspects of reading, writing, and speech. The materials used in administering Tests 1-12, 18, and 20-37 of the examinations are contained in a special manual. They consist of the following: a Van Riper Angle Board for Item 20, a peep hole card for item 18, a list of sentences containing speech sounds in initial, medial and terminal positions together with the corresponding phonetic symbols for use in Items 26-37, a list of word groups for use in Items 21-35, a set of reading passages with flaps and questions for Items 1-22, a mirror for observing eye movements in Items 1-12 which can be folded into an A-stand for Item 15, four sets of words for use in Item 15, and a word finding for use in pointing out single words to the subject.

The abbreviations under the section on eye movements indicate the following: passage method of reading, total fixations made, reversals, questions answered correctly, six-year norm, eight-year norm, twelve-year norm, adult norm, and superior adult norm.

In tests 1-4 the reading is oral and in tests 5-8 it is silent. The time is the total reading time for the passage, and in each case the norm encircled is the one next below the performance. In Items 9-12 the abbreviations stand for abnormally long fixations, number of binocular aphasic divergences, extent of verbalization, and eye tremors. It is recommended that the Gray Oral Reading Test be used for Test 13 and the Nelson or Nelson-Denny Silent Reading Examination for Test 14. Scores should be converted to age norms.

Test 16 requires the copying of the sentences with each hand, forwards and backwards. The sentence contains all the letters of the alphabet. Test 17 is for simultaneous writing reversals. The clinician holds his hand over the subject's eyes, the subject stands close to the blackboard with arms well extended to sides

(beyond tips of shoulders), the instructions are given to write with both hands at once, and the letters are pronounced in the order listed, the subject is encouraged to write spontaneously and rapidly and is not allowed to see the results of his efforts until the test is finished. The letters reversed or partially reversed by each hand are encircled. Reversals made by the unpreferred hand in naive subjects should not be considered serious evidence of lack of cerebral dominance.

Ocular dominance is tested by using a card with a hole in the center. The subject holds the card first in the left, then right, and then in both hands; each time dropping the card to the side after an observation. In bringing the card to the front of the face the subject is asked to bring it from the bottom for the first trials, then from the right, then from the left, and then from the top. The clinician stands about fifteen feet away and asks for reports on whether the pencil he holds in his hand is pointed up or down. The clinician should move about between observations and encourage a different set for each observation. Ten trials are taken and the number of each trial encircled opposite L or R depending upon the eye used.

Item 19 calls for the following: Hand preferred in writing, hand in taking pencil offered in the median plane (three trials), hand used in using scissors, and foot used in kicking baseboard (three trials). In offering the pencil the subject is instructed to sit squarely with table and with hands clasped tightly in front of him. The pencil is then laid about six inches in front of the subject's hands with the point toward the subject. The subject is instructed to pick up the pencil as quickly as possible after a signal is given. The kick test is administered with the subject standing close to and facing the wall. He is instructed to kick the wall three timesas quickly as possible after the signal.

Test 20 is made with a modification of the Van Riper Angle Board. Simultaneous writing while blindfolded is required. The procedure is similar to that of Test 17. The two letters and the word are written with the angle board in each of the indicated positions. Reversed letters are encircled according to the hand used in reversing them.

The abbreviations in Item 21 stand for the following phrases: Transient aphasia, articulatory aphasia, agraphis, and alexia. In filling the blank opposite Item 27 the phonetic script for the proper sound is placed above the line and the substituted sound immediately below the line. The sounds are given on the speech and reading test cards. The test is administered orally by the examiner who must be careful to pronounce the sentences correctly himself. Each sentence contains words in which the sound appears in initial, median, and terminal positions. Several trials may be given on any one sound. The object is to discover which sounds cannot be formed and which sounds are habitually altered. The first abbreviation in Item 31 stands for malformed dental arch. In Item 38 hypert-turb stands for hypertrophied turbinates.

Tests 15-20 are for a lack of cerebral dominance. In Test 15 the number of erect words read should be larger than the number in any of the other lists. The rotated words will normally be read with somewhat greater difficulty. The reversed and inverted words are usually read with about equal difficulty unless the subject has had experience with type-setting. If the reversed words are read nearly as easily as the erect words, or much more easily than the inverted words, there is evidence of a lack of cerebral dominance.

In Item 16 the letters formed with the non-preferred hand should be of poorer

Case _____ Clinician _____ Date _____

READING (EYE MOVEMENTS)

P.	Me.	Fix.	Nev.	.	6	8	12	Adl	S.Adl
1.	Or.	___	___	a	5	3	2	--	-
2.	Or.	___	___	a	7	5	4	3	-
3.	Or.	___	___	a	16	11	8	6	4
4.	Or.	___	___	ab	54	29	24	19	12
5.	Si.	___	___	ab	80	53	40	30	15
	(Time	___	sec.		43	28	19	13	10)
6.	Si.	___	___	abc	-	82	33	46	21
	(Time	___	sec.		-	49	27	18	14)
7.	Si.	___	___	abc	-	-	82	57	31
	(Time	___	sec.		-	-	44	26	20)
8.	Si.	___	___	abc	-	-	-	71	36
	(Time	___	sec.		-	-	-	30	21

9. Long Fix.___ 10. Aph. Div.___ 11. Verb___

13. (ORAL READING) (Test _____)
Age Norm: Rate _____
Errors _____

14. (SILENT READING (Test) _____
Age Norm: Vocabulary _____
Paragraph _____

15. (MIRROR READING)
Erect: _____ words
Rotated _____ words
Reversed _____ words
Inverted _____ Words

12. Eye Trem.

WRITING 16. "Pack my box with five dozen liquor jugs."

L _____

R _____

"sguj rouqil nezod evif htiw xob ym kcaP"

_____

_____

17. Simult. Writing Rever. 18. Ocular Dominance 19. Write Take Cut Kick
L: o e m b a c 4 7 3 6 1 2 3 4 5 6 7 8 9 10 L LLL L LLL
R: o e m b a c 4 7 3 6 1 2 3 4 5 6 7 8 9 10 R RRR R RRR

20.

	0°	15°	30°	45°	60°	70°	90°
Van- L	c n the l a cat		o y dog	e m hat	f t log	k m pig	s w key
RiperR:	c n the l a cat		o y dog	e m hat	f t log	k m pig	s w key

SPEECH (RHYTHM 21. Clon spm Ton Spm Thor Abdom Dys Breath Trem
22. Abrupt Init Prolong Insp Interrup Exp Vocal Trem
23. Tonal Rigid Intertonal Sound
24. Trans Aph Art Aph Aud Aph Agraphia Alexia
25. Verbal Syntatical Nominal Semantic

SPEECH (ARTICULATION AND TONATION 26. General Pathology _____
27. Sound: _____
Substitution:
28. Tongue: Tumor macro- micro- tic hemiatrophy
29. Uvula: long thick bifurcated double
30. Palate: cleft high hare-lip
31. Teeth: malform-arch malocution obtruded intruded defective open
32. Jaws: overshot undershot
33. Cavities: adenoid tonsil nasal-polypi hepert-turb septum
stenosis lary laryngitis sinus paralysis perichontritis
34. Audition: L_____/ ___R_____/ _____35. Ataxia:
36. Rapport_____.

Item 16: objects, situations, kind of people, friends.

Item 17: experience of conversion, mysticism, ritualism, taboos, fear, agnosticism, cynicism, rationalism, pantheism, social, gospel, attitude, denomination, customary grade at table, regular prayers, Sunday school attendances a month, church, principal sources of religious influence.

Item 18: general, specific, compulsive, felt need for expiation, guilty ideas, ambivalence, fear self-contempt, rationalization.

Item 19: religion, service, social, moral thrift, success, education, responsibility.

Item 20: superstition, thoughts, destructive tendencies, sexual-compulsions, compulsions to count, eat, lock doors and belongings, expect accidents.

Item 21: controlled principally by father, mother, sister, brother, boss, hero worship, sense of duty, expected reward.

Item 22: slow, apathetic, resistant, stiff, automatic obedience, catatonic, stereotype, left handed, right handed, hyperkinetic, hypokinetic, restless, tic, choretic movement, tense, peculiarity of facial expression.

Item 23: verbigeration, flight of ideas, divertability of attention, neologisms, auditory aphasia, short attention span, artificial speech, speech disorder.

Item 24: fear, death, pursuit, animals, falling, drowning, naked, guilt, sex, homosexual, oedipal, flying, fighting, eating, smoking, smothering, amnesia for dreams.

Item 25: insomnia, toss at night, somnambulism, unrested in morning, snores excessively, regular sleeping habits, fresh air, bed fellow.

Item 27: continued daydream story, repeated, systematized, bizarre, condensed, euphoria, many characters, self represented, represented as conquering hero, suffering hero.

Item 28: visual mode, parasthesia, Gedankenlautwerden in left ear, in right ear, men talking, women talking, voices recognized, considered real by case, experience under control, case's explanation of cause content of communication, prophetic value attached, thought to be voice of conscience, necromancy, **deja vu.**

Item 29: cephalic orbital, aural, dental, respiratory, cardiac, gastric, elimination, cancer, rheumatic, **lumbar, arc de cercle, displaced organs,** paralysis, taxis, kinesthesia, toxia, castration.

Item 30: persecution, watched, talked about, jealous, wronged, influences used against case, plans for revenge, grandeur, strength, power, wealth, noble birth, adventure, nihilism, adoption, systematized delusions, bizarre.

Item 31: grand mal, petit mal, absence, depersonalization.

Item 32: mate or lover, time love affair has lasted, ambivalent attitude toward mate or opposite sex, erotic attitude, inhibited attitude, anxious attitude, fearful, guilty, disgust, negative attitude toward opposite sex, satisfied with heterosexual status, number of kissing experiences, number of people kissed (exclusion of family), experience of petting (stimulating bodily contact other than kissing and holding hands), mutual masturbation, sexual intercourse, times, people, accept pay or reward for intercourse, witnessed intercourse, seduced.

Item 33: bisexuality, overt homosexual experience, invert, attitude of acceptance, anxiety, masturbation frequency.

Item 34: reaction to examination, depressed, anxiety, crying, systematization, hope, tremor, transference, asked for another appointment.

Item 35: Appearance of case: virile, weak, large, small, not dressed in taste, lack of social intelligence, lack of integration and security, moody, fearful, poor form, poor expression, not neat, dirty, poor manners, peculiar mannerisms, poor taxia, poor clothes.

Elaborations of items are as follows:

Item 1: This item must never be omitted from the first conference. Inclusion of it as a matter of professional ethics and an application of RULE 3. As in a number of the items, more than one of the abbreviations may properly be encircled. A child who has been registered because of a tendency to steal is asked, "You seem to have been in some trouble with your school principal lately; what was the matter?" If the child does not mention stealing, the clinician asks, "What about stealing?"The purpose of the questions is not to force a confession or to compel the child to talk about an unpleasant subject but first to give him a chance to give his own version of the problem and thus come to an understanding of the reason for his being in the clinic and then, if it appears that he still does not know why he is registered, to ask a direct question which will indicate what the clinician has in mind. This method of approach may appear too direct to the inexperienced worker, but it saves misunderstanding and actually serves to protect the case. Frequently the case is glad to have the worst "over with" before he has time to build up a story. If a case does not admit guilt the clinician does not force the issue or indicate disapproval. The clinician is not a legalist or a moralist at this stage; his task, primarily, is to come to an understanding of the case's personality rather than the case's guilt. Then there is always the chance that the case has been falsely accused. Cases which are registered for other reasons are approached in a similar manner.

Item 2: This item is for children only. It is a test of volition and honesty. The pencil trick (which can be demonstrated better than explained) is demonstrated and the case is given one minute to repeat the trick while the examiner looks away. The time the case continues trying to repeat the trick is recorded and also the method. The toestand is also administered for a maximum of one minute. A practice trial of ten seconds should be used.

Item 3: The following questions are numbered according to intellectual levels: (1) "I don't know you very well yet. Won't you tell me something about yourself? What kind of a little boy are you? Are you a good little boy or a bad little boy?" (2) "Tell me about yourself. What sort of personality do you have? Do you have a good personality or are you rather disagreeable? What sort of an impression do you make upon people?"

Item 4: (1) "What sort of things do you like to do?" (2) "What are your principal interests in life? What sort of an impression do you make upon people?"

Item 5: (1) "Do you like to play? What do you like to play? What do you like to play with? Whom do you play with? Where and in what places do you play? Tell me some of the things you have to play with." (2) "What sort of recreation do you get? With whom do you usually take your recreation?"

Item 6: (1) "What do you want to be when you grow up? Did you decide that all

by yourself? Do you want to get married and have children of your own? How far do you want to go in school?" (2) "What do you want to do when you get out of school? Who influenced you in deciding that? What subjects are you specializing in? Do you want to get married? How many children do you think you would like to have? How far do you intend to go in school?" (3) "What is your vocational ambition? Who has influenced that choice? What is your major? Your Minor? What are your hobbies? etc."

Item 7: (1) "What is there about _____ that you like so much? Why do you like to do that?" (2) "What is your motive in choosing that? Does that sort of thing mean a great deal to you? What are some of the other things that you want to get out of life? What would you say that life means to you in general?"

Item 8: (1) "Is there anything that might keep you from doing that? Do you think you will be able to do that?" (2) "What obstacle stands in your way? What are some of the things which you will have to overcome before you can achieve your ambition?"

Item 9: (1) "Has anything happened lately to make you feel bad? What are some of the things which make you feel unhappy?" (2) "Have you had any serious disappointment lately, such as disappointments in love, deaths in the family, or financial catastrophe?"

Item 10: (1) "Are you a happy boy or are you a sad boy? How happy do you feel? How sad do you feel? Do you ever feel you do not want to live any longer? Do you ever feel so happy that you just do not know what to do with yourself?" (2) "Do you get the blues frequently, or are you usually quite happy? How excited do you get when you are happiest? How do you feel at those times? How do you feel when you get the blues? Do you feel sick and exhausted? Do you feel as if you want to kill yourself? How often do you feel that way? Do those feelings come regularly?" (3) "Do you frequently feel melancholy? How excited do you get when you are feeling good? Have you ever considered suicide? Tell me about it. Do your feelings of elation and depression come in regular cycles or at regular times?"

Item 11: (1) "When you feel sad what do you feel sad about?" (2) "When you feel unhappy what do you think about?" (3) "What do you worry about mostly? Do you worry in spite of your better judgment? Do you feel yourself compelled to worry even though you do not feel that there is any cause for worry? Is this just a temporary worry or do you have it frequently?"

Item 12: (1) "What are you afraid of? Are you afraid of the dark or are you afraid of some people, etc.?" (2) "Do you have any fears? Are you afraid of the dark, etc.?"

Item 13: (1) "How do you get along with your brothers and sisters? Are they nice to you? How do you get along with your papa and mama? Do you like them? Do they like you? Which do you like better, etc.?" (2) "How do you get along with your girl friend? How do you get along in your family, especially with your brothers and sisters? Do you avoid each other or are you quite close to each other in your companionship, etc.?" (3) "How do you get along with your wife? Do you sometimes have tension which arises between you? What is the nature of these tensions or difficulties, etc.?"

Item 14: (1) "How do you get along at home? Do you think you have a nice home? Do you stick together? How is the household run?"

Item 15: (1) "Do you ever get mad? Tell me about some time that you got mad? What happened? Whom did you get mad at? Are there any people who don't like you? Did you ever get in a fight? Who won? Who stopped the fight? After that what did you do about it? How do you feel about the fight? After that what did you do about it? How do you feel about it now?" (2) "What sort of situations make you angry? What kind of people make you angry? Tell me about two or three of your enemies, etc."

Item 16: (1) "What one of your toys do you like best? Tell me about some place you like to be. What kind of people do you like best? Who is your best friend? Do you have any other people who are as nice to you as that?" (2) "What things or objects are you most attached to? What belonging means most to you? What places or situations are most attractive to you? What kind of people do you prefer as companions, etc.?"

Item 17: "Do you go to church? What church do you go to? Do you like church? Do you pray? What is there about church that you like? What is there about church that you do not like?" (2) "What is your attitude toward religion? Have you ever been converted? Do you feel that you have a religious calling? What part of religion appeals to you most, etc.?"

Item 18: (1) "Do you ever feel that you have been a bad boy? What is bad about you? What do you think you should do about it?" (2) Do you ever have a feeling of guilt? What do you feel guilty about mostly? Is it things that you think or things that you do that are bad? What have you been doing about it? What do you think you ought to do about it?"

Item 19: (1) "What do you think is the best thing in the world? What do you think is nicest of all?" (2) "What kind of ideals do you have? Tell me some of the ideals which you think are most important."

Item 20: (1) "Do you ever do things when you feel that you just can't help it? Doyou ever think things that you don't want to think?" (2) "Do you sometimes find yourself doing things for no reason at all, yet you can't help doing them? Do thoughts ever come to your mind and refuse to leave? Do you have some ideas which seem to be forced upon you? Tell me about them."

Item 21: (1) "What keeps you from doing naughty things? Does somebody watch you so that you will be good, or are you good just because you want to be? What is there to keep you from being bad?" (2) "How is your life kept under control? Is it controlled by people who watch you? What is there to keep you from becoming immoral or bad? What kind of self control do you exercise?"

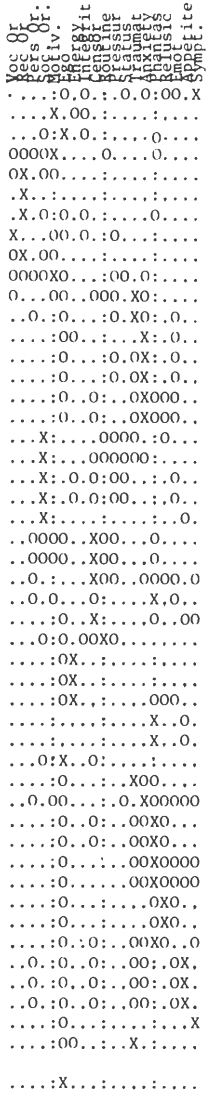
Items 22 and 23 can be indicated at this point in the examination without asking further specific questions.

Item 24: "Do you dream? Did you ever have a dream? Tell me your last dream."

Item 25: "Is it easy for you to go to sleep at night? Do you go to sleep at the same time every night? Do you sleep with the window open, etc?"

Item 26: In this blank record parts of a recent dream.

Item 27: (1) "What do you think about when you are all by yourself and there is nothing to do? Do you ever tell yourself a story or just play like things were happening? Tell me one of those stories." (2) "Do you ever daydream or imagine



Case _____ Clinician _____ Date _____ No. _____

1.*Problem: ESC DEN ACPT PROJ POL SYST ANX quer insgt
2. Volition: Pencil sec. Toe sec. SUBV PROT syst
3.*Communication: xxxXxxx Self-defense: xxxXxxx
4. Interest: stud mus proj dram soc compn part movie
gang athl mech gar pet coll toy doll game fam NARROW
5. Recreation: swng trap sand shk wgn tool doll pet
par ADLT OLD YNG sib frnd indr odr PHAN soc BRD UNPLN
6.*Ambition: Voc 1 2 SRC maj _____ min _____
Hob 1 2 Mar _____ Cha _____ Educ _____
7.*Motive: ? EXH POP SEC WEA SER MAS ASR AVN ROM RSC DOM
8.*Obstacle: IQ EDUC OPP PVT PHYS AGE RESP WIF CHD PAR
9.*Disappointment: FIN HEA EDUC SOC RECG DEA LOV CHILD
10.*Melancholia: xxXxSUI DEPR ANX ELA EUPH EXCI EXH CYC
11.*Anxiety: FIN HEA EDU SOC RCG DEA LOV PRG OST MAT PAR
CHI SEX REL PHL HOM SEZ ANG OBS DRM ACD EMP TEM
12.*Phobia: DARK PERSONS ANIMALS ACCIDENTS DEATH HIGH
DISEASE WATER STORMS OPEN CLOSED ALONE NEW DISTANT
13.*Tension: MATE SIB PAR IN-LAW COM-LAC SCH CHURCH EMPL
14.*Family: DEFEND PROJ ANX TEN INSEC CRIT UNACCEPT UNCER
15.*Anger: lst PEO ENC FGT _____
WIN LOSE STOP SOL ANX PEAR CMPT PROJ PHANT CLT
16.Attachment: obj sit peo _____ fr _____
17.*Religion: CON CAL MYS RIT TAB FEA CYN FAT PAN SOC
denom _____ grc pry ss mo. cn mo. src _____
18.*Guilt: GEN SPC CPL XPT IDE AMB FEA CPT RAT _____
19.Ideal: rel ser soc mor thr suc ddu rep _____
20.*Compulsion: SUPRS THOT DEST SEX COUNT EAT LOCK ACCID
21.*Control: FATH MOTH SIS BRO BOSS HERO DUT REW _____
22. Motor: SLOW APATH RESIST STIFF AUTO-OB CATA STEREO
l r HYPER HYPO RESTL TIC CHOR TENSE FACE-EXPR
23. Speech: VRBS FLIGHT DVRT NEOL A-APH SHT ATT ARTF DER
24.*Dream: FEA DEA PUR ANI FAL DRO NAK CLT SEX ROM CED
FLY FGT EAT SMO SMOTHER ANN _____
25. Sleep: INSOMN TOSS SOMNAM UNREST SNOR reg air fel _____
26.*Memory: _____
27.*Daydream: CNT RPT SYS BTZ CND EUP CHR SLF DNO BUF
28. Hallucination: VIS PARESTH GLAUT L R MEN WMN RCG
REAL CNTRL CAUSE _____ CONTENT PROPH CNSC NEC D-V
29.*Hypochondria: CEPH ORB AUR DENT RESP CARD CAST GL-H
ELIM CANC RHEU LUMB ARC DISP PRYL TAX KNSTH TCX CAST
30. Delusion PRSC WAT TLK JLS WRNG INFL PLN GRND STGTH
POW WEA BIR ADV NIHIL ADPT SYST BIZ _____
31.*Seizure: G-MAL ABSENCE DEPERS _____
32.*Heterosexuality: mat t AMB ERO INH ANX FRF GLT DSG
NEG sat KIS T P PET M M INTRC T P PAY WIT SEDU
33.*Homosexuality: BISEX OVERT INVERT ACCPT ANX MSTRB _____
34. Reaction: DPR ANX CRY syst hope TREM TRANSF APPT
35. Appearance: virl WEAK LRG SML TAST S-INT IN-SEC MDY
FEA FRM EXPR NEAT DIRT MANR MANPSM TAX CLTHS
36. RAPPORT x x x X x x x

things happening to your just for the fun of it? Tell me one of your daydreams, etc."

Item 28: (1) "Do you ever think that you see things and then find out that they are really not there at all? Do you ever feel things crawling over you when there really is nothing at all? Do you ever hear people talking to you when there really isn't anyone there at all, etc.?" (2) "Do you ever have visions that seem almost as real as actual events? Do you sometimes have the sensation of having things crawling over you? Do you hear words or sounds when there is no one around to account for them, etc.?"

Item 29: (1) "Does your head sometimes hurt? Do your eyes sometimes hurt, etc?" (2) "Do you have frequent headaches? Do your eyes bother you, etc.?"

Item 31: (1) "Do you ever have fits? Do you ever feel as if you were floating away or as if you did not really live?" (2) "Do you ever have seizures when you are not yourself? Tell me about it."

Item 32: (1) "Do you have a girl friend? How long have you had this girl friend? Do you sometimes like and sometimes hate her? Do you love her and want to touch her? Are you afraid to talk to her? Did you ever do anything together that was naughty? What? Were you afraid? How do you feel about it? Are you happy with this girl friend? Did you ever kiss a girl? How many times have you kissed a girl? Do you hold on to each other real tight sometimes? Do you ever touch each other under your clothes? How close did you get to each other? How many times did you do that? How many girls have you done that with? Did you ever pay a girl for that? Did you ever see anybody else do that? Did any girl ever try to get you to do that?" (2) Similar questions may be asked, but with the use of somewhat more adult language.

Item 33: (1) "Is it just as easy for you to like another boy as it is for you to like a girl? Have you ever been in love with a boy? Did you ever touch each other under the clothes? Or did you just feel like it? What are you going to do about it? Didyou ever play with yourself where you shouldn't?" (2) Same questions will beasked in somewhat more adult phraseology.

Items 34, 35, and 36 can be answered without specific questions.

At the end of the examination the clinician must realize that he has probably probed quite deeply into the intimate life of the case and while the case may benefit somewhat from having this more objective point of view established, he is likely to feel somewhat disorganized and fearful. Not infrequently, the case will feel that a criticism is implied from the nature of the questions in the last part of the examination. It may be necessary to encourage the case to suspend judgment until the next conference and not allow himself to be worried about anything that has been said. If the case is depressed and no further conferences are in prospect, it is absolutely essential that the clinician reassure the case and leave him with a constructive point of view.

12. **Special Information** (Form 8.2): Form 8.2 is simply a blank form on which special information about the case may be recorded. This information is usually of such a nature as not to be called for in the regular anamnesis. The personality profiles permit the clinician to score the individual with whom he holds his conference quickly and inconspicuously.

Case_____Clinician_____Date____No._____

1. _____ _____ _____
Informant Relation Remarks

_____

_____

_____

_____

_____

_____

_____

Informant's Traits:

1. Emotional Stability	x	x	x	X	x	x	x	2. Emotional Adequacy	x	x	x	X	x	x	x
3. Self Insight	x	x	x	X	x	x	x	4. Family Insight	x	x	x	X	x	x	x
5. School Insight	x	x	x	X	x	x	x	6. Case Insight	x	x	x	X	x	x	x
7. Interest in Case	x	x	x	X	x	x	x	8. Professional Training	x	x	x	X	x	x	x
9. Professional attitude	x	x	x	X	x	x	x	10. Completeness of Inform	x	x	x	X	x	x	x
11. Cooperate in Treat	x	x	x	X	x	x	x								

_____ _____ _____
Informant Relation Remarks

_____

_____

_____

_____

_____

_____

_____

Informant's Traits:

1. Emotional Stability	x	x	x	X	x	x	x	2. Emotional Adequacy	x	x	x	X	x	x	x
3. Self Insight	x	x	x	X	x	x	x	4. Family Insight	x	x	x	X	x	x	x
5. School Insight	x	x	x	X	x	x	x	6. Case Insight	x	x	x	X	x	x	x
7. Interest in Case	x	x	x	X	x	x	x	8. Professional Training	x	x	x	X	x	x	x
9. Professional Attitude	x	x	x	X	x	x	x	10. Completeness of Inform	x	x	x	X	x	x	x
11. Cooperate in Treat	x	x	x	X	x	x	x								

IV. THE DIAGNOSIS

1. **Advisability of differential diagnosis:** In clinical psychology the need for exact classification of mental disorders is not as great as one might suspect. A distinction needs to be made between those which are to be treated by direct methods and those which are to be treated by rational methods. The former do require a more or less clean-cut diagnosis before therapy is undertaken, the latter do not. Nearly all psychological practice requires an emphasis upon etiology which is far greater than many clinicians have suspected. A complete case history is not merely an aid to treatment but usually an integral part of that treatment. In these respects clinical psychology differs markedly from clinical medicine.

The following rules or principles are peculiar to indirect psychotherapy.

RULE 11: ONLY THE PATIENT CAN EFFECT A CURE.

RULE 12: THE PATIENT'S DIAGNOSIS IS SYNONYMOUS WITH THE CURE.

RULE 13: IMPROVEMENT IS IN PROPORTION TO THE INSIGHT WHICH THE PATIENT ACQUIRES INTO THE TRUE NATURE OF HIS DIFFICULTY.

In view of these principles it can be seen that the purpose of the preliminary diagnosis is merely to indicate the general type of therapy to be used. If direct therapy is indicated, then the clinician should proceed to a more or less clear-cut diagnosis; but if indirect therapy is indicated only the general procedures can be determined.

There is still another reason why the preliminary diagnosis need not be exact. In the field of the neuroses one never encounters two neuroses which are exactly alike nor does he ever encounter an unmixed neurosis. For instance, paranoid symptoms are almost universally present in the neuroses and yet their presence may be of secondary importance. Again, one may undertake the treatment of what at first appears to be an anxiety hysteria with some compulsive complications; after a short treatment the acute hysteriform symptoms may be dispersed, leaving only the mild but persistent compulsive symptoms to be dealt with. It is not particularly important whether the premilinary diagnosis is anxiety hysteria or compulsion neuroses. The only important decision is the one as to whether or not the case possesses the ego strength and accessibility necessary for psychoanalytic therapy.

2. **Recommendations** (Form 9.1): The most satisfactory plan is to go directly from the facts derived from the anamnesis to the therapeutic recommendations.

RULE 14: ALL RECOMMENDATIONS SHOULD BE WRITTEN IN DUPLICATE, ADDRESSED TO SOME INDIVIDUAL AND SIGNED BY THE AUTHORIZED DIAGNOSTIC CLINICIAN.

It is important that wherever a diagnosis is reported that it be reported in writing. An illustration of need for this procedure is the following: Suppose that a psychological clinic is using the pupils of a public school for practice testing in the training of its clinicians; suppose that the principal of the school asks for reports on the results of the testing. Until those results have been checked carefully by experienced clinicians no report, either oral or written, should be made. The making of an oral report in such an instance would not save the reputation of the

Clinic. Next let us suppose the Clinic checks the results of the testing and is ready to make a report on each case which is limited to the intelligence quotient. If the report is not made in writing the school may claim to have received certain recommendations which the Clinic does not wish to underwrite. The making of all recommendations in writing protects the Clinic against charges of unjustified recommendations as well as against distortion of recommendations.

Sometimes a clinician wishes to discuss certain aspects of a case which fall outside the province of a psychologist. Ordinarily such discussions are to be avoided since they open the clinician to charges of encroachment upon another profession. When a clinician wishes to discuss a case "off the record" he must be very sure to make clear to his listeners that he is not speaking professionally, and also, he should be very sure that he has given his listener a written psychological recommendation so that if ever there is question concerning the recommendations of the clinic a record of those recommendations will be available and can be clearly seen to be of a strictly psychological nature.

A psychologist must be very sure to make recommendations in as practical a form as possible, but at the same time make them complete enough so that he cannot be charged with overlooking any important elements in the diagnosis. Let us suppose that the following situations have arisen: A child needs opportunity room training, the parents of the child are unable to afford such advantages; the psychologist should have made a report which outlines a treatment of the child that is possible of attainment, but he should be sure to add to the report a recommendation that the child have opportunity room training if possible. In that way the psychologist protects himself against the charge of having overlooked the need for opportunity room training in the case.

Another important principle to be followed in making recommendations is that the psychologist stay within his field. None of the items in the physiological form may be reported in the diagnosis since those items are within the field of medicine. A case may have obviously defective vision, but the psychologist cannot suggest that the child has defective vision, or that he need glasses. In such a case the psychologist should recommend that the case have a "thorough eye examination" and that he should not be expected to succeed in school until the recommendations of an oculist have been followed. This distinction between professional areas may appear at first to be somewhat artificial and perfunctory but is nevertheless extremely important.

Sometimes the question arises as to what extent the psychologist may discuss his findings with a physician. The following principle applies in this situation: a psychologist may discuss psychological aspects of a case with any one whom he considers professionally responsible to the case but only to such an extent as he is sure that the listener will not misinterpret his statements; for instance, a psychologist may report the intelligence quotient of a case to a physician who is also working on the case only if he is sure that the physician understands the limitations, significance and general methods involved in the intelligence quotient.

When therapy is a matter of improvement of hygienic conditions in the home or school, the recommendation should be written in detail, summarized under points, and discussed with the case or with the responsible parties. If psychotherapy in the clinic is recommended, a simple written statement is all that is required.

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC

Form 9.1
Recommendations

To_____Concerning_____

Date_____193_____.

The diagnosis of the Clinic is limited to the psychological aspects of the case. It does not assume any responsibility for medical aspects. It is suggested that every case be taken to a medical physician for a thorough health examination in addition to the psychological examination.

Unless the following recommendations are carried out, little value can be attached to the services of the clinic. In general psychological problems are very persistnet and their treatment must be no less persistent if improvement is to be expected.

RECOMMENDATIONS

In the home: 1._____

2._____

3._____

4._____

5._____

In the school: 1._____

2._____

3._____

4._____

5._____

Other examinations recommended: 1._____

2._____ 3._____

4._____ 5._____

_____
Psychologist

3. **Classification of psychological disorders:** There are several clinical classifications now in use. The following is recommended for use at the present time. The categories refer to final diagnosis.

- General Mental Deficiency
  - Special Deficiencies
    - Speech, Reading, and Thought
      - Rhythmic
        - Stuttering
        - Articulatory Aphasia
        - Auditory Aphasia
        - Agraphia
        - Alesia
        - Strophosymbolia
        - Verbal Aphasia
        - Syntactical Aphasia
        - Nominal Aphasia
        - Semantic Aphasia
        - Transient Aphasia
        - Dyslogia
      - Articulatory and Phonic
        - Mutism
        - Lisp
        - Idiolalia
        - Barbaralalia
        - Dysphenia
      - Subject Disabilities
        - Arithmetic
        - Spelling
        - Arrested Development
      - Sensory Disabilities
        - Auditory
        - Visual
        - Others
    - Disciplinary Deficiency
    - Social Deficiency
    - Occupational Deficiency
    - Educational Deficiency
- Neurosis
  - Hysteriform Neurosis
    - Hysteria
    - Anxiety Hysteria
    - Hypochondria
    - Anxiety
    - Neurosthenia
    - Pathoneurosis
    - Organ Neurosis
    - Inhibited State
    - Traumatic Neurosis
  - Psychasthenia
    - Obsessive
    - Motor Compulsive Neurosis
    - Bisexuality
    - Homosexuality
    - Nymphomania
    - Stayriasia
    - Sadism
    - Masochism
    - Addiction
- Psychosis
  - Paranoid State
  - Schizothymia
  - Schizophrenia
    - Paranoid
    - Catatonic
    - Simple
    - Hebephrenic
  - Cyclothymia
  - Manic-Depressive Psychosis
    - Melancholia
    - Maniacal
    - Bi-Phasic

4. **Reporting diagnosis to the case:** Those cases which require a specific diagnosis before treatment should ordinarily be informed of that diagnosis. Those cases for whom the leap is made directly from facts to recommendations should know the recommendations and by the time the specific diagnosis is made during the course of their treatment they should be in position to receive that diagnosis. In general, then, it may be said:

RULE 15: THE PATIENT SHOULD BE INFORMED OF THE DIAGNOSIS AS SOON AS IT IS COMPLETED.

This rule applies to the reporting of intelligence test scores to the patient but not to the parents.

5. **Special diagnosis of study habits** (Form 9.2): Clinicians are frequently called upon to diagnose problems of students who are doing unsatisfactory work in college. The following form of interview will usually enable the clincian to make a rapid survey of the situation. Certain items may be followed up somewhat more at length than indicated in the form. This interview should never be used unless the student requests the diagnosis. Students who are sent to the clinician by instructors should be asked if they want all their problems discussed or would prefer to have the conference limited to an investigation of study habits only. The clinician in following this plan is simply observing RULE 2 which states that "The psychological clinic should never assume responsibility beyond that which is specifically delegated to it." The clinician should be very sure that the conferee specifically wants the entire interview before going into any personal matters.

(Ask all numbered questions. Ask indented questions only if previous answers indicate that they should be asked.)

1. What is your name?
2. What seems to be your difficulty?
3. How many hours are you carrying?
4. What are your subjects?
5. How are you getting along in (English)? (Also other subjects)?
6. What grades did you make last semester? (or in high school)?
   a. What was the matter in English? (also in other subjects)?
7. Are you working outside of school?
   a. For whom do you work?
   b. How many hours do you work per week?
   c. Are the hours regular? (Be specific).
8. Do you "batch"?
   a. How many of you are batching together?
   b. Do you get along all right with each other?
9. How are your finances?
   a. Are you in debt?
   b. Are you running up bills that your folks do not know about?
10. Do you see your way clearly throughout the rest of the semester?
11. Do you get plenty of social life?
12. What extra-curricular activities do you participate in?
13. Do you have all the dates that you want?
    a. Do you get along without dates because you want to or because you can't get the ones you want?
    b. Are things going along smoothly between you and your girl friend?
14. Are you under severe criticism from your parents or anyone else?
15. Have you had any serious disappointments lately: such as disappointments in love, deaths in the family, financial catastrophies, etc.?
    a. Have you made a satisfactory adjustment to it or does it bother you considerably in spite of your better judgment?
16. How old are you?
    a. What have you been doing since graduating from high school?

Case _____ Clinician _____ Date _____

Questionnaire

1. Problem _____
2. Present subjects Grades Hrs. study wk. Daily time Difficulties
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____
3. Last semester subjects Grades Difficulties
   a. _____
   b. _____
   c. _____
   d. _____
   e. _____
   f. _____

4.	Work _____	5.	Schedule _____	6.	Hrs. per wek. _____
7.	Batch _____	8.	Number _____	9.	Congeniality _____
10.	Finances _____	11.	Income $_____mo.	12.	Expend. $_____mo.
13.	Debts _____	14.	Secret bills _____	15.	Probable outcome
16.	Social outlet _____	17.	Dates _____ wk.	18.	Reason _____
19.	Quarrels _____	20.	Criticisms _____	21.	Activities _____
22.	Traumata _____	23.	Adjustments _____	24.	Age _____
25.	Recent occupations _____	26.	Vocational aim _____	27.	Reason in school ___

28. Aims of courses _____
29. Study: Distraction wrong selection of topics with questions
    Maturation Waste time Disinterest Ambiguous aim
30. Rapport _____

RECOMMENDATIONS:

1.	Advance preparation	2.	Recitation
3.	Maturation	4.	Anticipation
5.	Formulation	6.	Notes
7.	Lists: Tech. terms Vocab. Persons Rules Theories Principles Quest.		
8.	Attitude	9.	Self discipline
10.	Silent reading	11.	Study periods definite
12.	Schedule	13.	Library study
14.	Recreation	15.	Free time
16.	Social life	17.	Psychotherapy
18.	Reduced schedule	19.	See Dean
20.	See instructors	21.	Eye examination
22.	General health examination	23.	_____

17. Why did you come to college?
18. Do you have any special goal in mind toward which you are working?
    a. Did you select that vocation yourself or did your parents select it for you?
19. Why are you taking (Psychology)? (Also other courses)?
20. How many hours a week do you spend studying (English)? (also other subjects).
21. Do you study each subject at the same time each day?
22. Do you study each subject the same length of time each day?
23. Do you have trouble with your mind wandering while you are trying to study?
24. Do you find that you study the wrong things?
25. Do you formulate and answer questions over the material as you study?
26. Do you think of your lessons at odd moments when you are not actually studying and try to get new slants on the material?
27. Do you waste time?
    a. How much?
    b. Do you want me to help you arrange a time budget?
28. How badly do you want to solve your problem?

In addition to the results of the interview the clinician should consult the college personnel records for entrance test results and other information.

Of course it should be clearly borne in mind that any irregularity in the personal habits of a student may disrupt his entire emotional structure and render him unfit for study regardless of the number of hours spent with each book. Probably not more than half of the difficulties encountered by students in their preparations are attributable to improper study habits **per se.** Various anxieties are likely to be the cause of improper study habits and as such should be dealt with directly.

6. **Rules for study:** On the basis of the foregoing interview, any or all of the following study rules may be advised. It is best, whenever possible, to limit the rules given to the student to those which particularly fit his situation. **Advance preparation:** Prepare well in advance so that—**Recitation:** you may take full advantages of and participate in class discussion. Get the front seat habit; that may not be the most modest way to learn, but it is the easiest. **Maturation:** Study should be spaced so that there will be opportunity to turn the material casually over in the mind during walks to and from classes, odd moments, etc., before the class recitation. Students who study just before class session do not have time to let the material "ferment." Students who study for a certain time and then attempt to "forget about it all" do just that: they forget. Two kinds of preparation are required; intensive study and casual maturation. **Anticipation:** In preparation it is necessary to anticipate what is coming next. If one has no curiosity or attitude toward the successive paragraphs, he will miss any important points in them. **Formulation:** Lessons should be formulated into the same form as instructors use in examinations. If the instructor uses a short answer system in his test the student should formulate his subject matter into the same form of questions and answers. If the instructor emphasizes oral recitation in response to discussion questions, the

student should formulate such discussion questions and practice answering them orally as if in class.

7. **Notes:** If difficulty is encountered during class work, the student must resort to an adequate system of notes covering both reading and class discussions. **Lists:** Supplementary lists are usually advisable. They may be lists of technical terms or vocabulary, prominent personalities, and rules, theories or principles. Class notes should be supplemented by lists of questions asked in class either by students or instructors.

A happy and aggressive **attitude** toward school work frequently changes ineffective study to effective study. If the work is taken as drudgery, the student is not likely to succeed and probably should not succeed.

8. **Silent reading:** Of all the skills of greatest general value to college students that of silent reading has been shown to be of surpassing value. Silent reading efficiency can usually be improved at least sixty percent with a few sessions of clinicial guidance. **Study periods** should be of predetermined length in a naive student's case. The student should be in his seat at the beginning time and remain just as determinedly until the closing as if he were in class. During this period he should study as intensely as possible. At the close of the period he should stop whether he has finished his task or not, later on he may adjust this system so as to make it a little more flexible.

9. **Study schedule:** The following general rules apply to the making of a time budget. **Reasonable:** Most study budgets fail during the second week because they have been arranged too rigidly and do not allow a generous amount of time for idleness. **Free time:** There should be at least one hour each day when a student may feel himself absolutely free of responsibility. He should not study or do anything of a pressing nature during this time. **Similar daily progress:** Vacant periods should always be used for study, especially if they come at a time corresonding to class times on other days. Recreation and physical exercise should not be scheduled at a time which is customarily spent in study. Evenings should be left as free as posible, expecially free of routine preparation. Sunday should be left free. **Library:** Students should be advised to study at the library until their habits have been well established. In general, students waste time getting meals and making toilets. These duties should be scheduled rigidly.

10. **Subject Disabilities:** Certain subject disabilities present characteristic clinical pictures. The following outlines of attack are designed to enable the clinician to make a quick diagnosis. The factors possibly contributing to the disorder are listed in the order in which they should be investigated.

(1) Reading disability.
   A. Insufficient motivation:
      (a) Home: Do the parents demonstrate the need of reading proficiency? Do they read? Does reading occupy an important position in the domestic life?
      (b) Recreation: Has reading been presented as a form of recreation? Is literature available which is adapted to age of the case?

B. Insufficient vocabulary:
Has the case had opportunity to familiarize himself with a reasonably large vocabulary? Are foreign languages spoken in the home?

C. Oral inaccuracy in speech:
Oral speech is the original language function and precedes reading. If it is defective the defect may give rise to the use of approximations in all language function. This is particularly true in young children or in cases where intelligence is below normal.

D. Rhythmic disturbance of speech:
In addition to the handicap in the original language function the disordered rhythm may indicate transient aphasia.

E. Inconsistent disability:
Does the defect vary greatly in prominence from day to day? Emotional disturbances characterize nearly all cyclical behavior.

F. Slow:
Slow reading may merely be habitual.

G. Defective vision:
This affects reading proficiency but is not usually the cause of a special disability in that subject.

H. Defective eye movements:

I. Small fixation units:
These may be due to bad habits or an inability to integrate images appearing on the non-foveal unilaterally enervated areas of the retina.

(2) Language disability:

A. Poor usage in the environment:
Check usage of friends, teachers, and parents.

B. Insufficient instruction:
Administer remedial grammar.

C. Insufficient motivation:
Encourage success and disapprove failure, give opportunities for creative writing. Encourage free expression, both written and oral.

(3) Spelling disability:
Clinical experience seems to indicate that this disability is one of the least important in the diagnosis of general mental deficiency.

A. Distraction:
Look for emotional disturbances such as those found in anxiety.

B. Lack of phonetic cues:
Correct by phonetic training.

C. Inaccurate pronunciation:
Administer speech corrective exercises.

D. Peculiar associations:
Approach by analytic methods.

E. Aphasia:
Administer the general corrective measures for the aphasia disorders or try mnemonics as a stop-gap.

(4) Arithmetic disability:
   A. Mental deficiency:
      Because of its more exact standards the study of arithmetic is more likely to reveal general mental deficiency than other studies. For this reason many cases which are reported as specific arithmetic deficiencies are really cases of low intelligence. Give a general intelligence test first.
   B. Distraction:
      As in spelling.
   C. Dissociation with extra-curricular situations: Remedy by use of concrete concepts and construction of models to scale.
   D. Inadequate practice:
      Use diagnostic tests and correlated remedial exercises.

(5) Geography and history disabilities:
   A. Motivation:
      In the clinic the most common cause of these disabilities is insufficient motivation of the part of the teacher.
   B. Home criticism:
      Look for aversion to these subjects in the parents.
   C. Poorly trained teacher:
   D. Lack of concrete projects:
   E. Chance unfortunate associations with the subjects:
      Treat by analysis.

(6) Writing disability:
   A. Lack of general motor coordination.
      Administer general corrective measures.
   B. Interference with native manual preference:
      Determine degree and side of preference and treat by shift or tie-up accordingly.
   C. Hyperkinesis:
      Remove tensions and if difficulty persists analyze for hysteriform disorders.

(7) Speech disability:
   Distinguish between the articulatory and phonic and the rhythmic disturbance. Treat former by direct therapy as for other idiomotor disorders. Treat latter by indirect therapy and by such methods as are used in correcting aphasias.

V. THERAPY

1. **Records and reports:** All records of the case should be kept together and, when not carried on the person of the clinician, should be kept securely locked. Under no condition should they be shown outside the clinic or left where unauthorized persons might examine them.

RULE 16: EVERY CONFERENCE CARRIED OUT UNDER THE AUSPICES OF THE CLINIC MUST BE REPORTED IN DETAIL.

RULE 17: CLINIC RECORDS MUST NOT BE SEEN BY UNAUTHORIZED PERSONS.

2. **Clinician's daily report** (Form 10.1): The conference reports are numbered serially, the number in the series being inserted at A in occupational therapy, discipline, motor training, speech correction, reassurance, suggestive therapy, motivation, active therapy, catharsis, psychoanalysis, child psychoanalysis. F refers to questions asked by clinician. Elements of the dream are written in the numbered sections at G and their associations in the corresponding sections under H. K refers to assignment made to case, L his reaction to it, and M to the degree of rapport between clinician and case.

3. **First follow-up letter** (Forms 10.2 and 10.3): The letter should be adjusted to the recommendations made in the case, should appear personal, and should follow the rules of correspondence given later in this handbook. Routine follow-ups should be made at two, six and twelve weeks. Replies to follow-up letters should be answered by the clinic immediately with additional suggestions, reiteration of original suggestions, and encouragement.

4. **Progress** (Form 10.5): This form may be used for initial and terminal measurement of results where such results must be put into some quantitative form. A rough average adjustment score may be obtained by averaging the scores in Items 1-36. Items 37, 39, 42, 44, 46, and 48 are weighted by ten, Items 38 and 41 by five, Item 40 by thirty. Item 43 by three, Item 45 by seven, and Item 47 by fifteen.

5. **General Conference rules**: While methods must always be adapted to the needs of the case, there are certain general conference techniques which apply to all cases.

The conference should be planned in ten-minute blocks. The plans need not be strictly adhered to.

RULE 18: THERE MUST BE A PLAN HELD IN RESERVE FOR EVERY CONFERENCE.

RULE 19: CALL FOR THE DELIVER CASES UNDER FOURTEEN UNTIL CERTAIN THAT THEY WILL COME AND GO PROMPTLY ALONE.

When a young case is taken from school or from home, the clinician should escort him both to and from the conference. This protects the clinic from responsibility for loitering or accidents.

RULE 20: APPOINTMENTS MUST BE SPECIFIC AS TO THE TIME AND PLACE.

RULE 21: ALLOW TEN MINUTES FOR CASE TO APPEAR FOR APPOINTMENT. IF THE APPOINTMENT IS NOT KEPT, DISCOVER THE CAUSE AND MAKE ANOTHER APPOINTMENT AS SOON AS POSSIBLE.

RULE 22: MAKE INSTRUCTION DEFINITE AND DISTINGUISH CLEARLY BETWEEN SUGGESTIONS AND INSTRUCTIONS.

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC

Form 10.1
Clinician's Daily Report

A _____ _____ 193 _____ to _____
No. Case Clinician Date Time

B THERAPIES USED: Rem Dvs Oth Dsc Mtr Sp Rsr Sug Mtv Ath Cath Psa Cpsa

C PROGRAM FOLLOWED:

	Nature of Exercise	Time	Reason for Exercise	Reaction of Case
1				
2				
3				
4				

D QUESTIONS ASKED BY CASE: _____

E INFORMATION VOLUNTEERED: _____

F CATECHISM: _____

G DREAMS REPORTED: 1 _____ 2 _____ 3 _____
4 _____ 5 _____ 6 _____ 7 _____
8 _____ 9 _____ 10 _____ 11 _____
12 _____ 13 _____ 14 _____ 15 _____

H DREAM ASSOCIATION: 1 _____ 2 _____ 3 _____
4 _____ 5 _____ 6 _____ 7 _____
8 _____ 9 _____ 10 _____ 11 _____
12 _____ 13 _____ 14 _____ 15 _____

I WORD ASSOCIATION: _____

J FREE ASSOCIATION: _____

K ASSIGNMENT: _____ L REACTION: _____ M RAPPORT _____

N NEXT SESSION: _____

O DISCUSSION OF SESSION: _____

P QUESTIONS AS TO THERAPY: _____

Q REVIEWERS REMARKS: _____

R REVIEWER: _____

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC
(Reply to Dr. Geo. A. Kelly, Fort Hays Kansas State College, Hays)

Form 10.2

To_____ _____
Address

Concerning_____ _____
Date sent Date returned

Which of the following suggestions were you able to carry out?

1.

2.

3.

4.

5.

What sort of progress is being made in school now?

Under what conditions do you notice most improvement?

Under what conditions is the improvement least noticeable?

To what extent are you receiving cooperation?

Are there further problems which have arisen since the clinic or further services which we can render you?

October 14, 1936

Mr. John D. Doe
Superintendent of Schools
Jonesburgh, Kansas

My Dear Mr. Doe:

Since the Jonesburgh clinic, September twenty-sixth, we have been interested in following the progress of Mary Curtis. Were you able to carry out the suggestions which we made? Has Mary been able to adjust herself to the fifteen-minute periods of routine?

The extension clinic conferences were necessarily so short tht we could scarcely do more than get acquainted with your pupil's problems. Now we would like to keep in touch with you and be of any assistance we can in making helpful adjustments in the school and home.

We would appreciate receiving a nice long letter from you within the next few days. Remember that our only excuse for existing is that we may be of some help to you. Please make use of us in every possible way.

The enclosed form may be usedin your reply.

Yours very truly,

Harry Mason
Graduate Assistant

HM/fk
10.3

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC
(Address replies to Dr. Geo. A. Kelly, Hays, Kansas)

Form 10.5
Progress

To_____Concerning_____sent_____Met_____cl___

We are anxious to follow the progress of this person in a definite way in order to determine the extent to which our work has been effective. Because of your interest and contacts we are asking you to report on the convenient form below. Where two opposite traits are listed and this person in your estimation rates about average or half way between the traits you should encircle the middle figure, otherwise encircle the figure somewhat to the right or left depending upon the amount of the right or left trait.

Trait		Score	Change since_____ Worse - Better
1. Docile	- Aggressive	-2 -1 0 1 2	-2 -1 0 1 2
2. Lazy	- Industrious	-2 -1 0 1 2	-2 -1 0 1 2
3. Complaining	- Cheerful	-2 -1 0 1 2	-2 -1 0 1 2
4. Tired	- Energetic	-2 -1 0 1 2	-2 -1 0 1 2
5. Disinterested	- Interested	-2 -1 0 1 2	-2 -1 0 1 2
6. Distracted	- Calm	-2 -1 0 1 2	-2 -1 0 1 2
7. Inaccessible	- Communicative	-2 -1 0 1 2	-2 -1 0 1 2
8. Tardy	- Prompt	-2 -1 0 1 2	-2 -1 0 1 2
9. Secretive	- Open	-2 -1 0 1 2	-2 -1 0 1 2
10. Posture poor	- Good	-2 -1 0 1 2	-2 -1 0 1 2
11. Dependent	- Independent	-2 -1 0 1 2	-2 -1 0 1 2
12. Rebellious	- Cooperative	-2 -1 0 1 2	-2 -1 0 1 2
13. Sleepy	- Wide awake	-2 -1 0 1 2	-2 -1 0 1 2
14. Daydreams	- Alert	-2 -1 0 1 2	-2 -1 0 1 2
15. Restless	- Composed	-2 -1 0 1 2	-2 -1 0 1 2
16. Nagging	- Reasonable	-2 -1 0 1 2	-2 -1 0 1 2
17. Cries easily	- Mature	-2 -1 0 1 2	-2 -1 0 1 2
18. Shows off	- Modest	-2 -1 0 1 2	-2 -1 0 1 2
19. Fearful	- Courageous	-2 -1 0 1 2	-2 -1 0 1 2
20. Wastes time	- fficient	-2 -1 0 1 2	-2 -1 0 1 2
21. Interest narrow	- Broad	-2 -1 0 1 2	-2 -1 0 1 2
22. Quarrelsome	- Friendly	-2 -1 0 1 2	-2 -1 0 1 2
23. Shows temper	- Goo humor	-2 -1 0 1 2	-2 -1 0 1 2
24. Delinquent	- Good	-2 -1 0 1 2	-2 -1 0 1 2
25. Inactive	- Active	-2 -1 0 1 2	-2 -1 0 1 2
26. Follower	- Leader	-2 -1 0 1 2	-2 -1 0 1 2
27. Unpopular	- Popular	-2 -1 0 1 2	-2 -1 0 1 2
28. Cries easily	- Mature	-2 -1 0 1 2	-2 -1 0 1 2
29. Truant	- Dependable	-2 -1 0 1 2	-2 -1 0 1 2
30. Deceitful	- Truthful	-2 -1 0 1 2	-2 -1 0 1 2
31. Worried	- Happy	-2 -1 0 1 2	-2 -1 0 1 2
32. Dirty	- Clean	-2 -1 0 1 2	-2 -1 0 1 2
33. Slovenly	- Neat	-2 -1 0 1 2	-2 -1 0 1 2
34. Dowdy	- Tasteful	-2 -1 0 1 2	-2 -1 0 1 2
35. Helpless	- Self-reliant	-2 -1 0 1 2	-2 -1 0 1 2

36. Absences during last month_____x -1
37. Number of fights_____x -10
38. Minor disciplines_____x - 5
39. Major punishments____x -10
40. Delinquencies_____x -30
41. Complaints from parents teacher or adults____x - 5
42. Average Grades F (20) D (-10) c (0) B (10) A (20) wt. is 10
43. Member clubs_____x - 3
44. Residencies_____x 10
45. Other Offices_____x - 7
46. Has job (10)____mos. x 5
47. Fired_____x -15
48. Quit_____x -10

The clinic does not recognize any excuse for a clinician failing to keep a case under control. Disciplinary problems arise only when there is some question as to the clinician's authority or ability to enforce instructions. The clinician is expected to take whatever measures are necessary to maintain control and take them quickly. There should never be a delay of more than a few seconds. This rule is not difficult to follow if all instructions are made sparingly and thoughtfully.

RULE 23: THE CLINICIAN MUST CONTROL HIS CASE. ONE FAILING TO DO SO WILL RESULT IN HIS IMMEDIATE DISCHARGE FROM THE CLINIC.

The clinician should avoid any manifestation of emotion. One ill-timed gasp of surprise or disapproval may do more damage to a case than a series of conferences can correct. Some cases assume a jolly attitude toward the conferences, but the clinician should never permit this to mislead him into laughing either with or at the case. Good humor is desirable, but mirth, cynicism or satire destroy the clinical situation. Adverse criticism, of course, should never be offered unless for a definite purpose.

RULE 24: A CLINICIAN SHOULD NEVER GIVE ANY INDICATION OF EMOTION, SURPRISE, DISAPPROVAL OR MIRTH DURING A CONFERENCE UNLESS SUCH AN INDICATION IS DEFINITELY A PART OF THE PLANNED THERAPEUTIC PROCEDURE.

The clinician-case relationship is not a personal friendship in any sense, it is not a give-and-take situation. In general, the case should not be met socially until after the treatment has been completed, better still, not at all.

RULE 25: THE CLINICIAN MUST NOT UNDER ANY CONDITION CONFIDE IN THE PATIENT.

The clinical conference requires the utmost alertness on the part of the clinician. At every moment mechanisms are revealed by the case which even the best of clinicians is likely to overlook. It is a great mistake for a clinician ever to assume that "nothing is happening." The conference is always a strenuous experience for a clinician.

RULE 26: IMPORTANT FACTS ARE BEING REVEALED EVERY MOMENT OF A CONFERENCE.

The transference situation is important in every conference, but it should remain flexible and should not be based upon a personal attachment for the clinician as a real person. In order to keep the transference from developing to a primary affection, the clinician should avoid all physical contact with the case. Shaking hands and helping with coats should be avoided as much as is consistent with good manners. Children should never be 'hugged' or touched unnecessarily. This applies to children of the same sex as that of the clinician as well as to those of opposite sex.

RULE 27: AVOID PHYSICAL CONTACT WITH THE PATIENT.

A certain degree of depression tends to stimulate catharsis and the revelation of information which the case is usually reluctant to disclose. It is the task of the clinician to prevent the patient from becoming too depressed in any conference. A moderate amount of crying in anxiety cases is permissable and frequently to be

encouraged, but protracted crying should be avoided. Reassurance, redirection of the conversation, summary of facts of an objective nature, and termination of the conference may all be used to stem catharsis.

RULE 28: DO NOT PERMIT THE PATIENT TO BECOME TOO DEPRESSED IN ANY ONE CONFERENCE.

Frequently a patient will invite the clinician to concur in an opinion concerning right and wrong, religion, behavior of friends, etc. Since such an opinion may be an ego defense on the part of the patient, the clinician's concurrence will tend to repress the counter opinion in the patient and thus prevent a needed catharsis.

RULE 29: DO NOT CONCUR IN THE PATIENT'S OPINION ON PERSONAL OR CONTROVERSIAL MATTERS.

A clinician is sometimes tempted to correct defects in the attitude of the conferee's associates or in the social status of the patient. If these defects can be conveniently and legitimately changed and if they are truly abnormal, the clinician is justified in attempting the corrections. Ordinarily, this is not best.

RULE 30: TREAT THE CASE.

This rule is frequently applicable when a parent asks to have his child treated; the parent, being the one who has presented himself, should be dealt with first.

A conference with an adult case may be preceded by casual conversation. When the clinician seats himself, it should be taken as a signal to begin the clinical conference.

RULE 31: THE CONFERENCE BEGINS WITH THE SEATING OF THE CLINICIAN.

Immature clinicians are sometimes tempted to suggest escapes and rationalizations in helping the patient over difficulties.

RULE 32: A FAILURE MAY BE REORIENTED BUT NEVER ESCAPED.

It is usually considered a good sign when the patient develops an independence of the clinician. It indicates that the transference is broken and with it the need for transference. This normal termination of transference must not be confused with the ambivalent changes which a patient develops from time to time. The latter reveal quite clearly a personal feeling tone for the clinician and are colored distinctly with a critical, wounded or martyr attitude on the part of the patient. The ambivalent changes are usually brought about after a symptom has been counter-suggested, a difficult explanation made or the recollection of a particularly distasteful experience which the patient has decided not the reveal to the clinician. The second conference after the breaking of transference is the normal time for terminating the series of conferences unless a new series or cycle with a new transference situation is undertaken in order to dislodge more or different symptoms. When a case which is still in a stage of transference is discontinued by the clinician a transference neurosis resembling a traumatic neurosis is likely to develop.

RULE 33: TERMINATE THE THERAPEUTIC SERIES ON THE SECOND CONFERENCE AFTER TRANSFERENCE IS RESOLVED, UNLESS A COMPLETE NEW SERIES IS TO BE UNDERTAKEN.

RULE 34: USE REASSURANCE LIBERALLY IN THE LAST CONFERENCE OF A THERAPEUTIC SERIES.

6. **Classificiation of therapeutic methods:** The following classifications of general therapeutic methods are recognized in the psychological clinic.

Direct
- Remedial Training in Special Subjects
- Motor Training
- Speech Correction

Diversional
- Discipline
- General Diversion
- Occupational Therapy

Suggestive
- Reassurance
- Motivation
- Counter-suggestion
- Hypnosis

Cathartic
- Active Therapy
- Pure Catharsis
- Psychoanalysis
- Child Psychoanalysis

The direct methods are self-explanatory. The diversional methods are designed to redirect the patient's energies into contructive channels; to drain libido from the symptom. Discipline does not necessarily mean adverse criticism of the case, as used in the Clinic it means systematization of the patient's daily program. It is an extremely valuable method and will frequently yield results when all other methods appear to fail. General diversion consists in directing the attention of the patient to non-catharted ideas during a conference. It is used when a patient has already had enough catharsis during a conference or when conditions are such that complete therapy is not practical and the clinician is unwilling to open the case. In general, any occupational therapy is safe for any case provided it does not carry with it too much responsibility. The choice of an occupation or hobby should be based upon the desirability of an increased responsibility for the patient.

Reassurance (See RULE 7) is not the safe method which many clinicians think it to be. In general it should be used only at the close of a therapeutic series or when catharsis must be temporarily checked.

Hypnosis should ordinarily be avoided in the clinic. It is an outmoded procedure. Motivation is the adoption of the enthusiastic dynamic attitude on the part of the clinician and is used to break mild depressions or give general stimulation. It is a rather safe method if the patient identifies himself with the clinician, otherwise the patient may feel depressed when comparing himself with the clinician.

Counter-suggestion destroys rapport between clinician and case. It should be used with the greatest of caution. Although it may easily remove the symptoms

against which it is directed, unless the patient has been well prepared, another symptom will be substituted for those removed. Sometimes it is necessary to "give back the symptom" if counter-suggestion is prematurely applied. Properly used counter-suggestion will speed up a therapy which otherwise would be unduly protracted.

Active therapy is treatment by giving definite instructions to a case which are to be followed out before the next conference. It possesses some of the disadvantages of counter-suggestion, but is generally safer. If the instructions are not carried out, the patient becomes secretive and ashamed and the clinician loses rapport.

Pure catharsis is the free expression of catharted ideas. It is invaluable as a therapeutic method, but must not be permitted to go too far, i.e., precipitates a protracted depression. Inexperienced clinicians should use the cathartic method cautiously until they are able to estimate the probable effects on different cases. Catharsis never fails to develop immediately a state of transference in the case. The transference may be negative in some cases. Clinicians must bear this in mind. The case must be treated thereafter as one in which there is a state of transference. In nearly every instance, a certain amount of relief may be expected following the first cathartic conference. This relief is frequently only temporary and becomes permanent only after the patient develops insight into his condition.

The psychoanalytic method, as developed by Freud and his followers, is very complex, but if properly used is quite safe for any case. Certain modifications such as those used in the seating of the patient, etc., adapt it for use in the psychological clinic. Because of its complexity, no attempt is made to discuss it here. The method of child analysis is that developed by Anna Freud and Klein. It is complex and no attempt is made to discuss it here.

7. **Principles of therapy for rhythmic disorders of speech, reading and thought:** Two principles are involved; the first is that of setting up a new neutral gradient for the disordered function, the second is that of integrating the disordered function into a larger and more stable neutral gradient. If, for instance, stuttering is to be treated the therapy becomes a matter first of setting up a new speech gradient by changing the pattern of speech as much as possible, and second, of integrating speech into a larger gradient which includes writing, gesture, more extensive symbolism in thought, etc.

There are two main considerations to be followed in getting up the larger gradient: the relative stability of the new elements and the extent of symbolic formulation possible in the new elements. Thus if dysrhythmic speech is to be integrated with movements of the hands the clinician should first make sure that the subject has good control of his hands. Furthermore, since there is reversed symmetry both in the structure and the function of the two hands the speech should be integrated with the gestures of one hand only. The hand chosen should be the one preferred by the subject unless there is reasonable evidence for believing that the gradient of the other is inherently more stable. In the second place the clinician should require the movements of the hands to be highly symbolic if he wishes symbolic speech to be absorbed by the larger gradient. Simple swinging of the hands, snapping of the fingers, etc., are too simple to dominate speech or make any appreciable change in its gradient.

Precipitating causes of rhythmic disturbances may be somewhat alleviated by helping the case to make emotional adjustments. Either direct or indirect therapy

may be used. A good form of direct therapy is that devised by Van Riper. It consists of assigning difficult social situations to which the case is to adjust himself. The situations are to be met in the order of their difficulty.

8. **General conference aids:** Ordinarily it is best to have the patient sit across the table from the clinician. The table furnishes support for the elbows and aids the interview. Four to six feet of space should separate patient and clinician. During continuous free association, the patient should have his face turned toward a blank wall. During catharsis it is usually best for the patient to look at the clinician since some measure of confidence is gained from observing the clinician's facial expression. Some patients, however, develop better catharsis while looking away. Seating should be arranged so that neither conferee will have to face the source of light. As far as possible the clinician should avoid mannerisms for distracting movements. Ordinarily the conference report should not be written during a cathartic conference. A report may be made, however, during a strictly diagnostic interview.

Some cases have difficulty responding to the cathartic method. Considerable patience is required in instructing them during the first two or three conferences. The following instructions may be used: "I want you to start out today by telling me everything that comes to your mind. I want you to say just exactly what you think. It won't make a bit of difference to me, you can't shock me no matter what you say. If you feel like crying, I want you to cry. You can laugh, sing, swear, tell me what you think of me — anything. If you don't know where to start, start by telling me the things which you have most dreaded telling me. Perhaps there are some things which you had thought you would rather hold back. Suppose you start with those. You can fill in the explanation later."

If a patient appears to be on the point of giving some information but is embarrassed, the clinician may say, "You are a little embarrassed aren't you? It is quite all right, I probably could guess very nearly what it is you have to say but it will be better if you say it yourself first. You see we deal with problems like yours every day and while this may all seem very serious and unusual to you, I will not be shocked or surprised at all. Go ahead."

In continuous free association the patient is likely to make logical associations instead of free ones. The clinician may interrupt and say, "No, now you are explaining! Just say what comes to your mind. If I hear something that I think should be followed up I'll interrupt you." Sometimes a patient complains that he can think of nothing to say. The clinician may permit the conference to lapse into a silence of a full three or four minutes and then say, "What are you thinking of now?"

There are various ways of conducting word associations. The words may be given orally and may represent words from a dream or previous conversation. At other times words may be presented from a standard list, each word on a card. The usual plan is to pronounce the word and lay down the card before the patient at the same time. The case may be instructed to make a single spontaneous association or to make a series of associations. Sometimes the words are administered rapidly and every effort made to hurry the case. In this instance cards upon which the patient blocks or for which he makes unusual responses are thrown out into a separate pile and are presented again with the request that the patient explain his unusual response. This method should never be used with a

case who obviously has something in mind that he knows bears upon the diagnosis. The method is a direct attack upon the patient's integrity and should be used only when true resistance is being met.

A great many patients consciously withhold information. If they are made to understand that there will be no condemnation if they revise previous remarks, there should be little difficulty. The most willing and sincere patients will sometimes withhold information until the next conference.

Amnesia for dreams is nearly always a problem which will tax the clinician's ingenuity if he places any reliance upon this source of information. Some cases will develop an amnesia for dreams as soon as the therapeutic series is started. Others will develop an amnesia as soon as explanations have been offered. Still others report that they never dream. Of course, as every clinician knows, all cases start remembering dreams after the first few conferences. Sometimes a case may be told that he will dream during the following night and that he is to review the dream in his mind as soon as he awakes. The suggestion usually works, but sometimes the case reports that he can remember no details of the dream. Another plan is to have the case write the dreams as soon as he awakes in the morning, and still another is to have him determine to write the dream as soon as he dreams it, perhaps writing in the dark. Of course there is no such thing as a standardized translation of a dream; it all depends upon what the particular patient associates with the elements of the dream. Retelling of the dream and observation of the new details is always good practice.

In a general way, it may be said that the object of an analysis of an hysteriform disorder is to trace development back to the Oedipus situation, while in the case of an obsessional disorder, development must be traced back to pregenital stages. In each instance the intervening material must be well clarified for the case. The hysteriform case will usually show marked improvement after the recall of the Oedipus. The obsessional case does not respond so markedly to the reaching of the pregenital material. In many cases it is unnecessary to make a complete analysis.

In dealing with psychotic reactions one must usually employ some active therapy. In the schizoid types the analysis can profitably go back to the bisexual and masturbatory problems. Disciplinary therapy is not particularly advisable for schizoid types but is a very good therapy for cycloid types.

9. **Schemata of the psychopathology of the neuroses:** The following schemata are given as aids to therapy rather than as aids to diagnosis.

Neurosis	Symptom Formation	Conflict	Level
Hysteria	Conversion	Ego-Id	Regress to Oedipus
Anxiety	Displacement or Escape	Id-Real then Ego-Real	Oedipus
Actual Neurosis Hypochondria	Regression to Narcism	Ego-Real	Pregenital
Anxiety	Regression to Narcism	Id-Real	Pregenital
Neurasthenia	Regression to Narcism	Ego-Real	Pregenital (arrested)
Pathoneurosis	Regression to Narcism	Organ-Real	Mature
Organ neurosis	Conversion to Narcism	Ego-Id	Genital or Pregenital
Inhibited States	Ego Inhibition	Super Ego -Ego's sex	Genital or Pregenital
Traumatic Neurosis	Direct Defense	Id-Real	Mature
Psychasthenia	Displacement Ego Transference	Super Ego -Ego	Pregenital Anal Sadist

Solution	Principles	Common Symptoms
Compromise in symtom formation	Somatic compliance Identification Secondary gain Displacement upwards Gentialization of Organs	Seizure Paralysis Arc de cercle No palatal reflex Absence Hyperfunction Disturbed vision Globus hysterious Heminesthesia
Ego flight Id wins in symptom	Phobic Facade	Anxiety Phobias
Masochism		Hypochondria
Id flight		Anxiety
Id impoverished		Depression Asthenia
Organ wins Hypercathexis	Follows organic treatment	Post-operative anxiety
Compromise on Id fixed on single organ	Single organ	Cardiac Respiratory Muscular, etc.
Super Ego propitated Ego impoverished		Inhibitions
Real Wins		Shock
Super Ego wins Ego split	Expiation Atonement Internalization Isolation Undoing Depersonalization Relations rather than memories are repressed Secondary gain	Obsessions Compulsions Biphasic symptoms Bisexuality Ambivalence Affective emptiness Sexualizations of thinking Systematization Magic Rumination Hair-splitting Doubt Symptom related to masturbation

10. **Rules of mental hygiene:** Sometimes clinicians are asked to recommend rules of mental hygiene. Such rules are really nothing more than popular statements of common human needs, their formulation is a matter of convenience more than of principle. The statements should be brief enough to be readily remembered and simple enough to be readily applied. Following are some suggested rules of mental hygiene, clinicians may modify them or add others as circumstances require. Two statements are given for each rule, one for adults and one for children.

(1) Cling to the indestructables. Get your heart upon things which cannot easily be taken away from you.

(2) Develop widely varying interests. Learn to be interested in many different kinds of things. Misfortune and a changing society frequently require radical readjustment of one's interests.

(3) Treat all love affairs with respect. When people fall in love with each other, treat them with respect.

(4) Avoid projections. When things go wrong be very careful not to blame other people or things too much. Blaming people is a bad habit and will make a person very unhappy.

(5) Meet difficult problems with some emotion more effective than fear. Learn to be careful without being afraid.

(6) Make conscience your friend. When you think you want to do something that is wrong and your conscience will not let you just remember that that is the way your conscience has of keeping you from being unhappy.

11. **Instructions to a patient about to undergo psychoanalysis:** In general, the following rules should be given to a patient in the first conference in a psychoanalytic series:

(1) During each psychoanalytic conference, unless instructed otherwise, you are to express your thoughts just as freely as you can. Do not try to be logical or explain why different things have come to your mind, just express them as they come. Sometimes you may wonder if your thoughts are important enough to express. The answer is that if they are important enough to come to your mind at all, they are important enough to express. There must be absolutely no withholding of ideas: you must be your real self and talk just as you think.

(2) Your relations with your clinician are utterly impersonal. He is not to be looked upon either as a friend or a critic. What you say makes no personal difference to him whatever. He is interested in you not as a person but as a very important case which he is extremely anxious to cure. Nothing that you can say will make him either like you or dislike you.

(3) Outside the conference room, your relations with your clinician are only tobe those of very casual acquaintances. You should not attempt to speak to him except in matters relating to appointments or details of your analysis. Under no condition should you attempt to meet him or his family socially.

(4) As much as possible, avoid any attempt to estimate your clinician's opinion of you. You are not on display and personal attitudes are unimportant.

(5) Avoid self-evaluation. Frequently a patient wonders if he is good or bad, the point is that it makes no difference as far as the analysis is concerned. The only purpose of the analysis is to put the patient in complete command of himself.

(6) Do not discuss your analysis with anyone but your clinician until after it is finished. If you wish you may admit that you are under analysis, but your

discussion should go no further.

(7) At times you may develop very positive attitudes toward situations, people, or things. As much as possible, keep these attitudes from becoming fixed too soon; suspend judgment.

(8) Do not make any major decisions regarding your life plan, marital relations or career while under analysis. They are likely not to be permanent.

(9) Sometimes ideas will come to mind between conferences which seem very hard to retain or which seem repulsive. These are likely to be important to the analysis and you should make every effort to express them in the next conference.

(10) Report in conference all dreams and emotional experiences.

(11) You need not feel that the clinician is withholding explanation from you unnecessarily. The real solution of your problems will come to you first and with it will come the feeling of adequacy necessary to solve the problem. At times you may feel that you know the real source of your difficulty.

(12) Ultimately you will cure yourself. Your clinician will have acted only in the role of an adviser, the real cure will be administered by yourself, no one else can administer it for you.

In addition to a general background in Psychology and an intensive training in a normal psychology, clinicians should be familiar with the following books:

Adler, *The Practice and Theory of Individual Psychology*
Baker and Traphagan, *The Diagnosis of Behavior Problem Children*
Brown and Potter, *The Psychiatric Study of Problem Children*
Burt, *The Young Delinquent*
Cheney, *Outlines for Psychiatric Examination*
Fenichel, *Outline for Clinical Psychoanalysis*
Freud, *New Introductory Lectures on Psychoanalysis*
Garrett, *A Manual of Psychological and Physiological Tests*
Healy, Brenner, and Bowers, *Structure and Meaning of Psychoanalysis*
Henderson and Gillespie, *Textbook of Psychiatry*
Herrick, *Introduction to Neurology*
Malamud, *Psychopathology*
Morgan, *Psychology of the Unadjusted School Child*
Rasmussem, *The Principal Nervous Pathways*
Terman, *The Measurement of Intelligence*
Travis, *Speech Pathology*
White, *Outlines of Psychiatry*

VI. VOCATIONAL GUIDANCE

In the conduct of a work project for non-school young people arranged through the cooperation of the National Youth Administration (N.Y.A.), the clinic has developed some procedures for vocational guidance. These procedures have been developed principally by Miss Opal Emmons, Mr. John Hadley, Mr. Harry Mason, Miss Margaret Pankaskie, and Miss Iris Stevenson.

Every vocational guidance case must have a sponsor who is in a position of authority or influence with respect to the case and who is not connected with the Clinic. Since the Clinic cannot solicit clients and since each case must have some introduction to the work of the Clinic, this measure is necessary.

RULE 1. EACH VOCATIONAL GUIDANCE CASE MUST HAVE A SPONSOR WHO ASSUMES THE RESPONSIBILITY FOR MAKING THE REGISTRATION.

The most satisfactory arrangement has been to have young people who are working on a N.Y.A. county work project assigned to the Clinic for supervision of their N.Y.A. work. This brings them into immediate contact with the Clinic and enables the Clinic to observe their working habits and carry out systematic prevocational training.

The proper conduct of a vocational guidance project consists of several stages as follows:

1. **Occupational survey:** A survey of occupations available in the community, employers, representative skilled workmen, who might supervise apprentices or advise the Clinic on training requirements, permanency of occupations, new occupations likely to develop, industrial changes taking place in the community,and prevailing wage scales and working conditions.

2. **Job analyses:** Job analyses of vocations which appear to present possibilities for the Clinic's clients.

3. **Sponsor selection:** Selection of sponsors for each client and original contact between client and Clinic.

4. **Social history:** Compilation of a social history on each case through contact with social agencies, former employers, and the Works Project Administration (W.P.A.) office.

5. **Diagnosis:** Diagnosis of occupational aptitudes and opportunities (Form 3.1, Vocational Sociology; Form 7.6. Vocational Skills; and Form 8.1, Vocational Personality). These diagnostic examinations are mostly modifications of the other examinations used in the Clinic. When clients are assigned to the Clinic for their N.Y.A. time, these examinations are supplemented by observation of their working habits, promptness, skills, social adjustment, etc.

6. **Training:** Prevocational training in basic skills and habits necessary for the occupation indicated by the diagnosis. This training is carried out under an individualized prevocational training syllabus prepared especially for each case.

7. **Placement:** Placement in apprenticeships or vocations.

8. **Supervision:** Supervision of apprenticeships and early employment. Where the client is placed in an apprenticeship the Clinic is responsible for very close supervision of the working conditions and the requirement of frequent reports on the progress of the client. The Clinic should work out the apprenticeships in cooperation with organized labor in those occupations where organized labor maintains standards of skills and proficiency. The great danger is that apprenticeships set up by the Clinic may reduce standards of wage and working conditions. This can be prevented by proper care.

9. **Vocational Sociology** (Form 3.1). Following are suggested questions to aid the examiner in administering this form.

(1) Do you like to spend most of your time at home or do you like frequent changes? Are you more content with friends or relations or do you prefer to be with strangers. Do you travel much?

(2) What school did you attend last? What grade were you in when you quit school? Which subject did you like best; which did you dislike? Who was your favorite teacher? Why? Which teacher did you dislike? Why? Did you like school?

(3) Name some of the books which you have read. What magazines do you read? Do you read papers? Name them. How often do you attend the movies? Do you play cards, dance, go to parties? Do you belong to any gangs? Are you interested in athletics? Do you participate? What is your favorite amusement? How much money do you spend on amusements? How do you earn it?

(4) Have you ever belonged to an organization? Did you hold an office? Fill in the blanks with the name of the organization. If the case has held an office in one of the organizations encircle the number following officer which corresponds to the number of the organization in which the office was held and write the name of the office in the blank.

(5) Are your friends younger or older than you, girls or boys, etc.? Who is your best friend? What does he do? What do you like about him?

(6) What church do you attend? Are you a member? How often do you attend? What is it in religion that appeals to you? The abbreviations stand for denomination, member, the number of times case attends church per month, escape, romance, security.

(7) What do your parents want you to be? How do you get along with your family? Encircle any of the special attitudes shown by the case.

(8) Who is living in your home at the present time? List members in the blanks.

(9) Are you self-supporting? Do you have anyone else to support? Do you have some special duties at home or elsewhere?

(10) Do you have someone that you usually go to for advice? Do you usually make up your own mind or do you wait for suggestions from others? Do you give advice to or boss anyone?

(11) Are you happy? What do you worry about? Encircle the words indicating the nature of the case's worries. Abbreviations stand for health, finance, family, friend, education, social, death, love, recognition.

(12) Are you sick very much? Do you have any physical handicaps? List physical disabilities.

(13) Do you have any property of your own? Do you have some belongings which you share with someone else?

(14) Who criticizes you? What are you criticized for? Who punishes you? How? For what?

(15) Have you ever been in love? Who was your lover? How old was he? How old were you? How did you get along? What caused your friendship to end?

The examiner should check the personality profile opposite each item after he has received the case's answer or reaction to the questions. In Item 2 if the case liked school, encircle an x to the left, if he disliked school encircle an x to the right. Follow this procedure for the remaining items. Abbreviations in Item 5 stand for unpopular or popular, in Item 9 for responsible or irresponsible.

Encircle the "." in the analysis margin opposite each item in which something of significance is found.

Case _____ Age _____ Sex _____ Clinician _____ Date _____

Voc. Cr.	Rec. Cr.	School	Security	Family	Friends	Responsib	Properly			
								1.	Domesticity	like home, travel, stranger change
								2.	School like-dislike xxxxxxx	Fav. subj._____least liked__ school____Grade_____ Favorite teacher least liked
								3.	Amusements Narrow-broad xxxxxxx	read books___mag._____ Paper___movies___cards_____ dance___party___gangs_____ Athletics____favorite amus-ment money spent earned
								4.	Follower-leader xxxxxxx	organizations 1_____ 2_____3_____ officer 1 2 3
								5.	Unpop- pop xxxxxxx	Friends, younger, older, boys girls, noisy, quiet, wander, rough, married, single, leader follower, names.
								6.	Religion	den_____member_____ att toward fam, affect, proud critical, ashamed.
								7.	Family tie slight-strong xxxxxxx	par. amb. for case_____ att. toward fam, effect, proud critical, ashamed.
								8.	Household	members 1_____2_____ 3_____4_____5_____
								9	Respon-irres.	Dependents_____ home duties_____ other duties
								10.	Aggressive-docile	dominated_____ dominated by
								11.	Worry-cheerful	Health, fin, fam, friend edu soc, dea, lov, recog.
								12.	Health good-poor xxxxxxx	physical disabilities_____
								13.	Belongings	share_____own_____
								14.	Tensions	Criticized by_____ for_____ punished by_____ for
								15.	Love affair	lover_____age_____ age of case_____cause of termination

10. **Vocational Personality** (Form 8.1): In examining vocational guidance cases one of the first problems of the Clinic is to find out what kind of things the case is interested in, what he would like to do, and what he has had experience in doing. Besides determining his vocational interests it is also necessary to know something about his personal stability. Form 8.1 has been devised for this purpose. Below are some suggested questions and explanatory notes which should aid the examiner in administering this form.

(1) List in the blanks the things which the case states that he is interested in. "What are you interested in? What things do you like to do?"

(2) "What do you want to be? What would you like to do?" Abbreviations stand for social, finance, service, exhibitionism, mastery, and prestige. Encircle significant items.

(3) "What kind of work have you done? Have you ever worked in a store, office, cafe, etc.?" Encircle the items which the case has had experience. List any others which you mentioned.

(4) "Do you have a job at the present time? What do you do? Who is your employer? Where do you work? What were your duties? How much do you make?" Ask these questions about previous jobs, getting the date employed, and a cause of termination. Blanks are provided at the bottom of the sheet for this information.

Abbreviations in item 4 stand for: now employed, last employed, termination of the job.

(5) "Do you dance, sing, play a musical instrument, sew, or take part in dramatics? Do you have any other talents?"

(6) "Do you prefer to work indoors or out?"

Abbreviations stand for: neophobia, social, escape, dependent, independent. Encircle the abbreviations which seem to have a significant connection with the responses of the case as to the kind of surroundings he prefers.

(7) "Do you like to learn a job and then stick to it or do you like to change jobs often? Do you like to travel?"

(8) "Do you like to be bossed or would you rather boss? Do you like to feel responsible for a certain job?"

(9) "Are you entirely self-supporting? If not, who helps support you? Do you support anyone?"

(10) "How do you spend your free time? How much does your recreation cost?"

Abbreviations stand for escape, social, projection, sadism, masochism, homosexuality. Examiner should encircle the words which describe the form of satisfaction derived from the indicated recreation.

(11) "Can you typewrite? Can you do carpentry work?" List special mechanical abilities.

(12) "Can you cook? Do you sew? Do you go downtown to buy the groceries for the family? Do you do any other shopping for the family or yourself? Have you had any experience taking care of children?"

(13) List other abilities.

(14) "Who is your ideal person? What is his vocation? (It is often times necessary to state this question differently as to explain just what is meant by ideal.)

(15) "Have you had any chances for a job? Did you accept? Why?" Write the case's reaction or answer in the blank.

FORT HAYS KANSAS STATE COLLEGE PSYCHOLOGICAL CLINIC

Form 8.1
Vocational Personality

Case _____ Age _____ Sex _____ Clinician _____ Date _____

Amb	Aggr	Dev.ta	Stab	forsi mat		
.	X	X	.	XX	1. Interested in	List 1._____ 2._____ 3._____ 4._____
.	X	X	.	XX	2. Amb. Vag-dex xxxXxxx	soc, fin, ser, exh, mas, pres
X	X	X	.	. .	3. Experienced xxxXxxx	farm, office, store, cafe, others
.	.	.	.	. .	4. Act-inact xxxXxxx	now emp, last emp, termin of job
.	X	X	X	X .	5. Talented xxxXxxx	mus, dan, art, sew, drama, sing, others
.	.	.	X	. .	6. Surroundings prefer	hec, soc, osc, dep, indep, indoors-out
.	X	.	X	. .	7. Stability xxxXxxx	change, travel, routine
.	X	.	.	X .	8. Aggressive xxxXxxx	boss, take orders, respon,
X	X	.	.	. .	9. Non-self support xxxXxxx	other sources of income support others
.	.	.	X	. X	10. Recreation	type_____ cost____esc, soc, proj, sadist masc, home,
X	X	X	.	. .	11. Mec, Ability	typing, carpentry
X	X	X	.	. .	12. Domestic Ability	cook, sew, market, child care
X	X	X	.	. .	13. Other Abilities	
X	.	.	.	. X	14. Ideal	person vocation of
.	.	.	X	. .	15. Opportunities had	accept_____ Why?_____ reaction
.	.	.	X	X .	16. First job like-dislike xxxXxxx	termination_____
.	.	.	.	. .	17. Employer	best liked_____ least liked_____

Job: Employer : Place: Date:: Duties : Salary : Terminated:

___:_____:_____:_____:_____:_____:_____
___:_____:_____:_____:_____:_____:_____
___:_____:_____:_____:_____:_____:_____
___:_____:_____:_____:_____:_____:_____
___:_____:_____:_____:_____:_____:_____

(16) "What was the first job you held? Did you like it? Did you quit or were you fired? Why?"

(17) "Who was your favorite employer? Why? Which employer did you dislike the most? Why?"

The examiner should check the profile from the answers given to the questions asked in the items opposite each one.

In Item 2 of the profile encircle an x to the left if the case's ambition is vague, encircle one to the right if the case has a definite ambition. In Item 3, encircle an x to the left if the case has had little experience, encircle an x to the right if the case is experienced in some vocation. Use the same prodecure in checking the remaining items. The abbreviations in Item 4 stand for active or inactive, and in Item 9 for non self-supporting or self-supporting.

The x's in the analysis margin should be encircled opposite each item whenever anything of significance is discovered in the item. The abbreviations stand for ambition, aggresiveness, developed talents, stability, foresight, and maturity.

11. **Vocational Skills** (Form 7.6): The items are arranged in an order that is calculated to make administration as easy as possible, but this order need not be adhered to.

The first item is a test of oral propositional speech. Administering this test calls for considerable skill upon the part of the clinician, not as to manipulation of apparatus or memorizing instructions, but as to using the approach which will indicate spontaneous speech. The first approach might be, "Tell me what you think of the election," or "Tell me how you would spend a day if you could do anything you wanted to do," would be fair. "Tell me what you have been doing this Fall," might be all right if it would not embarass the subject. In some cases, this item should be passed up and filled out by the person who has administered the vocational personality form. Two rules must be complied with. If the first suggestion intended to initiate propositional speech fails, another should not be given until after several items have been passed. Second, the subject should not be put upon his guard so that he might know that his speech is being checked. Abbreviations of pathologies to be watched for are: speech dysrhythm, poor grammar, faulty syntax, alogical speech, faulty pronunciation, incomplete sentences.

The second item is the Gray Oral Reading Check List. This should be list number four. It should be administered and scored in accordance with the author's instructions, and in addition, the abbreviations at the left should be noted and encircled if the pathology indicated is present. The abbreviations stand for: tonic block, clonic block, mispronunciation, halting style, articulatory speech defect, and peculiar accent.

The third item is the Pintner Achievement Test. It is given and the total score recorded at the right by writing in the score made in the position which it would assume in the series given, and encircling it. The part scores should be recorded at the left after abbreviations of their totals.

Number four is the Stenquist Mechanical Aptitude Test, Form II. It is given according to the author's direction, and the score recorded at the right as in the above test. Any pathology noticed while administering the test should be noted in the left hand margin. The abbreviations stand for frustration, sluggishness, and aphasia. If aphasia is noted, write down the approximate time of the aphasic periods.

Case _____ Clinician _____ Date _____

	IV 10	V 11	VI 12	VII 13	VIII 14	Adl. 15	S. 17	Adl.
1. ORAL PROP. SPEECH	x	x	x	x	x	x	x	Dys.Cr.Syn.Alog.Pron.Inop.
2. GRAY ORAL (time)			69	64	60			Ton.Clon.pron.halt.art.acc
(errors)			6	5	4			
3. PINT. ACHIEV.	20	30	35	40	50			Inf.Aplg.Read.Arth. Voc.
4. STENZ. MECH II	24	23	31	34	36			Frust.Slugg. Aphasic
5. EYE MOVEMENTS (6) (Fix)			55			46		31 Lg.Fix.Rev.Aph.Div. abc
(Time)	40		27			10		
6. PROOF READ. (time)	4:0		3⅓	3:0	2⅓	2:0		1⅓ sp. Punc. Alog.
(score)	8		10		15		18	23
7. CARD SORT. (time)	3⅓		3:0		2⅓	2:0		1⅓ Clums. Alog. Incoo. Lg. Ret.
(errors)	6		4		3	2	1	0
8. RAPID CALC. (oral)	3		4		5	6		7 Alg.Meck. Mult, Add.
Written (time)	3:0		4:0		6:0		50	4⅓ Sub. Carr.
(errors)	5		3		2		1	0
9. FOLLOW INST. (oral)	3		4		5	7	8 9	10 Sh.Sp.Comp.Aud.Aph.Alex.
(writ.)	3		4		5	7	8 9	10 Trans.
10. LETTER WRIT. (cond)			4	5	6	7	8	Spl.Syn SS. Penm. Neat.
(form)	x	x	x	x	x	x	x x	Alg. Gram.
11. Bounc. Ball			5		10		15	20 Bas. Rhy. Assym. Incoo.
12. SPACE PERCEP.	3	5	6	7	8		9	10
13. ASTEREGG. (tactile)	1	2	2	4		5		Alog.
14. ASTEREDD (visual)				122		118	109	
15. MEASUREMENT (Calip)			3	4	5		6	7 Rough Alog.
(rule)			3	4	5		6	7
16. SAW TO LINE		4		8		16		Inep. Incoo. Stst. Assym.
17. PERS. APPEAR (Gen)	x	x	x	x	X	x	x x	x
CLEANLINESS (bod.)	x	x	x	x	X	x	x x	x Hds. Fac.Ear. Hair.Bo.Nails
(clothes)	x	x	x	x	X	x	x x	x
(mouth Hyg.)	x	x	x	x	X	x	x x	x Teeth.Tong.Hal. Path.
NEATNESS (cloth.)	x	x	x	x	X	x	x x	x Rag.Mend.Larg.Small.
(hair.)	x	x	x	x	X	x	x x	x Toup.Cut. Uncomb.Muss.
TASTE (gen)	x	x	x	x	X	x	x x	x Loud. Repuls. Shap.
Approp to occas.	x	x	x	x	X	x	x x	x Ovrd. Undor.
Approp to figure	x	x	x	x	X	x	x x	x Tight. Loose. Emph.
SHOES	x	x	x	x	X	x	x x	x Shine. Runov. Fit.
18. COLOR BLINDNESS	x	x	x	x	X	x	x x	x RG YB Tot. Agna.
19. BODY TYPE	x	x	x	x	X	x	x x	x Malnut.Asth.Pynik Athl.
20. FING. TREMOR	x	x	x	x	X	x	x x	x Int. Trem. Dysr.
21. ANASTHESIA	x	x	x	x	X	x	x x	x Conv. Mypoc.
22. PULSE	f		d		c		b	a Sit.Ac. 30 60 90 120 180
23. RESP.								Sit.Ac.
24. HAND DYNAMOM.	x	x	x	x	X	x	x x	x Max. Stab. Time
25. ROMBERG	x	x	x	x	X	x	x x	x Long. Trans.
26. LINE WALK	x	x	x	x	X	x	x x	x Atax. Het. hip. S&L. Pg. Sh.
27. VISION	x	x	x	x	X	x	x x	x L___/ 20___/ 20_____
28. ASTIG.	x	x	x	x	X	x	x x	x Scale Below
29. AUDITION	x	x	x	x	X	x	x x	x L___/ 20R___/ 20_____

L 0 30 60 90 120 150
R 0 30 60 90 120 150

REMARKS:

Item number five, Eye Movements, is checked from the Speech and reading Examination, passage number six. Pathologies to be noted are long fixations, aphasic divergencies and reversals. The small "abc" refers to the answers to the questions which are to be asked. If they are answered correctly the letters are encircled.

Item number six is a proof reading test for which copy has been hectographed and folded. The copy, folded, should be laid upon a sheet of carbon paper which has the carbon side up, and the following directions given. "This is a proof reading test. The material which is written here has mistakes in it, and you are to indicate which ones must be corrected before the material can be printed for publication. Take your pencil and encircle each mistake. Use a fairly heavy touch, and do the work as quickly as you can but remember that you must correct all the mistakes." If the subject asks "What kind of mistakes?" simply say, "Correct all the mistakes you can find." Time and score are both recorded. Items marked wrong that are right are deducted from the score, and three additional points are given if the right hand margin is marked for irregularity.

Item seven is a card sorting test. The cards should be thoroughly shuffled before they are brought out. Instructions follow: "The cards have been mixed up. You will notice that each one has a number on it. I want you to sort the cards into piles so that every card in a pile has the same **middle** digit or number. Sort them as quickly as possible but be sure to sort them correctly." If the subject does not understand the instructions, explain and demonstrate by putting the first four cards in piles, explaining why a certain card goes in a certain pile, but make a note on the record blank that extra instructions have been necessary. Time and errors are recorded. Abbreviations stand for clumsiness, alogical attack, incoordination of muscles, and long reaction time.

Item eight refers to a test of rapid calculation. The copy for this test is on hectographed sheets. The first part is oral, and the examiner should hold the paper during this part. Instructions to be read are at the top of the sheet. The examiner should say the digits at a rate of a little more than one per second, and wait ten seconds for a reply. Under A, if problem 1 is not completed or done properly, problem 2 should be given. In any case, give only enough problems under any one letter to allow the subject to get one right answer. Write down the answer given beside each problem. When the oral part is finished, give the subject the paper and tell him to do the operations indicated as quickly as possible, being sure to get the right answers. Keep time. Scratch paper may be provided for figuring. Key answers will be provided with which to check. Pathologies abbreviated for encircling in the left margin are alogical attack, mechanical erros, trouble inmultiplication, addition, subtraction, and carrying.

Item nine refers to the test for following instructions. These tests are hectographed, and instructions to be read by the examiner in the oral test follow. The instructions for the written test are included in the hectographed copy. Pathologies which may be noticed, and for which abbreviations have been included are: short attention span, inability to comprehend, auditory aphasia, alexia, transient aphasia.

Oral Instruction Test: "Now in order to hold a job you must do everything your boss tells you to do. You must listen closely to all he says and be sure to do things exactly as he tells you. I am going to tell you some things to do and I want you to

do them exactly as I say, as quickly as you can, and without asking questions."

"Look at the papers which I have given to you. There are a number of different forms such as squares, circles, triangles, etc. Each line is numbered. When you have finished line number 1, I wil ask you to do something with line No. 2."

"When I say 'pencils up,' you are to lift your pencil regardless of what you are doing. Do not put your pencil down on the paper until I say 'begin'."

(1) "Pencils up. Look at the rectangles at 1. When I say begin, but not before, make a circle in the first rectangle and also a letter A in the third. Begin." (5 seconds)

(2) "Pencils up. Look at the rectangle and square and oval at 2. When I say begin, make a figure 1 in the space that is in the oval but not in the square and rectangle, and make an x in the space that is in the square but not in the oval and rectangle. Begin." (10 seconds)

(3) "Pencils up. Look at 3. When I say **begin,** put in the first circle the right answer to the question. How many days are there in a week? In the second and third do nothing, but in the fifth put in any number which is wrong as an answer to the question which I asked you. Begin." (10 seconds)

(4) "Pencils up. Look at the shoes and chairs, etc. in No. 4. When I say begin, make a mark from the chair to the book going under the barrel and over the pitcher. Begin." (10 seconds)

(5) "Pencils up. Look at 6. When I say begin, cross out the letter just before E and also draw a line under the second letter after H. Begin." (10 seconds)

(6) "Pencils up. Look at 6. If 10 is more than 8, then when I say go, cross out the number 6 unless 6 is more than 9 in which case draw a line under the number 4. Begin." (10 seconds)

(7) "Pencils up. Look at 7. When I say begin, draw a line through every odd number that is not in a circle and also through every even number that is in a square by itself. Begin." (10 seconds)

(8) "Pencils up. Look at 8. Notice the three blanks and the three words. When I say begin, place in the first blank the last letter of the first word, in the second, the first letter of the last word, and in the last, the last letter of the middle word. Begin." (10 seconds)

(9) "Pencils up. Look at 9. If automobiles are older than horses put a cross in the first square. If not, draw a circle around the word **no.** Begin." (10 seconds)

(10) "Pencils up. Look at 10. Notice that the drawing is divided into five parts. When I say begin, put an A or B in the two largest parts and any number from 5 to 7 in the smallest part. Begin." (10 seconds)

Item 10 refers to a test of letter writing ability, and should be administered as follows: the examiner should say, "We want to find out how good a letter you can write. Let us suppose that you are applying for a job (indicate the type of job from the subject's preference or statement of interest in vocational personality examination) — to (indicate the name and address of an appropriate firm). Write as good and as neat a letter as you can. Be sure to include everything which your employer should know about you, but make the letter concise and to the point.

Item 11 refers to a bouncing ball contact. A board with two holes in it is provided as a compass, and with this, a pencil, and a piece of chalk, a circle is drawn on the floor. The diameter of this circle is two feet. The subject takes the ball and bounces it in the circle, dribbling with alternate hands, continuing until an error

is committed. An error consists in bouncing the ball outside the circle, catching the ball, or dribbling twice in succession with the same hand. Five trials are given, and the number of bounces in the most successful trial is recorded as the score. If the first trial results in a score of twenty or more, no further trials need be given. Abbreviations refer to poor basis rhythm, bodily assymmetry, either of build or of movement, and incoordination of muscles.

Item 12 refers to a test of space perception, performed with a special machine. The subject sits in a chair at a distance of ten feet from the front of the machine, with the center of the machine directly in front of him and the front of the machine parallel to a plane through his hips and shoulders. The examiner moves the right hand target to a fixed position and tells the subject to pull the one connected to the string (which the subject holds in his hand) as that is at the same distance from the screen at the front of the machine as the one which has been set. The examiner stands to one side until the subject has indicated that he has the target set, when the examiner notes the difference in the reading of the two scales. He then moves the right-hand target an inch or so from the first position, and a second trial is made. A third trial is made with the fixed target an inch or more in the opposite direction from the first position. The test is scored by computing the average of the three trials and giving credit as follows: Score of 10 indiciates that the average error is less than ¼". For each ¼" average error, one point is deducted. For example, a score of nine is given where the average error is just one quarter-inch, or less than one half-inch. A score of eight is given for values between one-half and three quarters, etc. Abbreviations stand for plus deviations predominating (target or string closer to screen), minus deviations, and alogical attack.

Item 13 refers to a test of ability to recognize forms held in the hand. A block is presented to the subject in each hand, starting with the ball and the block nearest like a ball. He is asked to hand back the one most like a ball. If the correct one is handed back, a score of five is given. If the wrong one is handed back, and the ball retained, the others are presented in descending order as a roundness. A score of five is recorded if a pefect record is made, and one deducted for each additional presentation required before the difference is noted. The abbreviation is for alogical attack.

Item 14 refers to the usual Pintner-Paterson Substitution Test. This test is given and scored in the usual manner, and the score recorded in the right margin.

Item 15 refers to a measurement test. Six small steel blocks are provided, also a pair of five inch spring calipers. The blocks should be presented in helter-skelter order and the following instructions given. "Here are some blocks which vary slightly in size aross this polished face" (Indicate with fingers used like spring calipers). "Take these calipers and line the blocks in order of size so that the largest will be here (indicate) and the smallest here (indicate)." A score of seven is given for perfect arrangement. One is deducted for ever pair reversed. If a block is two places out of place, two points are deducted. Abbreviations stand for: roughness, alogical attack.

Item 16 refers to a test of ability to saw a line. A two-by-four is marked off so that it should be square on the end if sawed to a line marked around it. The subject should be given the piece of two-by-four and told to place it over a low bench or chair (these must sit with their legs square on the floor) and told to saw the line or just saw next to it; he should be told that he may do either, just so that

he does one or the other consistently. The test is scored by placing a try-square across the sawed end and measuring down from the square to the wood at the point where the wood is farthest from the edge of the square. If the board is sawed within a sixteenth of an inch of square, the 16 on the record blank is encircled; if within an eighth, the 8 is encircled; and if within a quarter, the 4 is encircled. The pathologies which are abbreviated at the left are: general ineptitude, bodily incoordination, lack of systematization in attempt, and bodily asymmetry.

Item 17 is a check upon various items of personal appearance, to indicate what changes should be made and where improvement is necessary. The various items are subjectively judged and pathologies are abbreviated in the left-hand margin. This margin can also be used for notes concerning the various items. The first item is general appearance. The second item is bodily cleanliness, and the abbreviations noted are for hands, face, ears, hair, and body odor. A blank for cleanliness of clothing is also provided. Next is mouth hygiene, which is noted by an examination of the mouth, looking for pathologies, whether or not they are related to personal appearance. Teeth, gums, tongue, tonsils, dental arch should all be checked. The abbreviations are for teeth, tongue, halitosis, other pathologies. The next topic is neatness of clothing, and abbreviations stand for ragged, mended, large, and small. The next line is for hair, the abbreviations being as follows: "Toupee", which refers to appearance, rather than to actually having a wig, needs haircut, hair uncombed, hair messy. The next topic is taste in clothing and appearance generally; the abbreviations standing for loud, repulsive, and shabby. The next item is appropriateness to the occasion, and abbrevations are for overdressing and underdressing, relating to dressing beyond the requirements of the occasions, or without enough regard for the requirements of the occasion. The next line refers to appropriateness of clothing to the figure. The abbreviations are for tightness, looseness, and wrong emphasis. The next item is shoes, and abbreviations are for need of shine, runover appearance, and poor fit.

In Item 19, the body type is encircled, and the x's at the margin are used to indicate whether or not the figure might be a handicap in vocational or emotional adjustment. Good adjustment-value is indicated at the right, poor at the left. The abbreviations are for malnutrition symptoms, asthenic type, rhythmic type, athletic type.

The items from 18 on are physiological checks, the first one being for color blindness, using the Ishihara Color-blindness Test. The abbreviations are: total color-blindness, and chromatic agnosia.

Item 21. Finger tremor is indicated subjectively, the numbers being put down for a projected test which is not yet developed. Tremor can be tested with the elbow rested on the table, hand extended at an angle of about twenty degrees above the table top, and a sheet of paper laid on the fingers. Tremor is indicated on the number scale as if it were an x scale, much tremor at the left, and little at the right. The abbreviation in the margin is for intention tremor, which should be tested for by asking the subject to pick up some object from a table.

Item 21. Anesthesia may be determined by use of an algesiometer and asking a question concerning places upon the body where pain cannot be felt. The abbreviations are for suspected conversion symptom and for hypochondriacal attitude.

Item 22 refers to a check of pulse. The pulse is taken for a full minute with the subject in a sitting position. Then the subject is required to do twenty steps

standing run, being sure that a good high step is taken. Pulse is recorded for the first 15 seconds after the run has ceased. Then the examiner waits 15 seconds, and takes the pulse for 15 more seconds, recording after the number 30. Then waits 15 more seconds, takes pulse for 15 seconds, and records after 60. Similarly, the examiner waits 15 seconds and takes pulse for 15 seconds, and records after 90 seconds, etc. For rating of A, the record after 30, when multiplied by 4, should be no larger than the normal rate. For rating of B, rating after 60 is multiplied by 4 and compared with the normal rate. If pulse is not down to normal by this time, rating is D or F, and if pulse does not accelerate after standing run, rating is F. In the last mentioned case, the subject should consult a physician.

Item number 23, Respiration, is counted before the standing run, and for fifteen or thirty seconds immediately after. The number of full breaths per minute before the run is recorded after the abbreviation sit, which means sitting, and the number of full breaths per minute just after the standing run is recorded after the abbreviations Ac. which means accelerated.

Item 24. In the absence of a hand dynamometer, a small pair of bathroom scales, caliberated in pounds is used. This scale is grasped with both hands and gripped as hard a possible, the subject being told that he is to hold it there as long as he can. Maximum is recorded, then the point at which it is stabilized, the number of seconds before rapid decrease sets in. Abbreviations are for maximum, stabilized reading, and time of holding period.

Item 25. Romberg sign is tested in the usual manner.

Item 26. In using the line walk, the subject is first asked to walk toward a point with his eyes closed and covered by his hands. Then he is observed in natural walking. The abbreviations stand for ataxia, heel and toe walking, excessive hip movement, short and long steps, short steps, pigeon-toe walking. If deviation is more than 2 feet in 20, the examiner should note the direction of it.

Item 27, 28, 29. Vision and astigmatism are checked in the usual way with eye charts, and auditon is checked with an akemeter, the examiner recording the fraction of twenty feet at which the click of the akemeter can be heard.

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