CHARACTERISTICS OF FAMILIES ON WAITING LISTS AT THREE CHILD GUIDANCE CLINICS

Margaret E. Amell, Janet R. Conat,
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Margaret E. Amell
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Gordon J. Aldridge
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THESIS

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TABLE OF CONTENTS

LIST OF TABLES

INTRODUCTION

Public attention is being focused increasingly on the the critical problems arising from the great disparity between the needs for mental health services throughout the country and the resources available to meet these needs. This disparity was a central theme of the final report of the Joint Commission on Mental Illness and Mental Health. Action for Mental Health. The report has given additional impetus to the development of plans and experiments designed to stretch available personnel and resources to meet a maximum portion of the need.

The existence of waiting lists reflects this general inability of services to meet the totality of the demands upon them. Child guidance clinics have struggled with the waiting list problem for many years and have sought various ways of reducing them. Some of these attempts have been directed toward the mechanics of the application process. Others have dealt with screening procedures. In some clinics the character of the service offered has been modified in order to meet a maximum portion of the pressing demands.

One aspect of clinic experience that has an important bearing on the waiting list problem is the well-known fact

that a certain portion of the total number of applicants, in each clinic, are not actually ready to use the service when it is offered. The reason for great concern with factors of motivation is obvious. To the extent that scarce clinic resources are used for people who are not truly motivated to use the service, help is being withheld from some who are genuinely motivated but who cannot be reached.

The present study is an exploratory attempt to gain a better understanding of factors of motivation among people awaiting service, to determine what factors about such people might help to predict whether they will actually use service, and to determine whether the waiting period itself has an effect upon motivation.

The study had its origins in developments within the community of Lansing during the past several years. The Lansing Child Guidance Clinic has been rendering a diagnostic and treatment service since 1938. Its underlying philosophy is to provide the best possible professional service in accordance with the needs of the individual child. This includes not only diagnostic service but long-term treatment, where the professional judgment of the team

determines that this is the desirable course. Because of this commitment to a total service, and because of the large volume of need, the clinic has had very long waiting lists. As of June 30, 1961, the "referral" waiting list, consisting of people awaiting a diagnostic conference, was 197 cases. The treatment waiting list, consisting of people who had been through the diagnostic process and were awaiting treatment, was 138 cases.

In 1961 the Community Services Council of Lansing established an Outpatient Study Committee which set out to study all phases of the community mental health services in Lansing, including the waiting lists and what to do about them. In connection with its work, Dr. Gwen Andrew, Director of Research of the State Department of Mental Health, conducted a survey of people on the waiting lists of the Lansing Child Guidance Clinic. Using a mail questionnaire followed by telephone calls, Dr. Andrew reached most of the parents of children who were on the two waiting lists as of June 30, 1961. This survey indicated that 55.4% of those on the referral waiting list continued to want help from the clinic and 76.0% of those on the treatment waiting list continued to want help.

Using this study as a base, the students associated in the present project decided to gether information on the characteristics and attitudes of families on the waiting lists of the three clinics in which they were placed for field work training: The Grand Rapids Child Guidance Clinic, Beth Moser Mental Health Clinic in Jackson, which is both a child and adult clinic, and the Lansing Child Guidance Clinic.

The purpose of this research was not only to replicate and add to the findings of the survey that had been conducted in Lansing but, more particularly, to obtain a more qualitative insight into the factors that may help to explain why some families continue to maintain their interest in obtaining help while others change their minds and decide not to seek service. It was decided to interview a sample of families on the waiting lists of the three clinics in order to identify the factors that might be characteristic of "continuers" and "discontinuers."

Interviews were designed to gather information on the following groups of factors that might bear some relationship to decisions of continuing or not continuing contact with the clinic:

Identifying characteristics - We felt that the child's

parentage (i.e. natural or adopted child), the family's socioeconomic status, the education of the family members and the age of the child would have a specific relationship to continuance with the clinic.

Motivation factors - Since it is the parent rather than the child who must make application for service, we assumed that parental attitudes would be the primary consideration in determining the desire to seek and use clinic service. Encompassed in these attitudes are recognition of the problem and parental agreement on its nature and the appropriate treatment for it, as well as acceptance of responsibility and expectation that help can be effective.

Intervening factors between clinic contact and time of study. It is assumed that a waiting period prior to clinic service allows for the intervention of elements such as environmental changes and alternative services which might effect changes in the nature of the problem and, therefore, in the continuing desire of the parents for service.

Clinic factors - The consistency or lack of consistency between parental expectations and clinic practices was considered to be an important factor in determining whether the parent would want to continue.

REVIEW OF LITERATURE

While there is a considerable amount of literature bearing on continuance in the therapeutic process once treatment has been initiated, there is less written about factors apart from clinic services and client-worker relationships which may affect motivation to continue or discontinue contact with a child guidance clinic prior to actual involvement in the treatment process. While considering the following research findings relating to continuance, it is useful to keep in mind Lillian Ripple's remarks that "continuance is not synonymous with 'use' of casework service. . . however, continuance is the necessary antecedent to use of service."[1]

In a collaborative study of socio-cultural factors in psychiatric clinic services for children in the New York and San Francisco metropolitan areas, Henry Maas et al. relates socio-cultural factors to the use and outcome of children's psychiatric clinic services. In a previous study of four psychiatric clinics in the San Francisco Bay

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[1] "Factors Associated with Continuance in Casework Service," Social Work, II (1957), p. 87.

area conducted by R. Z. Apte *et al*. it was found that neither the referral source nor the type of presenting complaint are significantly associated with a positive outcome in use of services, yet the differential use of the children's clinics was apparently related to the occupational status of the child's family in that ". . . the trend is that more lower occupational status families terminate in consultation and referral services, more middle and upper occupation families tending to terminate in 'improved' status, although no occupational group is disproportionately represented among the 'unimproved' cases."[2]

Maas hypothesized that parental expectations provide the link between the social status and use of service. Replicating the Apte study in the San Francisco area, he obtained similar results. However, the New York data failed to support a relationship between these two variables. On the contrary, merging the data from the New York and San Francisco areas, Maas concludes that, while no definitive

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[2]"Socio-cultural Factors in Psychological Clinic Services for Children," *Smith College Studies in Social Work*, XXV (1955), p. 6.

relationships were established, those families which saw the clinic as the authority and expected merely to play a passive role tended to keep more appointments and to terminate in improvement. This attitude tended to be more frequent among lower social status families. On the other hand, parents who expect to share in a collaborative relationship with the clinic, an attitude tending to be more frequent in upper social status families, tended to keep fewer appointments and to terminate in no improvement.[3]

The research most pertinent to the interests of this study is reported in a series of articles by Lillian Ripple examining the preposition that a client's use of casework services is determined by the motivation, capacity and opportunities afforded him both by the environment and by the social agency from which he seeks help. The study differentiates two groups: Those having "external problems" and those having "psychological problems." Ripple found that there was a greater tendency toward continuance among clients with external problems. Also, in this group, a significant relationship was found between discontinuance and the judgment that the client was seeking an inappropriate

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[3]Ibid., p. 71.

service. In addition, while low hope that the problem can be resolved is not favorably associated with continuance, it is not clear whether the existing relationship varies with the degree of hope, but it is dependent on whether the problem is "external" or "psychological."

In the "psychological problems" group, environment was found to be of primary importance and motivation somewhat less so in relation to continuance. Among environmental factors, the influence of others was more important than social or economic conditions. It is of interest that the capacity of the client, including the factors of intellectual functioning and acceptance of responsibility for the existence of the problem, was not found to be associated with continuance or discontinuance for either group. In her final report, Ripple points out that slightly over one-half of the group having "external problems" were continuers, while only one-third of the "psychological problems" group continued in treatment.[5] This research is the basis for a

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[4] "Motivation, Capacity and Opportunity as Related to the Use of Casework Service: Nature of the Client's Problem," Social Service Review, XXX (1956), pp. 38-54.

[5] "Why Parents Discontinue Child Guidance Treatment," Smith College Studies in Social Work, XIX (1949), p. 118.

further study being conducted to determine whether the same or different factors distinguish those who use service productively from those who do not.

In a thesis dealing with the reasons for parents' discontinuance of child guidance treatment, Eva Smigelsky compared twenty-four families who discontinued on their own initiative to twenty-four families who continued in treatment. She found that "the traits most distinguishing of the two groups were parents' attitudes toward the child and clinic, age of child, and parent's ability to express anxieties about the child and about treatment in general."

Those parents who were generally accepting of a child were more likely to remain in treatment, and there was also greater likelihood for continuance for parents whose attitudes toward the clinic were essentially positive. In this regard, the waiting period was found significant only when considered in relation to the more important factor of parents' attitudes toward the clinic. Tending to support Ripple's findings, there was some indication that passive behavior disorders, as opposed to aggressive, were less likely to remain in treatment. This causes Smigelsky to speculate that if a problem is less disturbing to family

life the parents may be less likely to recognize the need for treatment. However, due to lack of clear definitions we are left uncertain of how the degree of disturbance in family life might be measured as well as what reasons might cause the parent to be less likely to recognize need for treatment.

George Levinger's article, "Continuance in Casework and Other Helping Relationships," reviews current research on continuance, integrating findings and pointing out gaps in our current knowledge. In order to generalize findings and make allowances for the diversity of definitions of continuance and variety of agency settings, Levinger defines continuance as persons (client, patient or counselee) remaining in a relationship with a helper (psychiatrist, therapist or social worker) for a minimum number of interviews. Accordingly, discontinuers are those persons leaving the relationship before completion of a minimal number of interviews.[6]

Levinger observes there is little systematic knowledge regarding the connection between a person's environment and

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[6] Social Work, V, No. 3 (July, 1960), p. 41.

continuance. Regarding occupation, it appears that housewives and patients with managerial or professional jobs are more likely to continue than those with more restrictive employment. On agreement between parents, Levinger cites Lake's thesis as reporting greater continuance where families showed a greater proportion of "positive agreement between the parents."[7] While research tends to show that the greater the potential for cooperation in the patient-helper relationship, the more likely the person is to continue, Lake's findings qualify this relationship by the degree to which the parents agree with the worker's perception of the core problem.

Levinger finds little evidence relating either to the length of waiting period and/or geographical distance to continuance. Lake examined the length of wait after the application interview at a children's clinic and found that those waiting over three months were more likely to discontinue. Levinger points to the need for further study of the relationships between these two factors and continuance.

With socioeconomic background, however, Levinger finds

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[7] Ibid., p. 45.

research evidence for a positive relationship with continuance, supporting Maas (see above), yet this is true more in adult than in children's clinics, for which there is no obvious explanation. While age, sex and race show no significance, social status appears to be influential in terms of the person's varying degree of knowledge of services and their accessibility to him. Regarding the nature of the client's personal attributes, including perception, motivation and personality, Levinger cites Blenkner's research which indicates that continuers had more problems which were primarily "psychological and interpersonal" in nature and Lake's conclusion that discontinuers are more likely to see the source of their problems in the neighborhood or community rather than within the family unit. This conflicts with Ripple's findings (see above). Levinger concludes that ". . . in general, discontinuers accept less responsibility for their problems than do continuers."[8] Again, this is apparently in direct opposition to Ripple's findings that no relationship existed between capacity, which included the factor of acceptance of responsibility, and continuance or

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[8] Ibid., p. 43.

discontinuance. There appears to be a need for further research in this area, as well as into the influence of personality factors in general. Levinger reports that, while the degree of disturbance has not been found to be a useful indicator of continuance, high anxiety is positively related to continuance. There is need for further clarification of these relationships.

Levinger appropriately calls our attention to the fact that variations in definitions of continuance, agency setting and the nature of the person's problems prohibit clear integration of research findings, but concludes that the very small number of continuance studies justifies integrating results in order to stress similarities in determinants of client continuance. He criticizes research methods which have been used on the basis of unclear operational definitions, vague data on which assertions are based, and also because reliabilities among judges' ratings are frequently not reported, statistical significance of findings is often questionable, and the representativeness of population samples studied is rarely assessed. Finally, Levinger points to the need for "integrating future research according to gradually improving conceptual frameworks."[9]

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[9] Ibid., p. 49.

METHODS AND MATERIALS

As pointed out in the introduction, this study addresses itself to an assessment of differences between "continuers" and "discontinuers" at three child guidance clinics.

Continuers are defined as those families who applied to the clinic and were waiting to be seen for their first personal contact at the clinic, the diagnostic interview.

Discontinuers are those clients who, for various reasons, decided to terminate further clinic contact without having the personal contact at the clinic.

Clinic Methods of Handling Waiting Lists

The purpose of the child guidance clinics is fivefold: The diagnosis of psycho-social problems in children and/or families, the treatment of these problems or referral to more appropriate sources, provision of consultation to other agencies engaged in work with children, and the training of social work and psychology students. The primary purpose is, of course, the extension of clinic resources to the client population. Because of the disparity between demands for service and resources, a gap in time between the

occurrence of the presenting problem and the time of the first clinic interview persists. During this time period, applicants are on a waiting list pending diagnostic study. It is from this waiting list that the population for this study was drawn.

Although all the clinics have clients waiting to be seen for diagnostic study, the methods of dealing with the waiting list vary with each clinic.

The Lansing Child Guidance Clinic sees clients who may be self-referred or referred by another source. Initial information is received by a secretary by telephone from the client and, on the basis of this information, the chief social worker places the client into one of the following categories on the waiting list: "Emergency," "Start ahead," "Ahead," and "Regular." The criterion for this classification is the professional judgment of the chief social worker as to the seriousness of the problem. The categories are used then to determine the order in which appointment dates will be given to applicants. A letter stating the appointment time of the first interview is sent to the parents approximately two weeks prior to the first interview.

The Beth Moser Clinic is similar to the above in that a

secretary receives information via telephone and the director, in consultation with the medical director and other staff members, decides whether or not the case is an emergency. If the case is not on emergency status, there will be a waiting period. However, a face sheet and questionnaire form is sent immediately to the parents upon referral. People who do not return the face sheet are assumed not to be interested in service. This step thus serves as an automatic screening measure to eliminate those least motivated. Applicants who return the face sheet are placed on the referral waiting list. They are not always given appointments in exact chronological order, since the degree of concern expressed by applicants is also considered.

The Grand Rapids Clinic uses some additional administrative procedures to shorten its waiting list. A secretary receives information by telephone and a judgment is made by the director as to the emergency status of the case. If the case is not an emergency, a face sheet requesting certain information is sent and the client is placed on the waiting list when this sheet is returned.

Approximately one month after the name is placed on the waiting list, a letter is sent to the client asking if he

wishes to continue clinic contact. If the answer is negative or the letter is not returned. the client's name is removed. This serves the purpose of "trimming" the waiting list.

The actual diagnostic procedures are relatively similar in all three clinics. The parents are interviewed by a social worker in order to obtain a social history. If indicated, the child may be seen by the clinical psychologist for testing, and both parents and child by the psychiatrist. A staff conference then takes place in order to reach consensus on the proper disposition of the best resources to meet this particular need. When this is determined, an interpretive interview is held with the parents, and the findings are explained to them.

Methods Used in Gathering Data

The primary instrument employed to gather data for this study wasthe interview schedule. Due to the relative unpredictability of client responses, it was decided that the interview schedule be open-ended in order to avoid limiting the responses. Responses were then to be categorized and coded.

The research group drafted a preliminary schedule. This was then reviewed by each of the three clinic directors and revisions made in accordance with their suggestions. The schedule was then pre-tested in the Lansing area. A random sample of five was drawn from the waiting list of the Lansing Clinic and interviewed. Upon further examination of the questionnaire after the pretest had been completed, all questions considered too redundant or repetitious were eliminated.

The other instruments employed were the preliminary questionnaire used by Dr. Gwen Andrew, research director of the State Department of Mental Health, during her study in the summer of 1961, and an explanatory letter addressed to the chosen sample at each clinic (see appendix).

The cover letter and preliminary questionnaire had already been sent by Dr. Andrew to the entire diagnostic waiting list at the Lansing clinic during the summer of 1961. It seemed unnecessary to repeat this when our research was begun in the fall of the same year. However, it was discovered that all the continuers had already been seen diagnostically or were scheduled to be seen. This limited the researchers to discontinuers. A sample of twenty

discontinuers was drawn randomly from a total of fifty-nine, excluding those who could not be contacted or who resided outside the "home" county. Personal interviews were arranged by telephone at the homes of the interviewees.

Since the Grand Rapids Clinic also had enough varilable data on continuers and discontinuers due to the letter requesting this information one month after referral, a sample could immediately be drawn from this population. One of every three was drawn. If the applicant lived out of the country or was unavailable, a new name was drawn from the list. A total of twenty on the diagnostic waiting list were contacted by telephone and interviewed at their homes. There was an equal number of continuers and discontinuers.

The researchers at the Jackson Clinic drew one name from every three from their waiting list after first sending out Dr. Andrew's questionnaire and cover letter. The response was limited to thirty-three per cent, producing a sample of forth, not all of whom could be contacted for an interview. A letter requesting return of the questionnaire was then sent to those who had not responded. Three questionnaires were returned. The researchers finally returned to the waiting list and repeated the sampling by drawing

more names. In this manner, they contacted thirty clients and were able to interview them in their homes. The researchers also limited their interviewing to the home county.

A word should be said at this point concerning the limitations of the samples at all three clinics. All the clinics provide service to more counties than the ones in which they are located. These other counties were exluded from the sample due to lack of available times. Also omitted were emergency cases which are seen quickly, and therefore, were not on the waiting list.

A tentative code was created for interview responses after the data were collected. This code was given to each interviewer for his own study in order to establish the completeness of the categories according to each interviewer's particular set of interview responses. When the code sheet was so studied, some questions and answers were eliminated due to repetitiveness and/or not being germane to the study of motivation.

In the code, discontinuers were first subdivided according to the reason for discontinuance, i.e. improvement of the problem, use of alternative services, one parent unwilling to continue, and child now too old for service.

Upon investigation after the data were collected, it became obvious that the total number of cases was too small to make such a fourfold subdivision feasible as each category was too small to permit analysis. Therefore, they were combined into one group (discontinuers) for the purpose of the analysis of the data. The four who were undecided as to whether or not they wished to continue were eliminated for the same reason.

The sample for the project consisted of seventy cases; thirty from the Jackson Beth Moser Clinic, twenty from the Lansing Child Guidance Clinic, and twenty from the Grand Rapids Clinic. Of this total, 29 were Continuers, 37 Discontinuers and 4 Undecided. The distribution of these cases, according to samples of continuance and discontinuance in each clinic, can be seen in greater detail in the following table.

The following chapter presents the data obtained as to the relationship of variables covered in the schedule to continuance or discontinuance.

TABLE I

SAMPLE CASES AS RELATED TO CONTINUANCE
IN THE THREE CLINICS

	Continuance	Discontinuance	Undecided	Total
Grand Rapids	10	10	0	20
Jackson	19	8	3	30
Lansing	0	19	1	20

PRESENTATION AND ANALYSIS OF DATA

The analysis which follows is limited to an examination of the association between various characteristics or attitudes of clients uncovered in the interviews and the desire of the clients to continue or discontinue contact with the clinic. The sole dependent variable to be examined is the desire to continue or discontinue. The independent variables are a variety of social characteristics and motivational factors, as defined and measured in the interview schedule.

The first observation to be made about the findings is that none of the relationships were statistically significant. That is, none of the characteristics or attitudes which we measured were clearly enough related to either continuance or discontinuance to come within the .05 probability standard for statistical significance.

While this report might stop at this point and dismiss all the data as insignificant, it should be noted that the lack of statistical significance is due, at least in part, to the small number of cases which were investigated. There were only seventy cases in all, of which twenty-nine were

continuers and thirty-seven were discontinuers. Even with sharp dichotomization, the numbers were rather small.

Although not significant, a number of the relationships were found to be in the expected direction. Others were completely unrelated or were in the opposite direction to the one anticipated. These results are reported as exploratory but suggestive findings and are compared with previous studies to indicate where they support or run counter to other evidence.

Identifying Characteristics

On the basis of previous studies, it seemed that the age of the child and the socioeconomic status of the family might be the characteristics that would have the greatest bearing on continuance or discontinuance. We did find, as Table 2 indicates, that there was some variation in regard to age, inasmuch as children who were ten years of age or older at the time of the initial contact with the clinic tended to discontinue, while those less than ten years of age seemed to have a greater tendency toward continuance. No relationship was found, however, between the age of the children at the time of the study and continuance.

TABLE 2

AGE OF CHILD AS RELATED TO DECISION TO CONTINUE CLINIC CONTACT

Age at Initial Contact	Continue (Per Cent)*	Discontinue (Per Cent)	Total (Per Cent)	Total (Number)
Under 10	50	50	100	(46)
10 & over	30	70	100	(20)

*In this and all subsequent tables, percentages are rounded off to the nearest whole number.

One of the factors that may account for the difference shown in Table 2 is that because there is a waiting period some of the older children in the over-ten group become older than the eligible age for clinic service. Other factors might be the adolescents' negative concept of the clinic, the problem manifested might require other help, the symptoms might change as the child gets older, and possibly more community help is available for the older group.

The previous studies that we surveyed made no differentiation of the posssible relationship between continuance and parentage. We felt those families in which the child was not the natural child of both parents would show a greater tendency toward discontinuance. It was found,

however, that the child's being a step-child or adopted child of at least one parent made no difference in the desire os the family to continue clinic contact. As expected, a majority, seventy-seven per cent, of the children lived with both natural parents.

For the purposes of our study we assumed parental education and family income to be the primary determinants of socioeconomic status. Before the interviews were conducted we felt the lower socioeconomic group would tend to discontinue due to the generally held conception that child guidance clinics serve primarily middle class clientele. As Table 3 shows, we arbitrarily divided family income at $6,000, which was the median of the distribution.

TABLE 3

FAMILY INCOME AS RELATED TO DECISION TO CONTINUE CLINIC CONTACT

Income	Continue	Discontinue	Total	
	(Per Cent)	(Per Cent)	(Per Cent)	(Number)
Under $6000	37	63	100	(27)
$6000 & over	51	49	100	(37)

*No response from two subjects.

It was sometimes difficult to obtain even an approximation of family income, although the desire was only for an estimation by the person being interviewed. In one instance, the interviewer was unable to convince the couple to give this information and was told it was none of his business. In another case, a divorcee received part of her financial support from her parents with whom she lived and this part of her income could not be estimated easily. Due to her low earnings outside the home she was placed in the under-$6000 category.

It was found that fifty-one per cent of those families in the higher income group continued while only thirty-seven per cent of those in the lower group were in this category, which supported our original hypothesis.

No such relationship was found between parental education and continuance. In most instances, the father and/or the mother had at least some high school education. It is of interest that when the mother had at least some college education the families tended to continue but this was not true of fathers. However, the number of cases was too small to permit anything more than speculation on this point.

Motivational Factors

Our central concern in this study was with the motivation of the parents to seek clinic help. In our interviews we sought information not only on the present attitudes of the parents toward obtaining help but on a variety of factors associated with their initial contact with the clinic that might be related to this desire for help.

The first factor to be examined in this area was the behavior of the child leading to initial clinic contact. As expected, we found that in the four instances where the child was in contact with the clinic due to involvement with the juvenile court the families tended to discontinue. The reason for this result would seem to be the clinic contact was imposed by an outside agency and the motivation did not originate within the parents. Given a lapse of time and a later choice, the parents decided to discontinue.

In the three instances where the presenting problem was of an organic nature, the families wanted to continue. A possible explanation in these cases might be that the parents did not accept the true nature of the child's condition and were hoping that the clinic diagnosis might disprove the existence of organic damage.

We defined "family and/or social adjustment" problems as those emotional maladjustments manifested in the child's presenting behavior which resulted in intra-family conflict or extra-family social dysfunctioning which stopped short of involvement with the law. As Table 4 reveals, the families showed a stronger tendency to continue when the presenting problem involved family and/or social adjustment than when it involved school adjustment or achievement. It should be pointed out that problems were classified in the above two categories according to parental opinions of the basic problem rather than after being verified through further investigation. It can be assumed, then, that because the behavior is listed as a school problem does not necessarily preclude the possibility that it reflects a problem in family adjustment as well.

TABLE 4

CHILD'S PRESENTING BEHAVIOR AS RELATED TO DECISION TO CONTINUE CLINIC CONTACT

Child's Behavior*	Continue (Per Cent)	Discontinue (Per Cent)	Total (Per Cent)	Total (Number)
School Problem	42	58	100	(24)
Family and/or social adjustment problem	67	33	100	(24)

*Excluding organic and legal problems.

One of our purposes in establishing these categories was to try to differentiate between what Ripple has called "external problems" and problems of a more "psychological" nature. Ripple found that there was a greater proportion of continuance among people who identified their problems as "external." In our classification the category of "school problem," which was our concept of an "external" type, showed a higher proportion of discontinuance than of continuance. This result was in the opposite direction from Ripple's findings. Our finding is, however, consistent with the preliminary study done by Andrew who also found that the family whose children displayed primarily academic problems tended to lose interest in clinic service.

Here again it is necessary to caution against definitive conclusions. Since our findings were not statistically significant, they cannot be assumed to disprove the Ripple findings in any way. Furthermore, there is some doubt in our minds as to whether the definition of "external" problems which we used was comparable to the one used by Ripple.

Our next focus of concern was not covered in any of the literature we reviewed. We wished to examine parental motivation for clinic help as influenced by their efforts to

seek prior help for the problem. We expected that parents who had sought other help prior to clinic contact were more highly motivated and, therefore, would be more likely to continue. It was found, however, that this factor had no bearing on continuance. There would seem to be reasons why the group which did seek prior help showed no significant trend toward continuance. If the parents received no help for the problem from the other source, this might either discourage them from continuing to seek any help or encourage them to seek more appropriate help, such as from the clinic.

As Table 5 reveals, our data tended to support Andrew's finding that parental self-referrals showed a considerable trend toward discontinuance while other referrals (except for the court cases noted above) remained relatively more interested in clinic service. The sharp drop-off in interest on the part of self-referrals would appear to be due primarily to the ambivalence on the part of these parents about seeking professional help for their problems. Many of these self-referrals were made at a time when the parents became upset over a specific incident even though the basic problem had been present for a longer period of time. In such

cases, the parents seemed to lose their motivation for clinic service after the specific incident had passed and the situation returned to the previous chronic status. In one instance, the mother became so upset about a fight her son was involved in at school that she made an immediate referral to the clinic by telephone. When the application blank arrived by mail a few days later she was no longer interested in an immediate appointment because the precipitating incident had passed, even though the boy's basic emotional problem was still present, and she did not return the application until another incident occurred.

TABLE 5

SOURCE OF REFERRAL AS RELATED TO DECISION TO CONTINUE CLINIC CONTACT

Referral Source*	Continue (Per Cent)	Discontinue (Per Cent)	Total (Per Cent)	Total (Number)
Self	28	72	100	(25)
School	55	45	100	(20)
Other professional	53	47	100	(15)

*Excludes friends and/or relatives.

Even though we had no evidence from other studies on which to base this hypothesis, we felt that parental agreement with the referral source on the nature of the problem and on the advisability of contacting the clinic would have a significant influence upon continuance. It was discovered, however, that the parents' agreement with the referral source on contacting the clinic did not reveal a trend in either direction. As Table 6 indicates, when they agreed with the referral source on the nature of the problem there was a slight tendency to continue, and when they disagreed there was a stronger tendency to discontinue. We have no data to indicate possible reasons why agreement with the referral source on contacting the clinic did not reveal a similar tendency.

TABLE 6

PARENTAL AGREEMENT WITH REFERRAL SOURCE ON NATURE OF PROBLEM AS RELATED TO DECISION TO CONTINUE CLINIC CONTACT

Parental Agreement with Referral Source	Continue (Per Cent)	Discontinue (Per Cent)	Total (Per Cent)	Total (Number)
Yes	66	34	100	(29)
No	27	73	100	(11)

*No response from one subject.

Another area not covered by other studies is the relationship between previous knowledge of the clinic and continuance. We expected that those families who gained their information of the clinic from friends or relatives would tend to continue, whereas those who learned of it through publicity would show a trend in the opposite direction. As Table 7 indicates, our findings directly contradicted this tentative hypothesis as the latter group revealed a slight trend to continue while the former group showed a strong trend to discontinue. Publicity about the clinic was communicated primarily through radio and television programming, newspapers and speeches by clinic personnel. After reviewing our findings, we now feel some reasons for these unexpected tendencies might be that friends or relatives could have inaccurate knowledge of the clinic services or, when conveying information about the clinic, could bring pressure to bear upon the parents to seek clinic help which might produce a negative reaction. Publicity, on the other hand, could be a more accurate and neutral introduction of the clinic to these parents. This area would seem to be closely related to the trend toward discontinuance of self-referrals and might indicate a need for motivational support outside the parents in enduring the waiting period.

TABLE 7

PARENTS' PREVIOUS KNOWLEDGE OF CLINIC AS RELATED TO DECISION TO CONTINUE

Source of Parents Knowledge of Clinic	Continue (Per Cent)	Discontinue (Per Cent)	Total (Per Cent)	Total (Number)
None	52	48	100	(21)
Friends and relatives	16	84	100	(19)
Publicity	64	36	100	(22)

In this same general context, we expected that parents' agreement between themselves concerning the nature of the problem and the advisability of contacting the clinic would have an important bearing upon continuance. We discovered that for both the sixty-four per cent who agreed and the thirty-six per cent who disagreed there was no trend in either direction. Our data do not provide us with any explanation for this unexpected development.

Again, in an area not covered by the previous studies we reviewed, we expected that the length of time parents waited between the point at which they became aware of the problem and the point at which they contacted the clinic would have a bearing upon continuance. It was found that

neither this nor the parents' reasons for waiting more than one week from awareness of the problem until contact with the clinic revealed a tendency in either direction. Another area in which we thought that ambivalence on the parents' part might be significant was their telling or not telling the child of their referral to the clinic. We found this had no effect upon continuance, and only thirty-one per cent of the children knew about the referral. Most of the parents did not tell their children of this because they had no definite appointment and were hoping none would be necessary. This would seem to reflect parental feelings about receiving help for the emotional problem within the family rather than the effect of the child's knowledge of the clinic contact upon continuance.

We felt that when relatives who knew about the clinic contact had an encouraging effect upon the parents' desire for service the families would tend to continue and the opposite would be true when the relatives' effect was discouraging or not present. This was borne out by our findings, as shown in Table 8. This would appear to be one area of support for the parents while waiting for service, as discussed earlier.

TABLE 8

RELATIVES' EFFECT UPON DECISION
TO CONTINUE CLINIC CONTACT

Effect of Relatives	Continue	Discontinue	Total	
	(Per Cent)	(Per Cent)	(Per Cent)	(Number)
Encouraging	67	33	100	(15)
No effect or discouraging	35	65	100	(26)

Intervening Factors

In this section, we are concerned with factors that arose after the contact had been made with the clinic - in other words, during the waiting period. These relate primarily to changes that may occur in the problem or in the environment which might affect the continuing need or desire for clinic service.

The first factor to be examined here was changes which have occurred in the problem since first clinic contact. We felt that families would tend to discontinue if the problem improved and continue if there was no change or it became worse. As Table 9 shows, this was borne out by our findings and supports Andrew's conclusion that children are withdrawn from clinic contact if their condition improves

while on the referral waiting list. Andrew found further that slightly more than a quarter of the parents continued to want an appointment even though their child had improved. Our finding that a little more than a third of the parents continue to feel this way would seem to lend strong support to her analysis. However, it should be noted that improvement was a general phenomenon for both groups since it was reported by sixty-five per cent of the total sample.

It should be mentioned that we recorded improvement in the problem if it was reported so by the parents. This does not necessarily mean there was basic psychological change for the better in all such cases but possibly that symptoms abated to some degree or changed to another form.

TABLE 9

CHANGE IN PROBLEM SINCE FIRST CLINIC CONTACT AS RELATED TO DECISION TO CONTINUE

Change in Problem Since Referral	Continue (Per Cent)	Discontinue (Per Cent)	Total (Per Cent)	Total (Number)
Improvement	36	64	100	(42)
No change or worse	60	40	100	(23)

*No response from one subject.

An area not covered in the literature which we felt would possibly be of significance in determining continuance has to do with changes that might have occurred in the environment between the time of referral and the time of the study. Such new situations might include birth of a sibling, death of a relative, change to new school or new teacher, or a change in residence. We found, however, that these environmental changes, if they occurred, had no effect upon the continuance of the families with the clinic.

Andrew found that only twenty-six per cent of the people who have sought clinic service had, in the interim, found other sources of help. Our findings were comparable in this respect. In our sample, seventy-six per cent of the families did not seek other sources of help. Of the twenty-four per cent who did, about three-quarters were no longer interested in clinic services, whereas fifty per cent of the group who had not sought other resources wished to continue clinic contact. Although the trend here is toward an association between seeking other sources of help and discontinuing, the numbers are too small to warrant any conclusions.

It was expected that efforts of the parents to change

their methods of handling the child's problem since referral would affect continuance. We found that fifty-two per cent of the families continued when the parents did change their methods while only twenty-nine per cent continued when they did not change, as Table 10 shows. This was as expected and would seem to indicate greater perception and motivation on the part of the parents who made an effort to effect change in the problem themselves while waiting for clinic service.

TABLE 10

PARENTAL CHANGE IN METHODS OF COPING WITH PROBLEM AS RELATED TO DECISION TO CONTINUE CLINIC CONTACT

Changes in Methods	Continue	Discontinue	Total	
	(Per Cent)	(Per Cent)	(Per Cent)	(Number)
Yes	52	48	100	(43)
No	29	71	100	(23)

Sixty-five per cent of the families changed their methods of coping with the child's problem. We found that for thirty-six per cent of these families the effect of this change was an improvement in the problem and the families tended to discontinue clinic contact, whereas for sixty-four per cent of the families the change had no effect

or made the problem worse and the families tended to continue, as expected (see Table 11). It would appear that when the change resulted in at least some improvement in the problem the parents felt clinic service was no longer necessary. If the change had no effect or resulted in a worsening of the problem the parents apparently considered further clinic help to be desirable.

TABLE 11

EFFECT OF CHANGE IN PARENTS' METHODS OF COPING WITH PROBLEM AS RELATED TO DECISION TO CONTINUE CLINIC CONTACT

Effect of Change	Continue	Discontinue	Total	
	(Per Cent)	(Per Cent)	(Per Cent)	(Number)
Improved	32	68	100	(20)
No effect or worse	78	22	100	(23)

A surprising development was that for seventy-six per cent of the families the parents felt waiting had no effect upon the problem. We had expected to find that waiting would have either a positive or negative effect upon the problem and would result in stronger trends toward continuance or discontinuance, depending upon the effect. For the eleven per cent of the families who felt the problem

improved while waiting there was a strong tendency toward discontinuance while a slighter trend toward discontinuance was found among those thirteen per cent who felt the problem became worse. Caution should be applied in considering these last two trends as the number of cases involved was very small.

Clinic Factors

We felt it would be important to examine the attitudes of the parents toward the practices of the clinic as it influenced their decision to continue seeking service. The first relationship to be considered in this context was the understanding of the parents of the necessity for waiting a period of time for service. We found that eighty-two per cent of the families realized they could not expect to be seen by the clinic immediately, which we defined as within one week of referral, while eighteen per cent did expect to be seen immediately. This result was expected because clients are told of the waiting period at the time of referral.

Maas discovered that parental anticipation of an "authoritative-passive clinician-patient relationship" was associated with continuance while anticipation of a

"collaborative patient-clinician relationship" was associated with discontinuance. If our term "advice" can be construed as similar to Maas' "authoritative-passive" category and "treatment" as similar to his "collaborative" category, our findings would tend to refute his conclusion and support the earlier findings for the San Francisco study. We found that fifty-four per cent of the families expected primarily advice and did not show a trend in either direction, while twenty-four per cent expected to participate in treatment and had a slight tendency toward continuance. This was expected due to our feeling that those who anticipated treatment would be more motivated than those who anticipated only advice.

We found that in sixty-two per cent of the cases, both parents could keep appointments with the clinic while in eighty-four per cent of the remaining families the father could not keep appointments if regularly scheduled interviews would be needed, and neither group showed any significant trend concerning continuance. The inability of the fathers to keep appointments was expected but it could be predicted from clinic experience that not all of the families which stated both parents could keep appointments would

actually do so, which indicates that motivation was not actually measured.

It was found in the Andrew study that persons waiting three months or less tended to want an appointment. For the fifteen months waiting period there was a considerable drop in interest by the people waiting, and this was followed by an increase in interest for those waiting sixteen through eighteen months. Our study revealed that those families waiting up to six months were relatively evenly divided in relation to continuance or discontinuance, while those waiting from six to eighteen months showed a tendency to discontinue, which supports the Andrew findings. There was no tendency found either toward continuance or discontinuance among those waiting over eighteen months.

TABLE 12

LENGTH OF WAIT FROM REFERRAL TO TIME OF STUDY AS RELATED TO DECISION TO CONTINUANCE OF CLINIC CONTACT

Waiting Period	Continue (Per Cent)	Discontinued (Per Cent)	Total (Per Cent)	Total (Number)
0-6 months	53	47	100	(17)
6-18 months	35	65	100	(26)
Over 18 months	48	52	100	(23)

The reasons for this slight tendency for those who had been waiting between six and eighteen months to discontinue are not clear, but it was discovered that sixty-nine per cent of the discontinuers in this group were indifferent or displeased about waiting this period of time. The continuers in this group were about evenly divided between accepting the necessity for this wait and being indifferent or displeased about it.

We expected that those people who had a negative attitude towards waiting would tend to discontinue, while those who had a positive attitude would tend to continue. It was found that those in the total group who were indifferent or displeased about waiting showed a slight tendency to discontinue, whereas those who had a positive attitude toward waiting revealed no trend in either direction (see Table 13).

TABLE 13

PARENTAL ATTITUDE TOWARD WAITING AS RELATED TO DECISION TO CONTINUE CLINIC CONTACT

Parental Attitude Toward Waiting	Continue (Per Cent)	Discontinue (Per Cent)	Total (Per Cent)	Total (Number)
Accepting	55	45	100	(29)
Indifferent or displeased	36	64	100	(37)

CONCLUSIONS

In summarizing the conclusions of this exploratory study, we wish to note first some of the weaknesses of the procedures of which we became aware as it progressed. The researchers found the selecting of the sample to be biased by geographical limitations, inability to contact some clients, and the lack of cooperation of others. Also, in coding data it was found that certain questions on the interview schedule were not adequately designed to elicit responses that could be categorized properly. Therefore, there is some question as to the reliability of the researchers' interpretations of the material given them by the clients.

Within these limitations, we were able to arrive at certain conclusions concerning the nature of the waiting lists at the three clinics which were the subjects of this study. It should first be mentioned that none of the relationships were statistically significant. This was due, at least in part, to the small number of cases which were investigated. We found that children who were ten years of age or older at the time of the initial contact with the clinic tended to discontinue, while those less than ten

years of age showed a greater tendency toward continuance. Seventy-seven per cent of the children lived with both natural parents, and it was found that parentage made no difference in the desire of the family to continue clinic contact.

If parental education and family income can be considered the primary determinants of socioeconomic status, we found that the lower socioeconomic group tended to discontinue while the upper socioeconomic group showed no strong tendency in either direction.

The families showed a stronger tendency to continue when the presenting problem involved family and/or social adjustment than when it involved school adjustment or achievement.

Our data tended to support Andrew's finding that parental self-referrals showed a considerable trend toward discontinuance while other referrals remained relatively interested in clinic service. In contradiction to our expectations, those families who gained their information about the clinic from friends or relatives showed a strong trend to discontinue while those who learned about it through publicity revealed a slight trend to continue.

A possible explanation for this might be that friends or relatives could have inaccurate knowledge of clinic services or when conveying information about the clinic could bring pressure to bear upon the parents to seek clinic help, which might produce a negative reaction. Publicity, on the other hand, could be a more accurate and neutral introduction to the clinic for these parents.

This area seemed to be closely related to the trend toward discontinuance of self-referrals and might indicate a need for motivational support for the parents from an outside source during the waiting period. When relatives' knowledge of the clinic contact had an encouraging effect upon the parents' desire for service, the family tended to continue, while discontinuance was noted when the relatives' effect was discouraging or when there was no effect.

Neither the length of time the parents waited between the point at which they became aware of the problem and the point at which they contacted the clinic nor their reasons for waiting more than one week to contact the clinic had a bearing upon continuance. The parents' telling or not telling the child of their referral had no effect upon continuance. Whether or not both parents agreed on the nature of

their child's problem or on the advisability of contacting the clinic there was no bearing upon continuance. All of these measures were designed to examine the effects of parental ambivalence on continuance, but the results were negative.

It was found, in support of Andrew's research, that families tended to discontinue if the child's presenting problem improved and tended to continue if there was no change or it became worse. A minority group (one-fourth of the parents in Andrew's study and a little more than one-third in ours) continued to want an appointment even though their child had improved.

It was found that environmental changes, if they occurred, had no effect upon continuance. While the majority of those cases which sought alternative services tended to discontinue clinic contact, numbers were too small to warrant any conclusions about a significant association with continuance. However, it is of interest that this trend is comparable to that reported in Andrew's study.

Parents who made efforts to change their methods of handling the child's problem after referral were more likely to want to continue with the clinic than parents

who did not make this effort. This was as expected and would seem to indicate greater perception and motivation on the part of the parents who made an effort to effect change in the problem themselves while waiting for clinic service. A majority of the families changed their method of coping with the child's problem. However, for only a minority of these families was the effect of change an improvement in the problem and the trend toward discontinuance. On the contrary, for most of the families the change had no effect or made the problem worse and they tended to continue.

A surprising finding was that more than three-quarters of the parents felt waiting for service had no effect upon the problem. Those parents who expressed negative attitudes toward having to wait for service showed a slight tendency to discontinue, while those who had a positive attitude showed no trend toward either continuance or discontinuance. On the other hand, the data did show that people who had been waiting between three and eighteen months tended to discontinue.

These findings are too fragmentary and inconclusive to permit positive generalizations. To the group that did the study they do seem to point, however, to some of the

complexities that are involved in motivation for clinic help.

It would appear that there is a minority group of parents who are strongly motivated, have a clear understanding of the nature of clinic service, and are ready to follow through on the original referrals, regardless of the waiting period and regardless of whether the child's problem may have improved while clinic service was being awaited.

For a majority of parents, however, motivation is not as clear or consistent. It is a much more transient phenomenon, subject to change on the basis of a variety of factors of which the most important is probably the degree of improvement in the child. It is always a question whether the people who drop out during the waiting period were too poorly motivated to have continued under any circumstances, or whether they could have benefited at that particular time although they were no longer accessible to help at a later period.

For at least some individuals, it seems likely that motivation is high enough at the point of referral to make the person accessible to help if help were to be available at that time. It is this group which justifies continuing efforts to improve screening procedures and to reduce waiting lists.

APPENDIX AND BIBLIOGRAPHY

Dear

Your child is on our waiting list for service from this clinic and we are interested in finding out how things are going since we last talked with you. As you know the demands for service are so great that we have to ask people to wait, often for a rather long time, before we begin to work with them.

We are very much concerned about this fact and we would like to review the situations of those people who have been waiting. Would you complete the attached questionnaire and return it to the clinic in the stamped envelope provided? This information will enable us to know more clearly the problems of those people who are waiting and to determine more about what kind of service they need.

We are sorry that we can't offer a definite appointment immediately but we want you to know we are moving as rapidly as possible to assist you. Your help with the enclosed information will be very useful for this purpose.

Thank you for your attention.

Sincerely,

Director

WAITING LIST STUDY

Please answer the questions below as fully as necessary in order that we may understand the intent of your comments.

Child's name_____
First Last

Is your child's problem essentially the same as it was when you first asked for an appointment?

____SAME
____BETTER (describe how)
____WORSE (describe how)

Who first suggested you contact the clinic? (physician, family service, school, friend, etc.)

Have you had any other kind of help with your child's problem since you contacted the clinic?

____No
____Yes

If yes, from what kind of person or agency (physician, private psychiatrist, family service, special class)? Explain as fully as you can.

Do you still want a clinic appointment? Yes _____
No _____

If "no," would you explain why not?

Is your need for service as urgent as it was when you first asked for an appointment?

Yes_____ More urgent____ Less urgent____

Why?

How old is your child now? _____ (age last birthday)

Thank you for providing this information.

PROPOSED INTERVIEW SCHEDULE

1. (For those who continue to want clinic appointment):

   On the questionnaire last summer, you indicated that you still wanted an appointment with the clinic. Do you still feel this way?

   (IF NO): a. What has happened to change your mind since you answered the questionnaire?

   (For those who no longer want a clinic appointment):

   On the questionnaire last summer, you indicated that you no longer wanted an appointment with the clinic. Do you still feel this way?

   (IF YES): What has happened to change your mind since you first contacted the clinic?

   (IF NO): What has happened to change your mind since you answered the questionnaire?

2. Why did you first decide to contact the clinic?

3. Did someone refer you? (IF YES): Who?

   (IF YES): a. Did you agree with their suggestion at the time? (If not, why not)?

   b. What was their idea of the problem? (Symptoms, diagnosis)

   c. How did you see the problem?

4. Had you ever heard of the clinic before you contacted it?

   (IF YES): What did you know about it?

5. How long did you wait to contact the clinic after you became aware of the problem? (length of time)

   a. Did you have a reason for waiting this long?

6. Did you contact other help before you contacted the clinic? (e.g. doctor, psychiatrist, minister or agency)

   (IF YES): a. Who?
   b. Were they able to help with the problem? (If yes, how)?

7. What changes in the problem have occurred since you first contacted the clinic? Has it improved, become worse or remained the same? (probe? in what way?)

   a. Has there been a change in the school environment? (different grade, classmates, teacher or school)

      When? (How long before or after you answered the questionnaire?)

   b. Have there been any changes in the membership of your family since your first clinic contact? When?

      Divorce_____ Separation_____ Death (who)_____
      Birth_____ Marriage_____
      Relative, friend or roomer moved in or out_____

   c. Has there been a change in parents' occupations?

      Occupation of husband at time of clinic contact:

      Now:

      Occupation of wife at time of clinic contact:

      Now:

      When did change occur?

   d. (If there have been any environmental changes): Have any of these changes had any effect on the problems which brought you to the clinic originally?

8. How old is your child now?

9. How old was (he) (she) when you first contacted the clinic?

10. Is (he) (she) your own child____, adopted___, step-child___.

11. Is your present (husband) (wife) the child's own (father) (mother)?

12. Can you give me an estimate of your family's average yearly income?

13. What was the last grade completed in school for: husband_____, wife_____, child_____.

14. Has there been a change in residence? When?

    a. (IF YES): Has this change affected the problem?

       How?

15. Did you contact another source of help <u>after</u> you contacted the clinic?

    (IF YES): a. What?
    b. How do you feel this help has affected the problem (improved, same or worse)? Why?
    c. What did they think the problem was?
    d. Did this source suggest you continue to seek clinic service____, discontinue___, didn't mention it___.
    e. Did this source feel that anything could help the problem? Explain:
    f. Do you think that anything can help the problem? (explain)
    g. Did someone suggest you contact this other resource? Who? Why?

16. Have you, as parents, changed your ways of coping with the problem since you contacted the clinic? (yes or no)

    a. What (is)(was) your principal means of coping with it?
       (Probe): Did you use discipline?
       What type?
       Under what circumstances?

Did you ignore it?
Did you ask someone else to help?
In what way
How do you handle the problem now?
(If there have been changes - why?)

17. Did you and your (husband)(wife) agree that your child (had)(has) a problem?

a. (IF YES): Do you both see your child's problem in the same way? (If not, how are your ideas different?)

b. (IF NO): Who felt there was no problem? Why?

18. Did you and your (husband)(wife) agree on contacting the clinic?

a. (IF NO): Who disagreed? Why? (Did they think there was no problem or that the clinic couldn't help?)

19. Did your child want to come into the clinic? Why? (If child didn't know about contact - why?)

20. Did any relatives know about your contact with the clinic?

(IF YES): a. Who?
b. Did they feel the clinic could help with the problem?
c. Was this encouraging or discouraging to you?

21. Would it have been possible for both parents to keep appointments with the clinic?

(IF NO): a. For whom would it have been difficult?

b. Why? (distance, time, occupational factors)

22. What expectations did you have of the clinic at the time of your first contact?

a. Did you expect to be seen immediately?

b. Did you expect a personal interview? with parents__, with parents and child___, just with child___.

c. What services did you expect from the clinic? (e.g. advice, discipline, treatment, referral)

23. Did the clinic meet your expectations?

(IF NO): In what way were you disappointed?

24. How long has it been since you first contacted the clinic?

25. How (do)(did) you feel about having to wait so long?

26. Did the clinic contact you while you were waiting?

27. Do you think they should have contacted you (more often)?

28. How was the waiting list explained to you?

29. What do you understand as the reasons for the existence of the waiting list?

30. Do you think waiting affected the problem? How?

(FOR DISCONTINUERS): Would you say that the waiting period has discouraged you from trying to get help for your child's problem?

(FOR CONTINUERS): We understand that having to wait so long is very discouraging. Some people give up in the process, but you haven't. Can you tell me why?

31. Do you feel there might be a better way of handling this situation? How?

INTERVIEW SCHEDULE CODE

1) 1. Continue
(1)

2. Discontinue
(1) improved
(2) alternative services
(3) one parent unwilling
(4) no longer a child

3. Indecision
(1) one parent unwilling
(2) problem recurring

2) 4. Behavior leading to initial contact
(1) School achievement
(2) School adjustment
(3) School phobia
(4) Legal misdemeanor
(5) Social adjustment
(6) Family adjustment
(7) Physiological illness
(8) Psychosomatic illness

3) 5. Source of referral
(1) visiting teacher
(2) teacher
(3) friend
(4) relative
(5) self
(6) clergy
(7) social agency
(8) psychiatrist
(9) other M.D.

6. Agreement with referral source on contacting clinic
(1) yes
(2) no

7. Agreement with referral source on nature of problem
(1) yes
(2) no

4) 8. Previous knowledge of clinic
(1) none
(2) publicity
(3) personal contact
(4) friends
(5) relatives

6) 9. Length of wait to contact clinic
(1) same day
(2) within one week
(3) one month
(4) 1 - 3 months
(5) 3 - 6 months
(6) 6 - 12 months
(7) over one year

10. Reasons for waiting more than one week
(1) hope of improvement
(2) contact other help
(3) no knowledge of clinic

7) 11. Help sought prior to clinic contact
(1) none
(2) school personnel
(3) clergy
(4) social agency
(5) psychiatrist or psychiatric agency
(6) other M.D. or medical facility

8) 12. Changes in problem since first clinic contact
(1) disappeared
(2) improvement
(3) slight improvement
(4) no change
(5) slightly worse
(6) much worse

9) & 16) 13. Environmental changes
(1) school
(2) teacher
(3) residence
(4) wife's occupation
(5) husband's occupation

9) & 16) cont.
(6) separation or divorce
(7) death
(8) birth
(9) reconciliation or remarriage
(10) special education

14. Effect of above
(1) improved
(2) no effect
(3) worse

10) 15. Age now
(1) 4 - 6
(2) 7 - 9
(3) 10 - 12
(4) 13 - 15
(5) 16 - up

11) 16. Age at initial contact
(1) 4 - 6
(2) 7 - 9
(3) 10 - 12
(4) 13 - 15
(5) 16 - up

12) & 13) 17. Relationship of child to parents
(1) natural child of both
(2) adopted child of both
(3) father's natural child
(4) mother's natural child

14) 18. Family income
(1) $0 - 3,999
(2) $4,000 - 5,999
(3) $6,000 - 7,999
(4) $8,000 - 9,999
(5) $10,000 - 11,999
(6) $12,000 - up

15) Education

19.	A.	father	1.	special ed.	4.	high
20.	B.	mother	2.	grade school	5.	college
21.	C.	child	3.	junior high	6.	beyond college

17) 22. Type of help contacted after clinic contact
(1) none
(2) school
(3) clergy
(4) social agency
(5) psychiatrist or psychiatric agency
(6) other M.D.

23. Effect of help
(1) improved
(2) no effect
(3) worse

18) 24. Change in methods of coping with problem
(1) yes
(2) no

25. Effect of change
(1) improved
(2) no effect
(3) worse

19) 26. Parents' agreement on problem
(1) agreement
(2) only wife sees it
(3) only husband sees it
(4) only one parent

20) 27. Parents' agreement on contacting clinic
(1) agreement
(2) wife opposed
(3) husband opposed
(4) only one parent

21) 28. Child's knowledge of clinic contact
(1) knows and is willing
(2) knows and is unwilling
(3) parents didn't tell - afraid of upsetting child
(4) parents unable to explain
(5) parents waiting for definite appointment
(6) parents hoping contact unnecessary

22) 29. Relatives' effect
(1) encouraging
(2) no effect
(3) discouraging

23) 30. Ability to keep appointments
(1) both could
(2) mother could not
(3) father could not
(4) both could not

24) 31. Expected to be seen immediately
(1) yes
(2) no

32. Expectations of service
(1) don't know
(2) advice
(3) treatment
(4) referral
(5) diagnosis only

25) thru 31) 33. Length of wait from clinic contact to now
(1) 1 - 3 months
(2) 3 - 6 months
(3) 6 - 12 months
(4) 12 - 18 months
(5) 18 - 24 months
(6) over 2 years

34. Attitude toward waiting
(1) accepting
(2) indifferent
(3) displeased

35. Waiting affected the problem
(1) improved
(2) no effect
(3) worse

36. Effect of waiting on attitude toward seeking help from clinic
(1) encouraging
(2) no effect
(3) discouraging

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