A COMPARATIVE STUDY OF PSYCHOSOCIAL CHARACTERISTICS OF PARENTS OF SIXTY FAMILIES WHO CONTINUED OR DID NOT CONTINUE RECOMMENDED TREATMENT AT THE LANSING CHILD GUIDANCE CLINIC

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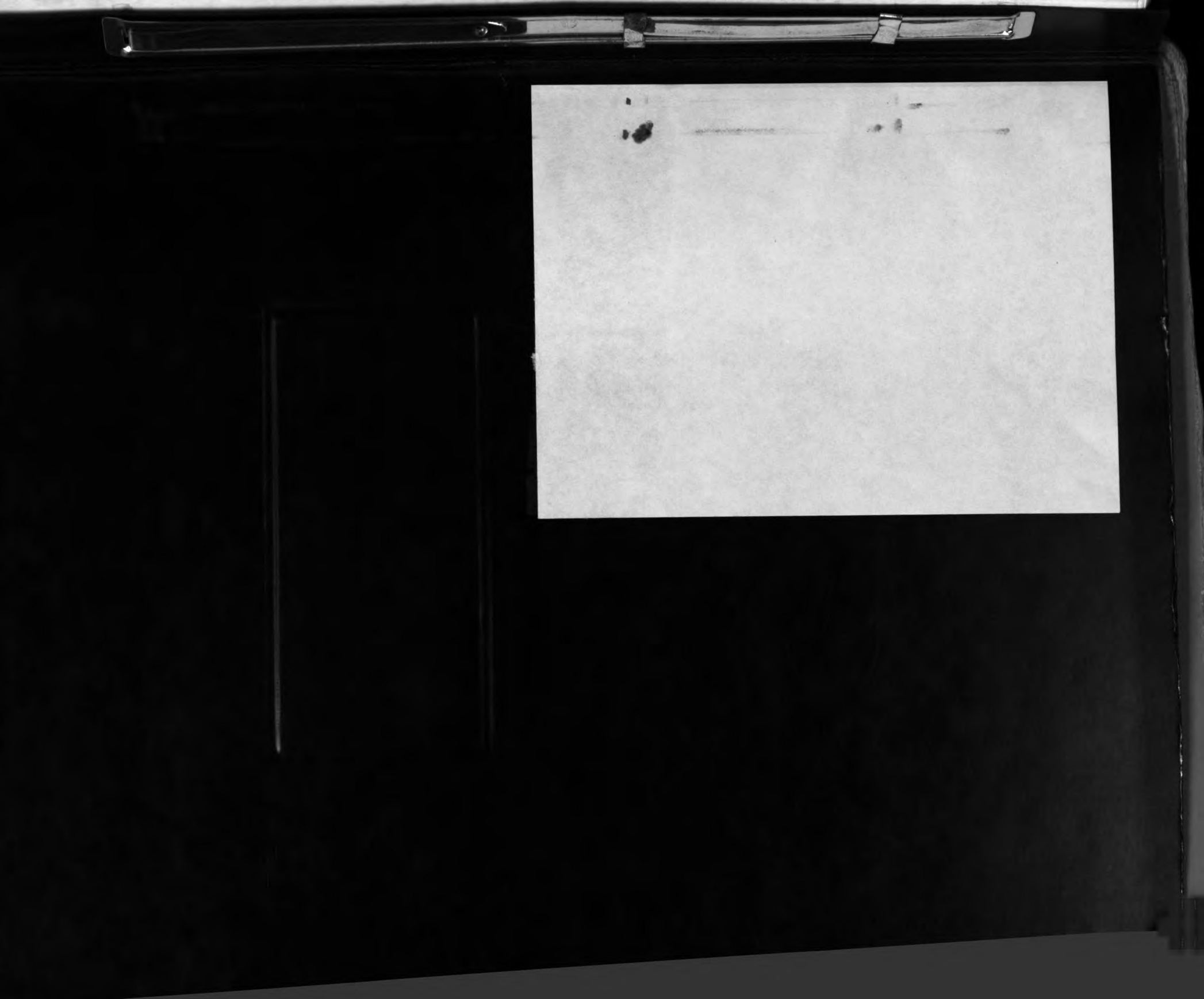
Marouf Hasain and Franklyn Wosek



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A PROJECT REPORT

Submitted to the School of Social Work, Michigan State University, in Partial Fulfillment of the Requirements for the Degree of

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CHAPTER I

INTRODUCTION

It is a well known fact that in both private and public agencies throughout the United States the demand for services far exceeds the supply of trained staff to meet this demand. In a highly complex society where demands for all kinds of services, not only social welfare, are great, there is a constant strain upon governmental sources and voluntary services.

A system of equitable selectivity as far as possible appears logical for those seeking social services, because for the present, at least, all those seeking social services cannot be served.

Sidney Koret and Barbara Harrington[1] pointed this out when they wrote:

> Therefore, it is suggested that some objective method of determining early in the course of contact certain persons are not going to be able to benefit from the services would be helpful. This would enable agencies to exercise greater selectivity in the choosing of cases and to utilize their personnel more effectively.

Knowledge of the parent-child relationship and better understanding of the complexities of this relationship are basic to this study. In view of this, the writers were attempting to look at and

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[1] Sidney Koret and Barbara Harrington, "An Objective Method for Prediction of Casework Movement", Social Work, Vol. 3, No. 4 (Oct. 1958), p. 45.

analyze factors which seemed to be associated with the relationship between parent-child relations and continuance or discontinuance in therapy in each case studied.

During the writers' experience at the Lansing Child Guidance Clinic, it was concluded that an exploratory study was needed to determine whether there is a consistent relationship between certain psychosocial characteristics of the parents and their decisions to continue or not continue treatment. It was hoped that such a study would contribute to the Clinic and to the field generally in the more skillful selection of cases. As a consequence, personnel would be utilized more effectively in meeting the acute demand for services.

The Lansing Child Guidance Clinic offers diagnostic and treatment facilities on an out-patient basis for children with emotional problems. Whenever possible, both parents and the child are seen in order to affect an adjustment in all concerned. Therapy of the child alone would be manifestly ineffective usually, inasmuch as normally the child returns to the family milieu. In general, the Clinic tries to improve and protect the mental health of children in the community by providing services and by being a participant in the community educational program that has as its purpose the promotion of healthy emotional development and recognition of emotional difficulties.

The Clinic has attempted to interpret its services to the community by various means. Through speeches to various groups by staff members, through staff conferences to which personnel of other agencies are invited, through its annual meetings with the coincidental reports, and through activity in community organization, the Clinic

has presented its program and policies.

The Clinic, formerly known as Lansing Children's Center, Inc., was opened in 1938 by the Ingham County Council of Social Welfare and became part of Michigan's Mental Health Program. This step followed a survey by the National Probation Association in connection with the prevention of delinquency, a pattern characteristic of the beginning of the child guidance movement in general. Its function was that of diagnosis and treatment of behavior and personality disorders of children, as well as prevention and education.[2]

At the present time, the Clinic is a joint state and local project supported by funds received from State taxes through the State Department of Mental Health and local sources. Examples of the latter are community chests, school boards, and boards of supervisors. The Clinic has an advisory board composed of citizens of the area served, which acts as a liaison between the community and the professional staff. The Board also assumes responsibility for the raising of local funds. Fees are not charged for services, although gifts to the Clinic by those served are accepted.

The Clinic serves the following four counties: Clinton, Eaton, Ingham, and Livingston.

The age range of children served is from birth to sixteen, or until graduation from high school

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[2]Marcella Jean Gast, "A Child Guidance Clinic as a Social Resource in a Small Metropolitan Community" (Unpublished Project for Master's Degree, Department of Social Work, Michigan State College, 1947).

The team approach, characteristic of child guidance, is utilized by the professional staff composed of a psychiatrist who is also the director, psychologists, and psychiatric social workers.

The chief psychiatric social worker is in charge of intake. Referrals received from various sources, i.e. parents, school, physicians, courts, churches, and social agencies are cleared through her. Only problems that seem to indicate that the child may have some emotional difficulty are considered accepted referrals. Other calls and requests are considered to be inquiries, such as one regarding a retarded child, and for the most part, are not recorded.

After the initial referral has been made, the procedure is to arrange an appointment for parents and child in accordance with the needs of the child and the Clinic's allocation of time. Although it is desirable to have the parents make the referral if possible, generally most referrals are made by parents upon the suggestion or advice of another person or agency. Since parents are encouraged to involve themselves in the study and planning for the child, it is deemed advisable that they take the initiative. To encourage parents to take the necessary initiative, it is the standard practice to see the parents. However, most referrals do come directly from the parent at the suggestion or advice of another person or agency. A psychiatric social worker is responsible for interviewing the parents to learn more about the child's problem and to gather information about his relationship and his general emotional and physical development. The child is seen by both a psychiatrist and psychologist for testing and evaluation. Following this, a staff conference is held for the purpose of reaching

a tentative diagnosis and making plans for helping the child. This conference includes not only the clinical staff, but also representatives of other agencies who have known the child. Following the staff conference, the parents and, whenever feasible, the child, are invited back to discuss the findings and recommendations.

CHAPTER II

REVIEW OF THE LITERATURE

The majority of studies related to the present study have indicated that no one factor is predominant in explaining why parents continue or discontinue treatment. Rather, there are indications that many factors operate together to discourage, frighten, or prevent parents from maintaining their contact with a clinic. Many theses from the Smith College School for Social Work indicate that discontinuance in child guidance clinics is often times related to parental attitudes toward the child and/or toward the clinic. Fears of association with a mental hospital or a clinic and misconceptions about clinic or agency function have been noted. In many cases conscious or unconscious resistance behavior is evident.[3] In one study, Eva Smigelsky[4] was able to discover some differentiating traits between parents who discontinue treatment on their own initiative and those who continued to termination of treatment. She found that those parents who accepted their child or unconsciously rejected their child tended to remain in

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[3]Edith Feldmad, "Why Children Discontinue Child Guidance Treatment", Smith College Studies in Social Work, Vol IX(1938), p. 27.

[4]Eva Smigelsky, "Why Parents Discontinue Child Guidance Treatment", Smith College Studies in Social Work, Vol. XIX(1949), pp. 118-9.

treatment, whereas those parents who openly rejected tended to withdraw from treatment. She also found that parents of pre-school children were more likely to discontinue contact with the Child Guidance Clinic than parents of older children. Her study indicated that the length of time a parent waited for treatment to be initiated was, in some cases, a contributing element in the parents' decision to discontinue. Generally, however, the waiting period became significant only when it was considered in relationship to the more important factors of the parents' attitude toward the clinic. Those parents who have confidence in the clinic and those who were able to express their anxieties about treatment in general were more likely to maintain their contacts.

The purpose of Ann P. Howell's study of twenty-four cases in which parents did not return to a child psychiatric unit for therapy was to determine whether the group has common characteristics which, when understood, would enable the unit to work with them more effectively during the intake process and at the time treatment was offered them. A schedule was formulated and filled out for twenty-four cases from material on file in the hospital and by questioning staff who had pertinent information concerning the cases. In addition to identifying information, the schedule covered four areas: 1) the nature of the presenting problem of the child and the clinic's diagnostic thinking about it; 2) the parents' personalities, problems, and attitudes toward help; 3) the plan the clinic made with the parents and 4) the overt responses the parents

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[5]Ann P. Howell, "Why Parents Did not Return to a Child Psychiatry Unit for Therapy," Smith College Studies in Social Work, Vol. XXVI (1956-1957), p. 120.

made when appointments for treatment was offered. The findings indicated that there were two groupings in terms of the mother-child relationships. The larger group consisted of controlling mothers, especially those exercising an over-protective dominion over their children. The smaller groupings was that of competitive mothers. It was suggested that each of these groups required specialized handling at intake responsive to their peculiar needs in the relationship with their children. The emphasis of the study was primarily on extending services to those parents during the intake process in a way which takes into account their special difficulties in seeking help in relation to their children.

Ruth Cameron[6] found that there were no significant differences between the mothers who discontinued treatment and those who continued with respect to the length of the waiting period, the similarity of sex, race, and religion of the mother and worker and the experience of the worker. The majority of the workers in both groups saw the etiology, personality, problems of the mother and the treatment recommendations as similar. The one area in which there were significant differences between the mothers who continued and those who did not was that of the conduct of the mother in treatment. A significant number of the mothers who discontinued were seen by the workers as overtly resistive, defensive or disinterested in treatment, and a significant number of the mothers who continued treatment were seen as interested in some kind of help for them-

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[6]Ruth Cameron, "Treatment Factors as Related to Discontinuance of Mothers in a Child Guidance Clinic", Smith College Studies in Social Work, Vol. XXVIII(1957), p. 63.

selves. There was no significant difference between the two groups with respect to seeking help for their children.

Idalynn Herzberg[7] found that when parents presented the problems of their children, they indicated primarily the precipitating features of their children's illness. Little self-realization of self-involvement by the parents in their children's problems was seen. It was also found that very frequently the parents' statement of the child's problem could be projected upon the children. The nature of the problems themselves were primarily passive with a minimum of acting-out behavior and could, therefore, be tolerated. It was found that when parental relationships were good, parent-child relations were good. When parental relationships were poor, parent-child relationships were sometimes good and sometimes poor.

Ernestine Baker Gerhard[8] explored one factor in a family's motivation for treatment at a child guidance clinic - the attitude of reasonable concern toward the child's problem on the part of both mother and father as rated by the examining psychiatrist. The definition used for parental attitude was whether both parents had come in for their individual interviews with the psychiatrists, as part of the diagnostic process at the Institute, and whether in the psychiatrist's

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[7] Idalynn Herzberg, "Why Clients Do Not Return After Intake Interviews", Smith College Studies in Social Work, Vol. XXVI(1956), p.62.

[8] Ernestine Baker Gerhard, "The Relationship of Parental Attitudes to the Offering and Acceptance of Treatment at a Child Guidance Clinic", Smith College Studies in Social Work, Vol. XXVIII(1957), p. 69.

opinion, the parents were "reasonably concerned" with the child's problem. Both items were readily obtainable on the case finding and the statistical cards at the clinic. The data used in the study showed that first, there were no significant relationship between the individual parental attitude of concern and the offering of treatment at the Institute. Secondly, the findings show a significant relationship between parental attitudes of concern and the family's acceptance when the concern was expressed by both parents and when they came into the clinic. The individual attitude of either parent, mother or father, did not effect a significant relationship to the family's acceptance of treatment. From these findings, speculations were made on the wisdom of considering not only the attitude of the individual parent, but also examining what the combined and reciprocal attitudes of the parents seemed to mean in the light of the family's motivation for treatment.

The purpose of Ann Schlussman's[9] study was to investigate those factors which enter into a parent's motives for not continuing with a request for help from a child guidance clinic. As a result of the detailed information obtained from each of the parents, it was found that they discontinued contact with the clinic because of a resistance to treatment which was based on conscious and unconscious fears, anxieties, wishes, needs and conflicts. Important factors in this were the parents' fear that the child was psychotic or mentally retarded and the pathological needs of the parent in relation to the child. The

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[9]Ann Schlussman, "Why Parents Fail to Follow Through With a Request for Help from A Child Guidance Clinic", Smith College Studies in Social Work, Vol. XXVIII(1957), p. 79.

parents still had ambivalent feelings with respect to seeking help at a psychiatric clinic and attempted to solve this conflict by means of the various defense mechanisms. The factor of a waiting period was frequently utilized in this way. In no instance did it represent a real reason for discontinuance of contact. Although psychological resistance to treatment was found to be a significant factor in a parent's failure to continue contact with a child guidance clinic, this factor is present even in those parents who do continue treatment. The author indicated that in the light of her study the significant question becomes one of difference between those parents who are able to accept psychiatry as a form of help and those who are unable to accept such help.

At present, attempts are being made in the theoretical realm to express and further explore the importance of the child-parent relationship in treatment at a child guidance clinic.

Rose Green[10] suggested that the thread of clinical work with parents in relationship to their children has been woven in several patterns. In the beginning there was a pattern of advice, suggestion and teaching which meant that there was manipulation of parents for the good of their children. There were problems and pitfalls in advice and persuasion; and many parents were unwilling or unable to be moved about "for the good of their child". The next step of direct psychological treatment of the parent as a person with his own problems, although not very rewarding, brought recognition of a concept

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[10] Rose Green, "Treatment of Parent-Child Relationships", American Journal of Orthopsychiatry, Vol. XVIII(1948), pp. 442-446.

which has been important ever since: the concept that a parent is a person in his own right.

Most writers in the field of child psychiatry seem to agree that the problem presented by the child is closely related to the neurotic patterns of the parents. Adelaide Johnson[11] and her co-workers have presented evidence that some disabling behavior in children, including anti-social behavior, represents a direct gratification of parental needs or has a demonstrable causal connection to such needs.

The mother-child relationship, communicated consciously and unconsciously, is believed by Marian Putnam[12] to play an important part in the child's life. The influence of this relationship, even if the two are separate, is recognized by the usual inclusion of the mother in diagnostic and treatment efforts. The interaction between a mother and her child is regarded both as a major source of child pathology and important route for treatment. She also points out that mother-child interaction as a source of pathology has long been the subject of clinical study.

Stanislaus Szurek, M.D.[13], believes that such authors as Lowery, Almely Dawley, Greig, Anna Freud, Silberpfenning, and Rogers, have clearly indicated the importance of the parent-child relationship in

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[11] Adelaide M. Johnson, "Factors in the Etiology of Fixations and Symptom Choice", Psychoanalytic Quarterly, Vol. XXII(1953), pp.475-496.

[12] Marian C. Putnam, "Notes on John I," Psychoanalytic Study of the Child, Vol. VI(1951), p. 53.

[13] Stanislaus Szurek, M.D., "Collaborative Psychiatry: Therapy of Parent-Child Relationships," American Journal of Orthopsychiatry, Vol. XII (1942), p. 511.

therapy. They have supported the theoretical concept that clinicians dealing with a child's behavior can only understand it in the context of intra-familial relationships.

A study of motivation, capacity and opportunity, as it relates to the use of casework service, is being presently considered by Lilian Ripple and her associates.[14]

The proposition being currently examined in this study is that the client's use of casework services is determined by his motivation, capacity and the opportunities afforded him both by his environment and by the social agency from which he seeks help. Her analysis to date, although not complete, indicates that the client's capacity for problem-solving and for use of casework help appears to be unrelated to continuance or discontinuance:

Among the motivational items discussed by Lilian Ripple, the following appeared relevant to this study:

1) The client's hope that the problem, as he defines it, can be resolved. Ratings of high hope were associated with continuance; low hope with discontinuance. But ratings of moderate hope were not associated with either.

2) The nature of the client's drive toward resolution of the problem as rated by the judge. If the drive is judged to be moderately or strongly in a positive direction, the client is likely to continue. Conversely, a rating of negative drive is associated with discontinuance.

3) The client's goal with respect to psychological equilibrium. It was found that those clients who sought some change in their way of acting were highly associated with continuance. Those clients who sought to retain their customary psychological equilibrium were not associated with either continuance or discontinuance.

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[14] Lilian Ripple, "Factors Associated with Continuance in Casework Services", Social Work, Jan. 1957, p. 87-94.

In summary, investigations reported have been undertaken to explore why parents have continued or discontinued largely in terms of face sheet data alone, or in studying the relationships, referral problems and continuance and discontinuance, or explored certain attitudes in relation to continuance or discontinuance. So far as it is known, no study has been found which has attempted to explore the same set of characteristics in relation to both continued and discontinued groups.

CHAPTER III

METHODOLOGY

SELECTION OF CASES FOR STUDY

The sample selected consisted of the first 60 cases referred to the Lansing Child Guidance Clinic in 1958; 30 of those continued and 30 of these who discontinued in treatment. In both the continued and discontinued groups acceptance of treatment was mutually agreed upon between parents and worker during the interpretive interview. The diagnostic study included a social history, psychological and psychiatric evaluations, staff conference notes, and the interpretive interview. Both groups were given notification of the first designated treatment date and those who did not continue, failed to appear for treatment.

PREPARATION OF SCHEDULE

The schedule was devised jointly by both students. It was divided into two main categories: 1) face sheet data and 2) parent-child relationships as measured by certain psychosocial factors. Face sheet data was selected because it was accessible and it is relevant to the total history of the case.

The face sheet included 13 items of information. These included: parents' age, religion, education and occupation; child's age, sex, and ordinal position in the family; problem for which the

child was referred, source of referral; lapse of time between referral and intake and interpretive interview. The lapse of time between the interpretive and the designated date of treatment was not recorded in those cases which did not continue. In some cases, identifying information regarding parents' age, religion, education, and occupation, was not recorded. Whenever possible, in such cases, the worker involved was consulted for information lacking in the record.

Parents' age was recorded in terms of years. Religion was classified into : Protestant, Catholic, and Jewish. "Education" was classified into the following items: below high school, high school, college and not recorded. In order that the categories for parents' occupation might be large enough to test for statistical significance, the census classification was extended to include as one category "white collar" and "professional". The category "blue collar" includes all non-white collar factory employees and those persons who did comparable work in other settings. Skilled and unskilled workers are generally classified separately; however, such a division could not be considered in this study as detailed occupational information was rarely available in the case records.

In regard to the child's age, the age intervals used were calculated to the nearest birth date. The classification used for recording the child's ordinal position was as follows: "oldest", "youngest", "inbetween", and "only". The reasons for the child's referral were based on the Michigan State Department of Mental Health Classification. This classification included the following categories:

1. Conduct Disorder - anti-social behavior, including truancy, stealing, defiance, running away, temper

tantrums, cruelty, overly aggressive, and sex offenses.

2. Habit Disorders - enuresis, nail biting, thumbsucking, masturbation and ticks.

3. Personality Problem - chronic unhappiness, pre-psychotic symptoms including withdrawal, day dreaming, depression, fears, anxiety, inferiority and poor social adjustment.

4. Learning and Developmental Problem - for educational disabilities, (such as slowness in academic learning or special subject disabilities)

5. Functional - any physical complaint with an organic condition outside of illness, such as blindness or anesthesia.

Classifications used for determining the source of referral were as follows: parents, school, court, physician, social agency, ministry, and self. In one case, a fifteen year old girl referred herself. In this case, the parents' were later seen for the diagnostic study.

Four items were selected to determine the parent-child relationship: 1) parents' mutual perception of the child's problem; 2) help expected as stated by parents at time of intake; 3) parents' attitude toward child; and 4) type of problem relationship.

Because there appeared to the writers to be significance in the parents mutual agreement that the child had a problem that required help, or the parents overt or covert disagreement, or the parents partial agreement, the classification used for determining the parents mutual perception of the child's problem was divided into two general categories: 1) some agreement and 2) little agreement. "Some agreement" was defined as mutual agreement or partial agreement that a problem exists and the child required help from professionally trained individuals. Many clinicians have stated that parents seldom see the child's problem

as it actually is or the reasons for it, but still some agreement is reached as to a need for therapy. "Mutual agreement" used here means agreement between the parents regarding the child's problem. "Partial agreement" as defined in this study, signified that one parent might well have recognized the child's needs while the other parent may not have done so, but acquiesced. "Little agreement" was defined as limited acceptance by one or both parents that a problem existed, or acceptance by neither one or both, or acceptance on the part of one but not by the other. To illustrate: some parents may agree that the child's behavior is not entirely "normal", but they add that he will outgrow this naturally. Some may refuse to face the fact that a problem existed at all and may be forced into acceptance of the Clinic's services by authority, i.e. courts or schools; or one parent might have forced the issue of clinical service for the problem he sees in the child while the other parent refused to see the existence of any real problem.

The category of "help expected" as stated by the parents at the time of intake, was considered important by the writers because of the need for direct involvement of the parents in any help for the child. Help expected by parents at time of intake was classified into the following categories: 1) to change the child in terms of his presenting symptomatology. For example, a child was referred for poor academic school achievement and for refusing to study. The worker, in this instance, stated "parents felt that the clinic could help the child through telling him how to behave in school and help him to realize

the importance of school". 2) parents sought help for their own problems and/or for help and understanding to modify their reaction to the child. For example, in one case a child was referred for her negativism and unwillingness to accept parental controls. In this case, it was recorded, "mother indicated the possibility that the child's negativism was the result of her constant attempt to discipline the child". This exemplified the mother's awareness of her involvement in the child's behavior and her need to further explore her own behavior in relation to her child.

Parents' attitudes toward the child were classified into four categories: 1) controlling, 2) rejecting, 3) over protecting, and 4) inconsistent. "Controlling" was defined as parents' need to rigidly structure the child to a specific pattern without considering the feelings and needs of the child. For example, in one case the worker stated, "parents feel that the child's behavior has improved, since they have 'cracked down'. The child is not allowed to participate in any activities unless he completes his homework...parents have tried sitting him on a chair, taking TV privileges away and talking to him as a means of controlling his behavior...mother feels that she has talked to the child for hours about his behavior and when she is through, he will go in the other room and then do the same thing over again. Mother seems to be quite concerned about the small issues, such as punishing him for not helping with the dishes and correcting him for table manners. The psychiatric evaluation reported that "excessive control was indicated by the child's reaction to authority figures".

"Rejecting" implied that the parent, consciously or unconsciously,

did not want or like the child. For example,in one case the child referred was the fifth oldest of seven children. His mother was pregnant at the time of the intake study. His father was known as an alcoholic who deserted periodically. Developmental history indicated: "At the time of this child's birth, father deserted and mother felt overwhelmed with all the family responsibilities...mother feels that with the exception of child referred, father's periodic absences has helped the other children to learn the meaning of cooperation and responsibility.....mother feels that the child referred is not an aggressive child and wishes that he would be a go-getter....he returns home late from school and sulks when he is asked to do his share of work. Mother feels that she cannot count on him". Paychiatric evaluation pictured this child as "an unhappy child who has the ability to give the impression of happiness, which is his defense against the under-lying insecurity and a deep feeling of rejection and a lack of understanding by everyone around".

"Overprotection" implies that parents read danger into situation where danger was remote, or where there was absence of objective danger as differentiated from the normally concerned parents. For example, the mother who continuously cried warnings to her nine year-old in relation to his capable "bike-riding" when the dangers were not real, was being over-protected. Again, when she learned that he had been exposed to measles in school immediately she became anxious, over-solicitious and attempted to find symptoms before they appeared.

"Inconsistent" refers to any combination of the three categories

described above. For example, one case record examined stated as follows: "The mother feels that she is never certain that she is doing the right thing. She feels that after she punishes the child she has done the wrong things and refrains from doing it the next time. She recognizes that this is not good, since the child does not know what to expect. She also recognizes that there are days when she is not tired as a result of work and is less apt to be grouchy. The child feels that the mother punishes him more than sister, and mother admits not knowing who to punish at times".

"The type of problem relationship" which was the second major category in the schedule, was divided into seven items: 1)child, 2) mother, 3) father, 4) child-father, 5) child-mother, 6) child-mother-father, and 7) father-mother. This classification was an attempt to designate the basic relationship origin of the child's pathology. For example, in one case according to the diagnostic study, the child behaved aggressively in all his family relationships. The basis of the child's generalized aggression, however, was the result of her relationship with her mother. It was determined that because the mother associated independence with aggressiveness, she could not tolerate her daughter's inclination for independence. This was considered as an example of a problem relationship where the child-mother relationship was regarded as the point of origin for the child's pathology. Another case example describing a mother-father-child problem relationship, is as follows: This child was known to have temper tantrums. "The mother feels inadequate in her role as mother and wife. She resents staying

At home all the time while the husband makes weekly out-of-town trips and is out practically every night of the week because of business. The mother treats her child harshly as a result of her feelings of being neglected and accuses her husband of lacking interest in the family".

The data was classified and tabulated by the hand sorting method. Some recognition must be given to the limitation of the data from which the findings and conclusions were drawn. First, the face sheet data differed from record to record. Further, the items pertaining to other than face-sheet information required the value judgment of the writers. To avoid the bias of value judgments in such instances, both writers independently read the record material and then discussed the items. To further avoid bias, one of the regular staff of the agency was requested to pull at random ten records, five from the group that continued and five from the group that discontinued and analyzed them as the writers did. In the ten records analyzed by the staff member there were forty possible answers. The results of this analysis revealed that the staff member and the writers disagreed on six answers. There were four occurrences of disagreement in regard to the group that continued and two occurrences of disagreement in the group that discontinued. There were three occurrences of disagreement in the parents' attitude toward the child category; two occurrences of disagreement regarding the type of problem relationship category, and one occurrence of disagreement in the help expected by parents at time of intake category. The results of this analysis indicate a minimum of bias and a relatively high degree of accuracy regarding consistency of agreement.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

For the purpose of presentation and analysis the data has been divided into two sections: 1) face sheet data and 2) data on the parent-child relationships.

Each writer analyzed his group independently, and a joint comparison was made of the two groups. In reporting the findings there will be no attempt to test for statistical significance. This was an exploratory study. Because of the many factors involved in the analysis and the small number of cases, tests for statistical significance were generally not applicable. The writers were interested in determining the patterns of relationships studied which might be suggested for future research. The findings are as follows:

FACE SHEET DATA

None of the parents who continued were over fifty years of age, whereas the group who discontinued included four parents over the age of fifty. The fact that the older parents discontinued might suggest lack of motivation. It is generally recognized that with the progression in age, the potential for change becomes more difficult. Since continuation in therapy implies the effecting of some change it is to be expected that some relationship between discontinuance in treatment and the older age category would be found. (See Table I)

TABLE 1

PARENTS' AGE IN CONTINUED AND DISCONTINUED CASES

Age	Continued		Discontinued	
	Fathers	Mothers	Fathers	Mothers
Total.....	30	30	30	30
Below 30.....	3	5	0	2
30 - 39.....	15	17	13	17
40 - 49.....	12	8	9	6
50 and over.....	0	0	3	1
Not recorded.....	0	0	5	4

Because one-third of the parents' religious denominations were not recorded on the fact sheets, it is difficult to draw definitive conclusions. The factor of religion did not seem to discriminate between the group who continued and the group that did not continue, as revealed in table 2. In all cases where religion was recorded, both parents and child were of the same religion.

TABLE 2

RELIGION IN CONTINUED AND DISCONTINUED CASES

Religion	Continued	Discontinued
Total.....	30	30
Protestant.....	19	16
Catholic.....	1	3
Jewish.....	0	1
Not Recorded.....	10	10

It was found that there was no difference between mothers and fathers

in regard to the level of educational background. There was a slight difference between the continued and discontinued groups in regard to those who had college education in contradistinction to those with high school education. Thirty-seven percent of parents who were college graduates continued and twenty-eight percent of parents who were college graduates discontinued. This is shown in Table 3.

TABLE 3

PARENTS' EDUCATION IN CONTINUED AND DISCONTINUED CASES

Education	Continued	Discontinued
Total.....	60	60
Did not finish high school.....	10	14
High school graduate.....	20	20
College graduate.....	22	17
Not recorded.....	8	9

In the group that continued there were more fathers who had professional or white collar occupation than in the group that discontinued. Conversely, there were more fathers in the discontinued group who were designated as having blue collar occupations. More than two-thirds of mothers in both groups were housewives. Of the few who were not housewives, those who continued were in the professional or white collar class, whereas those who discontinued, who were not housewives, were in the blue collar class. (See Tables 4 and 5)

TABLE 4

FATHERS' OCCUPATION IN CONTINUED AND DISCONTINUED CASES

Occupation	Continued	Discontinued
Total.....	30	30
Professional & White collar..	17	14
Blue collar.....	13	15
Not recorded.....	0	1

TABLE 5

MOTHERS' OCCUPATION IN CONTINUED AND DISCONTINUED CASES

Occupation	Continued	Discontinued
Total.....	30	30
Professional & White collar..	7	4
Blue collar.....	0	3
Housewife.....	23	21
Not recorded.....	0	2

Table 6 shows that there are more boys than girls in both groups combined. There is a disproportionately large number of the girls who continued. There are a greater number of girls whose parents involve themselves in treatment in the group who continue. It is speculated that there is more parental concern about the adjustment of girls. The larger number of girls who continued with treatment, may in turn be related to the findings that more girls were referred for "conduct disorders". This suggests that parents may tend to be more concerned about acting out girls than acting out boys.

TABLE 6

SEX OF CHILDREN IN CONTINUED AND DISCONTINUED CASES

Cases	Sex	
	Male	Female
Total.....	44	16
Continued.....	18	12
Discontinued.....	26	4

In the group that continued two-thirds of the children were younger than ten years of age. Less than half of the children in the group that discontinued were less than ten years of age. One-third of the children in the group that continued were over ten years of age and over half of the children in the group that discontinued were over ten years of age. This would tend to indicate that there is greater likelihood for the younger child to continue in treatment. It is speculated that there is a slight trend that parents who continue are willing to continue treatment while their children are of pre-school age. It is speculated further that it is more convenient for pre-school children to be brought to the clinic than for the school age children. There is a slight trend that the younger the age of the child, the stronger the trend for continuance of therapy. Home-centeredness of the child forces the parent to continue treatment. It is generally agreed that the pre-school child's world centers on its own primary familial relationships. It is suggested, therefore, that responsibility for any adjustment problem in the child occuring prior to the school age would be displaced, rationalized, or

projected with greater difficulty by the parent to sources external to the family. The fact that t ere is a greater occurrence of older children in the group that discontinued as compared to the continued group might suggest a greater resistance, for whatever reasons, on the part of these parents for a more objective evaluation of their participation in the child's difficulties. It is additionally speculated that there might be a greater resistance on the part of older children and they might prevail upon the parents to discontinue. The discussion of the data and related inferences were based on Table 7.

TABLE 7

AGE OF CHILDREN IN CONTINUED AND DISCONTINUED CASES

Age Frequency	Continued	Discontinued
Total.....	30	30
Less than 10.....	20	13
Over 10.....	10	17

In the group that continued there was a greater number of children in the oldest ordinal position than in the group that discontinued. One might speculate that the older the child the greater the pressure exerted on him for adaptation which is beyond his ego-coping strength. Conversely, the younger the child, both in position in the family and chronological age, the more protected he is from overwhelming pressures. The discussion of the data and related inferences were based on Table 8.

TABLE 8

ORDINAL POSITION OF THE CHILD IN CONTINUED AND DISCONTINUED CASES

Position	Continued	Discontinued
Total	30	30
Oldest	15	9
Youngest	3	5
Inbetween	9	12
Only	3	4

It is of interest to note that there were no learning and developmental problems in the continued group as compared with six children as so classified in the group that discontinued. The writers are raising the question of the significance of the learning and developmental problems. Many authorities agree[15] that factors such as greater intra-punitive trends and regressive trends are generally associated with learning and developmental problems. When this related to the data, namely that there were no children who were so classified in the continued group, but there were six who were so classified in the discontinued group, a suggestion is offered that the learning and developmental problems that appear in the discontinued group are the outcome of greater parental mishandling and/or traumatization of the children. The discussion of the data and related inferences were based on Table 9.

[15] Edward Liss, "Libidinal Fixations as Pedagogic Determinants", American Journal of Orthopsychiatry, 14(1944), 2, pp. 126-131.

TABLE 9

REFERRAL PROBLEM IN CONTINUED AND DISCONTINUED CASES

Cases	Conduct Disorders	Personality Problem	Learning And Development	Habit Disorder
Total.....	31	15	6	8
Continued.....	18	9	0	3
Discontinued.....	13	6	6	5

There was no appreciable difference between the group that continued and the group that discontinued in regard to the source of referral. (See Table 10)

TABLE 10

SOURCE OF REFERRAL IN CONTINUED AND DISCONTINUED CASES

Source	Continued	Discontinued
Total.....	30	30
School.....	12	14
Court.....	2	3
Doctor.....	9	6
Agency.....	0	1
Parents.....	6	5
Church.....	0	1
Child(self).....	1	0

The factor of time waited between the referral and intake interview did not discriminate between the group that continued and the group that discontinued. (See Table 11)

TABLE 11

TIME LAPSE BETWEEN REFERRAL AND INTAKE INTERVIEWS IN CONTINUED AND DISCONTINUED CASES

Months	Continued	Discontinued
1.....	5	7
2.....	9	5
3.....	4	4
4.....	2	4
5.....	4	3
6.....	0	3
7.....	1	0
8.....	0	0
9.....	3	1
10.....	1	3
11.....	0	0
12.....	1	0

There is a slight trend in the direction of a greater delay in the time interval between intake and interpretive interviews when the continued group is compared with the discontinued group. Conversely, there is a slight trend for the parents in the continued group to be seen earlier than the parents in the discontinued group. According to one study cited[16] in the literature, social workers generally have more difficulty in communicating acceptance and understanding to resistive clients. It may be speculated that the social worker sensing the lack of responsiveness to self-involvement in the parent, upon intake, may unconsciously defer the interpretive interview after the initial intake interview. The client, in turn, may have sensed the caseworker's attitude and reacted accordingly by becoming still more resistive. The discussion of the data and related inferences were based on Table 12.

[16] Sidney Love and Herta Mayer, "Going Along with Defences In Resistive Families", Social Casework, February 1959, Vol. XI No. 2, p.69.

TABLE 12

TIME LAPSE BETWEEN INTAKE AND INTERPRETIVE INTERVIEWS IN CONTINUED AND DISCONTINUED CASES

Months	Continued	Discontinued
1.....	19	17
2.....	9	6
3.....	2	5
4.....	0	2

PARENT - CHILD RELATIONSHIPS

There were a greater number of controlling parents in the discontinued group and also a greater number of rejecting parents. Conversely, there were more overprotecting and inconsistent parents in the group continued. It appears that neither of the controlling or rejecting parents have respect for the individuality of the child. Both parents who are inconsistent and overprotective might indicate more involvement with the child and in this way relate more to treatment. It is of interest that the controlling and rejecting categories account for twenty-five of the parents of the discontinued group, while it accounts only for fifteen of the continued group. In contrast, the categories of inconsistent and overprotective accounted for fifteen in the group that discontinued as compared to five in the continued group. A conceivable speculation might be that the controlling parent might view the greater permissiveness frequently recommended by social workers as a potent threat to his own adjustment in relation to the child. The greater degree of rejection reflected in the parents of the discontinued group

might be associated with the lack of adequate, h althy self-involvement with their child. The greater degree of inconsistency reflected in the continued group while reflecting a certain quality of conflict and helplessness in relation to the children, nevertheless, points to personal involvement in their children's lives. The appreciably greater number of overprotective parents in the continued group again may be a reflection that generally greater concern for the child, whatever the reason, tends to enable them to persevere in the treatment relationship. The discussion of the data and related inferences were based on Table 13.

TABLE 13

PARENTS' ATTITUDE TOWARD CHILD IN CONTINUED AND DISCONTINUED CASES

Cases	Controlling	Rejecting	Inconsistent	Overprotecting
Total..	26	14	8	12
Continued.....	10	5	7	8
Discontinued...	16	9	1	4

All parents in the continued group reflected at least some agreement in the child's problem, while almost a third of the parents in the discontinued group reflected little agreement. This might be related to the earlier discussion that the parents who show at least some agreement in the perception of their child's problem, also tend to offer one another mutual support that might in turn also contribute to the parent's capacity to sustain the treatment relationship. The discussion of the data and related inferences were based on Table 14.

TABLE 14

PARENTS' MUTUAL PERCEPTION OF CHILD'S PROBLEM IN CONTINUED AND DISCONTINUED CASES

Cases	Some Agreement	Little Agreement
Total	51	9
Continued.....	30	0
Discontinued.....	21	9

Table 15 shows that in the group that discontinued four times as many parents sought to "change" the child as compared to those who sought "self-help". Whereas in the group that continued almost half of the parents sought self-help. One might speculate that a greater self-awareness of one's own participation in the adjustment difficulties of the child is related to continuance or lack of it in discontinuance.

TABLE 15

HELP EXPECTED AT TIME OF INTAKE IN CONTINUED AND DISCONTINUED CASES

Cases	Change	Self-Help
Total.....	40	20
Continued.....	16	14
Discontinued.....	24	6

When there is a centering of the problem in the child-mother-father there is apt to be continuation of treatment. Where there is child-mother or child-father there is apt to be discontinuation of treatment. It is generally understood that a parent's ability to continue treatment may in part be related to the degree of ego support and

helpful participation, either directly or indirectly, he derives from the marital partner. One possible inference that might be derived from the greater number of children where the origin of the pathology was centered in either one or the other parent-child relationshipmmight suggest that there is a greater sense of isolation of the marital partners from one another. In turn this might heighten the need for marital counselling. The threat to the status quo of the relationship in these situations might contribute to the greater inability of these parents to continue treatment. Furthermore to the degree that the child's symptom meets the parent's own need, which he cannot satiate in the marital relationship, the parent would have difficulty in continuing treatment, unless there is successful marital counselling to dissipate the need. In other words, it might be inferred that the preponderant number of either father-child or mother-child relationships as the point of origin for the child's pathology might really point to a greater degree of marital breakdown in the parents of the discontinued group. The discussion of the data and related inferences were based on Table 16.

TABLE 16

FAMILY PROBLEM RELATIONSHIP IN CONTINUED AND DISCONTINUED CASES

Cases	C	C-M	C-F	C-M-F	F	M
Total.....	0	19	4	36	0	1
Continued.....	0	7	0	23	0	0
Discontinued.....	0	12	4	13	0	1

CHAPTER V

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

Thirty families who continued treatment and thirty families who did not continue treatment following completion of the referral and intake study of their child at the Lansing Child Guidance Clinic in 1958 were studied to determine whether there is a consistent relationship between certain psychosocial characteristics of the parents and their decisions to continue or not to continue treatment. Data secured from the face sheet of the record and the intake study were analyzed.

Certain findings appear to be clearly drawn at this point. The findings of this study seem to indicate that, in general, the level of education was higher in the continued group than in the discontinued group and that those in the professional or white collar category tended to continue treatment more than the blue collar group.

The findings also show that more boys than girls were referred and of the girls a disproportionately large number continued.

It was revealed that two-thirds of the children who continued were younger than ten years of age, which indicates that there is a greater likelihood for the younger child to continue in treatment. In regard to the children involved, it was shown, too, that the greatest number of children were in the oldest ordinal position.

In the continued group there were no learning and developmental problems as compared with six children so classified in the group that discontinued.

There was no appreciable difference between the group that continued and the one that discontinued as regards the source of referral. Nor was there any considerable difference in the time factor between the referral and intake interview and those who continued and those who did not. However, there was a slight trend toward continuance with those who waited a shorter period between the intake interviews and the interpretive interview than in the discontinued group. This leads to the recommendation to the Lansing Child Guidance Clinic that insofar as possible the interpretive interview follow as promptly as possible the intake, in order to better serve the needs of those who are referred.

The parent-child relationship analysis confirms the hypothesis of the writers' that the decision to continue or discontinue treatment was based primarily on this factor.

There were a greater number of controlling and rejecting parents in the discontinued group. Conversely, there were more overprotecting and inconsistent parents in the continuing group.

All parents in the continued group reflected at least some agreement regarding the child's problem, it was shown, while almost a third of the parents in the discontinued group reflected little agreement.

Interestingly in the group that discontinued, four times as many parents sought to change the child as compared to those who sought help for the child and themselves. Whereas, in contrast, in the continued

group almost half of the parents sought self-help.

It is concluded that family relationships, particularly marital relationships, were important to the continuance or discontinuance of treatment. Those who had some good marital relationships were more apt to continue.

The original hypothesis of the writers that the decision to continue or discontinue treatment is based primarily on the nature of the parent-child relationships has been supported. Certain other factors related to face sheet material have been observed and appear to be related to continuance and discontinuance of treatment.

It is recommended that in the future, face sheet data in the Lansing Child Guidance Clinic be filled out more completely. It is recognized that for many reasons this is not always possible, but it is helpful from many aspects. Further it is recommended that in any future studies of this nature larger sampling be utilized to ensure a greater degree of statistical accuracy.

Since this study suggests the importance of the parent-child relationship in continuance and discontinuance of treatment, it is recommended that the nature of the parent-child relationship should be closely examined to facilitate planning and continuance of clients in Child Guidance.

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APPENDIX

SCHEDULE

I GENERAL INFORMATION

PARENTS	MOTHER	FATHER
Age	_____	_____
Religion	_____	_____
Education	_____	_____
Occupation	_____	_____

CHILD Age_____ Sex_____ Religion_____

Ordinal position of child: Oldest___Youngest___Only___Inbetween___

Problem for which child was referred: _____

Source of referral:_____

Lapse of time between referral and intake interview: ____Wks.___Mo.

Lapse of time between intake and referral interview: ____Wks.___Mo.

II PARENT - CHILD - RELATIONSHIPS

Parents' mutual perception of child's problem:
Some Agreement_____Little Agreement_____

Help expected as stated by parents at time of intake interview:
To change the child in terms of his present
_____symptomatology.
Sought self-help for ones problem and/or sought
_____help to modify their reaction to child.

Parents' attitude toward child:
Controlling___Rejecting___Overprotecting___Inconsistent___

Type of problem relationship:
Child___Mother___Father___Child-Mother___Father-Child___
Child-Mother-Father___Mother-Father___