# AN EXPLORATORY INVESTIGATION OF CASES REOPENED AT THE FLINT CHILD GUIDANCE CLINIC IN 1952

by
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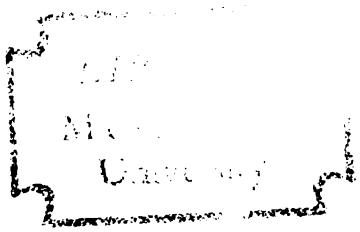

# AN EXPLORATORY INVESTIGATION OF CASES REOPENED AT THE FLINT CHILD GUIDANCE CLINIC IN 1952

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Ward Wayne Wood

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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November 1956

Approved: _____
Chairman, Research Committee

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Director of School

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I am especially grateful to the members of the Flint Child Guidance Clinic staff for their observations and suggestions as to the formulation of this study.

Finally I would like to acknowledge the assistance the typist, Mrs. Ann Brown, gave in establishing a degree of order to a paper that formerly had none.

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# CHAPTER I

## INTRODUCTION

In his second year field placement at the Flint Child Guidance Clinic the writer became progressively interested in the characteristics of the intake and consequent service given to the great number of referrals made to the clinic. Because the number of referrals exceeded by far the number which could be adequately processed the staff members were examining agency procedures to determine whether changes might be made to enable them to handle more cases. The writer was interested in this problem as he had observed some referrants which seemed to need immediate attention but due to the four to five week waiting period became discouraged and lost interest in clinical service. Also in a few cases it seemed that the problems were stated in words that indicated the parents' need and desire for help in correcting an upsetting situation. After a four or five week waiting period they did not respond to the clinic's offer of an appointment to clarify the situation. The reasons for such reactions can be as varied as the cases involved and are sufficiently comprehensive to entail an entire study.

In this regard the staff members of the Flint Child Guidance Clinic had long been wondering if there were any

# CHAPTER I

## INTRODUCTION

uniform characteristics in reopened cases. If these characteristics were known, they wondered, would the clinic be able to reduce the need for additional and possibly repetitive service. In this way the waiting list might be reduced. The interest in the nature of reapplications was expressed in questions of the following nature: Why was the case reopened? Was it for the same reason as the previous opening? Who requested the reopening of the case--the same person as at last opening or some other person? How much time had elasped since the case was closed? What type of service was given at the last opening--diagnostic treatment or testing? It was believed that the answers to these questions might indicate need for some modification of clinic procedure and perhaps furnish insight as to where and how the change should be made. It was hoped that extra time and duplicated effort could be minimized so that a maximum amount of time could be directed toward the processing of new cases.

Three hypotheses were formulated for this project: (1) Few cases are reopened for treatment. "Psychological Testing Only" is the primary reason for the reopening of cases. (2) When initial treatment has not included both the child and his parents, it is more likely that there will be need for "reopening" than when both parents and child have been included in the treatment services. (3) Cases carried on a continued casework treatment basis are less likely to be reopened than those which have received only intermittent services.

The first hypothesis follows the staff's belief that "Psychological Testing Only" is in a decided majority since it is standard procedure to retest infants and young children. It is not considered possible to ascertain their capacities reliably with just one occasion of testing. The second hypothesis is predicated on the assumption that if both parent and child are involved in the treatment process the treatment will be more effective and there will be less need to return to the clinic. The third hypothesis contains much the same principle of effectiveness but length of time is advanced as one of the necessary factors.

Dennis Brown, a staff member of the Flint Child Guidance Clinic carried out a similar project as partial fulfillment of the requirements for the degree of Master of Social Work at the University of Michigan. He described the characteristics of cases reopened at the Flint Child Guidance Clinic during 1954. In the present report the year 1952 has been selected in order to determine whether there is a clear trend or pattern in reopened cases during the two years, 1952 and 1954.

The setting for this study is the Flint Child Guidanc Clinic, which has been operated since 1946. A clinic had existed before 1946 for short periods of time but shortage of operating funds and/or lack of available trained personnel during World War II forced it to discontinue operations. However, in 1946 a group of Flint civic leaders were instrumental in aranging meetings with officials of the State Department

of Mental Health to have one of the joint state and community supported child guidance clinics established at Flint. The Flint clinic was established to serve, within the limitations of personnel, time, and distance, Genesee, Lapeer and Shiawassee counties. The services and functions have been described in the Flint Child Guidance Clinic By-Laws as follows:

(a) The diagnosis and treatment of children from birth to the age of sixteen, or until they have finished high school, who present emotional, personality, or behavior problems to themselves, their parents or the community.

(b) To counsel and aid parents.

(c) To work for the prevention of maladjustments of children through community education.

(d) To help children and parents by cooperating with social agencies and other community organizations interested in the welfare of children.

(e) To cooperate with the Department of Mental Health in the overall State Plan for the prevention of mental illness.[1]

Direct diagnostic and treatment services are offered to patients and consultation given to various community agencies in regard to the behavior problems of children who are of interest to those agencies and whom the agencies are attempting to assist.

Diagnostic cases are those in which the child and his parent(s) have been seen by the clinic to determine the nature

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[1]State of Michigan Department of Mental Health, "Program and Policy Statement" (Detroit, Michigan: 1952), pp. 2-4 (Mimeographed).

of the child's difficulty, but subsequent to the evaluation of the situation are not seen for treatment by the clinic. However, the clinic may make recommendations for the care of the child. Cases handled in this manner are for the most part accepted for "psychological testing only." In this situation a child is administered a psychological test to determine his intellectual operating level and potential capacity, and treatment is not considered. A recommendation is sent to appropriate agencies and interpretations of the child's functioning level are always given to the parents along with suggestions as to his handling.

A treatment case is one in which subsequent appointments are made for the child or parent(s) for the purpose of influencing a change in the child's reactions to his situation or through the parents effect a change in the situation. Often the parent or parents are seen to maintain an involvement in the child's problem but they are not interviewed for the purpose of providing personal insight. Sometimes only the parent or parents come regularly to the clinic since the child seems to be reacting quite naturally to a disturbing home situation. It is considered most effective however, in terms of a satisfactory readjustment of the relationship between the child and parent, to have the parents and child concurrently receive clinic services. One staff member may be involved in therapy with the child while another staff member usually has contact with the parent or parents.

When consultation service is given to another social agency the child and family are not usually interviewed by the clinic staff, but rather the consultation is offered on the basis of the information submitted by the agency concerned. Frequently the clinic and another social agency will work cooperatively. That is, the clinic will provide direct service for the child while the community agency maintains contact with the parent(s).

The clinic is primarily interested in prevention of behavior disorders, emotional disturbances, and mental illness. Prevention, more than any other function, is its reason for being. The founders of the child guidance program and the staff members of the clinic realize that this aim is not realized by the communities they serve. The clinic is trying through whatever media are available to educate people to use more effectively the service offered by the clinic. This process is an essential job; a prerequisite to effective social work practice and more markedly important in the area of prevention. Prevention involves an awareness of "warning signals." The parents, the teachers, and the community need to know what is a deviant behavior problem, what is abnormal behavior and not a "phase" in the child's development. The clinic tries to provide this knowledge by meeting with Parents and Teachers' Organizations, Child Study Clubs and many other groups, which might affect the mental hygiene care of children. The Flint Child Guidance Clinic has had to acknowledge that the pressure of current demants for treatment and

diagnosis of the more severely disturbed children has pushed prevention into the background. They have learned that education is a slow process which may at times show no progress but nevertheless is an extremely important function.[2]

In 1952 the Flint Child Guidance Clinic had a staff of one full time psychiatrist who was the clinic director, three psychiatric social workers, two clinical psychologists, and a mental health nurse. The three psychiatric social workers provided casework treatment to parents and children and in addition one functioned as casework supervisor. The clinical psychologists provided clinical treatment and psychometric services. The mental health nurse served primarily as liaison person between the clinic and the Public Health Departments of the three counties served, as well as being a teacher and consultant to the hospitals, schools, various associations for the retarded, blind, and other groups concerned with physical and mental health. The nurse was instrumental in organizing many of these groups. She also did incidental counseling to clinic patients and their parents.

In-service training was offered at the clinic for students of psychiatry, psychology, and social work with stipends financed by both the local community and the State Mental Hygiene Department.

The Flint Clinic serves three counties, Genesee, Lapeer, and Shiawassee in which there is a population of

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[2]Interview with Chief Social Worker, 4-1-55.

approximately 350,000. This area is highly industrialized with two automobile factories, Chevrolet and Buick located in Flint, Genesee County. Farming is more prevalent in Lapeer and Shiawassee Counties than in Genesee County, although the the farming is usually supplementary to the main jobs at the factories in Flint. This means two jobs, extra long hours and a fairly high standard of living so that one might find homes bereft of mutual activities but rich in household furnishings and clothes. There will be no attempt to prove or disprove this conjecture but it is believed that the factor of the father and sometimes the mother being absent because of employment may be significant in the development of problems brought to the clinic.

Thus this study of the cases reopened at the Flint Child Guidance Clinic in 1952 will focus on the characteristics of the cases to determine whether or not there are trends or patterns present in 1952 and 1954.

## CHAPTER II

## HISTORICAL BACKGROUND AND CURRENT OPINION

Although there is considerable literature about the child guidance movement and about therapy with children, the writer was unable to find any studies dealing specifically with the reopening of cases in child guidance clinics.[1]

The rise of the child guidance movement, which was largely a product of interest in preventive psychiatry, is usually dated from about 1921, when the National Committee for Mental Hygiene, backed by the Commonwealth Fund, entered upon a program for the prevention of delinquency.

The forerunners of this movement--in Chicago, Philadelphia, Baltimore and elsewhere--are well known, and some of the most distinguished pioneers both here and abroad made their contributions during the 1920's. A study identified eleven psychiatric clinics for children in 1919 and found 776 in the United States in 1939. These clinics for children were of many types, most of them closely following hospital models, others an educational pattern, and still further the "demonstration" type of clinic, described by Stevenson,

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[1]Major sources of possible information considered were Social Casework, Journal of Orthopsychiatry, Mental Hygiene, and Journal of Psychiatric Social Work.

Witmer and others.[2] The first demonstration clinics were set up in 1922 in St. Louis and Norfolk with the purpose of

> showing the juvenile courts and child caring agencies what psychiatry, psychology, and social work have to offer in connection with the treatment of the problem child, and by properly directed and effective methods of treatment not only to help the individual delinquent to a more promising career but. . . todecrease the amount of delinquencies.[3]

Stevenson and Smith record in detail the development of child guidance theory and practice during the demonstration period and later.[4] Out of their experience certain conclusions emerged which form the basis for much of the present child guidance work. One of the earliest policies was that which is now a basic principle: that child guidance services should not be limited to any one diagnostic group, such as delinquents or "pre-psychotics" and that services are most effective with children of adequate intelligence whose difficulties have not been of too long duration.

> The theory that clinics should find a means of distinguishing and then treating all maladjusted children was put to test in connection with a health survey in Monmouth County, New Jersey. There it was found by investigators that thirty-nine per cent of the children in the public schools needed further psychiatric study and treatment. A demonstration clinic unit, consisting of psychiatrist, psychologist and psychiatric social worker, worked in the county for about a year and showed conclusively that need for psychiatric help is not the only factor determining

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[2]Gordon Hamilton, Psychotherapy in Child Guidance (New York: Columbia University Press, 1947), p. 6.

[3]Lawson G. Lowrey, "The Child Guidance Clinic," Childhood Education, Vol. I (1924), p. 100.

[4]Stevenson and Smith, op. cit.

> amenability to treatment. The full implications of the failure were perhaps not seen at the time. Emphasis was put upon the magnitude of the problem and the lack of community facilities to carry out the treatment program, and the individual families' attitudes toward the treatment of the children were largely attributed to rural outlook rather than to variation in the desire for psychiatric help.[5]

Through the demonstration clinic experience clinic structure and policies were established which have been followed by most urban child guidance clinics since that period. Typically a child guidance clinic staff consists of psychiatrists, psychologists and psychiatric social workers in the ration of 1: 1: 2 or 3, and sometimes includes a pediatrician as well.

> The objective of such a clinic is held to be bettering the adjustment of children to their immediate environment, with special reference to their emotional and social relationships, to the end that they may be free to develop to the limit of their individual capacities for well balanced maturity.[6]

Child guidance clinic staffs no longer think primarily in terms of prevention but are interested in helping children with their present problems for the sake of present satisfactions. To this end the clinic offers its social, psychiatric, and psychological services to children and their parents and, in addition, usually carried on a program of education designed spread a knowledge of mental hygiene throughout the community.

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[5] Helen Witmer, Psychiatric Clinics for Children (New York: The Commonwealth Fund, 1940), pp. 52-53.

[6] Ibid., pp. 54-55.

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[5] Helen Witmer, Psychiatric Clinics for Children (New York: The Commonwealth Fund, 1940), pp. 52-53.

[6] Ibid., pp. 54-55.

For the most part such clinics receive patients through the medium of social agencies (including courts and schools) although referrals from parents are beginning to outweight social agency referrals in some clinics. The clinics tend to exclude from service or to give only limited service to children suffering from extreme mental defects or neurological handicaps and refer such situations to the community resources which are established for the case of such conditions. The methods of psychiatric and casework treatment used in the clinics vary considerably but few, if any, clinics confine their work chiefly to diagnosis.

## Related Studies

In Brown's study seventy-four cases were reopened.[7] Twenty-eight were reopened for "testing only" and forty-six were reopened for regular diagnosis and treatment. There was a ratio of thirty-three boys to thirteen girls in the diagnosis and treatment category. Also within this category there was only one negro child. While the negro population is not proportionally represented in the reopened cases of 1954 in the Flint Child Guidance Clinic it was found in a research report[8]

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[7] George Dennis Brown, "The Nature and Description of Cases Reopened in the Flint Child Guidance Clinic in 1954" (unpublished Master's thesis, University of Michigan, 1954).

[8] "Differential Utilization of the Facilities of a Michigan Child Guidance Clinic," Research Report No. 17, March, 1955, Michigan Department of Mental Health.

made for the Michigan Department of Health of the Lansing Child Guidance Clinic that " if the total area is considered the proportion of non-white clients does not differ significantly from the proportion of non-whites in the general population in the one-to-nineteen age group. That is, non-whites are neither over nor under represented in the clinic group."[9] It was found, however, that two of the six counties in the clinic area account for all the non-white clients. Thus, it should be said that even though non-white clients were not represented in proportion to the population in each of the six counties they were represented in proportion to the population when the entire six county area is used as the basis for analysis. The noteworthy fact that Ingham County, in which county the clinic is located, accounts for eighty-seven per cent of the clinic's non-white population raises the question as to whether or not accessibility through proximity is the cause for this representation. However, the issue remains that for the total area the non-whites were proportionally represented whereas in the two studies of reopened cases in the Flint clinic there wasnot proportionate representation.

At the reopenings during 1954 the cases were serviced in the following manner: twenty-one were schdduled for treatment; eight were referred to other community agencies; seven cases were scheduled for child treatment only if the parents followed through on the clinic's recommendations for

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[9] Ibid.

them to request assistance at other agencies for their particular difficulties; placement was recommended in four cases; in five instances the family failed to complete the diagnostic process; and one case was given consultation only.

Brown stated in his conclusions "that the greater number of the study children were either eldest or youngest in the sibling order" and that "the age range of the children placed them primarily in the latency to adolescent psychological growth periods." He felt that problems at these stages could be indicative not only of the youggster's confusions as they moved from one stage to another, but also to the parents feelings of their inabilities to understand and assist the youngsters as they begin to move from being quite childlike to a greater exploration of the desire for independence.

It was also noted by Brown that the majority of referrals came from sources other than the parents which gave some indication of the way in which the clinic is meeting the needs of the community as referrals usually reflect community knowledge of the clinic's availability and functions. He also considered that the fact that parents made as many referrals as they did demonstrated the satisfactions gained by the parents during the original contact and that if the parents had grasped the purpose of the clinic on the previous contact they would, theoretically, recognize earlier the re-emergence of a problem and hasten to use the available facilities to combat that problem. He also indicated that previous contact with the clinic might have had quite the opposite effect

upon the parents in that their increased awareness of their involvement in the problem could build a stronger resistance to returning to the clinic especially if their guilt feelings regarding the problem have not been resolved.

The theory or belief that cases which had been involved in the treatment process are less likely to be reopened was not substantiated or refuted by Mr. Brown's study. The results were inconclusive. This pattern was not startling because such a hypothesis assumes too many conditions to be considered in a study which is only concerned with it as a single aspect of a larger problem. What kind of "treatment" is presupposed is one question that might be asked. Psychotherapy, casework, relationship therapy, supportive therapy are "treatment" processes which seem to have different meanings to different people. An answer to the question of "what kind of treatment" is that the suggested processes are different depths of therapy adapted to personality and reality factors but with the same long range goal of a more satisfactory adjustment for the individual.

Diagnosis, as defined by Florence Hollis, is

> the attempt of the worker to understand the nature of the clients difficulty in order to offer him the kind of assistance most likely to enable him to improve his social functioning. One of the first broad questions to be answered when we begin working with a client is: Does this person's trouble arise mainly from inner or outer pressures? Is it due primarily to the situation in which he finds himself or principally to elements within his own personality

> which help in dealing with the normal vicissitudes of life?[10]

If the social situation is the primary cause of the trouble then the casework treatment deals with modifying or helping the client to modify the external situation so far as this is possible. However, if the trouble is primarily due to an inability to deal adequately with their social relationships because of an emotional disturbance there is a different focal point for treatment. Modification of the individual's feelings toward his social situation is the goal to be reached in this instance. Naturally neither internal or external sources of problems are mutually exclusive. Because of the importance of diagnosis to treatment any supposition as to the effectiveness or ineffectiveness of treatment should also consider the accuracy and completeness of the diagnosis. Treatment is definitely strengthened or weakened by the accuracy of the diagnosis. (Miss) Hollis felt that

> it is the difference between starting to build an unknown picture from a pile of jigsaw puzzle pieces and undertaking that same job with the knowledge that the puzzle is one of a half dozen with which one is already thoroughly familiar.[11]

There is another question regarding reopened cases and the treatment process in general which should be considered and that is how was termination of treatment affected. Did the agency play an active role in this process?

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[10]Florence Hollis, "The Relationship Between Psychosocial Diagnosis and Treatment," Social Casework, February, 1951, pp. 55-56.

[11]Ibid.

> Termination is a part of the total treatment process and with relationship as the medium of treatment, it follows that in a child guidance clinic, parent and child will inevitably move toward a new beginning apart from clinic support and dependency.[12]

The ending should be part of the beginning. The inclusion of the parents not only at the beginning of treatment but at the ending in terms of the support they give their children has an easing effect on the children.

> In cases where parental cooperation is enlisted from the first, every step for the child from beginning to end seems easier. . . . Where a child feels a parents' support in entering the treatment situation and has been given a positive and genuine reason for coming, his beginning may be many times more meaningful and he seems to present the inner problems in relationship more quickly and with a milder and more constructive type of anxiety. When a child is ready to end his therapeutic experience, the availability of parental support in reality makes the transition less painful and less time consuming.[13]

Very little has been said about termination in cases which are not responsive to treatment. This is an important area in efficient use of clinic time, recognition of limits, development of skills diagnostically and treatment-wise, appropriate and timely referral, protection to client and community. Planned termination which includes the parents' and the child'd thinking about what it will mean to them is essential because they need the opportunity to work through some of the conflicting feelings aroused by the planned separation from the clinic.

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[12]Clarice Platt, "Termination Planning in a Child Guidance Clinic," Journal of Psychiatric Social Work, Vol. XXI, March 1952, p. 125.

[13]John A. Rose, M.D., "Relation of Therapy to Reality of Parental Connection with Children," Journal of Orthopsychiatry, April 1949, pp. 351-357.

"Movement in the termination phase of treatment is characterized by the ambivalence common to all steps from beginning through ending."[14] Also within the termination planning period because of the tendency to compare past and present thinking there is much of a productive nature about the last few interviews. It is as if the parent or child is hurriedly taking inventory of his feelings before coming and while coming to the clinic as compared to his present feelings. There may be some fear that the present comfort can not and will not exist without the support of the worker he or she has been seeing. It is, therefore, well to know that future contact can be made at any time.

The foregoing discussion has attempted to delineate possible areas needing concentration in clinics and social work agencies in general. This has been done within the context of this study because it is felt that reopened cases are an indication of a need that was unmet during the original contact for various reasons.

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[14] Ibid.

## CHAPTER III

## METHODOLOGY AND PROCEDURES

The problem and the reasons for its selection have been presented in the introductory chapter. In order to have a sample which the writer could analyze within a feasible time during his second year in the School of Social Work a time factor of one year was selected. Since a comparison between this study and Brown's study of 1954 was to be made, the year 1952 was chosen to eliminate the factor of a different administration and changing policies.

In planning a procedure or method to test the hypotheses it was decided to use a schedule[1] similar to the one used by Brown to determine the predominant characteristics of the cases reopened in 1952.

The data were obtained from the clinic reports for 1952 and from the records of the reopened cases. The clinic reports provided the writer with the case numbers of all cases reopened in 1952 which permitted an investigation of all such cases when pulled from the files.

The writer's tabulation was done by the hand sorting method and the analysis was concerned with that which predominated or was most prevalent. There were no classifications

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[1]See Appendix.

of the writer's making, rather it was felt that a descriptive account of the data would be more helpful. In this respect too the analysis consisted of determining the prevailing pictures or trends if any were present.

Both before and during the organization and writing of this paper a search for related literature was made to document statements made in the study.

## Objectivity and Validity

The writer has some reservations as to the degree of success he had in meeting the criteria of "adequacy, validity and representativeness,"[2] The criterion of adequacy of documents for scientific investigation refers to the regularity with which they supply certain kinds of data, that of validity, to the correspondence to reality of the information that they contain, and that of representativeness, to their being chosen in such a way as to permit inferences to a larger universe. The rather arbitrary use of terms in situations which were not classified or categorized tended at times to make the collection of a certain type of information difficult and sometimes impossible without some personal judgment. For instance there was no consistent method of recording the reasons for closing a case and sometimes one reason sounded the same as another that was found to be entirely different. More extensive

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[2]Hilde Landenberger Hochwald, "The Use of Case Records in Research," Social Casework, (No. XXIII, February 1952), pp. 71-76.

research was necessary to clarify this point. The facts then were not adequate.

The size of the sample is a limiting factor as to its representativeness. The inferences made from the information in this study are not substantiated in sufficient strength to allow application to a more general universe. The problem is too specific in time and area--one year and only reopened cases as opposed to reopened cases in relationship to the total number of opened cases within the same time limit.

# CHAPTER IV

## PRESENTATION AND ANALYSIS OF DATA

### "Testing Only" Cases

In 1952 there were sixty-nine reopened cases, thirty-one of which were reopened only for testing purposes. Since the reasons for having the tests administered are not particularly relevant to the questions and assumptions of this study little consideration will be given to those cases. It was assumed that there would be a large proportion of "testing only cases" and this was verified to the extent that almost half the total population fell into that category. However, since interpretation of the test results is often a function of the social worker and therefore represents an expenditure of clinical time some aspects of these cases will be discussed. It may be noted that in 1952 there were sixty-nine reopened cases while in 1954 there were seventy-four reopened cases. Approximately two-fifths of the reopened cases in each of these years were "Testing Only" cases.

Most of the thirty-one youngsters were being tested because they were being considered for adoption either immediately or in the near future. Several were born out of wedlock, deserted, or placed for adoption by one or both parents who, for many and individualized reasons, felt unable to care for

them. For some of the children there was a question of organic brain damage and concomitant low mental capacity so that information was needed to aid in long range planning for them. This question was often raised by child placing agencies in which the workers and foster parents had only limited social histories and observation of the child's behavior.

For eight of the thirty-one children the boarding or adoptive parents were seen immediately after the testing to interpret the children's feelings and limitations and tosuggest ways of meeting with the youngsters for mutual satisfactions.

In the testing only group there were seventeen males and fourteen females which is a rather even distribution. For the first time tested their ages ranged from three months to nine years and the average age was four years three months. For the last time tested their ages ranged from thirteen months to fourteen years with an average age of five years eight months. Therefore there was an average length of time between the first and last testing of one year five months. Every child was seen more than once as Table I indicates.

TABLE I

"TESTING ONLY" CASES REOPENED IN 1952

| Times Tested | Number of Children |
|---|---|
| Total | 31 |
| 2 | 17 |
| 3 | 13 |
| 4 | 1 |

The average number of times a youngster was tested amounted to a fraction less than 2.50. This means that in the seventeen months average time between the first and last testing each child was tested on the average two and one-half times or once in a six and two-thirds month period.

A contributing factor to the number of times these children were seen was the fact that the clinic, in 1952, worked very closely with the Genesee County Association of Parents and Friends of Retarded Children. Many children were retested for the purpose of providing material for clinic discussions within this group.[2]

## Diagnostic and Treatment Cases

In 1952 thirty-eight cases were reopened for diagnostic evaluation and treatment of which twenty-four were male and fourteen were female. The preponderance of boys over girls being seen at clinics has been noted and substantiated in other studies concerned with clinic intake. George Stevenson and Geddes Smith noted that "the clinic tends to see many more boys than girls"[3] and Mary Ellen Lippink noted too that "out of the thirty-eight children in the study, thirty-three were boys and five were girls."[4] This proportion is similar

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[2]Interview with Dennis Brown, April 5, 1955.

[3]George S. Stevanson, M.D., and Geddes Smith, Child Guidance Clinics (New York: The Commonwealth Fund, 1934), p.56.

[4]Mary Ellen Lippink, "Reopened Cases in a Child Guidance Clinic For a Six Month Period" (unpublished Master's thesis for the degree of MSW, University of Michigan, 1951).

to that found in Brown's study where he had thirty-three males and thirteen females.

It may be noted that among these thirty-eight cases there was none of the Jewish faith. This may be explained by the small sample that is under study here but it might be significant when compared to the average number of Jewish people seen yearly. It would be interesting to know how the so-called minority groups are represented in the total clinical population. In eleven instances no religious affiliation was declared while seventeen were of the Protestant faith, denomination unspecified, and eleven were of the Catholic faith.

In Brown's study he found only one Catholic, none of the Jewish faith, and one who did not specify religion. It would appear that the reasons for the relatively low number of Catholic and Jewish parents and children might be explored to determine whether they had other resources or whether the clinic facilities did not meet their needs.

There were no Negro children among the thirty-eight children in our study group and this again directs the focus upon the question as to the clinical representation of the minority groups relative to their population ratio. This study indicates for the year 1952 in the Flint Child Guidance Clinic that Negroes did not reapply or were not referred for the second time to the clinic.

> It has been the opinion by the clinic staff, as well as the staffs of some other agencies, Family Service in particular, that Negroes have not availed

> themselves of many of the community services offered by various agencies, and that too often Negroes come to the clinic under pressure from the court for participation in some delinquent type of activity.[5]

If the clinic staff's opinion is an accurate assessment of the situation this could partially explain the lack of "recidivism" for the negroes in this study group.

In B own's study the same pattern could be distinguished as he found only one negro among the reopened cases.

Among the thirty-eight children there were only six who had no siblings; eight had one sibling, nine had two siblings, six had three siblings, four had four siblings, four had five and one had six siblings. Of the thirty-two children who had siblings thirteen were the "oldest" child, ten were the "second child" and eight were the "youngest child." Four were the "third child," "three were the fourth," and "two were the fifth child." Actually there were more "oldest" and "youngest" children than second, third, or fourth children as some of the "youngest" children had only one sibling so they were the "second child" which explains the slight numberical advantage in the "second child" category.

Brown also found that the oldest and youngest children predominated the reopened cases.

The youngest child at the original opening was two years old, the oldest child was eighteen with twenty-four of the thirty-eight children coming from the age group four through nine. In the ten through eighteen years of age

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[5]Interview with Chief Psychiatric Social Worker.

category there were thirteen children. There is a decided majority of children in this instance, who are entering or are in the "latency period" which evidently for these children was so "latent." The highest incidence of cases occurred in this age group as there were six children in this group.

The youngest child at the last opening was four years old, the oldest child was eighteen with a distribution of eighteen in the four through nine age group and twenty in the ten through eighteen age group. In comparison with the first opening it appeared that there was a more even distributinn in the last opening of the cases. This difference was to be expected since the same group is being observed on a longitudinal basis as is also the fact that the number of children eight years old had the highest incidence of cases. When the first and last openings were compared, the higher proportion of cases occurred in the "latency period," a time span of approximately five years in which the child is "at rest" after the stormy confusing years in which he has supposedly resolved the problems of socialization and identification in terms of both ego development and sexual identification. English and Pearson consider the latency period to exist from age "six to eleven and adolescence from eleven on."[6] At the last opening a slightly higher proportion ocurred in the adolescent period which, in

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[6] O. Spurgeon English, M.D. and Gerald H. J. Pearson, Emotional Problems of Living (New York: W. W. Norton and Company, Inc., 1945), pp. 133-270.

our culture, is generally accepted as a time of moodiness, high aspirations, restlessness, and fluctuating degrees of self confidence.

Children in the latency and adolescent periods were also in the majority in Brown's study.

Since it is recognized that the stability of the home has a profound influence on children's sense of well being or their lack of it some consideration was given to the marital status of the parents involved in this study. Twenty-one of the children had parents who were married and living together and mong this group there were no remarriages. Fifteen children had divorced parents but in four instances the mother had remarried. Two children had only one parent because their fathers had died. These are instances of complete separation of parents which is only one criterion of the stability of the home. Such a criterion only indicates those cases where the marriage partners have felt for their own reasons, that their marriage should be ended. It does not indicate in any way the relationship of those who have not separated. It is significant to note that with the four instances of remarriage following a divorce there are twenty-five children who have two parent figures in their homes. This is approximately a two to one ratio; (25-13) that is, there are almost twice as many children who have two parent figures than there are children who have only one. How this is reflected, if at all, on the children's problems will be noted later under the discussion of "referral problems." A relatively significant

correlation is expected between the happiness of children and the marital happiness of their parents. Terman suggests that there are two reasons for such a correlation:

> (1) The probability that happy temperaments are in part a matter of heredity, and (2) the equally strong probability that long exposure of the child to an atmosphere charged with tension and conflict between parents conditions the immature personality in ways which make any kind of social adjustment difficult.[7]

It would appear that Brown found more family disintegration than could be ascertained in the case records of the reopened cases in 1952.

The area which the Flint Child Guidance Clinic serves is primarily urban and highly industrialized because in Flint, the hub of this service area, there are two large factories manufacturing Buick and Chevrolet automobiles. Therefore, in such a community it is assumed that a major portion of the working population will be employed by industry and they will be "factory workers."

In our study group there is a high representation of "factory workers,"[8] as fifteen of those employed classified themselves as such. There was no specification of degrees of "skill" or titles applied to their jobs. Fifteen "factory workers" is a high percentage of our study group as there were only thirty-four cases in which occupations of parent was considered since four children were living in a small institution.

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[7] Lewis M. Terman, Paul Buttenwieser, Leond W. Ferguson, Winifred Bent Johnson, and Donald P. Wilson, Psychological Factors in Marital Happiness (New York: McGraw-Hill Book Co., 1938), p. 32.

[8] Factory worker designates that the parent is a skilled or semi-skilled worker in an industrial plant.

In seven cases it was indicated that both parents were employed; however, this fact was not specifically covered on the face sheets or other material which was examinéd so the actual number of cases in which both parents were employed was not determined. In general the occupations of the income earners were those that would place them in the middle class income brackets. The following table shows a slight decrease in white collar jobs.

TABLE 2

OCCUPATIONS OF INCOME-EARNER AT TIME OF ORIGINAL OPENING AND REOPENING OF TREATMENT CASES

| Occupation | Original Opening | Reopening |
|---|---|---|
| Total | 38 | 38 |
| Factory | 15 | 15 |
| "White Collared" jobs | 9 | 7 |
| Other | 9 | 10 |
| Unknown | 5 | 6 |

In similar manner the Brown's study demonstrated the high incidence of referrals of children of factory workers.

The answer to the question of "who sought help for these children" showed that the people who were closest by association to the child or are engaged in children's work either advised the parent to refer the children, or referred directly to the clinic. Mothers had the highest number of referrals at the original opening in that there were fourteen.

In only five cases were the fathers involved and only one request for service was made by a father without a mother. The number of parents who applied to the clinic at the last reopening of the cases increased from fourteen to twenty-six cases which means that twelve "re-referrals" still came from outside the home situation. This is shown in the following table.

TABLE 3

REFERRAL SOURCES AT ORIGINAL OPENINGS AND REOPENING OF TREATMENT CASES

| Source | Original Opening | Reopening |
|---|---|---|
| Total | 38 | 38 |
| Parents | 14 | 26 |
| School | 10 | 7 |
| Agency | 8 | 3 |
| Other | 6 | 2 |

Since it is believed that treatment will be more effective if the persons involved see a need for it this may indicate that in twelve cases a need was recognized which formerly was unrecognized or at least they now knew where to take their problems. The other sources of referral were social agencies, schools, and physicians. Teachers were the second highest source of referrals in both the original and the last opening. Actually their influence in getting the parent(s) to make application doubtlessly makes them a larger source of intake

than the numbers indicate in that they really are the initiator of the request. It is clinic policy to encourage the schools to suggest that the parents refer themselves to the clinic. Such a policy may decrease the number of school referrals. "School referrals to the Worcester Clinic were said to have declined because the staff often suggested that teachers request mothers to make direct referrals.'[9]

Brown also found that the parents and agencies tended to be the usual source of referral and that when cases were reopened it was usually the parents who initiated the contact.

Among the thirty-eight reopened cases there were three cases that were referred primarily for "testing only" because of suspected retardation and the attendant learning difficulties. They were reclassified as diagnoses and treatment cases when it appeared that an emotional problem was predominant to the extent that it was impairing the otherwise adequate intellectual capacity. The remaining thirty-five cases were referred because of behavior problems that indicated, to the referral source, an unusual degree of emotional stress.

The Flint Clinic uses the State Department of Mental Health code of classifying referral problems or reasons.[10]

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[9] "A Children's Clinic as a State Hospital Contribution to the Community," Bulletin of the Massachusetts Department of Mental Diseases, XI, p. 4-5, quoted by Helen Witmer in Psychiatric Clinics for Children (New York: The Commonwealth Fund, 1940), pp. 154-155.

[10] Michigan State Department of Mental Health, Code for Classifying Referral Problems.

There are four general classifications: Conduct Disorders, Habit Disorders, Personality Problems, and Learning and Development Problems. The behavior problems of all the children referred to clinics usually can be most aptly described by one of the four classifications although the children were manifesting symptoms which also might be included under other classifications. Behavior problems are described by the classification which most characteristically fits them. The problem behavior covered by those descriptive headings is listed below.[11]

Referral Problems

Conduct Disorders
- Truancy
- Stealing
- Defiance
- Running Away
- Overly Aggressive
- Sex Offenses
- Destructive
- Negativism
- Lying
- Fire Setting
- Sibling Rivalry

Habit Disorders
- Stuttering
- Nail Biting
- Scratching and Pinching of the self
- Hyperactivity
- Enuresis
- Feeding Problems

Personality Problems
- Withdrawal
- Depression
- Anxiety
- Inferiority
- Suicidal
- Fearful

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[11] Ibid.

Learning and Developmental Problems
- Slowness in academic learning
- Specific subject disabilities
- Mental retardation
- Slow development

At the end of the diagnostic period the referral reasons for the original opening and last opening were tabulated in the following manner.

TABLE 4

REFERRAL REASONS OF TREATMENT CASES

| Reason | Original Opening | Reopening |
|---|---|---|
| Total | 38 | 38 |
| Conduct Disorders | 18 | 21 |
| Personality Problems | 14 | 9 |
| Learning and Development | 4 | 2 |
| Habit Disorders | 2 | 6 |

A noteworthy fact is that in both openings the most frequent referral reason is in the category of conduct disorders, and that the number of such referrals increased rather than decreased at the last opening. It might be assumed that such diagnosis would predominate as long as there were more children in the latency and adolescent stages of development. It may also be due to the fact that the problem is not only the child's problem but a problem of the

people around him. Does the "problem child" constitute the largest proportion of referrals to clinics for emotionally disturbed children? This is only midly suggested by the few cases surveyed in this study since there is no difference in the number of referrals for "conduct disorders" compared to the number for "personality problems".

In 1954 it was found that conduct disorders also were the major cause of both the initial referral and the reopening. However, in 1952 there were far fewer learning problems than in 1954.

The stated reasons for originally closing the thirty-eight cases indicated that five were closed because of improvement, six were referred to another agency, Family Service or a Children's Institution, three had required only consultation, seven actually received testing services only and did not complete the diagnostic sequence even though it seemed indicated, one was closed after diagnosis, eight were closed because of untreatability and eight were closed because of uncooperativeness. Sixteen of the twenty-one treatment cases were closed because of untreatability and uncooperativeness whereas improvement was statedin only five cases. It seems reasonable then to conclude that the prognosis for the cases turned uncooperative and untreatable would be unfavorable; that it is probable that the clients may continue to be upset by the symptoms and may therefore reapply to the clinic. Therefore, some degree of predictability as to who will reapply may be possible.

The stated reasons for the last closing of these cases indicated that four had improved, eleven were not treatable, ten were not cooperative, five were referred to another agency, three received "consultation" only, one was referred for "testing only," and four were closed because further clinic service was not indicated. The latter statements referred to four cases in which a combination of environmental manipulation and consultation had affected a sufficient change in the child's life situation to enable him to make a satisfactory adjustment. There was some question on the part of the writer as to why these cases were not termed "improved" but the differences were not explained satisfactorily. A pattern is evident when the original and last closing statements are compared in that the "not treatable" and "not cooperative" reasons for closing the cases are in a decided majority. A comparison of the initial and last closures is shown in Table 5.

TABLE 5

DISPOSITION OF TREATMENT CASES

| Disposition | Initial Closure | Last Closure |
|---|---|---|
| Total | 38 | 38 |
| Progress | 5 | 4 |
| Consultation Only | 4 | 4 |
| Lack of Cooperation | 23 | 21 |
| Referred another agency | 6 | 5 |
| Further service not indicated | 0 | 4 |

Twenty-one of twenty-five "treatment cases" were closed for those reasons leaving only four cases that were closed because of "improvement." Many of the so called "treatment cases" were never involved in treatment interviews but are termed treatment cases because treatment was indicated and recommended to them. Only seventeen cases were actually involved in weekly interviews.

Because of inconsistent tabulation of the reasons for closings it was impossible to compare the 1952 and 1954 situations.

The average length of time cases were originally open for either treatment or diagnosis was four months with the longest opening being for twelve months and the shortest one month. The average length of time of service for the last opening was approximately six months with the longest opening being twenty-four months and the shortest two months. Those cases in which improvement was noted were open for an average of fourteen months.

The length of time between the first closing and the reopening ranged from one month to five years with an average of approximately twenty months between closing and reopening. The distribution is scattered as Table 6 shows.

Brown found the longest time between openings was eighty-four months with an average of twenty-five and one-half months.

In the initial closing there were nine cases referred to other agencies and three of these were referred to two

The stated reasons for the last closing of these cases ted that four had improved, eleven were not treatable, re not cooperative, five were referred to another agency, received "consultation only," one was referred for ng only," and four were closed because further clinic s was not indicated. The latter statements referred to ases in which a combination of environmental manipula- d consultation had effected a particular change in the e life situation to enable him to make a satisfactory ents. There was some question on the part of the writer hy these cases were not termed "improved" but the dif- s were not explained satisfactorily. A pattern is when the original and last closing statements are d in that the "not treatable" and "not cooperative" rea- r closing the cases are in a decided majority. A com- of the initial and last dispositions is shown in Table 5.

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agencies at separate times. Five of the nine referrals were made to the F mily Service Agency and one of these resulted in a subsequent referral to the outpatient clinic at Pontiac. Other referrals were made to the Neuro-Psychiatric Institute at Ann Arbor, the Juvenile Court, a children's institution and the Association of Parents of Mentally Retarded Children. The two referrals to the children's institution involved direct placement but the other three were referred to determine the possibility of placement. Placement, then, was considered the most beneficial change for five of thirty-eight children, however, placement might have been considered in more than those five cases if there were more possibilities for placement.

TABLE 6

LENGTH OF TIME BETWEEN CLOSING AND REOPENING OF TREATMENT CASES

| Time | Number of Cases |
|---|---|
| Total | 38 |
| Less than 6 months | 7 |
| 6 months less than 12 months | 4 |
| 12 months less than 18 months | 7 |
| 18 months less than 24 months | 4 |
| 24 months less than 36 months | 9 |
| 36 months less than 48 months | 4 |
| 48 or more | 2 |
| 1 not determined | 1 |

Of the thirty-eight cases, thirty-two were re-opened once, five were re-opened twice, and one was re-opened three times.

Twelve children were retarded in school, two were in a specialized education room and five were not in school at all. Of the last group three were diagnosed as mentally retarded, one terminated school when he was sixteen and one had been expelled for creating a disturbance in school. Thus, there was a total of nineteen children who were not performing satisfactorily in school. Half of the study group were experiencing some difficulties in school. Five of these, however, were intellectually limited and could not be expected to function in the usual classroom.

As stated before there were only seventeen cases in which treatment interviews were conducted upon their reopening. Of these eight were treatment cases involving both mother and child, as six children were treated alone and three mothers came for treatment without their children. At the original opening the number of mother and child treatment cases was the same as at reopening but some children were seen for treatment at the reopening for whom treatment had not been previously considered. For eight cases the same persons were involved in treatment.

The treatment goals in these nine cases where only the mother or only the child was treated are an issue to be questioned in terms of whether or not psychotherapeutic aims are met. Psychotherapy cannot supply 'real" parental relationships; it is a special technique applied within the living experience, but not as a substitute. It aims to strengthen the person's ability to deal with real life situations,

helping him to meet his own basic needs, both economic and affectional. Psychotherapy is designed to affect the total functioning of the personality. According to Dr. Nathan Ackerman it means a person to person relationship, with progressive exposure and dissolution of the pathological patterns of defense. It attempts to relieve the handling of resistance mechanisms.

> Concealed fears, hates and blunted pleasures must be exposed and the true self be given the opportunity to assert itself. The patient must be sufficiently freed from fears to participate in satisfying new experiences. The corollary is that in child guidance satisfying and constructive opportunities for new experiences in the family and in society must be made available, and the whole process must be therapeutically conditioned.[12]

It is questionable whether or not the six children seen alone will have the 'new experiences in the family and in society," however, it would be well to know what the problems of the six children were before concluding they could not derive any therapeutic benefit from being seen at the clinic. It would be interesting, therefore, to know what the clinic hoped to do for these children.

This chapter has shown that there is a trend suggested by the characteristics of cases reopened in 1952 and 1954. The similarities are as follows:

In both years "Testing Only" cases comprised two-fifths of the reopened cases. Also, there was only a very limited number of reapplications made by Negroes, Catholics, and Jewish people found in both studies. The youngest or

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[12]Gordon Hamilton, Psychotherapy in Child Guidance (New York: Columbia Univ. Press, 1947), (Chp. VI.), pp.123-4.

oldest child in the sibling order was referred more than the second, third, or fourth child in both studies. The majority of the children referred were primarily in the latency to adolescent period. "Conduct Disorders" as a reason for referral were in the majority at both the initial opening and reopening. "Factory workers" predominated as the occupation of the head of the household in both studies.

There were a few dissimilarities noted; namely Brown's study indicated a higher degree of family disintegration, and that learning problems were more prevalent.

# CHAPTER V

## SUMMARY AND CONCLUSIONS

### Summary

This study concerns "An Exploratory Investigation of Cases Reopened at the Flint Child Guidance Clinic in 1952." Questions were asked and working hypotheses were formulated to ascertain what characteristics, if any, were peculiar to the reopened case. Perhaps if certain features seem to be characteristic of the reopened case it might then be possible to predict and prevent some duplication of effort required in reprocessing a case.

Since the client's degree of motivation for seeking help is essential in his ability to receive it and utilize it the question "Who requested the reopening of the case?" was asked. The answer was interesting, especially when compared to the source of the original referral of the child to the clinic. It was found that on the original referral fourteen mothers had contacted the clinic whereas the second chief source of referrals was the schools which had made nine. Physicians, social agencies, and court authorities were the other sources of referrals. In only five of the fourteen referrals made by the mothers were the fathers involved, that is, the men came with their wives and children to the clinic.

Upon the reopening, the number of referrals made by mothers increased to twenty-six--an increase of twelve. The schools were still second in number of referrals but because it is clinic policy to encourage the school authorities to recommend that the parents make their own referrals it was believed that their influence was greater than might be indicated by the source of referrals. The number of referrals made by physicians, social agencies, and the court diminished proportionately. In fact these three sources of referrals contributed the increase to the parent referrals as those from the school remained constant. Since it is clinic policy to encourage all agencies to recommend that the parents refer their child the question of who referred the child becomes less an index of motivation than one of attaining involvement. The increase in parent referrals, which almost doubled those at the original opening, is rather remarkable if it really indicated an increased feeling of involvement in twelve parents.

Another aspect of the reopened case that was investigated was the question "Will the same persons be involved, mother and child for instance?" In eight cases the same persons were seen for treatment, that is both mother and child. However, the remaining nine cases seen for treatment at the reopening did not involve the same persons as the treatment cases of the original opening. In six instances only the child was seen while three mothers came alone to the clinic for treatment.

The question of the time which elapsed between closing and reopening was asked primarily to determine if the periods were short enough to indicate that the case had been closed without sufficient reason. Of course this factor would only be significant if the clinic had initiated the closure as too many variables would exist if the parents had terminated their visits and therefore the clinic service. However, in the latter instance the question of elapse time would still have some application. Would the parent who in actuality terminated the clinic's service by abruptly ceasing to come return as quickly as the parent who in agreement with the clinic ceased coming? The average time between closing and reopening was twenty months with the shortest time being one month and the longest being five years. Ten returned within less than a year, eleven returned in time ranging from twenty-five months to sixty months.

It is interesting to note that although an average span of twenty months existed between the original opening and reopening the same problems were predominatly stated in both instances. However, the factor of time/or the previous contact with the clinic had somewhat affected the nature of the problems. Conduct disorders and personality problems constituted the two main reasons for referrals at both the original opening and the reopening but personality problems as a reason for a referral decreased from a total of fourteen at the original opening to nine at the reopening. This compared to an increase in "Conduct Disorders" and "Habit

Disorders" as referral reasons at the reopening. "Conduct Disorders" referrals increased from eighteen to twenty-one while "Habit Disorders" referrals jumped from two to six. It is to be wondered what caused this change in stated reasons for referrals and was this an indication of "regression" in those youngsters who were first termed "Personality Problems" and then later termed "Habit Disorders"?

> Deviations in the earliest stage of the selfhood express themselves as habit disorders. If the baby does not get adequate mothering he is forced back to his own body for pleasure and attention and the ordinary thumb-sucking, masturbation, and other body play may be prolonged or intensified as 'autoerotism'--extreme physical indulgence having somewhat similar effects. The child thus forced to love himself prolongs his infancy, does not outgrow his infantile habits, which, if not treated, continue as part of the permanent personality structure.[1]

If the reverse had been true, that is a decrease in the "Habit Disorders" referrals and a corresponding increase in "Personality Problems" referrals at the reopening this would not have been surprising. This is a question which can only be speculated upon since insufficient detail as to treatment and diagnosis was available. Another noteworthy fact is the predominance of "Conduct Disorder" referrals and their increase at the reopening of the cases. This trend raises the question of how much "change" has occurred within the primary relationships because this disorder "will persist only when

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[1]Gordon Hamilton, Psychotherapy in Child Guidance (New York: Columbia University Press, 1947), (Chapter II), pp. 26-27.

there are severe parental frustrations, harshness, or lack of love for the child."[2]

The above observation becomes more meaningful when it is considered that only seventeen cases had been involved in treatment interviews and at the reopening not even the same persons were seen as was discussed earlier in this chapter. The service that was given at both the original opening and the reopening was primarily diagnostic. In twenty-five instances treatment was recommended but for eight children treatment never eventuated while nine referrals were terminated after diagnosis because of referrals to other agencies or "consultation only" was sufficient. Thirty-one of the sixty-nine cases reopened in 1952 were for "testing only." So in summation the service that was given to these sixty-nine cases was: "testing only" for thirty-one cases, diagnosis and treatment for seventeen cases, and diagnosis only for twenty-one cases.

## Conclusions

It was hypothesized at the start of this study that when initial treatment has not included both the child and his parents, it is more likely that there will be need for "reopening" than when both parents and child have been included in the treatment services. There were only seventeen treatment cases and of these eight included both child and

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[2]Ibid., p. 29.

parent and nine involved only one of the two persons. If this could be extended by induction it might be said that the results of this study tend to negate the hypothesis but this is not conclusive evidence owing to the small number of treatment cases. A much larger number of treatment cases would be necessary before a valid comparison could be made on which to base a conclusion having any general application.

The results of this study, inconclusive as they are, tend to make one wonder if the inclusion of both child and parent in treatment is the crucial issue in reopened cases because of other characteristics peculiar to them. The length and regularity of treatment for instance might have a more direct bearing on the likelihood of a case being reopened. This was stated as an hypothesis as follows: Cases carried on a continuous casework treatment basis are less likely to be reopened that those which have received only intermittent service. The study tends to substantiate the hypothesis in that only seventeen original treatment cases were reopened. However, there are too many questions unanswered, to state that"continuous casework treatment" will decrease the number of reopened cases. For instance it is now known that many of the reopened cases were better served by diagnosis, consultation or a referral to another social agency and so when this is considered one wonders if this study only indicates that fewer cases required treatment as compared to the other services of the clinic. The hypothesis would be supported more fully if it could be shown that cases carried on a "continuous

treatment" basis were in a minority when compared to those cases needing but not receiving treatment for different reasons. However, this information has not been demonstrated. Another questionable part of the hypothesis was the arbitrary use of the term "continuous" in that it placed treatment cases in two categories; those on a "continuous" basis as opposed to those not on a "continuous" basis, and no definition of the distinguishing term was given. Since the hypothesis was formulated to test the belief that fewer treatment cases would be reopened if the treatment were of sufficient regularity and length of time to affect improvement or change it should be restated to include those qualifications. It would read as follows: Fewer treatment cases will be reopened if the treatment interviews are of sufficient regularity and duration to effect improvement or change. This implies that the therapist and the patient terminate the treatment process since improvement or change is stated as a condition. The converse situation, that is, the treatment was terminated by the client alone, existed in the treatment cases of this study. Several were closed because of "failure to keep appointments" and untreatability" within a four month period. In actuality they were "treatment cases" in name only as treatment can not exist if there is no utilization of it.

The third hypothesis stated that it is believed that the largest single category of reopened cases is "Psychological Testing Only." This was supported by the fact that of the sixty-nine cases thirty-one were referred for "testing only";

a figure close to two-fifths of the total number of reopened cases.

The number of reopened cases in 1952 closely paralleled the number of reopened cases in 1954. There were seventy-four reopened cases that year, five more than in 1952. Also, the number of "testing only" cases in 1954 coincided with the number of such cases in 1952--twenty-eight to thirty-one. This similarity for the two years indicates a pattern of the probability of cases returned to the clinic. There is no control over the number of referrals made to the clinic and generally the referrals are scheduled for a diagnostic evaluation in the order of the date the clinic was contacted. So assuming there is little control over the referrals made to the clinic and the subsequent reopening of cases there then must be other selective factors contributing to the similarity in numbers for those two years.

A comparison of the facts found in 1952 and 1954 revealed other similarities such as the increase in referrals from parents at the reopening. The parent referrals at reopening almost doubled those of the original opening in 1954 which is greater increase than occurred in 1952 but still indicating the same trend. More significant perhaps is the similarity in the predominant complaint at both the original opening and reopening for both years. "Conduct Disorders" were the referral problem in the majority of cases at both openings in 1952 and 1954. There was also an increase at the reopening in the number of "Conduct Disorders" referrals for

the two years. So it seemed that during 1952 and 1954 the majority of the cases were returning with the same problem. It is to be noted also that there was a similarity in the relatively low number of cases involved in continuous treatment interviews, which factor in itself tends to point to a cause for the unresolved problem. Again it might be asked, "What kind of help did the parents want and how radically different was the help offered?" "Could the parents have been treated more effectively"? Of course there are many other factors to be considered. One might speculate on the fact that aggressive, mean, acting-out children represented the highest number of referrals in reopened cases for the two years. It seems significant to note that in the initial referral, as well as in the reopening, conduct disorders are in the majority. Why is this so? What are the distinctive differences in the problem of adjustment for those children and their parents that they should ask for help and not get it or use it? Is it the nature of the problem--the kinds of parents and children, the skills of the staff, or is it a combination of all these factors? Further clarification is needed in this area.

It would be helpful if further study might also be done in establishing whether the trends which the writer has observed might be consistent over the past decade. It might also be helpful if comprehensive research might be done concerning the diagnostic aspects as well as the treatment

provided to determine the differential factors between cases which return for future service and those which do not re-apply.

In conclusion, the writer has demonstrated:

1. That about two-fifths of the reopened cases are for "Testing Only."

2. That there is a consistent picture of more boys of the latency and adolescent periods referred to the clinic, and there are few Catholics and Negroes re-referred and that the oldest and youngest child seem to predominate in re-referrals.

3. That parents usually make the greatest number of referrals and that "conduct disorders" were the primary reasons were also substantiated. However, the writer found that in the Brown study there seemed to be a trend of greater learning problems than in the reopened cases of 1952.

The writer could not conclusively prove that the factors of "continuous treatment" status or parent and child participation in treatment were significant in the reopened cases of the year 1952 or 1954.

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APPENDIX

## Schedule

I. Testing only cases

1. Case number
2. Sex
3. Age when first tested
4. Age when last tested
5. Number of times tested

II. Diagnosis and Treatment Cases

1. Case number
2. Sex
3. Religion
4. Rate
5. Number of siblings
6. Place in sibling order
7. Maximum age at original opening and reopening
8. Minimum age at original opening and reopening
9. Average age at original opening and reopening
10. Marital status of parents at original opening and reopening
11. Occupation of head of household at time of opening and reopening
12. Referral source at time of opening and reopening
13. Referrals reasons at opening and reopening
14. Referal problems at opening and reopening
15. Disposition and reasons for closing at original opening and reopening
16. Length of time open for treatment at original opening and reopening
17. Length of time between closing and reopening
18. Reasons forclosing and who initiated same
19. Number of reopened cases taken on for treatment
    a. Parent(s)
    b. Child
    c. Other
20. Referrals to other agency
21. Number of time cases were reopened
22. Grade at time of first and last referral

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