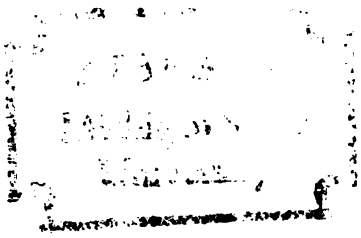
A STUDY OF COMMUNITY-CLINIC RELATIONSHIPS AS REFLECTED BY REFERRALS TO LANSING CHILD GUIDANCE CLINIC, APRIL THROUGH JUNE, 1955

M. MARIANNE MARIN



A STUDY OF COMMUNITY-CLINIC RELATIONSHIPS AS REFLECTED BY REFERRALS TO LANSING CHILD GUIDANCE CLINIC, APRIL THROUGH JUNE, 1955

by

M. Marianne Marin

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Director of school

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TABLE OF CONTENTS

LIST OF TABLES

TABLE PAGE

CHAPTER I

INTRODUCTION

The effectiveness of agency or clinic service is dependent on the relationships of the community resources as they work together with mutual health and welfare goals. A clinic, such as the Lansing Child Guidance Clinic with which this study deals, cannot stand alone in a community but must be integrated with the various social agencies and other community resources which make use of the clinic, and which provide the various types of services beyond the function of the clinic. This allocation of referrals requires that agencies understand one another and utilize facilities appropriately.

This understanding is gained largely through interpretation of services and functions. The importance of interpretation in its broad sense, and not in the special meaning which it has developed through its use in social work, cannot be underestimated. Some common, almost trite ideas regarding it prevail. For instance, an agency cannot live long without interpretation. There is an inevitable interdependence between interest and understanding as the resulting convictions lead to support and acceptance of the program. Indifference or expressed hostility on the part

of the public or other agencies may in part be the result of faulty or insufficient interpretation. Further, the best interpretation is good service, promptly and considerately rendered.[1]

In a democratic society social services are not imposed by the will of the state upon those presumed to need them, nor are they established in response to a demand from those who are to be the recipients alone, but from a much broader cross section of the community. This includes those who wish to see such services made available so that the community as a whole might be a better place for its members. These persons must be sufficiently convinced of the soundness of the program to be willing to see it maintained. In the case of a clinic, which receives its support from both state and local sources, there is a necessity of convincing the legislative body that it is a sound program so that adequate appropriations might be forthcoming. Further, it seems apparent that the standards of professional performance which can be achieved ultimately depend upon the degree to which they are understood and appreciated by those who furnish the support, as well as those

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[1]Anita J. Faatz, "Interpretation in the Public Agency," National Conference of Social Work Proceedings, Atlantic City, 1941 (New York: Columbia University Press), p. 685.

who receive the benefits.[2] Public understanding results essentially from policy, carefully formulated and followed.

Basically, it is the concepts of interpretation and understanding, and practice, with which this study deals.

The Problem and Its Selection

Several factors have raised interest currently in the clinic function, its service, and the understanding of the program. First, the increased use of the clinic in the last few years has made it impossible to meet the demands for service on a current basis and a waiting list has been established. Clinic records show an average per month of twenty-eight referrals in 1954, thirty-one referrals in 1955, and forty referrals in the first three months of 1956, a quarter usually with fewer referrals. The waiting list in itself raises questions regarding relationships between the clinic and those referring cases to it. Is the clinic better understood or is it being used more without understanding? Are schools, courts, social agencies, physicians and parents using the clinic appropriately or has it become a catchall for all types of problems? Because of the increase in caseloads, is an increased emphasis on the selection of caseload or limitation of intake a possibil-

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[2] Mary Clarke Burnett, "The Social Worker in Agency-Community Relationships," ibid., pp. 671-84.

ity? Should treatment, diagnosis or consultation be the main focus?

Further, from the writer's limited experience, there seemed to be a general lack of understanding regarding the clinic from parents coming to the clinic. Their conception generally seemed to be either very broad, e.g., "help," or limited, e.g., "advice." It seemed also that the general public, based again on the writer's observations, had little idea of the clinic and what it did, other than the fact that it helped parents with problem children. In this regard a survey or poll of the community's understanding in general was considered, but it would be a larger project than one might feasibly undertake in a few months' time. It seemed probable that this study might give a partial picture of the community's understanding of the clinic and the services provided.

Finally, interest was stimulated because of a recent survey of family and children's services in Lansing.[3] This survey, conducted by the Community Research Associates, Incorporated, included some evaluation of the clinic and its service to the community. The need for evaluation and re-evaluation is essential to progress and better service. It is the writer's opinion that this study, although limited

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[3]The survey was begun in the spring of 1955. Frank T. Greving, of Community Research Associates, Incorporated, 124 East Fortieth Street, New York, New York, directed the survey.

in scope, may supplement the survey by giving a more extensive and focused picture of the clinic's service. This opinion is based on the use of a larger sample and the consideration of all cases referred, not only a study of cases accepted for treatment. The survey, only briefly mentioned here, will be discussed more completely in the next chapter.

The problem considered in this study can be briefly stated as follows: there may be divergence between the referral source's understanding of clinic function and the clinic's interpretation of clinic function. Also, there may be divergence between clinic theory and practice. If this is true, it would tend to decrease or limit the understanding of clinic function by those who use it.

For the purpose of study the following questions, which contain the essence of the problem, were formulated:

1. What is the relationship between the clinic's stated function and the type of cases referred from the referral sources which are given service at the clinic? Stated otherwise, is there divergence between the practice of the clinic and the theoretically stated function of the clinic?
2. What is the relationship between the clinic and the referral sources in their understanding of

clinic function? Stated otherwise, is there divergence between the clinic and the referral sources in their understanding of clinic function?

3. What are the characteristics of those children who have been referred to the clinic and who have been served by the clinic?

Because of the writer's role as a student social worker in the Lansing Child Guidance Clinic from November 7, 1955, to June 10, 1956, data were obtained, with the clinic's permission, to attempt to answer these questions. Originally, the study was to be based solely on cases referred from social agencies during a year's period to determine clinic-agency relationships. After discovering that the number of referrals from this source, social agencies, was small and scattered among the many agencies, which would make any general conclusions virtually meaningless, the writer decided to study the more general picture of relationships between the clinic and all who were using it.

Data were collected by use of a schedule with case records as well as by contacts within the clinic. These data, which will be presented and discussed in a later chapter, pertained to three broad areas, namely, the child, the referral, and the clinic's plan. Sources of data in-

cluded: 1) the case record, specifically the face sheet, intake and interpretive interviews with parents, psychologist's report, psychiatric evaluation, and report of the staff conference; 2) contacts with clinic staff; and 3) published statements of clinic program and policy. Only cases of Lansing children referred to the clinic in the second quarter of 1955 were used in the study because of the necessity of obtaining a workable sample in terms of size.

In attempting to determine the relationships between the clinic and referral sources, some working assumptions were necessary. First, referral is a meaningful index of understanding, i.e., the type of case referred indicates to a great extent the understanding of the clinic by the referral sources. Second, statements regarding the clinic and expectation of help made at the intake interview are another index of the extent to which the clinic is understood. Third, decisions and recommendations of the staff, namely, the clinic's plan, are an index of the practice of the clinic.

The Setting

As mentioned previously, the study was undertaken in the Lansing Child Guidance Clinic. The clinic, located at 420 West Ottawa Street, is a former house and office build-

ing, which was adapted to clinic use. Each staff member has office and play space of his (her) own with a general waiting room, large play space in the basement, and a library for use by staff members. At the present time the professional staff consists of a full-time psychiatrist, a chief psychologist, a chief social worker, a psychologist, two social workers, and four student social workers completing their second year of professional training. In addition, there are an administrative secretary and a receptionist-typist, on a full-time basis. Because of lack of funds, volunteer workers are engaged to do some of the typing.

The Lansing Child Guidance Clinic is a clinic where families may go for help when their children have emotional problems. It provides psychiatric and psychological service as needed. In general, it tries to improve and protect the mental health of the children in the community by providing services and educating the community to understand the factors promoting healthy emotional development and to recognize signs of emotional disturbance. This has been attempted by talks to various groups with a system of rotation used to determine which staff member will speak. Also, the staff conferences are used to interpret the function of the clinic in an effort to assist other agencies in

understanding its function.[4] Annual meetings, reports, and participation on community committees are also a part of its interpretive program.

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 the state 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.

At the present time, the clinic is a joint state and local project supported by the State Department of Mental Health and local agencies, such as 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 professional staff. The board also assumes responsibility for the rais-

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[4]During the time period considered in the study, nine speeches were given to various community groups. One television program was devoted to the clinic. In thirty-nine of the fifty-six cases staffed during this time, fifty-nine people from other community agencies attended staff conferences. The majority of those attending came from the school.

ing of local funds. Fees are not charged for service given, although gifts to the clinic by those served are accepted.

The area which the clinic serves includes Ingham, Eaton, Clinton, and Livingston counties. Lansing, the largest city in the area, has a population of approximately 100,000 people. There are nearly twenty agencies which are related to children's services in the community. The total case load of the clinic in 1955, according to its statistical report, was 441 children. Of this number, 277 were new applications.

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

The team-approach, characteristic of child guidance, is used in the service of the professional staff, with the chief psychiatric social worker in charge of intake. Referrals received from the various sources--i.e., parents, school, doctors, courts and social agencies--are cleared through her, and only a problem which seems to indicate the child may have some emotional difficulty is considered a referral. Other calls and requests are considered to be inquiries, and for the most part are not recorded. Besides performing the functions characteristic of their discipline, each staff member carries approximately fifteen treatment cases; about one-half of their time is spent on treatment.

This increased emphasis on treatment is a relatively new trend in the Lansing Clinic and is due to an administrative decision to reduce the waiting list of those children waiting for treatment, which means an increase in the number of children who have been referred waiting for diagnostic studies. The average time lapse between referral and first contact in the latter case is now three months.

The usual procedure of the clinic after a referral has been made is to arrange an appointment for parent and child when time is available. It is standard practice to see the parent and have them make the referral if possible, regardless of the actual source of referral. For the most part, referrals do come directly from the parent at the suggestion or advice of another person or agency, because parents are encouraged to involve themselves in the study and planning for their child. Once appointments have been arranged, a social worker discusses the problem and the child with the parents. The child is seen for testing by a psychologist and for psychiatric evaluation by the psychiatrist. This is followed by a staff conference by the three members of the team, and may also include workers from other agencies, the court, or the school if this is indicated from the study and if permission to contact these sources is granted by the parents. At this conference, a diagnosis and recommendation are formulated on the basis of

the information received. An interpretive interview is then arranged with the parent and also with the child if he is old enough to make his own decision regarding treatment.

A summary of clinic function and practice as found in the Lansing Clinic will be presented in Chapter V.

CHAPTER II

RELATED LITERATURE AND CURRENT OPINION

Related Studies

Community child guidance clinics have only recently recognized their responsibility for research. For the most part, the few studies which have been published were done by state mental health departments or in clinics which were affiliated with universities. In the latter type of clinic, the research interest has for the most part taken the form of basic research into child behavior.[1] Research, as it exists in public clinics, is largely at a descriptive level and does not include applied research or program evaluation.

Although there is much written about the child guidance movement and about therapy with children, the writer was unable to discover much literature or many studies which considered specifically the problem of this study.[2]

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[1] An excellent exception is Gartland's survey of the services of the Child Guidance Clinic affiliated with the University of Chicago. She attempted to determine the value of psychiatric social service in a hospital setting. Ruth Gartland, Psychiatric Social Service in a Children's Hospital (Chicago: University of Chicago Press, 1937).

[2] Major sources of possible information considered were Social Casework, Journal of Orthopsychiatry, Mental

However, the Gast study, as well as the study by the Michigan Department of Mental Health, considers some of the trends in services of the Lansing Child Guidance Clinic.

Gast, a graduate student in social work at Michigan State College, made an exploratory attempt to discover what the role of the child guidance clinic was in the community.[3] Questions in her study related to the type of service most frequently sought, the problems the clinic endeavored to treat, and its success in dealing with these problems. Its purpose was to provide a background of knowledge on which to build a community interpretation program.

She considered 148 cases of children seen in the first six months of 1946. She found that social agencies and schools referred approximately three-fourths of the children. Types of service given were diagnosis and treatment, each accounting for forty percent of the total service given, and consultation, accounting for twenty percent. Seventy-eight percent of all children referred were boys. Behavior and personality problems accounted for forty percent of the problems. Contacts, in the form of conferences, were made in one-third of the cases.

Hygiene, Smith College Studies in Social Work, and Journal of Psychiatric Social Work.

[3]Marcella Gast, "A Child Guidance Clinic as a Social Resource in a Small Metropolitan Community (unpublished Master's Project Report, Department of Social Service, Michigan State College, 1947).

Gast concluded that:

> services offered by a child guidance clinic in a community cannot be duplicated easily in the community. Its concentration of purpose to help children and their problems meets a special need. Cooperation with other resources in the community through referrals and consultation is essential.[4]

A study of the utilization of the facilities of the Lansing Child Guidance clinic was made in 1955 by the Michigan Department of Mental Health.[5] The study was based on an examination of the rates of utilization for the five-year period, 1948-1952.

The hypothesis tested was that rates of utilization are a function of the distribution and composition of the population in the areas served. The primary assumption on which the study was based was that there are social correlates of behavior and these are related to the demographic, economic, and social characteristics of the population. Methods used included plotting addresses of the children of all cases closed during this period and relating these to census tract information, particularly in the metropolitan area. Also race, age, and sex of the cases in the sample

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[4] Ibid., p. 14.

[5] Michigan Department of Mental Health, Differential Utilization of the Facilities of a Michigan Child Guidance Clinic, Research Report No. 17 (Lansing: Michigan Department of Mental Health, 1955).

were related to the characteristics of the general population.

Findings disproved the hypothesis that rates of utilization are a function of population distribution and composition, although they may be factors. Accessibility to the facilities of the clinic and socio-economic status were suggested as additional factors in determining clinic utilization. This was based on the findings that rates of utilization varied directly with accessibility and that the composition of those census tracts with the lowest and highest rates of utilization were related to socio-economic status of the area. This was indicated by occupation, schooling, and housing characteristics of the areas served.

Another study relating to the types of children referred to the Lansing Child Guidance Clinic is being made by Wright.[6] She is attempting to discover whether the school tended to refer more aggressive or more withdrawn children. Findings to this point have indicated that there was no distinct difference.

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[6]Jean Wright, "A Study of School Referrals to a Child Guidance Clinic for the Year 1954" (unpublished Project Report, School of Social Work, Michigan State University, in process).

Other Related Studies

Maas, in collaboration with others in a study of socio-cultural factors in clinic services for children, attempted to learn about the families using existing clinics, how they use them and what they expect from them, as well as the outcome of services given.[7] Specifically, they attempted to determine if there are socio-cultural factors contributing to the differential use families make of children's psychiatric clinics.

A study was made in six clinics in Metropolitan New York and three clinics in the San Francisco area with a total sample of 654 cases. Findings indicated that fifty-four percent of the children seen were of elementary school age, with one-third being older. The ratio of boys to girls was two to one. The presenting complaint was aggressive reactions in one-fourth of the cases, difficulties in social adaptation in twelve percent, and a school learning problem in ten percent. Occupational status of the families showed the families were either of high or low status with fewest from the lower-middle group. Other determinants of status--namely, education, mobility, type of

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[7]Henry Maas and Others, "Socio-Cultural Factors in Psychiatric Clinic and Services for Children: A Collaborative Study in the New York and San Francisco Areas," Smith College Studies in Social Work (Vol. XXV, February, 1955).

housing--were described. Parents and medical resources referred the child in one-half of the cases, with school and social agencies each referring approximately one-fifth of the total number of cases. Over one-half of the parents expected the role of the clinician to be authoritative.

The authors concluded that socio-cultural factors do contribute to the type of families using the clinic and to the way they use it. However, the study also pointed to the fact that these factors were not emphasized in clinics and to the fact that this information was not utilized.

In the Lansing area, a survey of family and children's services is in process. The study, undertaken by the Community Research Associates, Incorporated, in cooperation with the Community Services' Council of Ingham County, was co-sponsored by the United Community Chest and the Board of Supervisors of Ingham County. It is an attempt to evaluate the services to families and children in this area.

Preliminary recommendations relating to the Child Guidance Clinic indicated that a merger with the Adult Mental Health Center into a Community Health Clinic may be advisable. It further emphasized the need for a clinic of this type to be a part of an integrated network of services in the community. It would have responsibilities to provide direct treatment service to cases which are reasonably

productive, consultation service, and carefully planned educational activities. An open intake policy should be maintained, with applicants seen on a brief interview basis to determine whether the cases might be referred to appropriate community resources. Consultative service should be given to the major agencies concerned with adjustment problems.[8]

Related Areas

There have been some attempts to determine understanding of various social services by community members.[9] Much has been written regarding referral to and from social agencies. Attempts have been made to clarify when referral is necessary and, through channels of interpretation and education, to increase understanding of the function and purpose of child guidance clinics.[10] Perhaps the fact that

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[8]Report of the survey committee to the combined boards of the Mental Health Center and Child Guidance Clinic, March 2, 1956. In a telephone conversation with a representative of the Community Services' Council on May 7, 1956, it was learned that the final report would be released on May 17, 1956.

[9]See Viola Paradise, Toward Public Understanding of Casework (New York: Russell Sage Foundation, 1948). An example is found in Myrtle Reul, "A Study of the Lay Opinion on the Family Service and Other Social Work Agencies in the Jackson Area" (unpublished Master's Project Report, Department of Social Work, Michigan State College, 1954).

[10]One example is Harold A. Greenberg, Child Psychiatry in the Community, A Primer for Teachers, Nurses, and

interest in these areas exists is a step toward good working relationships between community resources. When agencies become concerned with the fact that other resources and those whose support they need, understand their function, more effective service can be given to a community.

Current Opinion

Relationships between mental health clinics and family agencies in particular have been discussed frequently. Because overlapping of areas seems to exist, there has been much effort to distinguish between the two areas, to determine similarities and differences.[11] This is perhaps a part of the existing confusion between social casework and psychotherapy. Some social workers consider their responsibility to be psychotherapeutic treatment. Other professional clinicians question the validity of this practice. The most common opinion, however, seems to be that both are needed and can provide a different service. The family field and the mental health field must each find its re-

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Others Who Care for Children (New York: G. P. Putnam's Sons, 1950).

[11] See Lucille N. Austin, "Relationships between Family Agencies and Mental Health Clinics," Social Casework (Vol. XXXVI, February, 1955), pp. 51-59, and Mary Reeve and Lorna C. Brangwin, "Family Service Agencies and Mental Hygiene Clinics," Social Casework (Vol. XXXIII, May, 1952), pp. 193-97.

spective place in the total community effort. They must work closely together if the community is to receive maximum service from either field.

The relationship of school and clinic is also emphasized, because the school is in a position to recognize problems. Children spend much of their day in school. There are several trends. One trend is to establish the school clinic. It is considered rewarding that psychological and psychiatric services can be offered to parents as part of the educational experience of their children. Another advantage includes the exposure of the clinic team to the teacher's problems and the difficulties the child presents in the school room. All of the disciplines in the school setting become aware of the value of weighing the situation, of seeing the child as a totality because of clinic influence. Further, cultural factors, so evident in the school system, become a routine part of the clinic's consideration. The teaching of mental hygiene to both student and staff is facilitated.[12]

Another trend is closer working relationships between the school social worker and the outpatient clinic in the community. With this system, the school social worker

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[12]Rose Goldman, "Some Aspects of the Integration of School Social Work into the Clinic Team of a School System" (Journal of Psychiatric Social Work, Vol. XXIII, January, 1954), pp. 82-86.

often acts as liaison between clinic and school in helping a child with his problem. She assists in preparing both child and parent for referral if it is needed.[13]

Another opinion regarding the clinic's role in relation to the school has been proposed. The clinic team should provide consultative service to the school. This is because of the lack of clinics to meet the needs of all communities and the cost of maintaining such clinics. This consultation would not necessarily be through a school social work program, but would be an effort toward educating the staff of the school system to deal with maladjustments of children.[14]

Because the clinics are not able to meet needs immediately, long waiting lists are common. Suggestions have been made to deal with this problem. The Guidance Center of Buffalo has attempted a differential approach to intake and the waiting list.[15] They have found that this type of approach results in the emergence of three groupings for potential treatment: 1) parent consultation, 2) continued

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[13]Philippa Eggleston, "The Role of the Clinic Social Worker in Relation to the School Child," Ibid., pp. 86-90.

[14]Keith J. Perkins, "Consultation Service to Public Schools by a Mental-Health Team," Mental Hygiene (Vol. XXXVII, October, 1953), pp. 585-95.

[15]David Hallowitz and Albert V. Cutter, M.D., "Intake and the Waiting List: A Differential Approach," Social Casework (Vol. XXXV, December, 1954), pp. 439-45.

work with parents only, 3) full treatment of parents and child. As a rule only those cases in the third group are placed on a waiting list. In 1953, this latter group comprised fifty-four percent of the cases which were seen for intake. Approximately one-third were placed in the first group, where service was characterized by periodic interview and follow-up contacts, and where the child's problem seemed to be reactive behavior to parents or the family situation. The second group, intensive work with parents only, presents deeper conflict in the parental relationship or in the parent-child relationship, but the child's problem had not acquired enough depth to require treatment and would seem to disappear in time if the parents could resolve their problems. The characteristics of the third group requiring full treatment are internalization of the child's problem and less emotional health and strength on the part of the parents.

Other suggestions regarding selection of cases for continued treatment exist, most of them stressing the need for skill in selectivity.

Another area of divergence between child guidance clinics seems to be related to function. Although theory in general has been relatively constant since the beginning of the chill guidance movement, different clinics at different times have had different philosophies and policies.

Some clinics are diagnostically oriented, while others consider themselves treatment-oriented. Still others feel their main responsibility is to offer consultative service to the various community resources. Because the orientation of any one clinic seems to be largely determined by its administration, one may expect that function would be changing. It can only be hoped that the total community is considered in determining the orientation of the clinic. This need again points to more effective service to the community, toward understanding and sound relationships between clinic and community.

CHAPTER III

METHODOLOGY AND PROCEDURES

The statement of the problem and reasons for its selection, as presented in the introductory chapter, suggest the basic methodology and procedures used in the study. The steps taken to complete the project can be outlined as follows:

1. Reading, informal contact, and observation
2. Selection of problem and sample
3. Construction of a schedule
4. Collection of data
5. Classification, tabulation, and analysis
6. Organization and writing

Reading, Informal Contact, and Observation

Before and during the course of the study reading pertaining to child guidance and to related studies was done. Also informal contacts, i.e., an interview with the chief psychiatric social worker and regular contact with the clinic staff throughout the school year, helped the writer in understanding the practice and function of the Lansing Clinic.

Selection of Problem and Sample

Soon after joining the clinic staff, the writer became interested in the problem of clinic understanding and

practice. In selecting the specific problem interest was focused directly on clinic-agency relationships. The study was limited to children with a Lansing address in order to limit the group to those children who might be referred from or to Lansing agencies. The number of children was established on the basis of the clinic's cards containing basic information and a record of diagnostic interviews on all referrals.

In order to have a sample with which the writer could work in the limited period available for research, the second quarter of 1955, April through June, was selected. According to the chief psychiatric social worker, this period was typical. Also it was more certain that these children, rather than those referred at a later date, had been seen for diagnostic studies at the clinic. At first it seemed that referrals in this time period may be influenced by the fact that it was the end of the school year, which may have meant many school referrals to determine promotion. Although it was one of the quarters which generally has the largest number of referrals (with only the last quarter having more in 1955), it seemed to be fairly representative of the entire year and previous year in terms of source of referral of cases opened for service. This fact is illustrated in the following table, which shows that the sample may be slightly higher in school re-

ferrals as expected, but is least representative in the social agency and court referrals.

TABLE 1

CASES REFERRED TO THE LANSING CHILD GUIDANCE CLINIC IN 1954, 1955, AND IN THE STUDY SAMPLE BY SOURCE OF REFERRAL

Source of Referral	1954*		1955		Sample**	
	Number	Per cent	Number	Per cent	Number	Per cent
Total	291	100.0	277	100.0	47	100
Parents	107	36.8	121	43.8	18	38
School	65	22.3	62	22.6	12	25
Physicians	44	15.2	34	12.4	6	13
Social agencies	43	14.8	25	9.3	7	15
Court	32	10.9	35	11.9	4	9

*1954 totals include statistics of Jackson branch of clinic also.

**Since sample is less than 100, percent may be inconclusive.

After it seemed possible to use this sample, a list of cases was made. Case records were pulled from the memo file. This is the file containing records of children who have not been seen because of unkept appointments or because consultation was offered. The writer, again using the list of names of the children in the sample, went through the active file, those cases open at the present time, to determine which records were located there. The

remaining cases in the sample were then known to be in the closed file, those cases which have been seen at the clinic but which were not active at the time of the study.

Schedule

After the cases were located, a schedule was constructed and consisted of three main areas: 1) Identifying information, 2) Referral, and 3) Clinic Plan (see Appendix A).

The identifying information was essential to give a description of the children referred to the clinic and also was essential in relation to the sources of referral. This gave an idea of the type of child referred in general by each source of referral. This area included the following factors:

> Age, sex, race, school grade, intelligence quotient, number of siblings, position, marital status of parents, address of child, parents' occupation, and parents' age.

Content relating to referral was selected to give an idea of what was referred and who referred and also what the parent and/or the referral source may know about and expect of the clinic. This was based on the assumptions that the type of case referred and the statements made at intake indicate the extent of understanding of clinic function by the referral source. Such questions as source,

stated problems, precipitation factors which affected referral, help expected, and indication of preparation of child or parent for coming to the clinic and knowledge of the clinic by their statement, were used. After testing the schedule, some of the information was difficult to find in the record or was not ascertainable. However, these questions were considered important to the problem as well as helpful information to be in the record, and so were not omitted from the study. It was felt that the lack of this information might be significant.

Content included in the third area, Clinic Plan, was determined primarily by the working assumption that decisions and recommendations of the staff are an index of the practice of the clinic. This area included the worker's subjective impression of attitude toward coming to the clinic, the problem as seen by staff, accepted or not accepted for treatment, reason for non-acceptance, and recommendations made. Also some idea of the use of other resources by the clinic was attempted by the recording of contacts made during the diagnostic study. It was felt that data in this area would be significant in comparing clinic practice and clinic theory.

Collecting of Data

Data were collected by reviewing each case record in the sample in relation to the information needed in the study. Because it was known that only some basic information, mainly identifying information, would be found in the

files of children who had been referred but not seen, the writer first collected and tabulated this information so that this group of children could be described. Some difficulty in collecting the main body of data, relating to referral, made it necessary for the writer to make a judgment in answer to some questions not specifically asked in the interview, but in which answers were indicated in other content of the study. Where this was not possible or if it was questionable, the data were considered "not ascertainable." An example of the former would be the impossibility of determining from the intake interview whether the child was prepared for coming to the clinic. By reading the psychological report and the psychiatric evaluation, the writer was able to determine the possible answer from the contact with the child and thus able to judge what the preparation might have been. An illustration of the latter is the worker's impression of the parent's attitude toward coming to the clinic that they were "uncomfortable." Since it is assumed most people are uncomfortable in seeking help with a problem, "uncomfortable" could not be considered significant and the data were considered non-ascertainable. Sources of data included the diagnostic study for collection of data required on the schedule, informal contacts, observation, and annual reports for data relating to clinic

practice and functions, and written statements on program and policy of the clinic and clinic theory.

Classification, Tabulation, and Analysis

Because of the variety of responses, an open-end questionnaire was used in the schedule. This made classification following the collection of data necessary. The answers in each case were listed and then classified according to common elements and completeness of classes. The classifications made were, for the most part, the writer's except for the "type of problem."[1] Difficulty in classifying the problem as seen by the clinic was experienced because the clinic does not have a system of classification and most diagnoses are descriptive and complex. The Lansing Clinic agrees with the proponents of the philosophy that psychiatric diagnosis is a synthetic procedure and a neat "label" cannot be given; one word cannot do it justice. It is a reformulation of the complaint on the basis of all available data.[2] Therefore, these diagnoses were described for purposes of analyses and were listed in Appendix B.

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[1]Classifications found in Ruth Gartland's study, Psychiatric Social Service in a Children's Hospital (Chicago: University of Chicago Press, 1937), were used.

[2]Leo Kanner, Child Psychiatry (Springfield, Illinois: Charles C. Thomas, 1937), pp. 113-16.

Further, there was some difficulty in classification because of the size of the sample. Broad classification would mean little and would tend to obscure the data. Too many classifications for the size of the sample likewise would tend only to point out the lack of common characteristics or diversity of data when one can assume it would not exist in a larger sample. In some instances it seemed that more description than classification was of value.

In tabulating the data, the hand-sorting method was used for the most part. First each of the questions was tabulated, followed by cross-tabulation of those factors of significance to the study.

Analyses of the data followed its tabulation. This was analyzed in relation to the three questions with which this study is concerned as stated in the introductory chapter and restated here:

1. What is the relationship between the clinic's stated function and the type of cases referred from the referral sources which are given service at the clinic? Stated otherwise, is there divergence between the practice of the clinic and the theoretically stated function of the clinic?
2. What is the relationship between the clinic and the referral sources in their understanding of

clinic function? Stated otherwise, is there divergence between the clinic and the referral sources in their understanding of clinic function?

3. What are the characteristics of those children who have been referred to the clinic and who have been served by the clinic?

The first question was answered by comparison of clinic practice and clinic theory and statement of function. The method of answering the second question was description and comparison of the characteristics of referral and the theoretically stated function of the clinic. The third question was answered by a description of all children referred during the time period selected. Presentation and analysis of data is found in the chapter following.

Organization and Writing

Organization in preparation for the writing of this project report and the writing itself was the last step toward completion of the report.

Objectivity and Validity

Much has been written regarding both the potential value of the use of case records in research and their limitations. Three areas of concern are adequacy, validity,

and representativeness.[3] The records used in this study were analyzed in these terms. The material needed was not always included in the record or perhaps was not asked. In this regard a pilot study, where one had a schedule to use during the interview to assure getting the information desired, might have been a better method to conduct such a study. Also, because of the lack of standardization in the recording, it is not known whether material had been gained in an interview and was not recorded or whether it was gained at all. A further complication was the fact that several different workers recorded the information. Workers, all with different degrees of experience and skill, cannot avoid affecting the type of material obtained and recorded, although basically their frame of reference is the same. The necessity of condensation of records into a meaningful report for purposes of convenience in handling and economy may, depending on the skill of the caseworker in being observant and selective, lose the essence of what did happen or what was said in the interview.

Limitations of the study itself must also be enumerated. The assumption that the statements made at intake indicate the extent of understanding of clinic function by

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[3]Hilde Landenberger Hochwald, "The Use of Case Records in Research," Social Casework (Vol. XXXIII, February, 1952), pp. 71-76.

the referring source may be questioned because, regardless of the source of referral, the parent is seen at intake. However, it seems possible that a school, doctor, court or social agency advising the parents to come to the clinic would also tell them something of it. Therefore, one would indirectly have the understanding of the clinic by the source of referral. Also it must be remembered that the study was based on first contacts recognizing that information pertaining to help wanted or the problem stated may not be the true problem.

The size of the sample used, though the sample itself is fairly representative, places another limitation on the study. It is a study of a specific situation and generalization is difficult. The inclusion of items from the schedule on which there was limited data may be interpreted as subjective.

Further, it was discovered during the course of the study that all telephone calls requesting service are not recorded. If it seems possible that it is a problem with which the clinic does not deal, another agency is suggested, and no record made; it is considered an inquiry. These would be significant in determining understanding of the clinic, it seems, as undertaken in this study. They might be considered to be inappropriate requests for service. They usually come from a child's parents.

CHAPTER IV

PRESENTATION AND ANALYSIS OF DATA

For purposes of presentation and analysis the data have been divided into the following sections:

1. Description of children referred but not seen
2. Characteristics of children seen
3. Characteristics of referrals made
4. Characteristics of the clinic plan

Description of Children Referred but Not Seen

A total of fifty-nine children was referred to the Lansing Child Guidance Clinic in the period, April through June, 1955. Of these fifty-nine, twelve children were not seen at the clinic. Reasons were not known in nine of the cases since appointments were neither cancelled nor kept. Of the remaining three cases, one was referred by the court, which decided to do its own planning after making the referral; one was referred by the mother on the advice of the school, and although only a week elapsed between the time of referral and the time an appointment was offered, the mother reported "things had gone too far"; and one was referred by the Catholic Social Service agency, and consultative service was given without accepting the case. In

one other case, this agency was seeking help in planning also, but the parents did not keep their appointment.

Because this group of twelve cases was not included in the sample which was studied, a description is presented here. Data are necessarily limited because only information received in the initial referral is included. There was no opportunity to get the additional information usually received in the intake interview.

Seven of the twelve children were boys, five were girls. Ages ranged from four to fifteen years, with only two children younger than eight years of age and five children over twelve years of age. The most common type of problems stated at the time of referral were truancy and stealing. Other problems included "child won't mind," a psychogenic disorder, school learning problems, difficulty in social adjustment, day dreaming, enuresis, and tics. There was one suicidal attempt and one exclusion from school. Sources of referral included four cases from parents, two from schools, three from social agencies, and one each from physician, court, and lawyer. The average time lapse between the time of referral and the intake interview was eight weeks.

In three instances, recommendations were made by the clinic without the usual diagnostic study. Foster home placement was indicated for two children who were not able

to function adequately in the home environment. One family, referred by the lawyer, stated they could afford a private psychiatrist if the child could not be seen immediately.

Those cases referred by social agencies, the court, and the lawyer indicated the type of help expected from the clinic while those from parents, schools, and the physician did not. Social agencies requested help in planning, as did the court. The lawyer wished to determine if the visits of one child's mother were sufficiently upsetting to the child to ask the court to remove her visiting privileges.

From this description, it seems possible that where parents did not initiate the referral there was less interest and motivation toward coming in for clinic service.

Characteristics of Children Seen at the Clinic

Forty-seven children were referred to the clinic and seen for diagnostic evaluation in the time period considered. Seven of the forty-seven cases were reopened, that is, the children were previously seen at the clinic. Of the forty-seven children, thirty-three were boys and fourteen were girls. This proportion is comparable to that found in most clinics of this type. Ages ranged from three to seventeen. By age group, the six and seven year olds, the ten and eleven year olds, and thirteen and fourteen year olds were nearly evenly represented with ten, ten, and

eleven children respectively. However, by school age group, which is the classification used in the presentation and analysis of data, the elementary school age group, six through eleven years of age, having twenty-four of the forty-seven children, outnumbered the preschool group by seventeen, and the junior high school and high school age group, twelve through seventeen years of age, by eight children. This can more clearly be shown as follows:

Age	Number
Total	47
0-5	7
6-11	24
12-17	16

Thirty-three of the children came from families where the parents were married and living together. In ten cases the child was living with one own-parent and one step-parent. In only four instances was a child living with one parent only, a relative or foster parents. In these findings one can see the refutation of the common belief that it is the child from the broken home that has difficulties. It seems possible that children from apparently stable families are as susceptible to emotional disturbances as children from broken homes. Information regarding the status of the marital relationship in the stable

families would be necessary to form conclusions on the effect of this factor on the mental health of children.

An attempt was made to determine whether many children came from any one part of the city from the addresses of the children, although on the basis of the size of the sample this could not adequately be determined. These forty-seven children in the sample did, however, come from a scattered area. Further, it seemed the occupation of the parent might lend significance in understanding the economic class of people served by the clinic. In over three-fourths of the families, the father was a drop forge or factory worker or other type of laborer. In nine cases the father or mother held white collar positions, or positions which involved work with people. From the records themselves, which usually give some indication of economic status, there was no evidence of poverty or economic hardship. Whether this would tend to corroborate the fact that child guidance clinics are thought to serve the upper middle or upper class families may be questioned.

The children's intelligence rating is one characteristic of the child that is important to the clinic, both in planning and in treatment. The distribution of these ratings, which are general because a variety of tests were used, was as follows:

Rating	Number
Total	47
Below average (to 89)	9
Average (90-109)	18
Above average (110 and above)	10
Not tested	10

Of the latter grouping, it was possible to assume that retardation was not present, since testing would have been done to determine its extent if it was suspected. This would be an essential determinant in planning for a child of this kind. It seemed from the findings that there was not, on the whole, a tendency to refer only the retarded child to the clinic, but rather it seemed possible referral sources wished to use it in its preventive and treatment aspects.

Ordinal position of the children was considered to be another significant characteristic of describing the children seen at the clinic. The following figures indicate the number of children in each position:

Position	Number
Total	47
Oldest	21
Middle	7
Youngest	11
Only	6
Not ascertainable	2

Characteristics of Referrals Made

The problems of the child as stated at the time of referral can be found in Table 2. When reading this table, it is necessary to remember that any given child may have been referred for one or more problems so that the total number exceeds the number of children referred. Also, it should be remembered that further study of the child may have revealed problems more significant than those given as the reasons for the child having been referred. The types of problems included in the classification[1] are as follows:

1. Projective behavior--temper, disobedience, stealing, quarreling, sex play, fighting, lying, running away
2. Introjective behavior--nervousness, restlessness, timidity, seclusiveness, day dreams, depression, slowness
3. School failure--lack of interest in school, poor grades, specific disabilities, slow learner
4. Habit disturbance--speech, enuresis, masturbation, soiling, thumbsucking
5. Psychogenic illness (illness without physical cause)--pains, tics, allergies, stomach disorders, kidney disturbance, and nosebleeds

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[1]Gartland, op. cit., pp. 9-10.

TABLE 2

PROBLEMS STATED AT TIME OF REFERRAL AS CHIEF REASONS FOR REFERRING TO THE CLINIC

Problem	Number	Percent
Total	90	100
Projective behavior	29	32
Introjective behavior	22	25
School failure	21	23
Habit disturbances	9	10
Illness without physical cause	9	10

From the table it can be seen that projective behavior accounted for almost one-third of the total number of problems and was the most common problem seen in the children referred. This is perhaps due to the fact that this is an obvious problem and most objectionable. The relatively high incidence of introjective behavior considered a problem in one-fourth of the cases referred might indicate that there is a growing awareness of the importance of this type of behavior, and more appreciation for prevention of more serious illness or symptomatology by early treatment. The high incidence of school failure may be due to the fact that the child with difficulty spends much time in school and is also apt to display difficulty there. It also may be considered a safer, less involving way for a parent to state a problem.

The relation of the stated problem to the age and sex of the children referred is of significance in knowing the type of children referred. This is shown in Table 3. In the pre-school group, habit disturbances had the highest incidence, followed by illness without cause, and an equal number of introjective and projective behavior problems. In the elementary school age group, projective behavior and school failure were found in an equal number of cases, thirteen, and were followed by introjective behavior found in nine cases. Of the twelve to seventeen year age group, projective and introjective behavior were the most common problems, stated in nearly three-fourths of the cases. In this latter group, there was no evidence of habit disturbance and only one psychogenic physical complaint.

From this study it appears that the young child is apt to display a habit disturbance frequently while the oldest child with emotional difficulties tends to act out his problems. This is consistent with most psychological theory in relation to children's behavior patterns.[2]

From Table 3 it can be noted that problems stated in the cases of girls were almost evenly divided between the five categories, with slightly more referred for introjective behavior. Projective behavior, accounting for nearly

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[2]Gordon Hamilton, Psychotherapy in Child Guidance (New York: Columbia University Press, 1949), pp. 24-34.

TABLE 3

PROBLEMS STATED AT TIME OF REFERRAL AS CHIEF REASONS FOR REFERRING TO THE CLINIC BY AGE AND SEX

Problem	Total	Age						Sex			
		3-5		6-11		12-17		Boys		Girls	
		Number	Percent*	Number	Percent	Number	Percent	Number	Percent	Number	Percent
Total	90	15	100	43	100	32	100	66	100	24	100
Projective behavior	29	3	20	13	30	13	41	25	38	4	17
Introjective behavior	22	3	20	9	20	10	31	16	24	6	25
School failure	21	0	0	13	30	8	25	16	24	5	21
Habit disturbances	9	5	33	4	10	0	0	4	8	5	21
Illness without physical cause	9	4	27	4	10	1	3	5	6	4	16

*Percentages, although inconclusive, are used for the purpose of clarity.

forty percent of all problems listed for boys, was the most common problem stated for the boys. Introjective behavior and school failure were listed the same number of times, each accounting for nearly one-fourth of the total number of problems. Habit disturbances and psychogenic illness were found in only nine instances out of the sixty-six symptoms stated for boys. These findings support the fact that boys seem to be and are expected to be more aggressive than girls in our society.

Regarding the relationship of ordinal position to the problem stated, projective behavior or school failure accounted for two-thirds of all problems stated at the time of referral. The middle child tended to display introjective behavior and the youngest child was projective, followed by introjective behavior and illness without physical cause. The only child displayed introjective behavior and school failure equally, and twice as often as projective behavior. This can be more clearly seen in Table 4.

The children were referred from five sources:

Source	Number
Total	47
Parent	18
School	12
Social Agencies[3]	7
Physicians	6
Court (or police)	4

[3]Social agencies include Visiting Teacher program,

TABLE 4

PROBLEMS STATED AT TIME OF REFERRAL AS CHIEF REASONS FOR REFERRING TO THE CLINIC BY ORDINAL POSITION

Symptom	Total	Ordinal Position				
		Oldest	Middle	Youngest	Only	Not Ascertainable
Total	90	40	16	20	11	3
Projective behavior	29	17	4	6	2	0
Introjective behavior	22	6	7	4	4	1
School failure	21	9	3	3	4	2
Habit disturbances	9	5	1	3	0	0
Illness without physical cause	9	3	1	4	1	0

In approximately one-third of the cases, it was suggested that the parents make a referral to the clinic. However, if the referral was made by the parent but at the advice or suggestion of someone else, the latter was considered to be the actual source of referral.

All but three of the referrals were made by telephone, with two persons referring in person. One referral, from another city, was made by letter.[4]

Catholic Social Service, Michigan State University Psychological Clinic, and Adult Mental Health Center.

[4]Under clinic policy, referrals made by telephone call, letter, or conference are accepted.

Precipitating factors affecting referral, help expected by parent and/or referral source, preparation of the child for coming to the clinic, and the amount of knowledge referring adults had about the clinic as indicated in the statements made at the time of the intake interview, were difficult to ascertain in many of the cases. These items were included, however, as mentioned earlier, because of the writer's belief that they are essential to good social work practice. Gordon Hamilton also states the importance of information of this nature in helping the client.

> On the one hand, we focus by means of understanding and restating the chief complaint; on the other, we focus through the request--what the client wants to do and what he wants us to do about it. This, in a special way, makes the relationship a dynamic one because we meet the client at the point of greatest interest. We try to find out what was the client's expectation in coming. What brings him to us? Why today? Did someone suggest it? What crystallized his decision to make the move? . . . The expectation is thus related to what the worker, representing the agency, can do about it, and it introduces the client to the agency service in a realistic way.[5]

Further,

> If the case has been referred by another agency, the client may not be sure why he has been sent, so it is important to find out from him what he has in mind. . . . It may be presumed that since he has come here he did have some idea in his mind. Especially, knowing the functions of the other agency or worker, one must guard against making assumptions that one therefore knows all about referral and how the client feels about

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[5]Gordon Hamilton, Theory and Practice of Social Casework (New York: Columbia University Press, 1951), p. 159.

> it. . . . When clients have been ill informed or have had fantasies about the agency and its services, their expectations may be out of proportion to what can be done for them either in general or by this agency in particular.[6]

Of the forty-seven cases, sixteen were referred following specific incidents such as the child stoned on the way from school, threatening suicide, stealing a gun, or sexually assaulted. Twelve referrals followed a talk with teacher, friend, or agency worker, five resulted from a visit to the doctor and five were referred because of fear on the part of the mother. Examples of this latter group are: "mother is afraid the child will get in trouble," "teacher said the child may fail; mother upset," "mother worried the child won't finish school." Nine were not ascertainable. Because the average time lapse between referral and first contact was from six to eight weeks, a discrepancy between what was said and what happened may exist.

The responses to the "help expected by parent and/or referral source" in the study were classified as follows:

> Planning, evaluation and treatment
> Advice ("how to handle," "advice," "how to stop bedwetting")
> Understanding of child and problem ("help him be happier," "am I doing something?")
> Change in the child ("get to the bottom of this so Tommy won't have this attitude," "help straighten him out or place him in foster home," "stop delinquent behavior")

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[6] Ibid., p. 161.

With school problem
None, don't know
Other ("relieve physical distress," "relieve mother's nerves," "help parents eliminate friction," "make home life happier")

There were seventeen requests out of fifty-nine for planning, evaluation and treatment, nine for advice, and seven for understanding; there were seven requests for a change in the child, and six for help with the school problem. There were four "other" requests, as described above in the listing and definition of the classification. Six indicated they wanted no help or did not know what help they expected and in three instances this was not ascertainable.

Social agencies, physicians and courts expected planning, evaluation, and treatment, while parents who referred on the advice of the school had the largest proportion in the "none, don't know" classification. In fact, five of the six statements in this category came from school referrals. Parents' expectations were more evenly distributed with nearly two-thirds expecting planning, evaluation, treatment, advice, and understanding of the problem. The largest number and percentage of expectations of change in the child also came from the referrals by parents (Table 5).

In seventeen cases, it was impossible to ascertain whether there had been any preparation of the child for coming to the clinic. In two instances, there was none.

TABLE 5

HELP EXPECTED AS STATED AT INTAKE
BY SOURCE OF REFERRAL

Help Expected	Total	Source of Referral				
		Parents	School	Social Agencies	Physi-cians	Court
Total	59	25	14	9	7	4
Planning, evaluation & treatment	17	5	3	4	3	2
Advice	9	6	0	1	2	0
Understanding	7	4	0	2	0	1
Change in child	7	4	2	1	0	0
With school problem	6	3	3	0	0	0
None, don't know	6	0	5	1	0	0
Other	4	3	0	0	1	0
Not ascertainable	3	0	1	0	1	1

In ten instances, one could infer from the child's attitude or statement that the child had been prepared. These are listed because of the impossibility of classifying them:

Child resentful (3)
"Physical condition"
"No problem"
Punishment because of "badness"
Guilty, as though reminded of school difficulty
"Bad boy"
"Crazy"
"Ask questions and I'm not crazy"

What was said in those cases where it is known there was preparation will also be listed for descriptive purposes:

"See a doctor again"
Doctor told child--"a talk"
"Like coming to another kind of kindergarten"
"Get help in understanding him"
"Place where people like kids, want to help them and see them play"
"Discuss problems"
"Talk over things"
"Place where they help you to learn better in school"
"Get understanding as to how you think"
"Because of school"
"Talk"
"Because of the way you treat sister" (twins)
"Place where people are trained to understand and find out why we have this problem"
"Because of reading difficulty"

It was impossible to ascertain what knowledge the parent and/or referral source had about the clinic in twenty-nine cases; five others had been at the clinic previously. Three said they knew nothing or little. Other indications of knowledge were:

Asked about price and was surprised that mother would be seen in treatment
Read about it in the newspaper
Came with a list of things do discuss--bad things only
Knew clinic could give diagnosis so the child could be admitted to Starr Commonwealth
Knew clinic could determine if child is retarded
Testing
Thought of coming here about another daughter who is failing in school
Expect treatment immediately
Thought she would remain with child during testing as one does in a doctor's office

Because of the limited information one cannot base any conclusions on these items in the study. They are of value, however, in describing and picturing what some people think of the clinic.

Characteristics of the Clinic Plan

The worker's impression of parent's attitude toward coming to the clinic was felt to be of value in judging the client's understanding of the clinic. The responses were divided into three groups: 1) "wanted to," meaning they were interested in help to the point where they indicated willingness to involve themselves; 2) "indifferent," meaning they came for advice or testing only, with no indication of willingness to involve themselves further; and 3) "did not want to or fearful," meaning they came from a sense of duty rather than a sincere desire for help. The workers felt that in eighteen cases parents came but did not want to, thirteen wanted to, and in eleven they were indifferent. In four cases this was not ascertainable.

Table 6 indicates that in cases referred by the schools and the court, parents seemed to be most resistant or fearful, while in those referred by social agencies, the parents wanted to come in nearly three-fourths of the cases. Nearly half of the parents who referred their children seemed to display an attitude of indifference toward coming to the clinic. These findings seem to indicate that social agencies which do use the clinic prepare parents for coming to the clinic, while parents see the court and school as representing authority and feel they must come in.

Parents themselves seem to be ambivalent as might be expected, since many parents, although desiring help for their child, seem to feel this is an admission of failure on their part.

TABLE 6

WORKER'S IMPRESSION OF PARENTS' ATTITUDE TOWARD COMING TO THE CLINIC BY SOURCE OF REFERRAL

Worker's Impression of Attitude	Total	Source of Referral				
		Parents	School	Social Agencies	Physicians	Court
Total	47	18	12	7	6	4
Wanted to	13	4	3	5	0	1
Indifferent	11	8	0	0	2	1
Did not want to, fearful	18	4	9	1	2	2
Not ascertainable	5	2	0	1	2	0

Of the forty-seven cases, thirty were accepted for treatment. The problem as seen by the clinic was in most cases a synthesis with the symptoms given as the method of handling the problem. As mentioned in Chapter III, in the paragraph on psychiatric diagnoses, it was difficult to classify this data. It seems significant, however, that the problems mentioned at the time of referral are considered the symptoms in the clinic diagnosis. A complete list of diagnoses can be found in Appendix B. From the data it

seems the anxious, insecure child with a lack of satisfying relationships who cannot function socially, intellectually or emotionally and who would possibly move toward a more severe disturbance, seems to be the type of child the clinic will accept for treatment. The more seriously disturbed children are more succinctly diagnosed--for example, "extremely disorganized," "psychotic state"--perhaps because of the fact that the problem is clearer. These children seem for the most part not to be accepted for clinic treatment, but residential treatment is recommended. Children diagnosed as mentally deficient or of low mentality cannot, as a rule, profit by treatment and were, therefore, not accepted for continued treatment. In the cases the clinic did not accept, suggestions or recommendations were made to the parents and/or the referral source. One case in the study was accepted primarily so that the parents could be given help in understanding children in general and their child, specifically.

Contacts by phone, letter or in person with other community resources were made in eighteen of the forty-seven cases according to the records, making a total of twenty-two contacts. These contacts included those people called in for the staff conference. The schools are frequently contacted on this basis. Since a majority of the diagnostic studies in the cases used were done during the

summer months, it is possible the schools were not contacted for staffing of cases. Therefore, the number of contacts made on the cases in the sample may not be representative. The following figures show the number and type of contacts made during the diagnostic study.

Contact	Number
Total	22
School	9
Police and Court	4
Social Service Exchange	2
Physicians	2
Visiting Teacher	2
Neuropsychiatric Institute	1
Youth Haven	1
Kalamazoo State Hospital	1

Time lapse between referral and the intake interview was considered to be an important indication of clinic practice, particularly in relation to the type of problem stated and the source of referral (Tables 7 and 8). From Table 7 we note that of all children displaying projective and introjective symptoms, nearly one-third were seen within two weeks. The average time lapse for all types of problems was six to eight weeks. On the whole, children displaying projective behavior seemed to be seen sooner than any other type of problem, possibly because of its objectional features. Children with the less obvious habit disorders were not seen as soon after referral, with nearly

TABLE 7

TIME LAPSE IN WEEKS BETWEEN REFERRAL AND INTAKE INTERVIEW BY PROBLEMS STATED AT TIME OF REFERRAL

Weeks	Total	Problem				
		Projective Behavior	Introjective Behavior	School Failure	Habit Disorders	Illness without Physical Cause
Total	90	29	22	21	9	9
0-2	21	10	8	0	1	2
3-5	16	5	2	5	1	3
6-8	28	8	3	10	3	4
9-11	11	4	3	4	0	0
12-14	14	2	6	2	4	0

TABLE 8

TIME LAPSE IN WEEKS BETWEEN REFERRAL AND INTAKE INTERVIEW BY SOURCE OF REFERRAL

Weeks	Total	Source of Referral				
		Parents	School	Social Agencies	Physicians	Court
Total	47	18	12	7	6	4
0-2	11	2	1	3	2	3
3-5	9	3	3	0	2	1
6-8	12	7	1	4	0	0
9-11	8	2	6	0	0	0
12-14	7	4	1	0	2	0

one-half waiting from twelve to fourteen weeks. About one-half of those displaying introjective behavior and one-third of those with school failure waited for nine or more weeks.

Children referred by social agencies and the court were seen sooner than children referred by other sources. This can be explained in part by the fact that these sources tend to refer children displaying projective behavior (Table 9). Cases referred by the school were not seen as readily, with seven of the twelve waiting nine weeks or more between referral and the intake interview. Although children referred by parents seemed to be distributed equally, on the whole, more seemed to wait at least the average number of weeks for all children.

TABLE 9

PROBLEMS STATED AT TIME OF REFERRAL AS CHIEF REASONS FOR REFERRING TO THE CLINIC BY SOURCE OF REFERRAL

Symptom	Total	Source of Referral				
		Parents	School	Social Agencies	Physicians	Court
Total	90	41	20	14	9	6
Projective behavior	29	10	8	6	2	3
Introjective behavior	22	11	4	3	2	2
School failure	21	9	7	4	1	0
Habit disturbances	9	7	1	0	1	0
Illness without physical cause	9	4	0	1	3	1

CHAPTER V

SUMMARY AND CONCLUSIONS

Summary

I. What is the relationship between the clinic's stated function and the type of cases referred from the referral sources which are given service at the clinic? Stated otherwise, is there divergence between the practice of the clinic and the theoretically stated function of the clinic?

This question can be answered best by comparison of the two factors involved. Consideration of functions or stated practice of the clinic will best set the pattern for answering this question.

1. It is a clinic that tries to protect and improve the mental health of the children in the community. From the study, one sees that all children referred are given diagnostic service. There is no restriction on sex, and children from birth through seventeen are served.

From the data presented one can note service was given to children of both sexes, although a larger number of boys were served. Also children ranging from three to seventeen were served by the clinic and, although there

were no referrals of children younger than three, it can be assumed that the clinic may have accepted them for evaluation of their development. Other characteristics of the children seen, such as marital status of parents, and parent's occupation, are of little significance in answering this question other than to indicate that children of all types of families are served.

An interesting question arising here is the number of children seen in proportion to the number of children in the Lansing area. This question of use of the clinic may warrant study.

2. The clinic prefers that the parent refer the child to the clinic, or that it is done with the parents' permission.

In approximately one-fourth of the cases, cases referred from sources other than the parent were accepted. In approximately one-third of the cases, it was suggested that parents make a referral to the clinic but nearly half of the referrals came directly from parents. In all of these cases, parent or child was seen at intake, making it possible to infer that permission was given for direct referral.

3. The clinic, although unable to treat mentally retarded children, does not restrict by intelligence for diagnostic service.

Data presented supported this function in that an almost equal number of children were found to be below average, and above average. Even those in which slowness or retardation was suspected were given diagnostic service. Five out of nine children below average were not accepted for treatment, and only one out of eleven children with above average intelligence was not accepted. Therefore, it seems that the clinic is not restricting its intake by intelligence for diagnostic service, although they do not accept mentally retarded children for treatment.

4. The clinic serves children with evidence of all types of emotional problems.

From the data presented, one may note that there is no limitation on the types of emotional problems or symptoms for which children may be referred.

5. The clinic tries to educate the community to understand the factors promoting healthy emotional development and recognizing signs of emotional disturbance. Further, it tries to educate them in regard to the function of the clinic, what it can do and what it cannot.

The clinic gives talks to various community groups regarding both emotional health and clinic function. Staff conferences are another method of interpreting function of the clinic.

6. The clinic takes full advantage of all resources in the community in dealing with every child referred.

In eighteen of the forty-seven cases referred, it was recorded that contact was made with other resources in the community during the course of the diagnostic study. Whether other contacts were made but not recorded cannot be determined. Most of these contacts were in the form of staff conferences. Three were requests for written reports. Two physicians were contacted and two cases were cleared and registered with the Social Service Exchange.

It seems possible that there may be some divergence between clinic function and practice based on the use of community resources.

II. What is the relationship between the clinic and the referral source in their understanding of clinic function? Stated otherwise, is there divergence between the clinic and the referral sources in their understanding of clinic function?

Because of limited information available, it was difficult to attempt to answer this question. Descriptive information given earlier in the presentation of material relating to preparation, and knowledge of the clinic, although inconclusive, showed the possibility that only a broad, but accurate, understanding of function exists.

Help expected as indicated at the time of referral might be indicative of understanding. Request for a change in the child, with the school problem, none or don't know, and the "other" classification accounted for twenty-three of the fifty-nine requests, while planning evaluation and treatment, advice and understanding accounted for thirty-three requests (Table 5, p.51). The latter types of requests could be considered appropriate, although the giving of advice may have a different meaning for parent and clinic. The clinic does give advice in the broad sense of the word, in terms of educating. However, it does not give specific advice to parents regarding a child. It believes in the parent's right to make his own decisions, in client involvement in change if results are to be possible. It does not include the ready-made prescription some parents expect.

Help with a school problem implies a kind of change in the child. The clinic does not see its function as changing a child but rather evaluating the situation and possibly giving psychiatric treatment. The latter may produce a change in the child but not in the "miracle cure" way and only with involvement on the part of family members.

Six parents stated they expected no help, or did not know what they expected. Five out of these six were school

referrals. In five other of the twelve school referrals, help expected was a change in the child and with the school problem. The other sources of referral seemed to be more appropriate in terms of help expected.

The problem stated and the problem found seemed to be directly related in all cases. The problems stated were seen by the clinic in its diagnosis as the symptom or way in which a child was handling his problem. On five cases, the problem stated did not indicate the severity of disturbance the clinic found. However, it seemed that the types of problems did show an extent of understanding of the clinic.

The clinic assumes that all parents referring children to the clinic do want help. Yet, from the data, it seemed that only thirteen of the forty-seven wanted to come to the clinic to the extent that they were willing to involve themselves. Five of these came from social agencies and four from parents. The majority of those referred from the school and from the courts seemed to be resisting service or were fearful (Table 6, p. 54).

III. What are the characteristics of children seen and served at the clinic?

From the presentation of the data, one sees that the children are from three to seventeen, with the majority be-

ing of grade school age. Approximately twice as many boys as girls are referred. The children tend to come from whole families, are the oldest children, and are of average intelligence.

The children display a variety of problems, projective behavior being most prominent in general and closely followed by introjective behavior and school failure. Boys and oldest children tend to display projective behavior and school failure most frequently. Girls displayed habit and psychogenic disorders. Introjective behavior was found equally by sex, but was most characteristic of the middle and only child. Children displaying projective behavior were referred most frequently by schools, social agencies, and the court, while parents seemed to refer children with introjective behavior most frequently. Schools also had the largest percentage of school problems. Social agencies, interestingly enough, referred no child because of habit disorders when it seems possible they may have been in a position to know about them.

The average time lapse was six weeks before contact. There were exceptions, for emergencies. Cases referred by social agencies and the court were seen soon after referral. Cases referred by the schools seemed to wait the longest before being seen. Children referred for projective behavior were seen more quickly while those displaying

introjective behavior and habit disorders were seen after the longest time.

Of the forty-seven cases, thirty were accepted for treatment. Those not accepted for the most part displayed a more severe disturbance which required hospitalization or institutionalization. Those accepted tended to have an emotional problem which hindered social, intellectual or emotional functioning of the child, which could become more severe. Recommendations were made for those who could not be treated at the clinic.

Conclusions and Recommendations

The problem considered in this study was stated as follows: there may be divergence between referral sources' understanding of clinic function and the clinic's interpretation of clinic function. Also there may be divergence between clinic theory and practice. If this is true it would tend to decrease or limit the understanding of clinic function by those who use it.

On the basis of the study's findings, it is difficult to draw a conclusion whether clinic function is or is not understood by the referral sources. The data available from the case records were so limited as to make answers to this question inconclusive. There is no proof of lack of understanding, however.

The clinic theory and practice seem to be directly related except in the area of use of community resources. This fact might raise the question of need to redefine function inasmuch as many of the children seen and accepted have waiting periods both preceding intake and treatment. Although this is a question which could partially be solved by additional staff, it seems possible that it is something more than that. When it is coupled with the fact that the clinic is used to a limited extent by community resources which one would expect to make referrals to the clinic, one may question whether these referral sources really understand and feel free to use the clinic. Is the waiting list something that agencies understand about the clinic, and are they discouraged by the waiting period? Do they find it easier to make their own plan without clinic help? Would it be more effective to serve more children who need help by consultation and/or brief service than the limited number the clinic can serve under the present policies? Or is it important and necessary that there be an agency as a child guidance clinic that can see emotionally disturbed children for treatment, even though such treatment may be available to a limited number? In short, is the clinic fulfilling its function of service to the emotionally disturbed children in the community?

Further, one can conclude on the basis of the findings that the children whom the clinic does serve, although limited in number, are children who need psychiatric or psychological service.

Recommendations which may be made from the study are limited. The writer suggests that:

1. An indication of the client's understanding of the clinic become a standard part of the intake interview and recorded, so that in working with a client, the worker can more adequately begin where the client is. Further, this would be helpful to the clinic in its program of interpretation and education.

2. All phone calls considered to be inquiries be recorded to help the clinic in interpretation and education.

3. The clinic itself objectively evaluate its program and policy periodically to see if it is providing the best service possible to the community; specifically, that it attempt to solve the problem of long waiting lists.

4. School children with problems be cleared through the Visiting Teacher program before referral is made.

This study suggests several topics for further study:

1. Why is there limited use of the clinic when the potential needs of children seem to be so great?

2, Do the agencies in the community recognize the symptoms of children with emotional problems?

3. If this apparent understanding exists, does it extend to the outlying areas served by the clinic?

4. Would more effective and extensive service be available if procedures of referral from community agencies were reformulated?

5. Are there special areas which require more emphasis in the clinic's program of interpretation and education?

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APPENDIX A

SCHEDULE

I. Child

Age_____ Sex_____ Race_____ School grade_____

Number of siblings_____ Ordinal position_____

Marital status of parents_____

Address of child_____

Parent's occupation(s)_____

II. Referral

New_____ Reopened_____ Means_____ Confirmation_____

Source_____ Advised by_____

Problems stated at time of referral_____

_____

What precipitated referral_____

Length of time between referral and intake_____

Help expected by parent and/or referral source_____

_____

Was child prepared for coming_____ By whom_____

What was he told_____

_____

What did referring adults know about the clinic (by their statement)_____

_____

III. Clinic

Who came for intake_____

Worker's impression of parents' attitude toward coming to clinic_____

_____

Problem as seen by staff_____

_____

Accepted_____ Not accepted_____

Other recommendations_____

_____

Reason for plan_____

Other contacts during diagnostic study_____

_____

APPENDIX B

DIAGNOSES

Psychoneurotic; dependency and feelings of inadequacy because of overprotection, becoming withdrawn

Feelings of anxiety, dependency, low self-esteem and aggression which he is handling by overconformity and arrest of psychosexual developments

Limited intellectual capacity; castration and aggression anxiety

Essentially healthy child; parents need an understanding of children

Child too restricted, handling by behavior problem

Child insecure; feels affection is based on fulfilling his many responsibilities

Neglected with chronic anxiety reaction, depression, and acting out

Rejected, insecure with feelings of badness

Depressed, withdrawn, insecure

Insecure, negativistic with combination of psychopathic and paranoid tendencies

Anxious, hostile, unable to express feelings

Angry at parents so is not conforming; speech difficulty

Character neurosis; hostility a cover-up for deep-seated fears

Mental deficiency

Tense, anxious, and hostile, showing signs of withdrawing from his environment

Misunderstanding on part of parent regarding school interpretation of child's mental ability

Mental deficiency

Situational reaction causing apprehension and anxiety with feelings of self-depreciation

Anxious, impulsive, extremely emotionally responsive with objective of self-gratification

Anxious, lacking confidence and overcautious

Pre-schizophrenia; below average mental ability with sexual preoccupation and lack of superego development

Extremely disorganized; psychoneurotic

Possible organic involvement; hearing loss; feelings of insecurity and inadequate

Hostile, especially toward mother, unwilling to express self, poor interpersonal relationships with danger of becoming sexually delinquent

Insecure, over-controlled by parents

Insecure, feelings of not being accepted, with sexual confusion

Anxious and insecure, which makes thinking and learning difficult

Situational reaction, hostile, preoccupation with family disunity

Situational personality disorder with poor capacity to relate and lack of inner resources

Anxious, hostile, possible sex problem and indications of manic-depressive behavior

Insecurity due to family friction and personality problems of parents

Lack of satisfying relationships with anyone, and need for acceptance to prevent more serious disturbance

Situational personality disorder; acting out hostility in passive negative way

Lack of stimulation, little interest in anything

No positive relationships and possible sex problem

Depressed and constricted

Constricted, depressed, and anxious, lacking feeling of acceptance

Psychotic state

Neurotic, near psychopathic personality

Hostile, overcontrolled, with possible break with reality suggested

Severely disturbed and disorganized

Schizophrenic; paranoid tendency

Hostile child with need for parents to understand and handle these feelings and their relation to other complaints

Insecure and rejected with tendency toward more psychomatic complaints and possible psychosis

Withdrawn and overconforming, with bedwetting

Anxious, overdependent, with no positive relationships

Anxious, depressed, and insecure because of pressures with need for mother to exert less pressure