

RELATIONSHIP OF CERTAIN FACTORS TO SUCCESSFUL
CASE CLOSURE IN A CHILD GUIDANCE CLINIC

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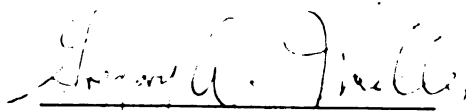
CLOSURE IN A CHILD GUIDANCE CLINIC

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ABSTRACT

RELATIONSHIP OF CERTAIN FACTORS TO SUCCESSFUL CASE CLOSURE IN A CHILD GUIDANCE CLINIC

by Harold Jay Fahs

This study is primarily concerned with the determination of what factors are most prognostic of therapy success in children seen at the Northwest Michigan Child Guidance Clinic, located at Traverse City, Michigan. For the purpose of this investigation therapy success has been defined as a case in which, in the opinion of the counselor, the child has improved over his condition at the time treatment started. Improvement does not have to be the result of therapy. An unsuccessful case is one which, in the opinion of the counselor, the child's condition has not improved over the time treatment started.

In addition to the above purpose the researcher has attempted to (1) determine agreement between counselor judgment, parental judgment, and researcher judgment in reference to case closure; (2) determine if therapy cases classified as successful, by the counselor, have remained successful; (3) determine the type of problem which may be the "best risk" for therapy; (4) and determine if the method

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of reporting and handling information in a child guidance clinic is adequate and accurate.

Five groups of referral categories were used. These categories were set up by the Michigan Department of Mental Health and consisted of conduct, habit, learning and developmental problems, functional illness, and personality problems. The period studied was eight years, from January 1, 1950 to January 1, 1958.

The records of 706 child guidance referrals were examined. From this population 253 satisfied rigid requirements of record completeness. Letters were written to parents of the selected children requesting them to fill out an enclosed questionnaire. The final workable sample consisted of 215 cases.

The relationship of the child's problem at time of referral to intellectual ability; duration of referred problem; parental attitude toward child; parental attitude toward therapy; counselor, parent, and researcher judgment regarding therapy outcome; and present status of case was determined by application of the chi-square method, Fisher Exact Probability Test, and percentage presentation.

When the parent's judgment regarding the outcome of a case was used as the criterion of success the following factors were found to be related to successful case closure;

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age of child above nine years and four months and intelligence quotient above 100 for problems classified under the conduct category; duration of problem less than thirty months and good parental attitude toward the child for problems classified under conduct, functional illness, and learning and developmental problems.

When the researcher's judgment regarding the outcome of a case was used as the criterion of success the following factors were found to be related to successful case closure: good parental attitude toward the child for referral problems classified under conduct and personality problems; duration of problem less than thirty months for referral problems classified under personality , functional illness, and learning and developmental problems; intelligence quotient above 100 for problems classified under learning and developmental problems; and age of child above nine years and four months for referral problems classified under the functional illness category.

When the counselor's judgment regarding the outcome of a case was used as the criterion of success the following factors were found to be related to successful case closure: good parental attitude toward the child for problems classified under the personality category; intelligence quotient above 100 for problems classified under the learning and

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developmental category; and age of child above nine years and four months for problems classified under functional illness problems.

Of the total number of cases closed as successful, by the counselor, 47 per cent have remained successful. Fifty-three per cent of the successfully closed cases reverted back to the original referral problem.

Of the total number of cases closed as successful, by the researcher, 72 per cent have remained successful. Twenty-seven per cent have reverted back to the original problem.

Of the total number of cases closed as successful, by the parent, 98 per cent have remained successful. One child reverted back to the initial referral problem.

Parental judgment of case closure seems to agree more with the researcher's judgment than with counselor's judgment.

Habit and personality problems seem to be the "best risk" for therapeutic results.

Methods of reporting and handling information in child guidance seem to be an administrative area which might be improved.

**RELATIONSHIP OF CERTAIN FACTORS TO SUCCESSFUL CASE CLOSURE
IN A CHILD GUIDANCE CLINIC**

By

,

Harold Jay Fahs

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CHAPTER I

THE NATURE OF THE PROBLEM

INTRODUCTION

It has been accepted for some time that the mental health of the adult is largely determined by the experiences of childhood.¹ The present adult entry rate into mental hospitals has been variously reported as being about one adult out of every ten. If we can alleviate or prevent emotional problems in childhood it seems in order to assume that adult entry rate into our mental hospitals would be lowered.

To accomplish the above purpose the State of Michigan, with the cooperation of local communities, has set up a total of eighteen child guidance clinics throughout the State of Michigan.² The primary function of a child guidance clinic is the treatment of incipient mental disease or severe emotional difficulty in children. The child guidance clinics in the State of Michigan are staffed by a child guidance psychiatrist, a child guidance psychologist, and a child guidance social worker. The

¹The Prevention and Early Treatment of Mental and Other Personality Disturbances. (State Department of Mental Health, 1954), p. 2.

²As of July 1, 1960.

suggested ratio is 1:1:3 respectively.

To insure that we are doing the best possible job in prevention of emotional disorders in children it is necessary that constant evaluation and research be undertaken. It is with this thought in mind that the following study is undertaken.

I. THE PROBLEM

Statement of the problem. The purpose of the present study is to (1) identify common concomitants of success or failure in child therapy; (2) to determine if therapy cases classified as successful closures by a therapist have remained successful in terms of the initial referral problem; (3) to compare the initial referral problem to the problem actually found by the therapist; (4) to determine the "best risk" for therapy in terms of length of treatment and the initial referral problem; (5) to determine how successful child guidance has been in correcting the initial referral problem; and (6) to determine if there is a need to improve methods of reporting and handling information obtained in a child guidance clinic.

Need for the study. One of the main crises that child guidance clinics in the State of Michigan have encountered for some time is the need for additional professional personnel. This need stems primarily from the fact that more children are being referred for treatment of emotional disorders than ever before.

To keep pace with the increasing number of referred children various clinic directors have attempted to compensate for lack of professional personnel by completely terminating intake referrals on certain days of the week, assigning a burdensome caseload to the existing staff, and allowing the "open and waiting" caseload to accumulate unduly. An "open and waiting" case is one which is open, has been accepted for therapy, and is currently waiting for a therapist to arrange scheduled interviews. These methods of compensation have, however, failed to alleviate the situation arising from the pressure of community demand for service, cases that present themselves as of an emergency nature, and the desire of child guidance clinics to be of continuous service. Clinics are thus forced to build up an initial appointment list and an "open and waiting" caseload for therapy. These lists are frequently so extended that cases wait as long as twenty-four months for therapeutic assistance.

Clinic public relations with schools, social agencies, the medical profession, courts, and referred families are threatened by this necessarily long "open and waiting" list. It is sometimes very difficult for parents to comprehend why they must wait for a public service which they partially support. The resulting negative kind of public relations, if allowed to gain momentum, opens the possibility of program curtailment rather than improvement. Yet of greatest importance is the fact that children who are in need of assistance are forced to forego the aid their parents seek for them.

Thus, the need for the study becomes apparent. There has been only a small amount of research on the prediction of therapy outcome and therapy stability with children, and to the author's knowledge no research of this type has been done in child guidance clinics in the State of Michigan.

Brief history of child guidance. The first child guidance clinics were an outgrowth of the new psychology of the "Boston Group".³ This group was comprised of William James, G. Stanley Hall, Adolph Meyer, and others of similar interests.

³ Adolph Meyer, "Thirty-five Years of Psychiatry In the United States and Our Present Outlook," American Journal of Orthopsychiatry, 8:9, July, 1928.

These men represented a union of psychology and psychiatry, both of which disciplines, under their influence, became humanistic. To James, mind was an active moving power, and all of its manifestations were of importance. Individuality, initiative, and freedom were to James the main desire. Hall was an ardent geneticist and much given to "instinct feelings" over rationality. Meyers, on the other hand, had long been interested in the developmental processes, especially as pertaining to the psychoses, and was strongly against theoretical systems and abstractions of any sort.

The development of child guidance was thus dependent upon the emergence of a set of hypotheses about human behavior and its disorders which were neither physiological nor fatalistic. Basically the 'Boston Group' believed that a human being is a living whole and not a sum of elements or a mysteriously split organism composed of mind and body. From this concept of human conduct a theory about mental disorders and their origins logically followed. These disorders were now regarded as being, for the most part, maladjustments of personality rather than diseases of the nervous system. It was Meyer's viewpoint that predominated throughout this era and it was his theories that underlaid the practices of the first child guidance clinics.

The Juvenile Psychopathic Institute in Chicago, now Illinois Institute for Juvenile Research, is generally credited with being the first child guidance clinic. The Institute was founded in 1909. In 1912 the Boston Psychopathic Hospital was established and put under the direction of men who shared the Meyerian point of view. A year later the Phipps Psychiatric Clinic in Baltimore was opened. Children were accepted as out-patients in both of the above clinics. Shortly afterward the National Committee for Mental Hygiene undertook surveys of school children and found many had behavior problems that called for study and treatment. By 1921 a fairly large number of clinics for children were in existence. These clinics, however, were mostly attached to mental hospitals, courts, schools, social agencies and colleges. Only a few of the early clinics had the characteristics of the later child guidance clinics.

The peculiarity of child guidance clinics (first established in 1922 under the name as demonstrations by the National Committee for Mental Hygiene of the Commonwealth Fund) is that they offered psychiatric treatment to children and social casework service to parents simultaneously. They also included a psychologist on the 'clinic team' who administered psychological examinations and often aided in treatment if necessary.

The psychiatric treatment offered children during this era was commonly referred to as psychotherapy. Psychotherapy was developed to be a controlled, not a controlling, process and when directed toward a child was to be used in an effort to modify the child's attitudes, to assist him to work out emotional conflicts, and to help him attain a more adult and mature attitude toward situations and individuals with whom he came in contact. It was assumed that the patient consciously involved himself to some degree in the therapeutic process and that transference was used as the chief medium of treatment. Therapy did not endeavor to make a person conform to harsh and depriving conditions nor to become as normal or mature as the theoretically 'average' person could be. Therapy did desire to allow a person to achieve a more adequate use of all his faculties within his own capabilities. Therapy was especially important to children since whenever pressure from without could be modified or inhibitions removed, the forces of growth were on the side of the therapist.

Psychotherapy offered adults differs from child psychotherapy due to the incomplete personality organization of the child. The most outstanding characteristic of the child is that of a weak ego organization and a

limited ability to manipulate inner impulses and external demands. A second difference, a direct outgrowth from the above, is a basically narcissistic character; hence self indulgence and feelings of omnipotence. A third distinction is the nearness to the surface of the unconscious, often causing children to act out and speak about matters that are embarrassing to an older person. The closeness of the unconscious to the surface of the child's consciousness can also be attributed to the incomplete super-ego development.

Brief history of child guidance in Michigan. By 1923 the interest in work with children stimulated the State Hospital Commission of the State of Michigan to establish the authority to set up child guidance clinics, but lack of appropriations made it impossible for such clinics to be organized. In 1944 the State Hospital Commission was abolished and the State Department of Mental Health was created in its place. Financial assistance was brought forth in 1929 when Senator James Couzens donated \$10,000,000. This money was donated with the stipulation that it be spent within a twenty-five year period of time. At a later date \$2,100,000 was added to the above amount. In 1930 the Children's Fund entered the field of child guidance and took as its

first step the task of training graduate students in social work.

In 1937 the Children's Fund combined with the Michigan State Hospital Commission to launch the present program in mental health. A child guidance clinic was set up at Traverse City to work with the local state hospital staff. The foundation gave \$11,000 to demonstrate the clinics in Michigan. William H. Kelly, M. D., currently the assistant director of the Department of Mental Health, was the first child guidance psychiatrist in the State of Michigan. The second child guidance psychiatrist was Norman Westlund, M. D., currently the director of the Saginaw Valley Child Guidance Clinic and the attending child guidance psychiatrist to the Northwest Michigan Child Guidance Clinic.

At the present time advisory boards, composed of local people actively interested in the development of and the continued support of the clinic, work with the Department of Mental Health and the clinic in matters of policy and finance of the clinic. This effort, in collaboration with the state's monetary support, supplies the necessary funds for operating. At this time the state is providing approximately 53 per cent of the total operating funds for clinic operations. The ultimate goal is a 50-50 sharing of costs between the State of Michigan

and the local community in which the clinic is established. Michigan's Child Guidance Program currently costs the state and the community about \$1,317,000 a year.

As of the middle of the fiscal year ending June 30, 1960, there were eighteen child guidance clinics in the State of Michigan and sixteen branch offices. A branch office is set up within a relatively small geographic area other than where the clinic is located. Its primary function is to give additional local clinic service where a full clinic is not justified or feasible. The local community contributes by supplying a professional worker and office facility for a full-time or part-time operation. The branch office is supervised by and augmented by occasional visits of other staff members from the clinic area.

Brief history of Northwest Michigan Child Guidance Clinic. James Decker Munson Hospital, in Traverse City, Michigan, was selected as a place where the Children's Fund of Michigan could give the best service available to children who lived in the northern portion of the lower peninsula.

Initially James Decker Munson Hospital was a general hospital belonging to the Traverse City State Hospital, an institution for the mentally ill. At a

later period Munson Hospital was legally separated from Traverse City State Hospital and came to be owned by the Traverse City community with a separate board of trustees.

In the spring of 1936 the name of the children's section of the new medical facility became the Central Michigan Children's Clinic. The first pediatrician of the children's section was Mark F. Osterlin, M. D., now deceased. In the year 1937 the Child Guidance Division of the Children's Fund sent a psychiatric social worker to initiate child guidance work in the area. This was a departure from the usual procedure because the worker was not under the supervision of a psychiatrist but correlated her activities with the pediatrician. Psychiatric and psychological consultation service was made available to the Child Guidance Division by the Traverse City State Hospital Staff.

Miss Hazel Hardacre is the third psychiatric social worker to function in the child guidance program in this clinic. Miss Hardacre arrived in 1938 and is still working in this capacity. In 1954, when the Children's Fund ceased to exist, the clinic was taken over by the Michigan Department of Mental Health. The name

of the clinic was changed to the Northwest Michigan Child Guidance Clinic and placed under the directorship of Miss Hardacre.

The child guidance clinic staff consisted of one child guidance social worker in the summer of 1937. Shortly after, because of the expanding request for service, it was necessary to increase the staff. Two additional child guidance social workers were engaged on a full-time basis and given the additional responsibility of setting of branch offices in Mason and Wexford counties. In 1955 a psychologist was employed and in 1957 an additional psychologist brought the staff total to five.

An attending psychiatrist reviews selected cases at periodic intervals and is available at all times for cases which require immediate expert psychiatric consultation. The attending psychiatrist is available to the clinic from the Saginaw Valley Child Guidance Clinic. In 1958 the third branch clinic of the Northwest Michigan Child Guidance Clinic was opened in Alpena, Michigan. Past, present, and future growth of the Northwest Michigan Child Guidance Clinic is quite evident. Table I shows the number of cases and types of problems seen at the clinic during the years 1954-1958.

Limitations of the study. The limitations of the study include the following points.

TABLE I

NUMBER OF CASES BY TYPES OF PROBLEMS 1954-1959

NORTHWEST MICHIGAN CHILD GUIDANCE CLINIC

Type of Problem

Year	Conduct	Habit	Personality	Learning & Developmental	Functional Illness	Other	Total
1954	35	2	29	57	29	1	153
1955	56	12	25	133	18	1	244
1956	66	8	33	155	11	2	275
1957	115	7	23	209	10	1	365
1958	133	16	20	206	10	0	375
1959	101	32	18	133	19	145	448
Total	506	77	148	893	97	150	1860

The above table begins in the year 1954 due to the fact that records are not available prior to this date. The table is extended to 1959 to include the last statistical summary.

1. The entire sample of subjects was drawn from the files of the Northwest Michigan Child Guidance Clinic at Traverse City. The sample represents cases which have accumulated over a seventeen county area.

2. The analysis of the referred cases will be confined to the years 1950-1957.

3. The sample used in this study is the caseload of five therapists, none of whom follows any one school of therapy.

4. Statistical prediction from the obtained data may be classified as a limitation due to the fact that prediction for individuals is based on group data. It is thus important to make an intensive analysis of each child to determine the personality and environmental make-up which has classified him as a child guidance referral.

5. The records used in this study were compiled with varying degrees of proficiency and may, in some cases, be incomplete or inaccurate. Material included in the case record is often quite subjective.

6. The variables used in this study are not the only variables that could, or should, be explored. The variables used are the ones selected by the author that seemed to be the most fitting for investigation of the problem.

II. DEFINITION OF TERMS USED

The terms used in this study are terms used in the child guidance clinics in the State of Michigan. Due to administrative policy the terms do not necessarily apply to other child guidance clinics located in different states. Definitions taken directly from the Michigan Department of Mental Health will be starred.⁴

*Child guidance clinic. A child guidance clinic is an out-patient clinic for children up to seventeen years of age which is staffed by a child guidance psychiatrist, child guidance social worker, and a child guidance psychologist. The function of the child guidance clinic is the alleviation and prevention of mental disorders in children.

Child guidance psychologist. A child guidance psychologist is a person trained to administer and interpret psychological tests for children and is capable of carrying on psychotherapy with children under the supervision of a child guidance psychiatrist, and is adequately trained in the area of psychology.

⁴ Michigan Department of Mental Health, Child Guidance Clinic Statistical Manual. (Lansing: Research Section, 1958), pp. 2-9.

Child guidance social worker. The child guidance social worker functions as an integral member of the clinical team in the child guidance setting, contributing to diagnosis and treatment of psychosocial factors related to the situation of stress for which the child patient has been referred.⁵

*Open case. A case is classified as open following the interview(s) with the child and/or the parent or responsible agent during which it has been established that the case is appropriate for clinic service.

*Reopened case. Any case opened for service which has previously been an open case at any state child guidance clinic is classified as a reopened case. All cases transferred to another clinic will be closed by the original clinic and reported as reopened by the receiving clinic.

*Successful closure. A successful closure is a case in which it is the opinion of the therapist that the child has improved over his condition at the time treatment started, regardless of whether or not this improvement is thought to be related to therapy.

⁵Definition suggested by the School of Social Work, Michigan State University.

*Unsuccessful closure. An unsuccessful closure is a closed case in which, in the opinion of the therapist, the child's condition has not improved over the time treatment started.

Psychotherapy. Psychotherapy is a planned and systematic application of psychological facts and theories to the alleviation of a large variety of human ailments and disturbances. Psychotherapy and counseling are used synonymously.⁶

Psychotherapist. Psychotherapist, as used in this study, refers to a person actively engaged in supervised psychotherapy with children. The term psychotherapist, therapist, and counselor are used synonymously.

In Chapter I the researcher has identified the purpose of the present study, given a brief history of child guidance, a brief history of the Northwest Michigan Child Guidance Clinic. In addition, the limitations of the study and definition of terms have been defined.

Chapter II will give a review of the literature pertaining to prediction of therapy outcome in child guidance.

⁶D. E. Fisher, The Meaning and Practice of Psychotherapy (New York: MacMillan Co., 1950), p. 9.

CHAPTER II

REVIEW OF THE LITERATURE

INTRODUCTION

Much has been written in regard to the prediction of therapy outcome and factors entering into the success and failure of psychotherapy. The greatest percentage of this material however deals primarily with adults rather than with children. This chapter will mention several studies that deal with adult population but the majority of the literature will be in reference to children and the prediction of therapy outcome in child guidance.

Psychotherapy With Children

The literature on psychotherapy with children is still limited and available authoritative texts are few in number. Furthermore, psychotherapeutic methods and processes in work with children have not up to the present been clearly systematized and fully described.

Every psychotherapist of experience is painfully aware of the amount of time wasted by carrying on therapy with cases which are unsuitable for such treatment. The greatest loss of time and effort is brought about by

selecting the child for psychotherapy on the basis of only one or two factors. For example, to select a child for psychotherapy on the child's motivation or the need of a mother figure would be entirely erroneous. It is necessary that the task of selection be approached from an open minded standpoint and that we be honest in our judgment of which cases can be completely cured, which can be helped to be more independent, and which do not have the slightest chance to benefit from psychotherapy. To accomplish this it is necessary that all factors which may affect treatment outcome be investigated previous to case acceptance or case goal setting. As Rees says, "Through psychotherapy we may sometimes hope to cure, more often to relieve, and always to support."¹

General Factors Related To Therapy Prediction

Factors which are related to therapy prediction have been investigated from a very general viewpoint to specific variables. Katzeneleogen has suggested that failure and success in psychotherapy is determined by: (1) the nature of the illness; (2) the time that is available for psychiatric assistance; and (3) the patient's mode of living both inside and outside the family. He

¹ J. R. Rees, Modern Practice In Psychological Medicine (London:Butterworth and Company, 1949), p. 381.

feels that if the biological and psychological needs of the individual are not gratified, treatment effectiveness is greatly impaired.²

Psychologic deprivation in early childhood has been investigated increasingly during the past twenty-seven years. The great majority of these investigations have convincingly demonstrated conspicuous deviations in both intellectual and emotional response when deprivation in childhood is evidenced. Goldfarb regards the family as a psychological climate which as such determines the personality development of the child.³

Beck states that various factors should be considered in relation to therapy prediction. Ego strength, capacity for relationship, capacity for insight, desire to be helped, quantity of conscious anxiety, quantity of repressed hostility, intelligence, and time available are all valuable criteria in determining whether or not therapy should be undertaken.⁴

² Soloman Katzeneleogen, Analyzing Psychotherapy (Philosophical Library Inc., 1958) p. 97.

³ William Goldfarb, Emotional and Intellectual Consequences of Psychological Deprivation in Infancy (New York: Grune and Stratton, 1955), pp. 105-118.

⁴ Bertram M. Beck, Short Term Therapy In An Authoritative Setting (Family Service Association of America, 1946) p. 66.

Ingham and Love indicate greater favorability of prognosis with specific factors.⁵ They are somewhat in agreement with Beck and state that age is an important factor when thinking in terms of treatment, the main generalization of age being that the older a person is the less likely he is to be adaptable to therapy procedure. They also discuss intelligence as a predictive factor but arrive at the loosely formulated statement that, "The more intelligence a person has the better chance for success in therapy, prognosis improves with intellectual ability, and different types of therapy go with very dull normal individuals and mental defectives." Ingham and Love also feel that flexibility, or the ability of a person to change conditions to meet his needs, is a fortunate asset in determining therapy outcome. They feel that previously attempted therapy may detract from the likelihood of success but does not necessarily preclude it.⁶

Behavior maladjustments are notoriously discouraging but sometimes not impossible to deal with successfully. The psychoneurotics as a rule are easier to treat. Disturbance causing most psychosomatic manifestations and the other psychoneuroses including the anxiety state,

⁵ Harrington V. Ingham and Leonora Love, The Process of Psychotherapy (New York: McGraw-Hill Book Co. Inc., 1954) pp. 147-148.

⁶ Ibid., p. 157.

depression, and hysteria are far more likely to show improvement.⁷

Dunner points out the following factors that have been assessed as favorable assets in predicting therapy outcome:⁸

1. High intellectual ability.
2. Ability to relate to others on a verbal level.
3. Young age at time of referral.
4. Average or above achievement before illness.
5. Sudden onset of problem.
6. Onset of problem due to external conflict.
7. Insight.
8. Seeking psychotherapy on own initiative.

The Institute For Juvenile Research selects cases for treatment on a rather loose basis but has produced successful treatment in many instances. However, the successful cases may quite possibly contain many of the factors which other authors have mentioned as criteria for successful prediction. The Institute selects child

⁷ Eugene E. Levitt, "The Results of Psychotherapy With Children: An Evaluation," Journal of Consulting Psychology, 21:189-196, 1957.

⁸ Ada Dunner, "Aspects of Prognosis For Patients Referred for Psychotherapy," Journal American Medical Women's Association, 11:203, 1956.

guidance cases on the supposition that the case is apparently treatable; (2) that resources seem available for treatment and the carrying out of recommendations; and (3) the problem is an important one to the community.⁹

Cameron in his book, General Psychotherapy Dynamics and Procedures, feels that the best cases for successful therapy are the early behavioral disturbances in children which represent a response to current stress. The anxiety states, provided they have not been extensively organized, also respond reasonably well. While a few psychopathic states seem to respond more spontaneously, they are definitely in the minority. Another important criterion of successful case prediction is motivation. The fact, however, that a person comes to a child guidance clinic requesting assistance by no means signifies that he wants assistance, or that he will continue in therapy. Intelligence is described as a factor that does not determine whether or not psychotherapy can be carried out but rather dictates the kind of psychotherapy which should be used. A person with low or below average intelligence will probably respond better to directive, social, or the

⁹ Institute For Juvenile Research, Child Guidance Procedures (New York: The Appleton Century, 1936), p. 36.

simpler forms of group psychotherapy. The more intelligent person will derive more benefit from the nondirective school. Age and duration of the problem are not strict components in themselves, yet the odds for success are in favor of the younger person and the shorter the duration of the problem. A case that has had a long duration will be more likely to be unsuccessful than successful. Previous assistance from a child guidance clinic does not mean positive failure but is a discouraging factor when one is attempting to predict therapy outcome. Cameron also feels that in the matter of case selection one must select on the basis of several criteria and that the criteria must be suited to a given technique or set of techniques. Thus the criteria may change according to the therapist handling the case, a factor which suggests that each child guidance worker know the techniques of therapy used by the other staff members when assignment of case for treatment occurs.¹⁰

Specific Studies Related To Therapy Prediction

Research has produced many interesting facts

¹⁰ D. E. Cameron, General Psychotherapy Dynamics and Procedures (New York:Grune and Stratton, 1950) pp. 43-65.

concerning specific variables and their relationship to therapy prediction. Bennett, in a study undertaken by the staff of the Rochester Guidance Center involving 200 experimental subjects from three to eighteen years of age, reports that prediction of therapy outcome depends upon the thoroughness of the diagnosis. Younger children are most amenable to treatment when the problem refers primarily to family experience. When distrust or distress revolves around the child's status in a social group, or reaches the point of ungovernable conduct, the outcome of therapy is not favorable. Children included in the study were functioning in the normal range of intelligence. Boys outnumbered the girls two to one, and half of the group were younger than thirteen.¹¹

Cunningham, Westerman, and Fischhoff, in a follow-up study of children seen at the Children's Center of Metropolitan Detroit found that out of 420 children girls made a better adjustment than boys. The "only" child, possibly because of lack of sibling competition, seemed to have responded well to treatment and was making the best adjustment at home. The oldest child in the family made the poorest adjustment. From the standpoint

¹¹ Chester C. Bennett, and Carl R. Rogers, "Predicting the Outcomes of Treatment," American Journal of Orthopsychiatry, 11:210-219, 1944.

of diagnosis, children diagnosed as psychoneurotic and having transient situational disorders showed the most favorable results.¹²

Parental attitude studies have presented themselves quite frequently in the literature. A study undertaken by Dukette points out that Catholic parents who seem to minimize the services of the clinic refer children who present more serious problems than do average child guidance referrals. These children are not to be classified as unsuccessful cases to work with but present a higher ratio of unsuccessful closures. Another feature of importance is the unusually high rate of adolescents included in this group.¹³

Hartin brings forth essentially the same material as Dukette in a study carried on at the Brooks County Guidance Institute in Pennsylvania. Attitudes of parents were studied in forty-seven cases. As a rule parents who came with attitudes that were favorable toward establishing a treatment relationship remained interested in treatment, but the clinic staff found it difficult to change or modify the

¹² James M. Cunningham and others, "A Follow-up Study of Patients Seen In The Psychiatric Clinic for Children," American Journal of Orthopsychiatry, 26: 602-610, 1956

¹³ Rita Dukette, "Attitudes of A Group of Catholic Parents Toward Child Guidance Treatment," Smith College Studies In Social Work, 10: 102, 1939-1940.

attitudes of those who did not want the clinic's help. A few more than half of the parents left the clinic with the same attitudes with which they had come. This information would seem to have valuable implications if the referred child identifies with the attitude of one or both parents.¹⁴

The outcome of a study by Herkimer states that the initial attitude of parents toward a child guidance clinic cannot be used as a shortcut to prognosis. Rather the clues of treatability of parents and children lie within the more fundamental areas of the real feelings of the parent toward himself and his child.¹⁵

Additional comments of interest, when dealing with attitudes, are found in the study undertaken by Wilson. This study showed that when the attitudes of both parents and child are favorable toward treatment, there is a great likelihood that the case will be continued and that the child's adjustment will improve. If the attitudes of both parents are unfavorable, and for the most part unmodifiable,

¹⁴Ruth E. Hartin, "Parents attitudes Toward Child Guidance Treatment," Smith College Studies in Social Work, 10:103, 1939-1940.

¹⁵Jesse K. Herkimer, "The Relation Between Parents Attitudes For Coming To A Child Guidance Clinic and The Outcome of Treatment," Smith College Studies in Social Work, 10:103, 1939-1940.

little can be accomplished by the clinic. In some instances in which the child does not want help from the clinic, help to the parents in dealing with the situation more effectively may aid in the child's adjustment. Sometimes, when the child's pattern of behavior is very deep-seated, the study brings forth the feeling that there will be no response to treatment regardless of the desire for help on the part of either the child or the parent.¹⁶

Kleinman feels that intellectual ability should not be used as a basis for selection of a child for treatment. She feels that the less gifted benefits no more nor less from treatment than the superior child. Unless otherwise indicated a child guidance clinic should accept the dull normal on the same basis as any other child for treatment.¹⁷

A study undertaken by Glassman also points out that psychotherapy in child guidance clinics appears to be successful with children of dull normal intelligence as well as with those who are above average. Few children with intelligence quotients below eighty however, are given

¹⁶ Ruth Anna Wilson, "Effects of Attitudes Toward Child Guidance Treatment and Its Outcome," Smith College Studies In Social Work, 18 & 19: 131-132, 1947-1948.

¹⁷ Frances Z. Kleinman, "Intellegence As A Factor In Child Guidance Treatment," Smith College Studies In Social Work, 20:114-115, 1949-1950.

direct treatment.¹⁸

Elliot feels that successful treatment seems to be dependent upon the parent's real sense of need for help, capacity to understand symptomatic behavior, ability to effectively carry out treatment suggestions and willingness to have their own problems studied in so far as they relate to the patient's problems. She also feels that unsuccessful treatment goes along with distant location - thus lack of parental cooperation.¹⁹

Bonnet, in a study involving sixty child guidance cases, states that success or failure bears no statistical relationship to sex, age, or quality of school work. Comparison of cases in regard to physical classification showed that case failure occurred more frequently in children having marked sensory defect, glandular disturbances, and marked general over-development. Factors in the home situation related to success or failure showed little difference; composition of family, social contacts of the

¹⁸Lillian Glassman, "Is Dull Normal Intelligence a Contra-Indication For Therapy?", Smith College Studies In Social Work, 13:275-298, 1943.

¹⁹Mary Elliot, "A Study of Factors Associated With Success Or Failure In Treatment of Child Guidance Clinic Patients". (Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931), pp. 13-21.

family, source of referral, or size of family.²⁰

MacIntire, in a study involving thirty school referral cases, states that the most successful closures were girls between the ages of six through ten. In this particular study the most successful closures had superior intellectual ability. There seemed to be no relationship between the economic status of the family or the marital adjustment of the parents.²¹

Peterson concludes, through a study of fifty cases from the Providence, Rhode Island, Child Guidance Clinic, that two-thirds of the fifteen cases that were failures were children whose parents were openly rejecting. The cases which had the least success were those which the parents were convinced that the problem had a physical basis. Cases which were helped the most were cases in which the parents sincerely desired help from the child guidance clinic for themselves or for their children.²²

A study of seventy-nine adolescent children treated by

²⁰ Esther Bonnett, "A Comparison of Patients Successfully Adjusted With Those Unimproved At Close of Treatment". (Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931), pp. 10-56.

²¹ Virginia MacIntire, "Factors Relating To Treatment Outcome In A Child Guidance Clinic," Smith College Studies in Social Work, 18:131-132, 1947-1948.

²² Electra Peterson, "Prognostic Clues In The First Interview In Child Guidance," Smith College Studies in Social Work, 18 & 19:133-134, 1947-1948.

the psychiatrists of two child guidance clinics was undertaken by Allbright and Gambrell. They attempted to answer two questions: (1) Are adolescents less amenable to treatment than children of other ages? (2) Can the chance of their being successfully treated be predicted at all accurately from a consideration of their personality traits? The fact that at each clinic all the children were treated by a single psychiatrist was considered some control over treatment variation. It was found that thirty-nine per cent of the children were successfully treated, twenty-six per cent made some progress, and thirty-five per cent did not respond to treatment at all. A comparison of these percentages with others reported for unselected groups of child guidance referrals led to the conclusions that adolescents differ very little from other children in their response to child guidance treatment. With regard to the second question, it was found that a surprisingly accurate estimate of the probable results of treatment could be made from a study of certain personality traits. If the adolescents confined their aggression to certain areas, or were timid and retiring, and if they responded to aggression by renewing their attack or by giving way to annoyance and temper, the probability of being helped by psychiatric treatment was

very high. On the other hand, if adolescents tended to avoid frustrating situations, they were unlikely to be aided by treatment unless they gave evidence in some area of having initiative and being able to assume responsibilities. If the adolescent was extremely aggressive and hostile in almost all situations the chance of successful treatment was slight. Only two out of fourteen such children were classified as successfully closed.²³

Quite prominent in the prediction of therapy outcome is the lack of professional skill in treatment methods. The proportion of cases in which the child fails to continue treatment probably is quite high. Feldman's study suggests that unsuccessful case closures often come about by improper case work methods, including the transfer of a case to a different worker. She also suggests that failure of the child to continue treatment is often due to the parent's attitudes toward them and toward treatment as well.²⁴

In a study by Maberly in Britain of 500 children, it was pointed out that age was not an important factor in

²³Sue Allbright, and Helen Gambrell, "Personality Traits As Criteria For the Psychiatric Treatment of Adolescents," Smith College Studies in Social Work, 9:1-26, 1938.

²⁴Edith Feldman, "Why Children Discontinue Child Guidance Treatment," Smith College Studies in Social Work, 10:27-28, 1938-1939.

determining success of treatment. There was also no bearing on the child's ordinal position in the family and successful or unsuccessful closure. Children of average intellectual ability responded best to treatment. This group was followed by children of above average intellectual ability. Age had more to do with successful closure than intellectual ability. A child of fourteen responded better to treatment than a child of six with the same intellectual ability.²⁵

Hofstein in his study states that the ability to profit from treatment depends on various factors. He feels that cultural differences, involvement of parents, and purpose and goals of treatment should all be taken into account when considering children for treatment. If the above mentioned factors are not favorable the possibility of unsuccessful therapy outcome is increased.²⁶

Davis in her master's thesis attempted to ascertain what factors may be related to varying degrees of success in the treatment of patients referred to a child guidance clinic and to show by means of a follow-up investigation to

²⁵ Alan Maberly, "After Results of Child Guidance: A Follow-UP of 500 Children Treated At The Travistock Clinic, 1921-1934," *British Medical Journal*, 1:1130-1134, 1939.

²⁶ Saul Hofstein, "Social Factors In Assessing Treatability in Child Guidance," *Children*, 4:48-53, 1957.

what extent the child maintained the rating of success which he was given at the close of treatment. The sample consisted of sixty-five cases from the Judge Baker Child Guidance Clinic in Boston, Massachusetts. The following conclusions were drawn:

1. Sex is unrelated to social adjustment.
2. Neither age nor intelligence were found to be related to adjustment whether at the end of treatment or at the time of follow-up. No differences of importance were found when physical condition, nativity, economic status, and marital status were considered.
3. Partial or absolute failures occurred where there was extreme lack of affection.
4. Length and intensity of treatment bore no relation to the outcome of the case.
5. Intangible aspects of family life play a very important part in the outcome of therapy.²⁷

Hylan's study was concerned with a comparison of treatment in adjusted and non-adjusted cases in an attempt to ascertain whether the psychiatric interpretations which give rise to treatment recommendations, the kind and number of recommendations themselves, or the inclination

²⁷ Ellen E. Davis, "Factors Related To The Outcome of Treatment In A Child Guidance Clinic," (Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1934) pp. 72-75.

of parents to carry out treatment recommendations offer any basis for the prediction of successful treatment. It was found that:

1. The kind and number of recommendations offer no index as to the probability of success in the treatment of cases.

2. In the adjusted group 58 per cent of the parents cooperated in carrying out suggestions as to more adequate ways of handling the children's problems, while only seven per cent cooperated in the non-adjusted group. This is a significant difference and suggests that cooperation of parents is associated with success in the adjustment of cases.

3. Cooperation on the part of the child is associated with success in the adjustment of cases.

4. Chances of successful adjustment is fairly good if the child is cooperative even though the parent is not.²⁸

Maslen in a follow-up study of sixty-five patients found that the trend toward successful closure increased when the children were under eleven years of age, of high intellectual ability, in good physical condition, and came

²⁸Mary Champlin Hylan, "A Study of Factors Associated With Success or Failure In The Treatment of Child Guidance Clinic Patients," (Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932), pp. 39-43.

from harmonious homes. The amount of treatment and type of case are relatively unimportant determinants when measuring successful case closure. The best risk is the case in which the child is of high intellectual ability and the parents are willing to accept advice.²⁹

MacGregor's study attempted to determine whether certain objective factors related to the patient and to his environment have significant bearing on his adjustment following treatment. The sample consisted of 297 closed cases which were given treatment service at the Institute for Child Guidance, New York City. Conclusions were as follows:

1. Boys showed a tendency to respond more favorably to treatment than girls.
2. There was consistent, though slight, increase of successful treatment with increase in age.
3. More success in treatment was obtained with higher intellectual ratings.
4. The intermediate child in the family seemed to respond more favorably to treatment, although the size of the family and the home group with whom the child lived seemed to bear little relationship to adjustment.

²⁹Albertina Aida Maslen, "A Study of Factors Associated With Success or Failure In Treatment of Child Guidance Clinic Patients," (Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932), pp. 26-28.

5. The source of the referral appeared to have no relationship to final adjustment.³⁰

In a study done by Leslie it was shown that success in treatment had no bearing on intellectual ability, number of school terms repeated, or physical condition of the referred child.³¹

The Institute of Juvenile Research, an agency of the Department of Public Welfare, State of Illinois, undertook a three year-study to evaluate the effect of psychotherapy. The Institute sees anywhere from 800 to 1,000 child patients diagnostically in its Chicago clinic, and accepts for treatment about 200 to 300 of these cases, all that the available number of therapists permits. Both parents and children may be seen in therapy, depending upon the individual case, and treatment is carried out by psychiatrists, psychologists, and social workers.

The basic design of the study was to compare the present psychological adjustment of a sampling of cases treated at

³⁰ Madeline Leitch MacGregor, "The Relation Between Degree of Adjustment and Certain Objective Traits of The Patients". (Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931), pp. 22-24.

³¹ Myrtle Leslie, "A Study of Factors Associated With Success or Failure In Treatment of Child Guidance Patients," (Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932), pp. 40-41.

the Institute of Juvenile Research during the period 1944 to 1954, inclusive, with a suitable control group. The experimental groups consisted of 237 children. The control group consisted of ninety-three children and 69 per cent of the cases were males.

The data of this study indicates that there is no difference at follow-up between adjustments made by treated and untreated child patients.³²

The above information corroborates a recent survey conducted by Levitt of thirty-seven investigations of the efficacy of psychotherapy with children.³³

Therapy prediction through the use of psychometrics has been very limited. Literature pertaining to the prediction of therapy outcome through the use of psychometrics in a child guidance clinic is meagre. Most of the studies dealing with adult prediction make use of the Rorschach Personality Test and the Minnesota Multiphasic Personality Inventory. Other instruments have been used

³²Eugene E. Levitt and others, "A Follow-Up Evaluation Of Cases Treated At A Community Child Guidance Clinic," American Journal of Orthopsychiatry, 29:337-349, 1959.

³³E. E. Levitt, "The Results of Psychotherapy With Children: An Evaluation," Journal Consulting Psychology, 21:189-196, 1957.

but to a lesser extent.

Siegel made use of the Rorschach Personality Test for diagnostic and prognostic purposes in child guidance. In addition the instrument was used to measure the effectiveness of therapy. It was felt that significant and predictive trends could be measured by the presence of certain traits in the personality structure.³⁴

Rogers and Hammond in their study of 109 unselected veterans attempted to predict the success of treatment by means of the Rorschach Personality Test. The psychologists did not make better than chance predictions about the outcome of treatment under three separate methods of treating the Rorschach protocol.³⁵

Rogers in an earlier study attempted to predict continuation of adult therapy by use of the Rorschach Personality Test. The results were negative.³⁶

³⁴ Miriam C. Siegel, "The Diagnostic and Prognostic Validity of The Rorschach Test In A Child Guidance Clinic," American Journal of Orthopsychiatry, 18:113-119, 1948.

³⁵ Lawrence S. Rogers, and Kenneth R. Hammond, "Prediction of The Results of Therapy By Means of The Rorschach Test," Journal Consulting Psychology, 17:8-15, 1953.

³⁶ Lawrence S. Rogers, and others, "Predicting Continuation In Therapy by Means of The Rorschach Test," Journal Consulting Psychology, 15:368-371, 1951.

Auld and Eron made use of the Rorschach Personality Test to predict whether or not adult patients would continue psychotherapy. Their sample group consisted of thirty-three patients in the psychiatric out-patient clinic at the New Haven Hospital. Two-thirds of the patients were diagnosed as neurotic and the remaining one-third diagnosed as suffering from psychosis or character or behavioral disorders. Their prediction as to continuance of therapy was correct on 69 per cent of the subjects.³⁷

Gibby in his study states that the Rorschach Personality Test identifies the poor therapeutic risk as those with limited productivity, few content categories, lack of reference to sexual and other topics, little color response, and preference for good form response. Interpreted in the conventional manner, the above types of responses indicate that the patient is overly deliberate, does not talk much, has a tendency to stick to safe subjects when he does talk and centers his emotional reaction on card content.³⁸

The Minnesota Multiphasic Personality Inventory was

³⁷ Frank Auld Jr., and Leonard Eron, "The Use of The Rorschach Scores To Predict Whether Patients Will Continue Psychotherapy," Journal Consulting Psychology, 17:104-109, 1953.

³⁸ Robert Gibby, and Bernard Stotsky, "Prediction of Duration of Therapy From The Rorschach Test," Journal of Consulting Psychology, 348-354, 1953.

used by Wiert to predict response to psychotherapy. A total of 535 adult hospital patients was used in this study with reference to the Ego Strength Scale of the Minnesota Multiphasic Personality Inventory. He concluded that this scale was a good predictive instrument. Future samples proved that selected patients did show improvement but the use of the test did not point out all the patients that responded well to psychotherapy.³⁹

Barron points out that considerable caution should be exercised when using the Ego Strength Scale. It should certainly not serve as the only basis in which to accept a case for treatment.⁴⁰

The Wechsler-Bellevue as a predictor of continuation in psychotherapy was used in a study by Hiler. His study was carried out in the Veterans Administration Mental Hygiene Clinic at Detroit, Michigan. His sample consisted of 216 patients; 133 of whom were given the Wechsler-Bellevue. A comparison was made of the performance of patients who remained in treatment and those who terminated prematurely. Patients who remained in treatment scored

³⁹Robert E. Wiert, "Further Validation of The Ego Strength Scale," Journal of Consulting Psychology, 19-444, 1955.

⁴⁰Frank Barron, "An Ego Strength Scale Which Predicts Response To Psychotherapy," Journal of Consulting Psychology, 17: 327-333, 1953.

significantly higher in intellectual ability the difference being greater for the Verbal Scale than for the Performance Scale. With total intelligence held constant, the patients who remained in treatment did significantly better than the terminators on the Similarities subtest, a finding which is perhaps due to a greater ability to perceive relationships. Also, with total intelligence held constant the patient who remained in treatment did relatively less well on the Digit Span and Digit Symbol subtests. These subtests are very much affected by emotional disturbances and therefore these results probably indicated a greater degree of anxiety on the part of the patients who remained in treatment which perhaps served to motivate them to continue treatment.⁴¹

CONCLUSION

From the above studies it is quite apparent that many authorities have arrived at various conclusions regarding the relationship of specific factors to therapy prediction. The author will attempt to combine those factors which are generally in agreement in predicting therapy outcome, those factors which seem to have no agreement in

⁴¹E. Wisley Hiler, "Wechsler-Bellevue As A Predictor Of Continuation In Psychotherapy," Journal of Clinical Psychology, 17:192-194, 1958.

predicting therapy outcome and the factors which give evidence of probable therapy outcome.

The general conclusion regarding age of the subject and therapy outcome is that age of the child is of no significance. Adolescents have responded to therapy equally well as children of six years of age or older. The main difference seems to lie not in the age level but in the intensity and duration of the presented problem.

Intellectual ability does not seem to be a significant factor in predicting therapy outcome. Children of below average intellectual ability, average intellectual ability, and above average intellectual ability have been reported to respond equally well in therapeutic sessions.

The type of psychotherapy offered seems to be more important than the intellectual level of the child. Various authors have suggested that direct therapy be given to children who are functioning below dull normal intelligence. The more intelligent child seems to derive more benefit from the non-directive school of therapy.

Parental attitude toward the clinic and toward the child suggests evidence of the direction of case closure. Parents who maintain a healthy climate within the home and are sincerely interested in the clinic function lend support to the probability that case closure will be

successful. The real feelings of the parent toward himself and child are seemingly more important than the marital adjustment within the home.

If previous therapy has been attempted with a child the probability is that additional therapy will result in failure.

Although boys outnumber girls in the majority of the studies the data suggest that sex is not a determining factor in therapy prediction.

Literature pertaining to specific diagnostic classifications in child guidance presents too meagre a picture to form positive conclusions. It is suggested, however, that failure in therapy will result most generally with children classified as behavior maladjustments and psychopathic deviates. Favorable treatment seems to coincide with a relatively quick onset of problem due to external conflict and current stress.

The use of psychometrics for prediction of therapy outcome has been exceedingly meagre in child guidance. The majority of the literature pertains to adults and the use of the Rorschach Personality Test and the Minnesota Multiphasic Personality Inventory. Although test results provide a valuable contribution toward therapy prediction they are not to be used as the sole or determining factor.

Past studies have shown that various factors are of more value in prediction of therapy outcome than others. The researcher proposes to advance the comprehension of the subject through the following:

1. By separating referral problems into distinctive categories it may be possible to demonstrate that the studied factors effect specific referral categories in various degrees.

2. Due to the fact that the population studied is classified as rural urban, the obtained information has particular interest to child guidance clinics in a rural setting. Such a study has never been undertaken in the State of Michigan.

3. The cases used in this study have been seen on a therapeutic basis by five therapists, all of whom are still employed by the Northwest Michigan Child Guidance Clinic. In addition to the low number of therapists involved the availability of therapists for discussion of records has added validity to data which otherwise may have been misinterpreted.

Chapter II has presented a review of the literature pertaining to the prediction of therapy outcome in child guidance.

The following chapter will outline the method of sample selection, the method of case analysis, and the method of

follow-up. In addition the researcher will present the predictive factors, as used in this study, in relation to successful and unsuccessful case closure.

CHAPTER III

METHODOLOGY AND PROCEDURE

INTRODUCTION

In this study an attempt is made to determine the significance of various items in relation to common child guidance referral categories, the stability of successful closures, and the evaluation of specific child guidance practices.

For approximately fifty years investigators interested in the emotional development of children have made an attempt to predict the behavior of an individual under a given set of circumstances. Out of their research numerous convictions have appeared stating that it is possible to predict how children can or will, react when confronted with a given problem situation. The degree to which a child reacts to a problem and the degree of adjustment is still somewhat of a debatable question. It is this uncertainty in the final adjustment of children which has led the researcher to believe that much can be done in evaluating child guidance procedures.

The Sample

Method of Selection. The population for this study

consisted of 706 child guidance referrals seen at the Northwest Michigan Child Guidance Clinic located at Traverse City, Michigan. The cases chosen for the study sample were selected in the belief that a complete study of the child is necessary for a proper understanding of the problems presented by him. In all cases a history and an individual study, including psychiatric, physical, and psychological examination, were necessary. It was the researcher's feeling that no part of the study could be dispensed with if proper research outcome of the case was to result. The cases selected had all of the following characteristics:

1. A case was selected for study if it had been seen on a treatment or therapy basis. Cases that were given diagnosis only or psychological testing only were not used in the original selection. These cases were omitted due to the fact that a referral interview was at times unnecessary for a case classified as diagnosis only, thus making the record incomplete.

2. A case was selected for study if it contained a complete social case history. A social case history was classified as complete if it contained adequate information on the medical history, developmental history, duration of referred problem, social history, psychological data, and some identifying information pertaining to the children's parents.

3. A case was selected for study if it was classified at the time of referral as falling in one of the following categories:¹

A. Conduct Disorder. Conduct disorders cover a wide range of misconduct from minor misbehavior to grave delinquency. Such conditions may exist chiefly in the home, in the school, or in the community. The term "conduct disorder" is not generally applied to very young children. Examples of conduct disorder, as used in this study, include:

1. Truancy.
2. Fighting and quarreling.
3. Disobedience.
4. Untruthfulness.
5. Stealing.
6. Forgery.
7. Setting fires.
8. Destruction of property.
9. Sex offenses.
10. Delinquency.

B. Habit Disorder. Habit disorders are particularly prevalent during the pre-school period,

¹ Sanger Brown and others, Outline For the Psychiatric Classification of Problem Children (Lapeer Home and Training School Print Shop, 1945, pp. 3-4.)

although they occur at all ages. Habit disorders are often minor and transient in character in young children. In older children habit disorders may be more permanent.

Examples of habit disorders, as used in this study, include:

1. Nail biting.
2. Thumb sucking.
3. Nocturnal and diurnal enuresis.
4. Masturbation.
5. Habit spasms.

C. Personality Problems. Children in many instances display personality disorders of a nature which have come to be considered indicative of poor mental health. These disorders, if they tend to become exaggerated, later assume the characteristics of actual mental disease signs and symptoms. Examples of personality problems, as used in this study, include:

1. Seclusive states.
2. Depressed states.
3. Suicidal threats and attempts.
4. Day dreaming.
5. Feelings of inadequacy.
6. Shyness.
7. Fears of normal activities.

D. Learning and Developmental Problems. Learning and developmental problems are particularly prevalent during the ages four through ten. They are usually associated with school problems but some include delayed maturational problems of speech, walking, and coordination. The types of disabilities included in this category are associated with both average and below average intellectual ability. Examples of learning and developmental problems, as used in this study include:

1. Poor schoolwork.
2. Problems associated with dull normal or borderline intelligence.
3. Special mental disabilities.
 - a. In writing.
 - b. In reading.
 - c. In arithmetic.
4. Developmental patterns below age expectancy when the child has average intellectual ability.

E. Functional Illness. A functional illness problem is a behavior disorder which takes on the characteristic of a physical condition, even though there is no direct relation between the two. Examples of functional illness problems, as used in this study, include:

1. Headaches.
2. Skin disorders.

3. Vomiting.
4. Fainting
5. Convulsions

The total sample used in this study represents cases drawn from a seventeen county area.² The seventeen county area is the allotted territory for the Northwest Michigan Child Guidance Clinic. The area division is governed by the Michigan Department of Mental Health. The area covered by the study varies from walking distance to the Northwest Michigan Child Guidance Clinic to 138 miles away; the most distant point being the area served by the Northwest Michigan Child Guidance Branch Office located in Alpena, Michigan.

In selecting the cases from the case files many referrals were bypassed either because the records were inadequate or because some cases would not be classified as adults. Other conditions such as lack of case notes, incomplete social history, and lack of psychological data forced the rejection of some cases. The final sample of workable cases consisted of 253 drawn from the years 1950-1957. These years were chosen to allow adequate sample size representation and to permit at least two years to elapse to show outcome of treatment. There were additional

² See Appendix A for map giving description of seventeen county area.

factors that were unique with this period. (1) The director of the Northwest Michigan Child Guidance Clinic remained the same during this period. (2) All cases used in the sample represent the therapeutic effort of five therapists, all of whom are still employed at the Northwest Michigan Child Guidance Clinic.

Thirty-eight cases were omitted from the workable sample because of failure of the families to cooperate (31) and the impossibility of locating them by mail, telephone, through relatives, or personal contact (7). The returned questionnaire narrowed the working sample from 253 to 215.³ This figure represents all cases classified as usable with the exception of three cases which were omitted because they were cases of two therapists no longer on the staff of the Northwest Michigan Child Guidance Clinic, thus keeping the number of therapists to five instead of seven. Of the 215 workable cases the number of females totaled seventy-four. The males totaled 141. This proportion is in keeping with the reported state statistical summary which shows that boys are referred approximately twice as often as girls.

In the successful closure group there were 156 cases. The unsuccessful closure group consisted of fifty-nine cases. This classification was determined

³See Appendix B for sample questionnaire.

by the case closure of the therapist. In an attempt to test the authenticity of this classification the researcher set up a board of three professional workers, two child guidance psychologists and a child guidance social worker, to judge the classification of the closure from social history, case notes, psychological data, psychiatric interview if held, duration of problem and attitude of parent toward child.

Methods of Analysis: The case record of each individual child containing case history, psychological data, referral problem, counselor found problem, therapy notes, and other pertinent information was examined. This information was recorded on individual information sheets. The record sheets were classified according to referral problem and sorted into successful and unsuccessful closure groups. From each group tables were constructed to present the reported data. Due to the many comparisons involved: agreement of parent judgment and counselor judgment; agreement of parent judgment and researcher's judgment; significance of closure in relation to age; significance of intellectual ability in relation to closure; significance of duration of problem and closure; significance of parenteral attitude toward therapy and case closure; significance of parental attitude toward child - the most

⁴ See Appendix B for sample of individual information sheet.

practicable way of handling the material seemed to be by machine tabulation.

Data that was most applicable to "Mistic", the electronic calculator at Michigan State University, was punched on tape and processed. The data were treated by the application of the chi-square method of analysis. The chi-square method enabled the researcher to establish significance between the various factors studied and success or failure in therapy outcome.

Data not applicable to the chi-square method were treated either by Fisher's Test of Exact Probability or percentage presentation.

Method of Follow-Up. Due to the number of years covered in this study it was necessary to be prepared for the lack of correct address information. To reduce the number of postal returns the author attempted to establish the most recent mailing address list by: (a) locating directories for the communities that listed the names by street address and phone; (b) checking with the respective county agent when in doubt of the given address; (c) checking with the local physician; (d) checking with all private agencies who may have had contact with the family; (3) checking with the courts and police of each local community; and finally, (f) checking with the Armed Forces for service men who had been stationed at military

bases in the studied area and had later been transferred.

The initial form letter was forwarded requesting that the attached follow-up questionnaire be completed.⁵ The first attempt to contact the parent of the referred child was relatively successful. Out of the total initial contacts seven were returned for incorrect address. The researcher attempted to relocate these people but was unsuccessful.

After waiting for an arbitrary period of five weeks for follow-up returns the researcher sent a second request to the parents who had not responded.⁶ The parents who were within a twenty-five mile radius were contacted by phone and asked to complete the form if they had no personal objection to doing so. Many of the parents felt they did not desire to complete the form letter, and conversation with the parents revealed fear that the form would be filed in the child's clinic folder on a permanent basis, that the information would be held against the child, and that a return might "hurt the feelings" of the therapist or clinic administration.

The remaining nonresponders were sent a third letter of request, and some were contacted by phone. On five

⁵ See Appendix B for initial introductory letter.

⁶ See Appendix B for second follow-up request.

occasions the parent requested a personal interview to evaluate each question on the questionnaire with the researcher. The researcher set up the requested interview at the child guidance clinic. In all cases the parent seemed insecure and quite negative toward the clinic in general. This feeling was evident even though the therapist had classified some of the case closures as successful.

Referrals were returned from such distant points as Guam, California, and Florida. The replies from Guam and California were from military personnel who had been transferred from local military bases. The replies from Florida were from members of the teaching profession who had transferred from the local school system to school systems in Florida.

Eighty-five per cent of the questionnaires were ultimately returned.

The Data

To make possible the prediction of successful or unsuccessful case closures information is needed that will help distinguish between children most likely to succeed in therapy and those who will terminate in an unsuccessful case closure. The main hypothesis in this study is that certain information variables will

be associated with successful closures and other information variables with unsuccessful case closures. The main difficulty will be to dichotomize the various factors that operate to produce the particular closure.

In an effort to separate the present variables that operate toward successful or unsuccessful closures it was felt that each referral problem must be placed in a specific referral category. To do this the researcher used the referral category set up by the Michigan Department of Mental Health. In each referral category it would thus be possible to see how each predictive factor affected that particular classification. The predictive factors used were selected from staff discussion concerning factors of importance in successful treatment, past studies, and the researcher's own feeling toward the problem.

The predictive factors used in this study in relation to successful and unsuccessful closures in specific categories were as follows:

1. Age at time of referral.
2. Duration of problem before initial referral.
3. Intellectual ability of referred child.
4. Parental attitude toward child.

5. Parental attitude toward clinic.

In addition to the above list the researcher has attempted to form generalized constructive comments from the returned data and an analysis of the case records. The generalized constructive comments concern the following points.

1. Therapy success with reopened cases.
2. Therapy success with cases which are transferred from one worker to another
3. Agreement of the therapist and the parent regarding the success of the therapy.
4. Recurrence of referred problem after closure.
5. Incidence of new problems after case closure.
6. Types of problems most commonly referred.
7. Referred problem and counselor-found problem.

The data used in this study have no bearing on the school of therapy or type of counseling used. It is not the intention of this study to evaluate counseling or psychotherapy or best therapeutic procedure.

As stated above, most of the predictive factors are of an objective nature. In those instances in which subjectiveness necessarily enters in; the researcher, child guidance social worker and child guidance psychologist have shared judgment. This method has been adopted to insure greater consistency.

Chapter III has presented the methodology and procedure as used in this study.

The following chapter will discuss the analysis of various factors used by the researcher in attempting to predict therapy outcome.

CHAPTER IV

FACTORS RELATED TO CLOSURE OUTCOME AND CLOSURE STABILITY

This chapter is devoted to an analysis of the factors used by the researcher in predicting successful case closures and is approached from the standpoint that the various factors used may effect the studied referral categories in a somewhat different manner. Stating the above in an alternate manner one might say that sex, age, or duration of referred problem may effect a conduct problem differently than a learning and developmental problem.

The researcher hypothesized that children who had the following characteristics were poor risks in a therapeutic situation:

1. Chronological age above twelve.
2. Intellectual quotient below eighty.
3. Parents with a negative attitude toward them.
4. Parents with a negative attitude toward therapy.
5. A problem which had persisted over thirty months.
6. Therapy in which their case was transferred

from one worker to another.

7. Therapy in which their case was closed and then reopened.

8. Broken, emotionally unstable, or unhappy home.

9. Therapy characterized by lack of thoroughness of the social intake interview and lack of completeness in the psychological data gathered previous to staffing of the case.

The researcher feels that due to the small amount of knowledge concerning prediction of therapy outcome in child guidance work errors resulting in the rejection of the null hypotheses were less dangerous than errors confirming it and therefore the probability level of significance was established at the five per cent level. The tables which follow and explanation and discussion of each table summarize the findings concerning the variables which were studied in reference to each specific referral category.

Conduct referral category. The first category to be discussed will be the conduct category. Conduct disorders cover a wide range of misconduct from minor misbehavior to grave delinquency. Examples of conduct

disorders include stealing, fighting, destruction of property, and disobedience.

Conduct Referral Category

TABLE II

RELATIONSHIP OF PARENT AND COUNSELOR JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccessful By Counselor	Totals
Parent Judged Successful	10	3	13
Parent Judged Unsuccessful	28	11	39
Totals	38	14	52

p=.564 (Fisher Exact Probability) Not Significant

Table II presents parental agreement with counselor judgment. The relationships found are not statistically significant. The data indicate that parental judgment is unrelated to counselor judgment when dealing with conduct problems. It would seem however that the parent is somewhat less optimistic than is the counselor regarding the success of cases.

Conduct Referral Category

TABLE III

RELATIONSHIP OF PARENT AND RESEARCHER JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Researcher	Cases Judged Unsuccess- ful By Researcher	Totals
Parent Judged Successful	9	4	13
Parent Judged Unsuccessful	13	26	39
Totals	22	30	52

p=.026 (Fisher Exact Probability) Significant

Table III presents parental agreement with researcher's judgment regarding the success of cases. The findings are significant at the level chosen for this study. The data indicated that parental judgment is related to researcher's judgment in regard to success of therapy. This finding refers to the conduct category.

Conduct Referral Category

TABLE IV

RELATIONSHIP OF RESEARCHER AND COUNSELOR
JUDGMENT REGARDING SUCCESS OF THERAPY

Researcher's Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccess- ful By Counselor	Totals
Researcher Judged Successful	22	0	22
Researcher Judged Unsuccessful	16	14	30
Totals	38	14	52

p=Less than .001 (Fisher Exact Probability) Significant

Table IV presents researcher's and counselor's judgment regarding the success of cases. The findings are significant at the level chosen for this study. The data indicate that research judgment is related to counselor judgment in regard to success of therapy. This finding refers to the conduct category.

Conduct Referral Category

TABLE V

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	3	10	13
Unsuccessful Closure	21	18	39
Totals	24	28	52
p-.016 (Fisher Exact Probability) Significant			

When considering the prediction of therapy outcome, as judged by the parent, in relation to age of referred child the obtained exact probability value is of statistical significance. This finding applies to the conduct category. Success of therapy, as perceived by the parent, is related to the age of the child in that the older child seems more apt to profit from therapy. The median age of the children in the conduct referral category was nine years and five months.

Conduct Referral Category

TABLE VI

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	11	11	22
Unsuccessful Closure	14	16	30
Totals	25	27	52

$\chi^2 = 2.433$

p= Greater than .100 Not Significant

The relationship between success of therapy, as judged by the researcher, and the age of the referred child is of no statistical significance. This finding applies to the conduct category. The median age of the children in the conduct category was nine years and five months.

Conduct Referral Category

TABLE VII

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	21	17	38
Unsuccessful Closure	6	8	14
Totals	27	25	52
$\chi^2 = .231$			
p= Greater than .50 Not Significant			

When considering the outcome of therapy, as judged by the counselor, in relation to the age of the referred child the obtained exact probability value is of no statistical significance. This finding applies to the conduct category. Success of counseling, as perceived by the counselor, is not related to the age of the child. The median age of the children in the conduct referral category was nine years and five months.

Conduct Referral Category

TABLE VIII

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	2	11	13
Unsuccessful Closure	19	20	39
Totals	21	31	52
p=.032 (Fisher Exact Probability) Significant			

Table VIII shows the relation of therapy outcome, as judged by the parent, to intellectual ability of the child. The obtained exact probability is of statistical significance. The finding applies to the conduct category. The intellectual ability of the child is positively related in this sample to the parent's perception of the success of therapy. The median intellectual quotient of conduct cases was 96.

Conduct Referral Category

TABLE IX

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	8	14	22
Unsuccessful Closure	17	13	30
Totals	25	27	52
$\chi^2 = 1.360$ p = Greater than .20 Not Significant			

Table IX presents the relation of therapy outcome, as judged by the researcher, to intellectual ability of the child. The obtained probability is of no statistical significance. This finding applies to the conduct category. The intellectual ability of the children in this sample is not related to the researcher's judgment of success in therapy. The median intellectual quotient of conduct cases was 96.

Conduct Referral Category

TABLE X

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	21	17	38
Unsuccessful Closure	4	10	14
Totals	25	27	52
p=.084 (Fisher Exact Probability) Not Significant			

The obtained exact probability of Table X is of no statistical significance. This finding indicates there is no significant relationship between success of therapy as judged by the counselor, and intellectual ability of the child. This finding applies to the conduct category. The median intellectual quotient of conduct cases was 96.

Conduct Referral Category

TABLE XI

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	12	1	13
Unsuccessful Closure	11	28	39
Totals	23	29	52

p= Less than .001 (Fisher Exact Probability) Significant

Table XI shows the relation of counseling outcome, as judged by the parent, to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The obtained exact probability value is significant at the level chosen for use in this study. This finding applies to the conduct referral category. Case success is related

to the duration of the problem in that cases in which the problem has persisted for more than 30 months before therapy are more apt to result in outcomes judged by the parent as unsuccessful than are cases where the problem has been of a shorter duration.

Conduct Referral Category

TABLE XII

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	16	6	22
Unsuccessful Closure	7	23	30
Totals	23	29	52
$\chi^2=1.431$			
p= Greater than .20 Not Significant			

The obtained probability of Table XII is of no statistical significance. Case success, as judged by the researcher, is not related to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. This finding applies to the conduct referral category.

Conduct Referral Category

TABLE XIII

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	20	18	38
Unsuccessful Closure	3	11	14
Totals	23	29	52
p=.040 (Fisher Exact Probability) Not Significant			

Table XIII shows the relation of counseling outcome, as judged by the counselor, to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The obtained exact probability is statistically significant. Case success, as judged by the counselor, is inversely related to the duration of the problem. This finding refers to the conduct referral category.

Conduct Referral Category

TABLE XIV

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE PARENT)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	3	10	13
Unsuccessful Closure	34	5	39
Totals	37	15	52

p= Less than .001 (Fisher Exact Probability) Significant

Table XIV points out that success of closure, as judged by the parent, is related to the parent's attitude toward the child. It would seem that poor parental attitude toward the child is positively related to unsuccessful case closures, as perceived by the parent. This finding refers to the conduct category. Poor parental attitude was measured by evidence of parental rejection, hostility, and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Conduct Referral Category

TABLE XV

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE RESEARCHER)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	0	22	22
Unsuccessful Closure	10	20	30
Totals	10	42	52
p=.001 (Fisher Exact Probability) Significant			

The obtained exact probability of Table XV suggests that success of closure, as judged by the researcher, is related to the parent's attitude toward the child. Poor parental attitude toward the child, as judged by the researcher, is positively related to unsuccessful case closures. This finding applies to the conduct category. Poor parental attitude was measured by evidence of parental rejection, hostility and marital difficulty. This factor was recorded if it had been given orally by the referring

agent or if clinically interpreted by the counselor.

Conduct Referral Category

TABLE XVI

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE COUNSELOR)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	6	32	38
Unsuccessful Closure	9	5	14
Totals	15	37	52
$\chi^2 = 2.069$ p= Greater than .10 Not Significant			

Table XVI points out that success of closure, as judged by the counselor, is not related to the parent's attitude toward the child. Poor parental attitude is not significantly related to unsuccessful closures. This finding refers to the conduct category. Poor parental attitude was measured by evidence of parental rejection, hostility and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Conduct Referral Category

TABLE XVII

OUTCOME OF CHILD'S THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO PRESENT PARENTAL ATTITUDE TOWARD THERAPY

Closure Classification	Parental Reply to Question 6			Parental Reply to Question 7		Parental Reply to Question 10	
	No Help	Some Help	Great Help	No	Yes	No	Yes
Successful Closure	1	2	10	1	12	2	11
Unsuccessful Closure	12	21	6	18	21	13	26
Totals	13	23	16	19	33	15	37

Question Six = Assistance given to child at child guidance,
in Traverse City, was of Great Help____ Some Help____ No
Help_____.

Question Seven = Do you feel that you have a better under-
standing of the problem, for which the child was referred,
as a result of assistance received from the child guidance
clinic located in Traverse City? Yes____ No_____.

Question Ten = Would you refer additional children who are
having a behavior problem to a child guidance clinic?
Yes____ No_____.

Table XVII shows the relationship of present parental attitude toward therapy which has been conducted with their child. Question six, seven, and ten from the questionnaire were used for this purpose. Approximately 44 per cent of the parents reported that they received some help; 31 per cent stated they received no help. A better understanding of the problem was reported by 63 per cent while 37 per cent reported they were not offered a better understanding of the problem by the counselor. A total of 71 per cent of the parents stated they would refer additional children to the clinic for assistance.

Conduct Referral Category

TABLE XVIII

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY COUNSELOR

		Cases Presenting New Problems
Cases Reverting To Original Problem	26	14
Cases Remaining Successful In Terms Of Initial Referral Problem	12	9
Total Number of Successful Case Closures	38	23

Table XVIII points out the number of successful case closures, as judged by the counselor, where the problem has not returned and the number who have reverted to the original problem. Table XVIII also shows the number of new problems presented in each category. This table refers to conduct problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes____ No____Partially____) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes____No____. If so, state problem) of the questionnaire. Due to the fact that a successful closure is classified by the State Department of Mental Health as one showing improvement, regardless of

degree or from what source, the term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Out of the thirty-eight cases closed as successful twelve, or 32 per cent, have remained successful in terms of the initial referral problem. Of the thirty-eight successful closures twenty-three are reported as having new problems. The twelve cases which remained successful in terms of the original problem have developed new problems in nine instances. Of the twenty-six who reverted to the original problem fourteen have presented new problems.

Conduct Referral Category

TABLE XIX

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY RESEARCHER

		Cases Presenting New Problems
Cases Reverting To Original Problems	12	8
Cases Remaining Successful In Terms of Initial Referral Problem	10	2
Total Number of Successful Case Closures	22	10

Table XIX points out the number of successful case closures, as judged by the researcher, where the problem has not returned and the number who have reverted to the original referral problem. Table XIX also shows the number of new problems presented in each category. This table refers to conduct problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes___ No___ Partially___) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___). If so, state problem) of the questionnaire. Due to the fact that a successful closure is classified by the State Department of Mental Health as one showing improvement, regardless of degree or from what source, the term

partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the twenty-two cases judged as successful, by the researcher, ten, or 46 per cent, have remained successful in terms of the initial referral problem. Of the twenty-two successful closures ten are reported as having new problems. The ten cases which remained successful in terms of the original problem have developed new problems in two instances. Of the twelve who reverted to the original problem eight have presented new problems.

Conduct Referral Category

TABLE XX

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY PARENT

		Cases Presenting New Problems
Cases Reverting To Original Problem	0	0
Cases Remaining Successful In Terms of Initial Referral Problem	13	2
Total Number of Successful Case Closures	13	2

The above table shows the number of successful case closures, as perceived by the parent, where the problem has not returned and the number who have reverted to the original referral problem. Table XX also shows the number of new problems presented in each category. This table refers to conduct problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes___ No___ Partially___) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___). If so, state problem) of the questionnaire. Due to the fact that a successful closure is classified by the State Department of Mental Health as one showing improvement,

regardless of degree or from what source, the term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the fifty-two conduct cases thirteen were judged as successful by the parent. In terms of the initial referral problem 100 per cent of the successful closures have remained successful. The thirteen cases which remained successful in terms of the initial problem developed new problems in two instances.

Habit referral category. The following tables and presented comparisons are applicable only to the habit referral category. They are to be interpreted in the same manner as those classified under the conduct referral category. Habit disorders are often minor and transient in character but occur at all ages. Examples of habit disorders include nail biting, thumb sucking, masturbation, and habit spasms.

Habit Referral Category

TABLE XXI

RELATIONSHIP OF PARENT AND COUNSELOR JUDGMENT REGARDING SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccessful By Counselor	Totals
Parent Judged Successful	5	0	5
Parent Judged Unsuccessful	9	8	17
Totals	14	8	22
p= .076 (Fisher Exact Probability) Not Significant			

Table XXI presents parental agreement with counselor judgment. The differences found are not statistically significant. The data indicate that parental judgment is not statistically related to counselor judgment when dealing with habit problems. It would seem that the parent is somewhat less optimistic than the counselor regarding the outcome of therapy.

Habit Referral Category

TABLE XXII

RELATIONSHIP OF PARENT AND RESEARCHER JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Researcher	Cases Judged Unsuccessful By Researcher	Totals
Parent Judged Successful	4	1	5
Parent Judged Unsuccessful	3	14	17
Totals	7	15	22

p=.020 (Fisher Exact Probability) Significant

Table XXII presents parental agreement with researcher's judgment regarding the success of cases. The relationship is significant at the level chosen for this study. The data indicate that parental judgment is related to research judgment in regard to success of therapy. This finding refers to the habit category.

Habit Referral Category

TABLE XXIII

RELATIONSHIP OF RESEARCHER AND COUNSELOR
JUDGMENT REGARDING SUCCESS OF THERAPY

Researcher's Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccess- ful By Counselor	Totals
Researcher Judged Successful	7	0	7
Researcher Judged Unsuccessful	7	8	15
Totals	14	8	22

p=.019 (Fisher Exact Probability) Significant

Table XXIII presents counselor agreement with researcher's judgment regarding the success of cases. The relationship is significant at the level chosen for this study. The data indicate that research judgment is related to counselor judgment in regard to success of therapy. This finding refers to the habit category.

Habit Referral Category

TABLE XXIV

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	3	2	5
Unsuccessful Closure	8	9	17
Totals	11	11	22
p=.500 (Fisher Exact Probability) Not Significant			

When considering the prediction of therapy outcome, as judged by the parent, in relation to the age of the referred child the obtained exact probability value of Table XXIV is of no statistical significance. This finding applies to the habit category. The median age of the children in the habit referral category was nine years and nine months. Success of counseling, as perceived by the parent, does not seem to be related to the age of the child.

Habit Referral Category

TABLE XXV

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	4	3	7
Unsuccessful Closure	7	8	15
Totals	11	11	22

p=.508 (Fisher Exact Probability) Not Significant

When considering the prediction of therapy outcome, as judged by the researcher, in relation to age of referred child the obtained exact probability value of Table XXV is of no statistical significance. This finding applies to the habit category. The median age of the children in the habit referral category was nine years and nine months. Success of counseling, as perceived by the researcher, does not seem to be related to the age of the child.

Habit Referral Category

TABLE XXVI

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	7	7	14
Unsuccessful Closure	3	5	8
Totals	10	12	22

p=.448 (Fisher Exact Probability) Not Significant

Success of therapy, as judged by the counselor, in relation to age of referred child is of no statistical significance. This finding applies to the habit category. Success of counseling, as perceived by the counselor, is not related to the age of the child. The median age of the children in the habit category was nine years and nine months.

Habit Referral Category

TABLE XXVII

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN REJATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	3	2	5
Unsuccessful Closure	5	12	17
Totals	8	14	22

p=.231 (Fisher Exact Probability) Not Significant

Table XXVII shows the relation of therapy outcome, as judged by the parent, to intellectual ability of the child. The obtained exact probability is of no statistical significance. This finding applies to the habit category. The data indicate that success in therapy, as perceived by the parent, is unrelated to intellectual ability of the child. The median intellectual quotient of children in the habit category was 107.

Habit Referral Category

TABLE XXVIII

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	4	3	7
Unsuccessful Closure	4	11	15
Totals	8	14	22

$p=.175$ (Fisher Exact Probability) Not Significant

Table XXVIII shows the relation of therapy outcome, as judged by the researcher, to intellectual ability of the child. The obtained probability is of no statistical significance. This finding applies to the habit category. The intellectual ability of the child is not related in this sample to the researcher's judgment of the success of therapy. The median intellectual quotient of habit cases was 107.

Habit Referral Category

TABLE XXIX

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	6	8	14
Unsuccessful Closure	3	5	8
Totals	9	13	22

p=.569 (Fisher Exact Probability) Not Significant

The obtained exact probability of Table XXIX is of no statistical significance. This finding indicates there is no significant relation between success of therapy, as judged by the counselor, and intellectual ability of the child. This finding applies to the habit category. The median intellectual quotient of habit cases was 107.

Habit Referral Category

TABLE XXX

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or less	More Than 30 Months	
Successful Closure	3	2	5
Unsuccessful Closure	3	14	17
Totals	6	16	22

p=.100 (Fisher Exact Probability) Not Significant

Table XXX shows the relation of counseling outcome, as judged by the parent, to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The relationships found are not statistically significant. This finding applies to the habit referral category and suggests that case success, as judged by the parent, is unrelated to the duration of the problem.

Habit Referral Category

TABLE XXXI

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	3	4	7
Unsuccessful Closure	3	12	15
Totals	6	16	22

p=.864 (Fisher Exact Probability) Not Significant

The obtained probability of Table XXXI is of no statistical significance. Case success, as judged by the researcher, is not related to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. This finding applies to the habit referral category.

Habit Referral Category

TABLE XXXII

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	4	10	14
Unsuccessful Closure	2	6	8
Totals	6	16	22

p=.585 (Fisher Exact Probability) Not Significant

Table XXXII shows the relation of counseling outcome, as judged by the counselor, to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The obtained exact probability is not significant. Case success, as judged by the counselor, is not related to the duration of the problem. This finding refers to the habit referral category.

Habit Referral Category

TABLE XXXIII

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE PARENT)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	2	3	5
Unsuccessful Closure	6	11	17
Totals	8	14	22

p=.767 (Fisher Exact Probability) Not Significant

Table XXXIII points out that success of closure is unrelated to the parent's attitude toward the child. This finding refers to the habit category. The relationships found are not statistically significant.

Habit Referral Category

TABLE XXXIV

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE RESEARCHER)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	1	6	7
Unsuccessful Closure	2	13	15
Totals	3	19	22

p=.755 (Fisher Exact Probability) Not Significant

The obtained exact probability, of Table XXXIV suggests that success of closure, as judged by the researcher, is not related to the parent's attitude toward the child. Poor parental attitude, as perceived by the researcher, is not significantly related to unsuccessful closures. This was measured by evidence of parental rejection, hostility, and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Habit Referral Category

TABLE XXXV

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE COUNSELOR)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	1	13	14
Unsuccessful Closure	2	6	8
Totals	3	19	22

p=.286 (Fisher Exact Probability) Not Significant

Table XXXV points out that success of closure, as judged by the counselor, is not related to the parent's attitude toward the child. Poor parental attitude, as perceived by the counselor, is not significantly related to unsuccessful closures. This finding refers to the habit category. Poor parental attitude was measured by evidence of parental rejection, hostility, and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Habit Referral Category

TABLE XXXVI

OUTCOME OF CHILD'S THERAPY (AS JUDGED BY THE PARENT)
 IN RELATION TO PRESENT PARENTAL ATTITUDE TOWARD THERAPY

Closure Classification	Parental Reply To Question 6			Parental Reply To Question 7		Parental Reply To Question 10	
	No Help	Some Help	Great Help	No	Yes	No	Yes
Successful Closure	0	1	4	1	4	0	5
Unsuccessful Closure	8	6	3	8	9	1	16
Totals	8	7	7	9	13	1	21

Question Six = Assistance given to child at child guidance clinic in Traverse City, was of Great Help____Some Help____No Help_____.

Question Seven = Do you feel that you have a better understanding of the problem, for which the child was referred, as a result of assistance received from the child guidance clinic located in Traverse City? Yes____ No_____.

Question Ten = Would you refer additional children who are having a behavior problem to a child guidance clinic? Yes____ No_____.

Table XXXVI shows the relationship of present parental attitude toward the therapy which was conducted with their child. Question six, seven, and ten were used from the follow-up questionnaire for this purpose. Approximately 32 per cent of the parents felt that they had received great help from the clinic; 32 per cent received some help; and 36 per cent received no help. A better understanding of the problem was reported by 59 per cent while 41 per cent stated they did not have a better understanding of the problem. A total of 95 per cent felt they would refer additional children to the clinic for counseling.

Habit Referral Category

TABLE XXXVII

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY COUNSELOR

		Cases Presenting New Problems
Cases Reverting To Original Problem	8	0
Cases Remaining Successful In Terms Of Initial Referral Problem	6	4
Total Number of Successful Case Closures	14	4

Table XXXVII points out the number of successful case closures where the problem has not returned and the number who have reverted to the original referral problem. Table XXXVII also shows the number of new problems presented in each category. This table refers to habit problems. The above information was gathered from question four (Has past problem, or problems, disappeared?) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City?) of the questionnaire. Of the twenty-two habit cases fourteen were closed as successful by the counselor. In terms of the initial referral problem 43 per cent have remained successful. Approximately 57 per cent have reverted to the original referral problem.

The six cases which remained successful in terms of the original referral problem have developed new problems in four instances.

Habit Referral Category

TABLE XXXVIII

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY RESEARCHER

		Cases Presenting New Problems
Cases Reverting To Original Problem	2	0
Cases Remaining Successful In Terms of Initial Referral Problem	5	2
Total Number of Successful Case Closures	7	2

The above table shows the number of successful case closures, as judged by the researcher, where the problem has not returned and the number who have reverted to the original referral problem. Table XXXVIII also shows the number of new problems presented in each category. This table refers to habit problems. The above information was gathered from question four (Has past problem, or problems, disappeared?) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City?) of the questionnaire. Of the twenty-two habit cases the researcher judged seven as successful. Five of the seven successful closures, or 71 per cent, have remained successful.

Approximately 29 per cent have reverted to the original referral problem. The five cases which remained successful in terms of the original referral problem have developed new problems in two instances.

Habit Referral Problem

TABLE XXXIX

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY PARENT

		Cases Presenting New Problems
Cases Reverting to Original Problem	0	0
Cases Remaining Successful In Terms of Initial Referral Problem	5	2
Total Number of Successful Case Closures	5	2

Table XXXIX points out the number of successful case closures, as judged by the parent, where the problem has not returned and the number who have reverted to the original problem. Table XXXIX also shows the number of new problems presented in each category. This table refers to habit problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes___ No___ Partially___) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___). If so, state problem.) of the questionnaire. Due to the fact that a successful closure is classified by the State

Department of Mental Health as one showing improvement, regardless of degree or from what source, the term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the twenty-two habit cases five were judged as successful by the parent. In terms of the initial referral problem 100 per cent of the successful closures have remained successful. The five cases which remained successful in terms of the initial referral problem developed new problems in two instances.

Personality referral category. The following tables and presented comparisons are applicable only to the personality referral category. They are to be interpreted in the same manner as previous tables and presentations. Personality disorders, if they tend to become exaggerated, later assume the characteristics of actual mental disease signs and symptoms. Examples of personality problems, as used in this study, include shyness, fears of normal activities, seclusive states, and suicidal threats and attempts.

Personality Referral Category

TABLE XXXX

RELATIONSHIP OF PARENT AND COUNSELOR JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccess- ful By Counselor	Totals
Parent Judged Successful	33	4	37
Parent Judged Unsuccessful	27	16	43
Totals	60	20	80

p=.005 (Fisher Exact Probability) Significant

Table XXXX presents parental agreement with research judgment regarding the success of cases. The findings are significant at the level chosen for this study. The data indicate that parental judgment is related to counselor judgment in regard to success of therapy. This finding refers to the personality category.

Personality Referral Category

TABLE XXXXI

RELATIONSHIP OF PARENT AND RESEARCHER JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Researcher	Cases Judged Unsuccessful By Researcher	Totals
Parent Judged Successful	26	11	37
Parent Judged Unsuccessful	11	32	43
Totals	37	43	80

$$\chi^2 = 1.936$$

p = Greater than .10 Not Significant

Table XXXXI presents parental agreement with researcher's judgment regarding the success of cases. The findings are not significant at the level chosen for this study. The data indicate that parental judgment is unrelated to research judgment in regard to success of therapy. This finding refers to the personality category.

Personality Referral Category

TABLE XXXXII

RELATIONSHIP OF RESEARCHER AND COUNSELOR JUDGMENT REGARDING
SUCCESS OF THERAPY

Researcher's Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccess- ful By Counselor	Totals
Researcher Judged Successful	36	1	37
Researcher Judged Unsuccessful	24	19	43
Totals	60	20	80
p= Less than .001 (Fisher Exact Probability) Significant			

Table XXXXII presents researcher's and counselor's judgment regarding the success of cases. The relationship is significant at the level chosen for this study. The data indicate that research judgment is related to counselor judgment in regard to success of therapy. This finding refers to the personality category.

Personality Referral Category

TABLE XXXXIII

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	18	19	37
Unsuccessful Closure	22	21	43
Totals	40	40	80

$$X^2=1.160$$

p= Greater than .20 Not Significant

When considering the prediction of therapy outcome, as judged by the parent, in relation to the age of the referred child the researcher finds the obtained chi-square value of no statistical significance. This finding applies to the personality category. The median age of children in the personality category was eight years and two months.

Personality Referral Category

TABLE XXXIV

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	20	17	37
Unsuccessful Closure	18	25	43
Totals	38	42	80

$\chi^2 = .757$
 $p = \text{Greater than } .30$ Not Significant

Success of therapy, as judged by the researcher, in relation to age of referred child is of no statistical significance. This finding applies to the personality category. Success of counseling, as viewed by the researcher, is not related to the age of the child. The median age of the children in the personality category was eight years and two months.

Personality Referral Category

TABLE XXXXV

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	29	31	60
Unsuccessful Closure	6	14	20
Totals	35	45	80

$$X^2=1.376$$

p= Greater than .20 Not Significant

When considering the outcome of therapy, as judged by the counselor, in relation to age of referred child the obtained exact probability is of no statistical significance. This finding applies to the personality category. Success of counseling, as perceived by the counselor, is not related to the age of the child. The median age of the children in the personality referral category was eight years and two months.

Personality Referral Category

TABLE XXXXVI

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	15	22	37
Unsuccessful Closure	24	19	43
Totals	39	41	80

$\chi^2 = .895$
 $p = \text{Greater than } .30$ Not Significant

Table XXXXVI presents the relation of therapy outcome, as judged by the parent, to intellectual ability of the child. The obtained chi-square value is of no statistical significance. This finding applies to the personality category. The findings indicate that intellectual ability is unrelated to success in therapy as judged by the parent. The median intellectual quotient of the personality category was 107.

Personality Referral Category

TABLE XXXXVII

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	19	18	37
Unsuccessful Closure	20	23	43
Totals	39	41	80

$\chi^2 = .043$
 $p = \text{Greater than } .80$ Not Significant

Table XXXXVII illustrates the relation of therapy outcome, as judged by the researcher, to intellectual ability of the child. The obtained probability is of no statistical significance. This finding applies to the personality category. The intellectual ability of the children in this sample is not related to the researcher's judgment of success in therapy. The median intellectual quotient of personality cases was 107.

Personality Referral Category

TABLE XXXXVIII

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	25	35	60
Unsuccessful Closure	14	6	20
Totals	39	41	80

$$X^2=3.752$$

p= Greater than .05 Not Significant

The obtained exact probability of Table XXXXVIII is of no statistical significance. This finding indicates there is no significant relationship between success of therapy, as judged by the counselor, and intellectual ability of the child. This finding applies to the personality category. The median intellectual quotient of personality cases was 107.

Personality Referral Category

TABLE XXXIX

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	31	6	37
Unsuccessful Closure	11	32	43
Totals	42	38	80

$$\chi^2 = 2.476$$

p = Greater than .10 Not Significant

Table XXXIX shows the relation of counseling outcome to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The differences found are not statistically significant. This finding applies to the personality category and suggests that case success, as judged by the parent, is unrelated to the duration of the problem.

Personality Referral Category

TABLE L

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	30	7	37
Unsuccessful Closure	12	31	43
Totals	42	38	80

$$\chi^2 = 20.467$$

p = Less than .01 Significant

The obtained probability of Table L is statistically significant. Case success, as judged by the researcher, is significantly related in this sample to the duration of the problem so that children who had a problem for more than thirty months are less apt to be helped by therapy. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. This finding applies to the personality category.

Personality Referral Category

TABLE LI

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	35	25	60
Unsuccessful Closure	7	13	20
Totals	42	38	80

$$\chi^2 = 2.406$$

p = Greater than .10 Not Significant

Table LI shows the relation of counseling outcome, as judged by the counselor, to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The obtained exact probability is insignificant. Case success, as judged by the counselor, is not significantly related to the duration of the problem. This finding refers to the personality category.

Personality Referral Category

TABLE LII

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE PARENT)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	10	27	37
Unsuccessful Closure	31	12	43
Totals	41	39	80

$$X^2 = 1.441$$

p = Greater than .20 Not Significant

Table LII points out that success of closure, as judged by the parent, is unrelated to the parent's attitude toward the child. This finding refers to the personality category. The relationships found are not statistically significant.

Personality Referral Category

TABLE LIII

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE RESEARCHER)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	2	35	37
Unsuccessful Closure	39	4	43
Totals	41	39	80

p= Less than .001 (Fisher Exact Probability) Significant

Table LIII points out that success of closure, as judged by the researcher, is significantly related to the parent's attitude toward the child. It would seem that poor parental attitude toward the child is positively related to unsuccessful case closures as perceived by the researcher. This finding refers to the personality category. Poor parental attitude was measured by evidence of parental rejection, hostility, and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Personality Referral Category

TABLE LIV

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE COUNSELOR)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	1	59	60
Unsuccessful Closure	4	16	20
Totals	5	75	80

$p = .012$ (Fisher Exact Probability) Significant

Table LIV points out that success of closure, as judged by the counselor, is significantly related to the parent's attitude toward the child. Poor parental attitude is significantly and positively related to unsuccessful closures. This finding refers to the personality category. Poor parental attitude was measured by evidence of parental rejection, hostility, and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Personality Referral Category

TABLE LV

OUTCOME OF CHILD'S THERAPY (AS JUDGED BY THE PARENT)
 IN RELATION TO PRESENT PARENTAL ATTITUDE TOWARD THERAPY

Closure Classification	Parental Reply To Question 6			Parental Reply To Question 7		Parental Reply To Question 10	
	No Help	Some Help	Great Help	No	Yes	No	Yes
Successful Closure	0	12	25	12	25	10	37
Unsuccessful Closure	17	22	4	23	20	14	29
Totals	17	34	29	35	45	14	66

Question Six = Assistance given to child at child guidance
 clinic, in Traverse City, was of Great Help____Some Help____
 No Help____,

Question Seven = Do you feel that you have a better understand-
 ing of the problem, for which the child was referred, as a
 result of assistance received from the child guidance clinic
 located at Traverse City? Yes____No____.

Question Ten = Would you refer additional children who are
 having a behavior problem to a child guidance clinic? Yes____
 No____

Table LV shows the relationship of present parental attitude toward therapy which has been conducted with their child. Questions six, seven, and ten were used from the follow-up questionnaire for this purpose. Approximately 36 per cent of the parents felt that they had received great help from the clinic; 43 per cent received some help; and 21 per cent received no help. A better understanding of the problem was reported by 56 per cent of the parents. It is interesting to note that regardless of how much help was given to the child, both in understanding the problem and diminishing the symptoms of the problem, 82 per cent of the parents stated they would refer additional children to the clinic for counseling.

Personality Referral Category

TABLE LVI

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY COUNSELOR

		Cases Presenting New Problems
Cases Reverting To Original Problem	27	8
Cases Remaining Successful In Terms of Initial Referral Problem	33	5
Total Number of Successful Case Closures	60	13

Table LVI points out the number of successful case closures where the problem has not returned and the number who have reverted to the original referral problem. Table LVI also shows the number of new problems presented in each category. This table refers to personality problems. The above information was gathered from question four (Has past problem, or problems, disappeared?) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City?) of the questionnaire. Of the eighty personality cases sixty were closed as successful by the counselor. In terms of the original referral problem 55 per cent of the successful closures have remained successful. Approximately 45 per cent have reverted to the original referral

problem. The twenty-seven cases reverting to the initial referral problem developed new problems in eight instances. The thirty-three cases which remained successful in terms of the initial referral problem developed new problems in five instances.

Personality Referral Category

TABLE LVII

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY RESEARCHER

		Cases Presenting New Problems
Cases Reverting To Original Problem	9	1
Cases Remaining successful In Terms Of Initial Referral Problem	28	2
Total Number of Successful Case Closures	37	3

The above table shows the number of successful case closures, as judged by the researcher, where the problem has not returned and the number who have reverted to the original referral problem. Table LVII also shows the number of new problems presented in each category. This table refers to personality problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes___ No___ Partially___) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___). If so, state problem) of the questionnaire. Due to the fact that a successful closure is classified by the State Department of Mental Health as one showing improvement, regardless of

degree or from what source, the term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the eighty personality cases thirty-seven were judged, by the researcher, as successful. In terms of the initial referral problem twenty-eight, or 76 per cent, of the successful closures have remained successful. Approximately twenty-four per cent have reverted to the original referral problem. The nine cases reverting to the initial referral problem developed new problems in only one instance. The twenty-eight cases which remained successful in terms of the initial referral problem developed new problems in two instances.

Personality Referral Category

TABLE LVIII

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY PARENTS

		Cases Presenting New Problems
Cases Reverting To Original Problem	1	0
Cases Remaining Successful In Terms of Initial Referral Problem	36	5
Total Number of Successful Case Closures	37	5

Table LVIII points out the number of successful case closures, as judged by the parent, where the problem has not returned and the number who have reverted to the original referral problem. Table LVIII also shows the number of new problems presented in each category. This table refers to personality problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes___ No___ Partially___) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___ . If so, state problem.) of the questionnaire. Due to the fact that a

successful closure is classified by the State Department of Mental Health as one showing improvement, regardless of degree or from what source, the term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the eighty personality cases thirty-seven were judged as successful by the parent. In terms of the initial referral problem thirty-six, or 97 per cent, of the successful closures have remained successful. Only one case reverted to the original referral problem. Of the thirty-six cases which remained successful five developed new problems.

Learning and developmental referral category. The following tables and presented comparisons are applicable only to the learning and developmental referral category. They are to be interpreted in the same manner as previous tables and presentations. Learning and developmental problems are particularly prevalent during the ages four through ten. They are usually associated with school problems but may include delayed maturational problems of speech, walking, and coordination. Examples of learning and developmental problems, as used in this study, include: poor schoolwork, developmental patterns below age expectancy, and problems associated with dull normal or borderline intelligence.

Learning and Developmental Category

TABLE LIX

RELATIONSHIP OF PARENT AND COUNSELOR JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccess- ful By Counselor	Totals
Parent Judged Successful	7	1	8
Parent Judged Unsuccessful	14	8	22
Totals	21	9	30

p=.179 (Fisher Exact Probability) Not Significant

Table LIX presents parental agreement with counselor judgment. The differences found are not statistically significant. The data indicate that parental judgment is unrelated to counselor judgment when dealing with learning and developmental problems. It would seem that the parent is somewhat less optimistic than is the counselor regarding the success of cases.

Learning and Developmental Category

TABLE LX

RELATIONSHIP OF PARENT AND RESEARCHER JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Researcher	Cases Judged Unsuccessful By Researcher	Totals
Parent Judged Successful	7	1	8
Parent Judged Unsuccessful	3	19	22
Totals	10	20	30
p=.004 (Fisher Exact Probability) Significant			

Table LX presents parental agreement with researcher's judgment regarding the success of cases. The findings are significant at the level chosen for this study. The findings indicate that parental judgment is related to researcher's judgment in regard to success of therapy. This finding applies to the learning and developmental category.

Learning and Developmental Category

TABLE LXI

RELATIONSHIP OF RESEARCHER AND COUNSELOR
JUDGMENT REGARDING SUCCESS OF THERAPY

Researcher's Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccess- ful By Counselor	Totals
Researcher Judged Successful	9	1	10
Researcher Judged Unsuccessful	12	8	20
Totals	21	9	30
p=.089 (Fisher Exact Probability) Not Significant			

Table LXI presents researcher's and counselor's judgment regarding the success of cases. The findings are not significant at the level chosen for this study. The data indicate that research judgment is not significantly related to counselor judgment in regard to success of therapy. This finding refers to the learning and developmental category.

Learning and Developmental Category

TABLE LXII

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	5	3	8
Unsuccessful Closure	10	12	22
Totals	15	15	30

p=.341 (Fisher Exact Probability) Not Significant

When considering the prediction of therapy outcome, as judged by the parent, in relation to age of referred child, the researcher finds the obtained exact probability of no statistical significance. This finding applies to the learning and developmental category. Age does not seem to be related to success of therapy, as judged by the parent. The median age of children in the learning and developmental category was nine years and two months.

Learning and Developmental Category

TABLE LXIII

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	7	3	10
Unsuccessful Closure	10	10	20
Totals	17	13	30

p=.267 (Fisher Exact Probability) Not Significant

Success of therapy, as judged by the researcher, in relation to age of referred child is of no statistical significance. This finding applies to the learning and developmental category. Success of therapy, as viewed by the researcher, is not significantly related to the age of the child. The median age of the children in the learning and developmental category was nine years and two months.

Learning and Developmental Category

TABLE LXIV

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	10	11	21
Unsuccessful Closure	6	3	9
Totals	16	14	30

$p = .271$ (Fisher Exact Probability) Not Significant

When considering the outcome of therapy, as judged by the counselor, in relation to age of referred child the obtained probability level is of no statistical significance. This finding applies to the learning and developmental category. Success of counseling, as perceived by the counselor, is not related to the age of the child. The median age of the children in the learning and developmental category was nine years and two months.

Learning and Developmental Category

TABLE LXV

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	1	7	8
Unsuccessful Closure	15	7	22
Totals	16	14	30

$p=.009$ (Fisher Exact Probability) Significant

Table LXV illustrates the relation of therapy outcome to intellectual ability of the child. The obtained exact probability is of statistical significance. This finding applies to the learning and developmental category. The findings indicate that intellectual ability of the child is related to success in therapy as judged by the parent. The median intellectual quotient for this sample was 106. The brighter child is more apt to have his therapy judged successful by his parent than is the duller child.

Learning and Developmental Category

TABLE XLVI

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	2	8	10
Unsuccessful Closure	14	6	20
Totals	16	14	30

p=.012 (Fisher Exact Probability) Significant

Table LXVI illustrates the relation of therapy outcome as judged by the researcher, to intellectual ability of the child. The obtained probability is of statistical significance. This finding applies to the learning and developmental category. The intellectual ability of the child in this sample is positively related to the researcher's judgment of success in therapy. The median intellectual quotient of learning and developmental cases was 106.

Learning and Developmental Category

TABLE LXVII

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	8	13	21
Unsuccessful Closure	6	3	9
Totals	14	16	30

$p=.035$ (Fisher Exact Probability) Significant

The obtained exact probability level of Table LXVII is of statistical significance. This finding indicates there is a significant and positive relationship between success of therapy, as judged by the counselor, and intellectual ability of the child. This finding applies to the learning and developmental category. The median intellectual quotient of the learning and developmental category was 106.

Learning and Developmental Category

TABLE LXVIII

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	7	1	8
Unsuccessful Closure	6	16	22
Totals	13	17	30

p=.005 (Fisher Exact Probability) Significant

Table LXVIII shows the relation of counseling outcome to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The differences found are statistically significant. This finding applies to the learning and developmental category and suggests that case success, as perceived by the parent, is related inversely to the duration of the problem.

Learning and Developmental Category

TABLE LXIX

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	9	1	10
Unsuccessful Closure	4	16	20
Totals	13	17	30

p= Less than .001 (Fisher Exact Probability) Significant.

The obtained probability of Table LXIX is of statistical significance. Case success, as judged by the researcher, is related inversely in this sample to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. This finding applies to the learning and developmental category.

Learning and Developmental Category

TABLE LXX

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	10	11	21
Unsuccessful Closure	3	6	9
Totals	13	17	30

$p=.502$ (Fisher Exact Probability) Not Significant

Table LXX shows the relation of counseling outcome, as judged by the counselor, to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The obtained exact probability is not significant. Case success, as judged by the counselor, is not related in this sample to the duration of the problem. This finding refers to the learning and developmental category.

Learning and Developmental Category

TABLE LXXI

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE PARENT)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	1	7	8
Unsuccessful Closure	13	9	22
Totals	14	16	30

p=.03 (Fisher Exact Probability) Significant

Table LXXI points out that success of closure is related to the parent's attitude toward the child. This finding applies to the learning and developmental category. Poor parental attitude toward the child is positively related to unsuccessful case closures.

Learning and Developmental Category

TABLE LXXII

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE RESEARCHER)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	0	10	10
Unsuccessful Closure	0	20	20
Totals	0	30	30
p=1.00 (Fisher Exact Probability) Not Significant			

Table LXXII suggests that success of closure, as judged by the researcher, is not related to the parent's attitude toward the child. This finding refers to the learning and developmental category. Poor parental attitude was measured by evidence of parental rejection, hostility, and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Learning and Developmental Category

TABLE LXXIII

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE COUNSELOR)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	0	21	21
Unsuccessful Closure	0	9	9
Totals	0	30	30

p=1.00 (Fisher Exact Probability) Not Significant

Table LXXIII suggests that success of closure, as judged by the counselor, is not related to the parent's attitude toward the child. This finding refers to the learning and developmental category. Poor parental attitude was measured by evidence of parental rejection, hostility, and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Learning and Developmental Category

TABLE LXXIV

OUTCOME OF CHILD'S THERAPY (AS JUDGED BY THE PARENT)
 IN RELATION TO PRESENT PARENTAL ATTITUDE TOWARD THERAPY

Closure Classification	Parental Reply To Question 6			Parental Reply To Question 7		Parental Reply To Question 10	
	No Help	Some Help	Great Help	No	Yes	No	Yes
Successful Closure	0	2	6	5	3	0	8
Unsuccessful Closure	8	12	2	14	8	4	18
	—	—	—	—	—	—	—
Totals	8	14	8	19	11	4	26

Question Six = Assistance given to child at child guidance clinic, in Traverse City, was of Great Help____ Some Help____ No Help_____.

Question Seven = Do you feel that you have a better understanding of the problem, for which the child was referred, as a result of assistance received from the child guidance clinic located in Traverse City? Yes____ No_____.

Question Ten = Would you refer additional children who are having a behavior problem to a child guidance clinic? Yes____ No_____.

Table LXXIV shows the relationship of present parental attitude toward therapy which has been conducted with their child. Questions six, seven, and ten were used from the follow-up questionnaire for this purpose. Approximately 27 per cent of the parents felt that they had received great help from the clinic; 46 per cent received some help; and 27 per cent felt that they had received no assistance. A better understanding of the problem was reported by 37 per cent of the parents while 63 per cent did not feel that they had received assistance in understanding the child's problem at time of closure. Approximately 87 per cent stated they would refer additional children to the clinic.

Learning and Developmental Category

TABLE LXXV

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY COUNSELOR

		New Problems Presented
Cases Reverting To Original Problem	12	2
Cases Remaining Successful In terms of Initial Referral Problem	9	2
Total Number of Successful Case Closures	21	4

Table LXXV points out the number of successful case closures where the problem has not returned and the number who have reverted to the original referral problem. Table LXXV also shows the number of new problems presented in each category. This table refers to learning and developmental problems. The above information was gathered from question four (Has past problem, or problems, disappeared?) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City?) of the questionnaire. Of the thirty cases twenty-one were closed as successful by the counselor. In terms of the original problem 43 per cent have remained successful. Approximately 57 per cent have

reverted to the original referral problem. Two children in each category have presented new problems.

Learning and Developmental Problems

TABLE LXXVI

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY RESEARCHER

		Cases Presenting New Problems
Cases Reverting To Original Problem	2	0
Cases Remaining Successful In Terms of Initial Referral Problem	8	2
Total Number of Successful Case Closures	10	2

The above table shows the number of successful case closures, as judged by the researcher, where the problem has not returned and the number who have reverted to the original referral problem. Table LXXVI also shows the number of new problems presented in each category. This table refers to learning and developmental problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes___ No___ Partially___.) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___). If so, state problem) of the questionnaire. Due to the fact that a

successful closure is classified by the State Department of Mental Health as one showing improvement, regardless of degree or from what source, the term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the thirty cases in the learning and developmental category ten were judged as successful by the researcher. In terms of the initial referral problem eight, or 80 per cent, have remained successful. Approximately 20 per cent have reverted to the original referral problem. The eight cases which remained successful in terms of the initial referral problem developed new problems in two instances.

Learning and Developmental Category

TABLE LXXVII

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY PARENT

		Cases Presenting New Problems
Cases Reverting To Original Problem	0	0
Cases Remaining Successful In Terms of Initial Referral Problem	8	1
Total Number of Successful Case Closures	8	1

Table LXXVII points out the number of successful case closures, as judged by the parent, where the problem has not returned and the number who have reverted to the original referral problem. Table LXXVII also shows the number of new problems presented in each category. This table refers to learning and developmental problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes___ No___ Partially___) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___ . If so, state problem) of the questionnaire. Due to the fact that a successful closure is classified by the State Department of Mental Health

as one showing improvement, regardless of degree or from what source, the term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the thirty learning and developmental cases eight were judged as successful by the parent. In terms of the initial referral problem all of the successful closures remained successful. The eight cases which remained successful in terms of the initial referral problem developed new problems in only one instance.

Functional illness referral category. The following tables and presented comparisons are applicable to the functional illness category. They are to be interpreted in the same manner as previous tables and presentations. A functional illness problem is a behavior disorder which takes on the characteristic of a physical condition, even though there is no direct relation between the two. Examples of functional illness problems, as used in this study, include headaches, skin disorders, vomiting, fainting, and convulsions.

Functional Illness Category

TABLE LXXVIII

RELATIONSHIP OF PARENT AND COUNSELOR JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccess- ful By Counselor	Totals
Parent Judged Successful	15	1	16
Parent Judged Unsuccessful	8	7	15
Totals	23	8	31

p= .01 (Fisher Exact Probability) Significant

Table LXXVIII presents parental agreement with counselor judgment. The findings are significant at the level chosen for this study. The findings indicate that parental judgment is related to counselor judgment in regard to success of therapy with cases in the functional illness category.

Functional Illness Category

TABLE LXXIX

RELATIONSHIP OF PARENT AND RESEARCHER JUDGMENT REGARDING
SUCCESS OF THERAPY

Parental Judgment	Cases Judged Successful By Researcher	Cases Judged Unsuccessful By Researcher	Totals
Parent Judged Successful	15	1	16
Parent Judged Unsuccessful	0	15	15
Totals	15	16	31

p= .01 (Fisher Exact Probability) Significant

Table LXXIX presents parental agreement with researcher's judgment regarding the success of cases. The relationship is significant at the level chosen for this study. The findings indicate that parental judgment is related to researcher judgment when dealing with functional illness problems.

Functional Illness Category

TABLE LXXX

RELATIONSHIP OF RESEARCHER AND COUNSELOR JUDGMENT REGARDING
SUCCESS OF THERAPY

Researcher Judgment	Cases Judged Successful By Counselor	Cases Judged Unsuccess- ful By Counselor	Totals
Researcher Judged Successful	14	1	15
Researcher Judged Unsuccessful	9	7	16
Totals	23	8	31

$p = .002$ (Fisher Exact Probability) Significant

Table LXXX presents researcher's and counselor's judgment regarding the success of cases. The relationship is significant at the level chosen for this study. The data indicate that research judgment is related to counselor judgment in regard to success of therapy. This finding refers to the functional illness category.

Functional Illness Category

TABLE LXXXI

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	10	6	16
Unsuccessful Closure	5	10	15
Totals	15	16	31

$$\chi^2 = 2.092$$

p = Greater than .10 Not Significant

When considering the prediction of therapy outcome, as judged by the parent, in relation to age of referred child the researcher finds the obtained chi-square value of no statistical significance. This finding applies to the functional illness category. The age of the child does not seem to be related to success of therapy as perceived by the parent. The median age of the children in the functional illness category was nine years and nine months.

Functional Illness Category

TABLE LXXXII

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	13	2	15
Unsuccessful Closure	6	10	16
Totals	19	12	31

p= .006 (Fisher Exact Probability) Significant

Success of therapy, as judged by the researcher, in relation to age of referred child is statistically significant. This finding applies to the functional illness category. Success of counseling, as viewed by the researcher, is negatively related to the age of the child. The median age of the children in the functional illness category was nine years and nine months.

Functional Illness Category

TABLE LXXXIII

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO AGE

Closure Classification	Below Median Age	Above Median Age	Totals
Successful Closure	16	7	23
Unsuccessful Closure	2	6	8
Totals	18	13	31

p= .036 (Fisher Exact Probability) Significant

When considering the outcome of therapy, as judged by the counselor, in relation to age of referred child the obtained exact probability is statistically significant. This finding applies to the functional illness category. Success of counseling, as perceived by the counselor, is negatively related in this sample to the age of the child. The median age of the children in the functional illness category was nine years and nine months.

Functional Illness Category

TABLE LXXXIV

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	5	11	16
Unsuccessful Closure	8	7	15
Totals	13	18	31

$$\chi^2 = .736$$

p = Greater than .30 Not Significant

Table LXXXIV shows the relation of therapy outcome to intellectual ability of the child. The obtained chi-square value is of no statistical significance. This finding applies to the functional illness category. The data indicate that intellectual ability of the child is unrelated to success in therapy as judged by the parent. The median intellectual quotient of children in the functional illness category was 103.

Functional Illness Category

TABLE LXXXV

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	5	10	15
Unsuccessful Closure	5	11	16
Totals	10	21	31

$p = .074$ (Fisher Exact Probability) Not Significant

Table LXXXV shows the relation of therapy outcome, as judged by the researcher, to intellectual ability of the child. The obtained probability is of no statistical significance. This finding applies to the functional illness category. The intellectual ability of the children in this sample is not related to the researcher's judgment of success in therapy. The median intellectual quotient of children in the functional illness category was 103.

Functional Illness Category

TABLE LXXXVI

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO INTELLECTUAL ABILITY

Closure Classification	Cases Below Median I.Q.	Cases Above Median I.Q.	Totals
Successful Closure	7	16	23
Unsuccessful Closure	3	5	8
Totals	10	21	31

$p = .742$ (Fisher Exact Probability) Not Significant

The obtained exact probability of Table LXXXVI is of no statistical significance. This finding indicates there is no significant relationship between success of therapy, as judged by the counselor, and intellectual ability of the child. This finding applies to the functional illness category. The median intellectual quotient of children in the functional illness category was 103.

Functional Illness Category

TABLE LXXXVII

SUCCESS OF THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	12	4	16
Unsuccessful Closure	5	10	15
Totals	17	14	31

$p = .024$ (Fisher Exact Probability) Significant

Table LXXXVII shows the relation of counseling outcome to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The relationships found are statistically significant. This finding applies to the functional illness category and suggests that case success, as judged by the parent, is inversely related to the duration of the problem.

Functional Illness Category

TABLE LXXXVIII

SUCCESS OF THERAPY (AS JUDGED BY THE RESEARCHER)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	15	0	15
Unsuccessful Closure	2	14	16
Totals	17	14	31

p= Less than .001 (Fisher Exact Probability) Significant

The obtained probability of Table LXXXVIII is of statistical significance. Case success, as judged by the researcher, is inversely related in this sample to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. This finding applies to the functional illness category.

Functional Illness Category

TABLE LXXXIX

SUCCESS OF THERAPY (AS JUDGED BY THE COUNSELOR)
IN RELATION TO DURATION OF PROBLEM

Closure Classification	Duration of Problem		Totals
	30 Months or Less	More Than 30 Months	
Successful Closure	11	12	23
Unsuccessful Closure	6	2	8
Totals	17	14	31

p= .177 (Fisher Exact Probability) Not Significant

Table LXXXIX shows the relation of counseling outcome, as judged by the counselor, to the duration of the problem. The duration of the problem which occasioned the referral was taken from the social worker's intake referral sheet. The obtained exact probability is not significant. Case success, as judged by the counselor, is not related to the duration of the problem. This finding refers to the functional illness category.

TABLE XC

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE PARENT)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	4	12	16
Unsuccessful Closure	9	6	15
Totals	13	18	31

p= .043 (Fisher Exact Probability) Significant

Table XC points out that success of closure, as perceived by the parent, is related to the parent's attitude toward the child. This finding applies to the functional illness category. It would seem that poor parental attitude toward the child is positively related to unsuccessful case closure as judged by the parent.

Functional Illness Category

TABLE XCI

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE RESEARCHER)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	1	14	15
Unsuccessful Closure	1	15	16
Totals	2	29	31

$p = 1.326$ (Fisher Exact Probability) Not Significant

Table XCI points out that success of closure, as judged by the researcher, is not significantly related to the parent's attitude toward the child. This finding applies to the functional illness category. Poor parental attitude was measured by evidence of parental rejection, hostility, and marital difficulty. This fact was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Functional Illness Category

TABLE XCII

RELATION OF THERAPY OUTCOME (AS JUDGED BY THE COUNSELOR)
AND PARENTAL ATTITUDE TOWARD REFERRED CHILD

Closure Classification	Parental Attitude Poor	Parental Attitude Good	Totals
Successful Closure	1	22	23
Unsuccessful Closure	1	7	8
Totals	2	29	31

$p = .576$ (Fisher Exact Probability) Not Significant

Table XCII points out that success of closure, as judged by the counselor, is not significantly related to the parent's attitude toward the child. This finding refers to the functional illness category. Poor parental attitude was measured by parental rejection, hostility, and marital difficulty. This factor was recorded if it had been given orally by the referring agent or if clinically interpreted by the counselor.

Functional Illness Category

TABLE XCIII

OUTCOME OF CHILD'S THERAPY (AS JUDGED BY THE PARENT)
IN RELATION TO PRESENT PARENTAL ATTITUDE TOWARD THERAPY

Closure Classification	Parental Reply To Question 6			Parental Reply To Question 7		Parental Reply To Question 10	
	No Help	Some Help	Great Help	No	Yes	No	Yes
Successful Closure	0	5	11	7	9	0	16
Unsuccessful Closure	6	7	2	9	6	3	12
Totals	6	12	13	16	15	3	28

Question Six = Assistance given to child at child guidance clinic, in Traverse City, was of Great Help____ Some Help____ No Help____.

Question Seven = Do you feel that you have a better understanding of the problem, for which the child was referred, as a result of assistance received from the child guidance clinic located in Traverse City? Yes____ No____.

Question Ten = Would you refer additional children who are having a behavior problem to a child guidance clinic? Yes____ No____.

Table XCIII shows the relationship of present parental attitude toward therapy which has been conducted with their child. Question six, seven, and ten from the follow-up questionnaire were used for this purpose. Approximately 42 per cent of the parents felt they had received great help; 39 per cent received some help; and 19 per cent received no help. A better understanding of the problem was reported by 44 per cent of the parents. It is interesting to note that regardless of how much help was given to the child 90 per cent of the parents stated they would refer other children to the clinic for counseling.

Functional Illness Category

TABLE XCIV

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY COUNSELOR

		Cases Presenting New Problems
Cases Reverting to Original Problem	9	5
Cases Remaining Successful In Terms of Initial Referral Problem	14	3
Total Number of Successful Case Closures	23	8

Table XCIV points out the number of successful case closures where the problem has not returned and the number who have reverted to the original referral problem. Table XCIV also shows the number of new problems presented in each category. This table refers to functional illness problems. The above information was gathered from question four (Has past problem, or problems, disappeared?) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City?) of the questionnaire. Of the thirty-one functional illness cases twenty-three were closed as successful by the counselor. In terms of the original referral problem 61 per cent of the successful closures have remained successful. Approximately 39 per cent have reverted

to the original referral problem. The nine cases reverting to the original referral problem developed new problems in five instances. The fourteen cases which remained successful in terms of the initial referral problem developed new problems in three instances.

Functional Illness Category

TABLE XCV

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY RESEARCHER

		Cases Presenting New Problems
Cases Reverting To Original Problem	0	0
Cases Remaining Successful In Terms Of Initial Referral Problem	15	2
Total Number of Successful Case Closures	15	2

The above table shows the number of successful case closures, as judged by the researcher, where the problem has not returned and the number who have reverted to the original referral problem. Table XCV also shows the number of new problems presented in each category. This table refers to functional illness problems. The above information was gathered from question four (Has past problems, or problems, disappeared? Yes___ No___ Partially___) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___). If so, state problem) of the questionnaire. Due to the fact that a successful closure is classified by the State Department of Mental Health as one showing improve-

ment, regardless of degree or from what source, the term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the thirty-one functional illness cases fifteen were judged as successful by the researcher. In terms of the initial referral problem all of the cases judged as successful by the researcher remained successful. The fifteen cases which remained successful in terms of the initial referral problem developed new problems in two instances.

Functional Illness Category

TABLE XCVI

PRESENT STATUS OF CASES JUDGED SUCCESSFUL BY PARENT

		Cases Presenting New Problems
Cases Reverting To Original Problem	0	0
Cases Remaining Successful In Terms of Initial Referral Problem	16	2
Total Number of Successful Case Closures	16	2

Table XCVI points out the number of successful case closures, as judged by the parent, where the problem has not returned and the number who have reverted to the original referral problem. Table XCVI also shows the number of new problems presented in each category. This table refers to functional illness problems. The above information was gathered from question four (Has past problem, or problems, disappeared? Yes___ No___ Partially___) and question five (Have additional behavior difficulties occurred since child was last seen at the child guidance clinic in Traverse City? Yes___ No___ . If so, state problem) of the questionnaire. Due to the fact that a successful case closure is classified by the State Department of Mental Health as one showing improvement, regardless of degree or from what source, the

term partially improved as used in question four is classified as a case that has remained successful. In some cases however, this classification is in error due to the fact that complete success in therapy has reverted to partial or minimal success. Of the thirty-one functional illness cases sixteen were judged as successful by the parent. In terms of the initial referral problem all of the successful closures, as judged by the parent, have remained successful. The fifteen cases which remained successful in terms of the initial referral problem developed new problems in two instances.

Summary

The relationship between a successful and an unsuccessful case closure was analyzed in reference to four factors.

The factors were (1) age; (2) duration of referred problem; (3) intellectual ability; and (4) parental attitude toward child.

In addition to the above analyses the researcher attempted to measure (1) agreement of parent judgment with counselor's judgment and researcher's judgment; (2) agreement of counselor's judgment and researcher's judgment; (3) present parental attitude toward therapy as related to outcome of therapy; (4) number of cases that have remained successful in terms of the initial referral problem; (5) number of cases that have reverted to the original referral problem; and (6) number of cases that have presented new problems.

When considering prediction of success through the use of the above four factors, in reference to the five referral categories, the chi-square method of analysis and the Fisher Exact Probability Test showed:

1. Researcher and counselor judged age as a predictive factor in relation to the functional illness category. Both parent and researcher felt the younger child was more apt to benefit from therapy than the older child.

When considering the conduct category the parent judged age as a predictive factor and felt that the older

child was more apt to benefit from therapy than younger child.

Age was not judged as a significant predictive factor by parent, researcher, or counselor in relation to habit, personality, or learning and developmental categories.

2. Intellectual ability was of no statistical significance for problems classified as habit problems, personality problems, and functional illness problems. Parent, researcher, and counselor judged intelligence as a significant predictive factor in relation to the learning and developmental category. Intelligence was judged as a significant factor by the parent in relation to the conduct category.

Where intellectual ability was considered a predictive factor, the brighter children were shown as more apt to profit from therapy.

3. Duration of problem and success in therapy was found to be significantly related, by parent and researcher, to learning and developmental problems and functional illness problems. The researcher also considered duration of problem as a significant predictive factory when used in reference to the personality category. Counselor and parent also considered duration of problem a predictive factor for conduct problems.

Duration of problem was not judged as a significant

predictive factor by parent, researcher, or counselor in relation to habit problems.

Where duration of problem was considered a significant predictive factor the children who had problems that had persisted for less than thirty months were shown as more apt to profit from therapy.

4. Parental attitude toward the child in relation to prediction of therapy outcome was significantly related, by the parent, to conduct problems, learning and developmental problems, and functional illness problems. The researcher considered parental attitude a predictive factor in reference to conduct problems and personality problems. The counselor felt parental attitude was a predictive factor when used only in reference to personality problems. Parent, researcher, and counselor felt that parental attitude toward the child was not significant when used in reference to habit problems.

Poor parental attitude toward the child was shown to be positively related to unsuccessful case closure where parental attitude was considered a significant predictive factor.

From the data gathered throughout the parents of referred children it is apparent that present parental attitude toward therapy is an item worth analyzing rather closely. Approximately 34 per cent of the parents stated their children had received great help from the clinic. Approximately

26 per cent of the parents felt that their children had received no help. Some help was reported by 40 per cent of the parents.

A better understanding of the child's problem was reported by 52 per cent of the parents. Approximately 48 per cent of the parents felt they did not have a better grasp of the child's problem upon termination of therapy. It is interesting to note that regardless of the amount of assistance the parent felt he had received at the clinic or the degree of understanding of the referred problem 84 per cent of the parents said they would refer other children for counseling assistance.

Of the total number of cases judged as successful by the counselor 47 per cent have remained successful, while 53 per cent have reverted back to the original problem.

Over half of the total cases the counselor considered successfully closed are no longer classified as successful by the parent. Fifty-two children of the 156 successful closures have developed new problems.

Of the total number of cases closed as successful by the researcher 72 per cent have remained successful, while 27 per cent have reverted back to the original problem.

Of the ninety-one cases judged as successfully closed by the researcher seventeen have developed new problems. Over half the total cases considered successfully closed by the re-

searcher were classified by the parent as remaining successfully closed.

The parent judged seventy-nine cases as successfully closed. Of these seventy-nine the parent classified seventy-eight as remaining successfully closed. Twelve of the seventy-nine children successfully closed by the parent have developed new problems.

The relationship of parental judgment and counselor judgment regarding success of therapy is somewhat conflicting. Counselor judgment and parental judgment were related only when dealing with personality and functional illness problems. Counselor and parent seemed to disagree on the success of closure in the remaining three categories.

Parental judgment and researcher judgment regarding success of therapy related in all categories except those referrals classified under personality problems. It would seem that parental judgment of successful closures are more closely related to researcher's judgment than to counselor's judgment.

Researcher's judgment and counselor's judgment were related when dealing with conduct problems, habit problems, personality problems, and functional illness problems. Counselor and researcher seemed to disagree on the success of closure in reference to learning and developmental problems.

Parent, counselor, and researcher were in agreement in reference to the closure of problems classified under

the functional illness category.

RELATING THE FINDINGS TO THE CHILD GUIDANCE SETTING

It is possible now, from the analyses provided by the foregoing chapters, to construct a composite picture of some of the factors related to therapy outcome and closure stability. Certain factors are associated generally with successful or unsuccessful closure while additional factors need to be looked at in reference to closure stability.

For those who desire to utilize the findings the type of area from which the total sample was drawn must be taken into consideration. The area studied would be classified as rural urban, small city and refined farm area, and may not offer the type of children and problems presented in a metropolitan district.

FACTORS RELATED TO SUCCESSFUL CLOSURE

What factors are related most definitely to prediction of successful counseling outcome? Only factors with a level of confidence at or beyond the five per cent level of confidence have been used in drawing the composite picture.

When considering case selection for successful outcome

it would seem that referrals presenting habit problems have the least number of variables to statistically satisfy. All four of the tested variables (1) age, (2) duration of referred problem, (3) intellectual ability, and (4) parental attitude toward referred child, were found to be related to success in a statistically non-significant manner. It is interesting to note however that parents report 57 per cent of the successful closures, in the habit category, reverting back to the original referral problem.

The group which seems to have the next best chance of success in a therapeutic situation are those with personality problems. For this category duration under thirty months and a good parental attitude toward the child were found to be statistically significant by researcher or counselor. The remaining factors, age and intellectual ability, were not found to be statistically significant by parent, researcher, or counselor.

CHAPTER V

SUMMARY AND CONCLUSIONS

The Problem

The determination of what factors are most useful in predicting therapy success with children, the stability of successful therapeutic closures, and an evaluation of specific child guidance practices is a most difficult task. The material gathered previously consists mostly of data which have been loosely formulated and applied to children who have not been categorized according to specific referral problems. Such data has been used by most child guidance clinics in attempting to arrive at conclusions regarding treatment and clinic practices.

The problem of this study was (1) to select and to analyze some factors hypothesized to be related to successful therapy closure; (2) to determine if therapy cases classified as successful by a counselor have remained successful; (3) to compare the initial referral problem to the problem actually found by the counselor; (4) to determine the "best risk" for therapy in terms of length of treatment and the initial referral problem; (5) to determine how successful child guidance has been in correcting the initial referral problem; and (6) to determine if there is a need to improve methods of reporting and

handling information obtained in a child guidance clinic.

Because the school age population and the public awareness of emotional problems in children has increased during the past several years it is understandable that the child guidance clinics in the State of Michigan have become overburdened. The increase in children being referred to child guidance clinics much outweighs the increase in professional staff. The public's concern with emotional problems of children has become more acute each year for the past several years. Child guidance clinics are adding more professional service, new clinics are being established, and communities are demanding legislation leading to more and more service. If negative public opinion of the present program is allowed to gain momentum, it may curtail the improvement of this situation. It is necessary that some method of sorting be attempted to enable clinics to determine which child will benefit most from therapeutic interviews.

The main hypothesis of this study is that there are relationships between specific characteristics of the referred child and his actual problem as classified which determines the probability of successful counseling.

The Findings

The analysis of the factors studied in relation to successful or unsuccessful case closure resulted in a number of findings.

1. At or beyond the five per cent level of confidence the following factors appeared to be significantly related by parent, counselor, or researcher, to successful case closure; intellectual ability above 100 for referral problems classified under the learning and developmental category; intellectual ability above ninety-seven for problems classified under the conduct category; duration of problem less than thirty months for referral problems classified under conduct, personality, functional illness, and learning and developmental problems; and good parental attitude toward the child for referral problems classified under conduct, functional illness, personality, and learning and developmental problems.

2. Age of referred child was statistically significant when used as a predicting factor by parent, counselor, or researcher, for conduct and functional illness problems. The younger child seemed to benefit more from therapy when classified as a functional illness problem while the older child benefited more when classified as a conduct problem.

3. Intellectual ability seemed to have no significant relationship to case closure when used in reference to habit, personality, or functional illness categories.

4. Parental attitude toward child seemed to have no statistical significance to case closure when used in reference to referral problems classified under the habit

category.

The findings resulting from the analysis of cases closed as successful by the counselor and their status to date indicate the following:

1. Over half of the successfully closed conduct, learning and developmental, habit, and personality problems have reverted to the original referral problem.

2. Over half of the successfully closed functional illness problems have remained successful in terms of the initial referral problem.

The findings resulting from the analysis of agreement between counselor judgment, parental judgment, and research judgment indicate the following:

1. Parental agreement with counselor judgment is significant at or beyond the five per cent level of confidence only when referring to problems classified under the personality and functional illness categories. Parental agreement with counselor judgment is not statistically significant for problems classified under conduct, habit, and learning and developmental categories.

2. Parental agreement with research judgment is statistically significant at or beyond the five per cent level of confidence when dealing with conduct, habit, functional illness, and learning and developmental categories. Parental judgment is unrelated to researcher judgment in

judgment in reference to problems classified under the personality category. Parental judgment seems to be more in agreement with researcher judgment than counselor judgment when attempting to determine case closure.

3. Counselor judgment and researcher judgment of successful closures are significantly related in reference to problems classified under the conduct category, habit category, and functional illness category.

The findings relating to the initial referral problem and the counselor-found problem are incomplete due to the fact that the majority of the records fail to point out the counselor-found problem.

In addition to the above findings the following have been explored:

1. Can one determine the "best risk" for therapy in terms of length of treatment and the initial referral problem?

The average length of treatment time spent with each referral category was found to be as follows: (1) personality and learning and developmental problems nine months; (2) conduct problems eleven months; (3) functional illness problems thirteen months; and (4) habit problems twenty months.

The "best risk" for therapy in terms of length of treatment would seem to be problems classified under the personality category. This category has the shortest re-

ported treatment time and is also one of the two categories having the fewest number of factors associated with success of treatment.

2. How successful has child guidance been in correcting the initial referral problem?

The overall picture of success in the cases used in this study is somewhat contradictory. The total number of closures classified as successful by the counselor amount to three-fourths of the sample. The returns from the parent suggest that less than half of the children were successful closures in terms of the initial referral problem. It would seem that the method of classifying cases as successful is in error or that parent and counselor estimation of case improvement are in contradiction.

3. Is there a need to improve methods of reporting and handling information in a child guidance clinic?

In compiling the needed information for this study it was apparent that the reporting and handling of information is an area in child guidance which might be improved.

In looking over the returned questionnaires it is apparent that counselor judgment and parental judgment of case closure differ considerably. The differences seem to be great enough to warrant comment.

At the present time the counselor in child guidance work is required to close a case as "successful" or unsuccessful". To force a choice from two wide extremes may

possibly bring into play the "halo" effect on many case closures. It seems only natural that a counselor, after working with a child for several months, can see improvement in one of many areas. According to the present closure system a case that shows improvement, regardless of whether or not this improvement is related to therapy, is to be closed as successful. It is the researcher's opinion that cases are being classified as successful when the improvement is barely enough to warrant minimal adjustment.

To improve the method of reporting that is presently used it is suggested that additional categories be considered for case closure classification. By using additional categories the counselor would not necessarily be forced into a misleading judgment.

A possible closure classification might consist of the following:

1. Successful closure. A case is to be closed as a successful closure only when the referred child has satisfactorily adjusted to the problem found by the counselor.

2. Partially successful closure. A case is to be closed as partially successful when the referred child has partially adjusted to the problem found by the counselor.

3. Unimproved or failure. A case is to be closed as unimproved or a case failure when the referred child fails to adjust, or partially adjust, to the problem found

by the counselor.

Another facet of reporting which seems to be quite irregular is the classification of the original referral problem into one of the five problem categories set up by the Michigan Department of Mental Health.

Due to the fact that some clinics do not have a listing of the problems that fall under a specific category many problems are misclassified. It is interesting to note that counselors working in the same clinic consistently classify identical referral problems in different categories. Secretarial help is given the responsibility of classification without proper written guidance or verbal directions, and in many instances the referral problem is one that is reported over the phone or one that is misinterpreted by the intake worker. From such misinterpretation it seems quite apparent that statistics being reported are possibly quite misleading and insignificant.

To allow for more accurate and adequate reporting the researcher suggests the following:

1. Due to the fact that most referral problems can be easily classified under the five headings suggested by the State Department of Mental Health, it would seem feasible to standardize a total list of referral problems under the five headings. This list could be brought up to date by clinic directors, or the State Department of Mental Health, each year.

2. Each clinic in the State of Michigan should be given copies of the suggested list. Classification would then become quite uniform and have more statistical significance. It would make little difference if clerical help or professional personnel did the categorization under this suggested plan.

An additional area of reporting which may warrant review is the disposition classification as used by the State Department of Mental Health. At present there are certain closure dispositions which do not fall under any of the suggested headings. For example, if a case is closed which needs further care but the family or the patient is not ready to accept such treatment is impossible to classify the case correctly. An additional classification might be one which would provide disposition for children who do not desire to come to the clinic for weekly sessions but do so only to satisfy their parents.

Other illustrations of inadequate disposition could be cited to illustrate possible alterations, however the above illustrations suggest that possible changes may be in order.

In looking over the case records from the years 1950-1957 several problems of reporting were consistently encountered. The material in the case folders seemed to be deficient in the following manner:

1. The counselor in many instances failed to state what he believed to be the referred problem. This lack of counselor-found basis for the referred problem may be synonymous to a physician treating symptoms, not the disease.

2. Goals in therapy were not set in the majority of cases in accordance with the problem. Many cases were taken with the supposition that removal of the presenting problem was to be the end goal. In many cases such goals were impossible.

3. Case notes on psychiatric consultation seemed to be absent in most instances.

4. Many closures of the studied cases were completed without notifying the referral agent or the parent. In closing a case in this manner no interpretation of the child's problem was given.

5. Cases that received treatment and cases that did not receive treatment were left open for seemingly unnecessary periods of time. Several cases were left open for seven years or more with possibly one interview taking place. This practice would seem to be unwise both professionally and statistically.

When reviewing treatment outcome of reopened cases it is interesting to note that therapy failure is significantly more prevalent than therapy success. The factor that seems

to be significant in reopened cases is that the therapist has attempted to treat the referral problem and not the counselor-found problem. The outcome seems to allow alleviation of the referred problem and recurrence of problem behavior in the same or different form.

To change the above situation it would seem that the counselor, with the aid of the clinic staff, must identify the cause of the problem and attempt to alleviate or cure the identified cause or situation. If this is not feasible to some clinic staffs it may be advantageous to allow the counselor to depreciate the significance of the referral problem, thus allowing other problem symptoms to appear and permit the cause of the referral problem to come to the surface. By following this procedure the counselor may be allowed to rid himself of the tendency to feel obligated to treat the referral problem and the tendency to close a case as successful when it is not.

Therapy cases which have been repeatedly transferred from one worker to another show case failure. Due to the extremely high failure rate it would seem advantageous for the clinic staff to discourage the transfer of cases from one worker to another. One should not interpret the above suggestion however to mean that transfer of cases necessarily means therapy failure but rather previously attempted therapy mitigates against successful closure. The observed

frequency of failure in transferred cases corroborates the data given by Ingham and Love¹, and Cameron².

¹Ingham and Love, loc. cit.

²Cameron, loc. cit.

Implications For Further Research

In the course of carrying out this investigation a number of issues and questions were raised which were beyond the scope of this research. To further advance the study of child guidance procedures additional research is needed.

1. The interrelationship of the various factors studied upon each other is one of the most needed areas of future investigation. The investigation of factor interrelationship could be readily applied to each of the five categories of referral problems.

2. Another important study would be the attempt to weigh various predictive factors and set up a predictive table for success in therapy. This research would help to show the relationship of some predictive factors and how one might offset another.

3. Some children's problems were alleviated and terminated by counseling only the parents of the referred children. A future study might consist of identifying the type of case for which this method is most effective, and the direction in which to proceed.

Due to the fact that the record keeping system of the State Department of Mental Health and that of each individual child guidance clinic lacks in uniformity it would be most advantageous to make a complete study of

the method of reporting in order to offer recommendations
for improvement.

BIBLIOGRAPHY

- Ackerman, Nathan, and Peter B. Neubauer. "Failures In The Psychotherapy of Children," In Hoch, P. H. Failures In Psychological Treatment. New York: Grune and Stratton, 1948.
- Allbright, Sue and Helen Gambrell. "Personality Traits as Criteria For the Psychiatric Treatment of Adolescents." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1938.
- Allen, Fredrick. "Creation and Handling of Resistance to Clinical Practice," American Journal of Orthopsychiatry, II (July, 1932), 268.
- Anderson, Forrest N. and Helen Dean. "Some Aspects of Intake Policy and Practices." Los Angeles: Child Guidance Clinic of Los Angeles, 1950. (Unpublished Study.)
- Ash, P. "The Reliability of Psychiatric Diagnosis," Journal of Abnormal and Social Psychology, XXXIV (April, 1949), 272-277.
- Auld, Frank. "The Use of Rorschach Scores To Predict Whether Patients Will Continue Psychotherapy," Journal of Consulting Psychology, XVII (April, 1953), 104-109.
- Balser, Benjamin Harris. Psychotherapy of The Adolescent. New York: International Universities Press, 1957.
- Barron, F. "An Ego-Strength Scale Which Predicts Response To Psychotherapy," "Journal Consulting Psychology, XVII (October, 1953), 327-333.
- Baum, Betty. "Factors Relating To The Later Adjustment of Children Unimproved By Child Guidance." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1939.
- Beck, Bertram. Short Term Therapy In An Authoritative Setting. Family Service Association of America, 1946. 110 pp.

- Bellak, L. B. Pasquerelli, and S. Braverman. "The Use of The TAT In Psychotherapy," Journal Nervous and Mental Disease. CX (July, 1949), 51-65
- Bennett, C. C. and C. R. Rogers. "Predicting The Outcomes of Treatment," American Journal of Orthopsychiatry. XI (April, 1941), 210-221.
- Blackman, E. "Some Tests For The Evaluation of Case Work Methods," The Family. VI (July, 1925), 132-137.
- Bonnett, Esther Belle. "A comparison of Patients Successfully Adjusted With Those Unimproved At Close of Treatment." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932.
- Boynton, Alice Elizabeth. "A Study of Factors Associated With Success or Failure In The Treatment of Child Guidance Clinic Patients." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931.
- British National Association for Mental Health, Follow-up On Child Guidance Cases, London: Publication Department, National Association for Mental Health, 1951.
- Brown, Sanger and et. al. Outline for The Psychiatric Classification of Problem Children. Michigan: Lapeer Home and Training School, 1945.
- Burch, Hilde. "The Role of The Parent In Psychotherapy With Children," Psychiatry, XI (May, 1948), 169-175.
- Burgess, E. W. "The Family As A Unity of Interacting Personalities," The Family, II (March, 1926), 3-9.
- Cameron, D. Ewen. General Psychotherapy Dynamics and Procedures. New York: Grune and Stratton, 1950.
- Caplan, Gerald (ed.) Emotional Problems of Early Childhood. New York: Basic Books, Inc., 1955.
- Carberry, M. A. "Attempt To Determine The Consistency of Judgments Regarding The Adjustment Status of Children Examined By A Child Guidance Clinic," American Journal Juvenile Research, XIX (April, 1935), 75-92

- Cassell, R. "Criteria Used by The Staff of The Institute for Child Guidance in Assigning To Patients the Status, "Successfully Adjusted," or "Unimproved." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932.
- Chance, Erika. Families In Treatment. New York: Basic Books, Inc., 1959.
- Cohen, Marion and Ellen Davis. "Factors Related To The Outcome of Treatment in Child Guidance." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1934.
- Colby, Kenneth M. A Primer For Psychotherapy. New York: Ronald Press Company, 1951.
- Coleman, J. L. "Teaching Basic Psychotherapy," American Journal of Orthopsychiatry, XVII (October, 1947), 622-627.
- Crowdon, C. H. Three Years of Follow-up. Ohio: State Bureau of Juvenile Research, 1946.
- Cunningham, J. M., Hester Westerman, and Joseph Fischhoff. "A Follow-up Study of Patients Seen In A Pshcyiatric Clinic For Children," American Journal of Orthopsychiatry. XXVI (July, 1956), 602-612.
- Davidson, M. "Relationship of Adjustment Status of Child Guidance Clinic Cases To Age, Mental Capacity, and School Placement," Journal Juvenile Research, XIX (July, 1935), 160-170.
- Davis, Ellen. "Factors Related To The Outcome of Treatment In A child Guidance Clinic." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1934.
- Dawley, Almena. "Inter-Related Movement of Parent and Child In Therapy With Children," American Journal Orthopsychiatry, IX (October, 1939), 748-754.
- Despart, J. Louise. Children of Divorce. New York: Doubleday and Co., 1953.
- _____. "Therapeutic Readiness In Child Psychiatry," Psychiatry, XII (May, 1949), 153-158.

- Dixon, Wilfred and Frank J. Massey. Introduction To Statistical Analysis. New York: McGraw Hill Book Co., 1957.
- Donley, Dorothy. "Psychotherapy With Children " Edgewood Medical Monograph, I (July, 1950), 116-125
- Dreikurs, Rudolph. "Psychotherapy Through Child Guidance," Nervous Child, VIII (July, 1949), 311-328.
- Dukette, Rita. "Attitude Toward Child Guidance As A Factor Affecting Treatability." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1939.
- Dymond, R. F. "Can Clinicians Predict Behavior?" Journal Personality, XXII (December, 1953), 151-161.
- Elliot, Mary K. "A Study of Factors Associated With Success Or Failure In Treatment of Child Guidance Clinic Patients." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931.
- Ellis, Albert. "A comparison of Child Guidance Clinic Patients Coming From Large, Medium, and Small Families," Journal Genetic Psychology, LXXIX (May, 1951), 138-144.
- Ely, William and Augusta Bronner. New Light on Delinquency and Its Treatment. New Haven Press, 1936.
- Escalona, Sibylle. "Some Considerations Regarding Psychotherapy With Psychotic Children," Bulletin Menninger Clinic, XII (July, 1948), 126-134.
- Eysenck, H. J. "The Effects of Psychotherapy-An Evaluation," Journal Consulting Psychology, XVI (November, 1952), 319-324.
- Family Service Association of America. Child Therapy. A Case Work Symposium. New York: Family Service Association of America, 1948.
- Feldman, Edith. "Why Children Discontinue Child Guidance Treatment." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1938.
- Fisher, D. E. The Meaning and Practice of Psychotherapy. New York: MacMillan Co., 1950.

- Forer, B. R. and R. S. Tolman. "Some Characteristics of Clinical Judgment," Journal Personality, XXII (December, 1953), 151-161.
- Foster, A. "A Study of The Personality Make-Up and Social Setting of 50 Jealous Children," Mental Hygiene, XI (January, 1927), 53-57.
- Freud, Anna. The Ego and Mechanisms of Defense. New York: N. Y. International Press, Inc., 1936.
- Gibby, R. J. "Prediction of Duration of Therapy From The Rorschach Test," Journal Consulting Psychology, XVII (October, 1953), 348-354.
- Gilbert, G. M. "A Survey of Referral Problems In Metropolitan Child Guidance Clinics," Journal Clinical Psychology, XII (January, 1957), 37-42.
- Glassman, Lillian. "Is Dull Normal Intelligence A Contra-Indication For Therapy?", Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1943.
- Goldfarb, William. Emotional and Intellectual Consequences of Psychological Deprivation In Infancy. New York: Grune and Stratton, 1955.
- Hamilton, Gordon. Psychotherapy In Child Guidance. Columbia University Press, 1947.
- Harris, D. H. "Brief Psychotherapy and Enuresis," Journal Consulting Psychology, XIX (August, 1955), 246.
- Harris, R. E. and C. Christiansen. "Prediction of Response To Brief Psychotherapy," Journal Psychology, XXI (January, 1946), 269-284.
- Hartin, Reuth E. "Parents' Attitudes Toward Child Guidance." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1939.
- Hartsock, Hortense. "A Study of Factors Associated With Success or Failure In Treatment of Child Guidance Clinic Patients." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931.

- Hattwick, B. W. and M. Stowell. "The Relation of Parental Overattentiveness To Children's Work Habits and Social Adjustment In Kindergarten and First Six Grades of School," Journal Educational Research, XXX (November, 1936), 169-176.
- Healy, William. "Treatment and What Happened Afterward," Boston Massachusetts: Judge Baker Child Guidance Clinic, 1940.
- Herkimer, Jesse K. "The Relation Between Parents' Attitudes For Coming To A Child Guidance Clinic and The Outcome of Treatment." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1939.
- Hiler, E. W. "Wechsler-Bellevue As A Predictor of Continuation in Therapy," Journal Clinical Psychology, XIV (April, 1958), 192-194.
- Hoch, Paul H. and Joseph Zuvin. Psychopathology of Childhood. New York: Grune and Stratton, 1955.
- Hofstein, Saul. "Social Factors In Assessing Treatability In Child Guidance," Children, IV (March-April, 1957), 48-53.
- Houtz, Annie and Evelyn Kostick. "Preparation of Juvenile Delinquents for Treatment," American Journal of Orthopsychiatry, XVII (January, 1947), 143-150.
- Hutton, L. "Length of Treatment In Child Guidance Clinics," Journal Mental Science, XCI (October, 1945), 511-517.
- Hylan, Mary Champlin. "A Study of Facts Associated With Success or Failure In Treatment of Child Guidance Clinic Patients." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932.
- Ingham, Harrington and Leonora Love. The Process of Psychotherapy. New York: McGraw Hill Book Co., 1954.
- Institute for Juvenile Research, Child Guidance Procedures. New York: Appleton-Century Co., 1937.
- Jesness, R. F. "To Refer Or Not To Refer," Occupations, XXX (April, 1952), 521-524.

- Johnson, L. J. "Hope For Three Out of Four," Tab Survey, LXXXLLL (October, 1947), 271-273.
- Karlin, E. "The Neurotic Child: A Study of Fifty Children Manifesting Functional Nervous Disorders." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1930.
- Katzeneleogen, Soloman. Analyzing Psychotherapy. New York: Philosophical Library, Inc., 1958.
- Kiersted, Louise Evert. "A Study of Factors Associated With Success or Failure In The Treatment of Child Guidance Clinic Patients." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931.
- Kleinman, Frances. "Intelligence As A Factor In Child Guidance Treatment." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1949.
- Kotkov, B. and A. Meadow. "Rorschach Criteria for Predicting Continuation In individual Psychotherapy," Journal Consulting Psychology, XVII (February, 1953), 16-20.
- Lebo, D. "Age and Suitability for Nondirective Play," Journal Genetic Psychology, LXXXIX (December, 1956), 231-238.
- Lehrman, Louis. "Success and Failure of Treatment of Children In the Child Guidance Clinics of The Jewish Board of Guardians," New York: Jewish Board of Guardians, 1949.
- Leslie, Myrtle. "A Study of Factors Associated With Success Or Failure In Treatment of Child Guidance Patients." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932.
- Levitt, E. E. "The Results of Psychotherapy With Children: An Evaluation," Journal Consulting Psychology, XXI (June, 1957), 189-196.
- _____. "Comparison of Remainers and Defectors Among Child Clinic Patients," Journal Consulting Psychology, XXI (August, 1957), 316.

- _____. "Comparative Judgemental Study of Defection From Treatment At A Child Guidance Clinic," Journal Clinical Psychology, XIV (October, 1958), 429-432.
- _____. "On Locating Closed Clinic Cases For Follow-Up Studies," Mental Hygiene, XXXXII (January, 1958), 89-93.
- Lowrey, Lawson. "Psychiatry for Children," American Journal Psychiatry, CI (November, 1944), 375-378.
- Luft, J. "Implicit Hypotheses and Clinical Prediction," Abnormal and Social Psychology, XXXXV, (November, 1950), 756-759.
- _____. "Differences in Prediction Based On Hearing vs. Reading Verbatim Clinical Interviews," Journal Consulting Psychology, XV (April, 1951), 115-119.
- Maberly, Alan. "After Results of Child Guidance: A Follow-Up of 500 Children Treated At the Travistock Clinic, 1921-1934," British Medical Journal, I (January, 1939), 1130-1134.
- MacFarlane, Jean W. Studies In Child Guidance. Washington: Society for Research In Child Development, National Research Council, 1938.
- MacGregor, Madeline. "A Study of Factors Associated With Success or Failure In The Treatment of Child Guidance Clinic Patients. The Relation Between Degree of Adjustment and Certain Objective Traits of The Patients." Unpublished Master's thesis, Smith College, Northampton, Massachusetts.
- Martin, A. R. "Study of Parental Attitudes and Their Influence Upon Personality Development," Journal Educational Psychology, LXIII (June, 1943), 596-608.
- Maslen, Albertina. "A Study of Factors Associated With Success or Failure In Treatment of Child Guidance Clinic Referrals. A Comparison of Patients Rated "A" with those rated "E" In Adjustment At Follow-Up." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932.

- McIntire, Virginia. "Factors Relating To Treatment Outcome In Child Guidance Clinics." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1947.
- Meehl, Paul E. Clinical vs. Statistical Prediction. Minneapolis: University of Minnesota Press, 1958.
- Meyer, M. M. "The Direct Use of Projective Techniques In Psychotherapy," Journal Projective Techniques, XV (June, 1951), 263-267.
- Meyer, Adolph. "Thirty-five Years of Psychiatry In The United States and Our Present Outlook," American Journal Orthopsychiatry, VIII (July, 1928), 9.
- Mode, Elmer B. The Elements of Statistics. New York: Prentice Hall, Inc., 1946.
- Monroe, Walter. Encyclopedia of Educational Research. New York: MacMillan Co., 1952.
- Morris, Don P. et. al. "Follow-Up Studies of Shy, Withdrawn Children," American Journal of Orthopsychiatry, XXIV (October, 1954), 743-754.
- Mosak, Harold. "Problems In The Definition and Measurement of Success In Psychotherapy," ed. Wolff, Werner, and Precker: Success In Psychotherapy. New York: Grune and Stratton, 1952.
- Mowrer, Hobart. Psychotherapy: Theory and Research. New York: Ronald Press Company, 1953.
- Neustatter, W. L. "The Results of 50 Cases Treated By Psychotherapy," The Lancet, I (April 6, 1935), 769-799.
- Pascal. G. R. and Melvin Zaz. "Psychotherapeutics: Success Or Failure," Journal Consulting Psychology, XX (July, 1956), 325-331.
- Pergo, Ruth. "A Study of Factors Associated With Success Or Failure In The Treatment of Child Guidance Clinic Patients. The Present Adjustment of Cases Closed As Successfully Adjusted." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932.

- Perl, Ruth and Abraham Simon. "Criteria Of Success and Failure In Child Guidance," American Journal Orthopsychiatry, XII (October, 1942), 642-658.
- Peterson, Electra. "Prognostic Clues In The First Interview In Child Guidance," Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1947.
- Pllak, Otto. Social Science and Psychotherapy For Children. New York: Russell Sage Foundation, 1952.
- Polsky, Sylvia. "Follow-Up Study of Thirty-five Cases Closed As Successful By Child Guidance Clinic." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1940.
- Rees, J. R. Modern Practice In Psychological Medicine. London: Butterworth and Co., 1949.
- Rexford, Eveoleen., et. al. "A Follow-Up Of A Psychiatric Study of 57 Antisocial Young Children," Mental Hygiene, XL (April, 1956), 196-214.
- Richards, William, and William J. Norton. Biography Of A Foundation. Children's Fund of Michigan, 1957.
- Rittenhouse, Mary Wood. "A Study of Factors Associated With Success and Failure In The Treatment of Child Guidance Clinic Patients. A Comparison of Patients Rated A With Those Rated E In Present Adjustment." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931.
- Rogers, C. R. "Therapy In Guidance Clinics," Journal Abnormal and Social Psychology, XXXVIII (April, 1943), 284-289.
- _____. Client-Centered Therapy. Boston: Houghton Mifflin Company, 1951.
- Rogers, L. S. "Prediction of The Results of Therapy By Means of The Rorschach Test," Journal Consulting Psychology, XVII (February, 1953), 8-15.
- Rogers, Lawrence., et. al. "Predicting Continuation In Therapy By Means of the Rorschach Personality Test," Journal Consulting Psychology, XV (October, 1951), 368-371.

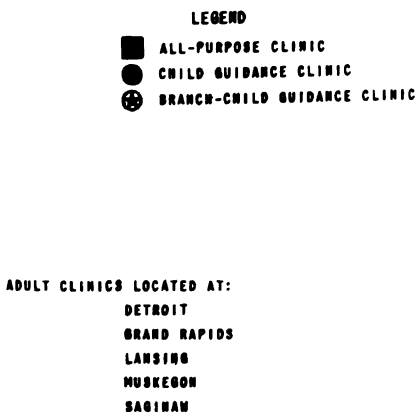
- Ross, B. M. "Some Traits Associated With Sibling Jealousy In Problem Children." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1931.
- Rotenberg, Gertrude. "Can Problem Adolescents Be Aided Apart From Their Parents." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1947.
- Severson, Eliza Jane. "A Study of Factors Associated With Success and Failure In The Treatment of Child Guidance Clinic Patients. Patients Showing A Marked Change In Adjustment At The Time of The Follow-Up Study." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1932.
- Shaw, F. J. "Some Postulates Concerning Psychotherapy," Journal Consulting Psychology, XII (November, 1948), 426-431.
- Shirley, M., et. al. "Outgrowing Childhood's Problems: A Follow-Up Study of Child Guidance Patients." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1940.
- Siegel, M. G. "The Diagnostic and Prognostic Validity of the Rorschach Test In A Child Guidance Clinic," American Journal Orthopsychiatry, XVIII (January, 1948), 119-133.
- Smith, Stephenson. The Psychological Origin and Treatment of Enuresis. University of Washington Press, 1948.
- State of Michigan Department of Mental Health. The Prevention and Early Treatment of Mental Illness and Other Personality Disturbances. Michigan: Department of Mental Health, 1954.
- Stevenson, George. Child Guidance Clinics-A Quarter Century of Development. New York: Commonwealth Fund, 1934.
- Szurek, S. A. "Problems Around Psychotherapy With Children," Journal Pediatrics, XXXVII (November, 1950), 671-678.
- Tarrasch, Herra. "Results of Child Guidance Work In Two County Clinics," Journal Child Psychology, II (Section 2, 1951), 229-243.

- Taylor, J. W. "Relationship of Success and Length In Psychotherapy," Journal Consulting Psychology, XX (October, 1956), 332.
- Thorne, Frederick C. Principles of Psychological Examining. Vermont: Journal Clinical Psychology, 1955.
- Tibbetts, C. "Success Or Failure On Parole Can Be Predicted: Study of 3000 Records of Youth Paroled From Illinois State Reformatory," Journal Criminal Law, XXII (May, 1931), 11-50.
- U. S. Department of Health, Education, and Welfare. Evaluation In Mental Health. Public Health Service Publication No. 413. Washington, D. C.: U. S. Government Printing Office, 1955.
- Wallinga, Jack V. "The Probation Officer's Role In Psychiatric Cases," Journal Criminal Law, Criminology, and Police Science, L (November-December, 1959), 364-367.
- Wilson, Ruth A. "Effects of Attitudes Toward Child Guidance Treatment and Its Outcome." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1940.
- Wirt, R. D. "Further Validation On The Ego-Strength Scale," Journal Consulting Psychology, XIX (December, 1955), 444.
- Witmer, H. L. Psychiatric Clinics For Children. New York: The Commonwealth Fund, 1940.
- _____. The Nature of Psychiatric Interviews With Children. Massachusetts: Harvard University Press, 1952.
- _____. "The Outcome of Treatment In A Child Guidance Clinic: A Comparison and An Evaluation." Unpublished Master's thesis, Smith College, Northampton, Massachusetts, 1933.
- Wolberg, Lewis R. The Technique of Psychotherapy. New York: Grune and Stratton, 1954.
- Yaskin, J. C. "Delayed Favorable Effects In Psychotherapy," Journal Nervous and Mental Disorders, C (June, 1945), 550-556.

APPENDIX A

**AREA MAP DESCRIBING SEVENTEEN COUNTY AREA SERVICED
BY NORTHWEST MICHIGAN CHILD GUIDANCE CLINIC**

State of Michigan
DEPARTMENT OF MENTAL HEALTH
COMMUNITY MENTAL HEALTH CLINICS



APPENDIX B

INDIVIDUAL INFORMATION SHEET

SAMPLE QUESTIONNAIRE

INITIAL INTRODUCTORY LETTER

FOLLOW-UP REQUEST

SUBJECT'S INFORMATION SHEET

CASE NUMBER: _____

GROUP NUMBER: _____

1. Name: _____;
 Last First Middle
2. Date of birth: _____ Sex: Male ____ Female ____.
3. Age at date of referral: _____ Years ____ Months.
4. Date of referral: _____ Closure Date _____.
5. Case Reopened: 1. _____ 1. Why _____.
 2. _____ 2. Why _____.
6. Medical history: _____
_____.
7. Developmental history: _____
_____.
8. Referral problem as given: " _____
_____.
9. Referral source: Family ____ M.D. ____ Court ____
School ____ County Agent ____ Self ____ Other _____.
10. Name and address of above referral source: _____
_____.
11. Duration of presented referral problem: _____ Months.
12. Classification of referral problem: 1 ____ 2 ____ 3 ____ .
13. Additional presented problems: _____
_____.
14. Length of treatment: _____ Months.
15. Referred problem and counselor found problem:
Same _____ Different _____.
16. Counselor found problem: _____

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17. Previous professional help: Agency _____.
Date of assistance: From ____ to _____.
18. Foster child: Yes ____ No ____.
19. If a foster child give period of time: ____ Months.
20. Number of foster homes subject has been in: _____.
21. Ordinal position in family: ____ out of ____.
22. Intellectual Quotient: A.A. ____ Average ____ B.A. ____.
23. List of standardized tests given by clinic:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____
24. Recommendation made by psychologist: _____
_____.
25. Referred case could have been handled by school
counselor: Yes ____ No ____
26. Referral was made to school counselor: Yes ____ No ____.
27. Personality diagnosis: _____

_____.
28. Personality diagnosis made by: Social Wk. ____ Psychol-
ogist ____ Combination of Psychologist and Social Wk. ____.
29. Personality diagnosis: Subjective ____ Objective ____
Combination of both: _____.
30. Available record information:
1. Insufficient: _____

_____.

2. Sufficient: _____.

3. Additional comments: _____.

31. Name of subject's father: _____
Last First Middle

32. Name of subject's mother: _____
Last First Middle

33. Last known address of above: _____.

34. Parental factors:

1. Married _____ Divorced _____.

2. Happily Married: Yes _____ No _____.

3. Deceased: Father _____ Mother _____.

4. If deceased: When _____ How _____.

5. Parental Rejection: Yes _____ No _____ By _____.

6. Parental attitude toward clinic:

Favorable _____ Unfavorable _____ Unknown _____.

7. Parent in need of psychiatric assistance:

Father: Yes _____ No _____

Mother: Yes _____ No _____

8. Parent receiving psychiatric assistance from:

Psychiatrist _____ Which parent? _____.

M.D. _____ Which parent? _____.

Agency _____ Which parent? _____.

9. Parent in need of interpretation of child's problem:

Father: Yes _____ No _____

Mother: Yes _____ No _____

10. Interpretation of child's problem given to:

Father: Yes _____ No _____

Mother: Yes _____ No _____

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35. Parental acceptance of interpretation: Yes ____ No ____.

Comments: _____
_____.

36. Case closure: Successful _____ Unsuccessful _____.

37. Statistical closure: Same as above _____

Different than above _____.

38. Therapist: _____.

39. Referral taken by: _____.

40. Additional comments:

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CHILD GUIDANCE CLINIC

FOLLOW-UP STUDY

DIRECTIONS: Place an (X) after selected response.

1. Name of child seen at Traverse City Child Guidance Clinic:

.....
Last

First

Middle

2. Child was initially referred to clinic for.....
on..... Do you feel that this was the main problem at the time of referral?

Yes..... No.....

3. If answer to above question is "No" please give your impression of what the main problem was at the time of referral?

4. Has past problem, or problems, disappeared? Yes..... No..... Partially.....

5. Have additional behavior difficulties occurred since child was last seen at the Child Guidance Clinic in Traverse City?

Yes..... No..... If so, state problem

6. Assistance given to child at Child Guidance Clinic, in Traverse City, was of

Great Help Some Help..... No Help.....

7. Do you feel that you have a better understanding of the problem, for which the child was referred, as a result of assistance received from the Child Guidance Clinic located in Traverse City?

Yes..... No.....

8. Since child has stopped coming to the Child Guidance Clinic, at Traverse City, has additional help been received from another agency, or agencies?

Yes..... No..... Name of Agency

9. If additional help has been received has it been of benefit?

Great help Some Help..... No Help.....

10. Would you refer additional children who are having a behavior problem to a Child Guidance Clinic?

Yes..... No.....

11. Please give reason, or reasons, for your answer to above question.

12. Please list any suggestions, or comments, that you may have pertaining to your relationship with the Child Guidance Clinic, located in Traverse City, Michigan.

13. Name of person completing above information.

.....
Last

First

Middle

14. Relation to referred child.....



NORTHWEST MICHIGAN CHILD GUIDANCE CLINIC

JAMES DECKER MUNSON HOSPITAL

TRAVERSE CITY, MICHIGAN

HAZEL D. HARDACRE
DIRECTOR

April 13, 1959

Dear Parent:

As a part of my doctoral dissertation, through Michigan State University, I am doing a follow-up study on all children seen at the Northwest Michigan Child Guidance Clinic through the years 1950-1957.

This study is being undertaken to help improve the services offered to children who will visit child guidance clinics in the near future. Your assistance is greatly needed.

It would be greatly appreciated if you would fill out the attached questionnaire, and return it in the self-addressed and stamped envelope by May 22, 1959.

Thank you for your kind cooperation and assistance.

Sincerely yours,

Harold Fahs

HAROLD FAHS
Psychologist

Approval of:

Hazel Hardacre

Hazel Hardacre, Director
Northwest Michigan Child Guidance Clinic



NORTHWEST MICHIGAN CHILD GUIDANCE CLINIC

JAMES DECKER MUNSON HOSPITAL

TRAVERSE CITY, MICHIGAN

HAZEL D. HARDACRE
DIRECTOR

June 1, 1959

Dear Parent,

You recently received a letter requesting that an enclosed Follow-Up Study be completed and returned. This Follow-Up Study is to help improve the services offered to children who will visit the Northwest Michigan Child Guidance Clinic in the near future. A self-addressed return envelope was included for your convenience.

In tabulating the completed forms I find that your form is missing. No doubt this is due to the fact that you have been too busy, the form being misplaced, or some other adequate reason.

It would be greatly appreciated if you would fill in the enclosed form and return it before June 12, 1959. Your cooperation, and completed form, is a necessity in making this study a success.

Thank you for your assistance.

Sincerely yours,

Harold Fahs

Harold Fahs,
Psychologist

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~~MAR 10 1964~~

NOV 10 1964

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