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Comparison and evaluation of long term and short term cases: the study of factors entering into the length of treatment.

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Comparison and Evaluation of
Long Term and Short Term Cases:
The Study of Factors Entering into
The Length of Treatment

Submitted by
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(B.S., Boston University, 1942)
In Partial Fulfillment of Requirements
for the Degree of Master of Science in Social Service
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CHAPTER I
INTRODUCTION

STATEMENT OF PROBLEM

Recognizing the limitation induced by a lack of funds and adequately trained workers in the three disciplines, psychiatry, psychology and social work, the Providence Child Guidance Clinic is constantly seeking ways of spending its available energy at the point of largest social return. One of the ways in which the clinic has attempted to meet this problem of constructively applying its services where they will be utilized qualitatively and quantitatively is by use of the research method. Thus many studies have been stimulated over the years seeking to establish criteria for the selection of cases to be served.

In order to establish any such criteria, it is necessary to understand, in what cases already treated at the clinic, its time appeared most profitably utilized on behalf of the child and parent. In view of the long waiting lists, the clinic felt a study of long term and short term cases, with the emphasis on clues to the possible predictability of length of treatment, might be helpful, as a guide in selecting cases. This knowledge could be useful, not so much for the exclusion of long-term cases, but from the point of view of over-all clinic planning; in order, that the clinic might not at a
given time become too heavily loaded with long-term cases.

Twenty cases were randomly selected from all cases treated in the clinic from 1946 to the end of 1952 and studied for clues which might prognosticate length of treatment. An attempt was made to study these cases for factors which might indicate why some cases were carried longer than others or what the significant features in long term and short term cases were.

Since the greatest emphasis in a child guidance clinic is placed on the mother-child relationship, and the goal in treatment is often the improvement of this relationship, the writer concerned herself with this area in the study of the twenty cases. Answers were sought to the following questions:

1. How does adequacy of the parents affect length of treatment, if at all?

2. Does the parent's involvement in treatment affect the length of treatment?

3. Were there any significant gains in the parent and/or child in long term cases? In short term cases?

4. Is there any relation between length of treatment and outcome of treatment?

5. Did length of treatment and closing appear to be a planned part of treatment in long term cases? In short term cases?
JUSTIFICATION OF THE PROBLEM

There is at present only one complete operating unit at the Providence Child Guidance Clinic serving the emotionally disturbed children in the city of Providence, plus many other towns, cities and communities in the state of Rhode Island. This clinic too, is the only one in Rhode Island accepted as a member of the American Association of Psychiatric Clinics for Children. Long waiting lists have long been a problem, and with the increasing recognition and acceptance by parents, teachers, courts and the general community of the preventive help rendered to the child, will come even greater numbers knocking at the door. How to provide the most purposeful services to these troubled children and parents is a vast perplexing administrative problem which is much too vast and complex for any one study to attempt to answer. However, it is hoped that this study may stimulate others, since there has been no similar study in this clinic, and that the information resulting from this investigation will be helpful administratively in the selection of cases. Thus the optimum use of the clinic team, psychiatrist, psychologist and psychiatric social worker, will be possible.

Since this is a social work thesis, the writer has not attempted to evaluate the quality of treatment with child or parent, but has utilized material in the written records, and that obtained verbally from the members of the three
disciplines involved, when available.

**SOURCES OF DATA**

The sources used in this thesis are case records from the files of the Providence Child Guidance Clinic and literature related to the subject.

**SCOPE**

This study has been based on twenty cases, ten each of long term and short term cases, randomly selected from the files of the clinic during the period from January 1946 through December 1952. It is necessarily limited by the small number of cases as well as the possible subjective factor of the psychiatrist and/or caseworker in retaining one case for extensive treatment and closing another after a few contacts. Ernest Kris, Ph. D., points up this very human tendency in discussing the value of the personal analysis.

The psychiatrist does not work in a neutral field. He is, himself, exposed to forces that work upon him. The more he is concerned with unconscious process, the clearer this interplay of forces becomes. Since in most serious and affective psychotherapeutic techniques, unconscious forces are mobilized, the process of continuous self-evaluation and self-analysis might be said to be actually a concomitant of an essential part of psychotherapeutic work. 1

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Nathan Ackerman, M.D. agrees that "there are limitations to what each therapist (and caseworker) can do, depending on his personality, training, skill and setting in which he works," Dr. Ackerman does not feel that this should be the basis for the creation of new forms of therapy. However, he does emphasize the importance of understanding that such factors as the therapist's (and caseworker's) background, professional orientation, temperament, social values, and prejudices, exercise a potent influence on the therapeutic experience. They may either enhance the effectiveness of the therapy or impair it.

METHOD OF STUDY
The case study method of research has been used in this thesis. The cases were selected at random from all the cases in the files from 1946 to 1952. Long term cases are defined as those wherein the psychiatric social worker and/or the child's therapist saw the child for thirty or more interviews; while short term cases were considered

2. The writer's insertion.


4. The writer's insertion.

5. Ackerman, M.D., op. cit.
only when they were treatment cases and involved twelve or less interviews with the caseworker and/or psychiatrist.

The following criteria were set up for selection:

of long term cases; (1) the application was accepted for treatment service by the clinic, (2) parent and/or child was seen for thirty or more therapeutic interviews, (3) included were those cases closed and then reopened as long as the total number of interviews totaled thirty or more; of short term cases; (1) the application was accepted for treatment service by the clinic, (2) parent and/or child was seen for no more than twelve therapeutic interviews and no less than five. Since the average or typical clinic case is accepted by the administration in this setting as falling within this latter category, the short term cases as used here are considered typical child guidance cases. To a limited degree in this study, then, this group of cases is used as a control group.

Excluded from the total list were those cases accepted by the clinic for diagnostic consultation or psychometric service. Such cases are ordinarily accepted for a specific service, such as mental retardation, psychiatric opinion of a personality, psychological testing prior to adoption, and so forth. Cases given such services are closed when that particular service is completed. Also excluded were those treatment cases where the mother withdrew without the clinic's
In all, 206 cases fell within the definitions for the two groups. Each case in the particular group was assigned a number. Through use of a table of random numbers, the twenty cases, ten long and ten short term ones, were selected for use in this study. Some of the records used were not complete as to objective material. The recording, often summarized due to pressure of work, frequently did not indicate clearly diagnostic material, treatment plans, degree of relationship or movement of the parent and/or the child.

Since the records of several caseworkers were used for this study, it was found that there was individual emphasis in the interviewing and recording of the interviews. Some interviews were long and in detail, while others were brief. Thus in those cases in which there was a lack of pertinent material, the writer obtained additional information whenever possible from the caseworker and/or the therapist. Also utilized to determine the progress and direction of the case were the reports of the treatment conferences and closing summaries of the caseworker and therapist, if available.

A limiting factor in the study was found in those cases where diagnostic and treatment plan material were not complete. In addition, there were variations in the skills of individual caseworkers, trained or students.
BACKGROUND

To understand more clearly the reason for this study (inability to meet the demand for services), the evolution and progress of the child guidance movement will be described briefly. Particular emphasis will be paid to the growth of the clinic which is the setting for this study.

The child guidance movement evolved when professional recognition was given to the philosophy that "childhood is the golden age of mental hygiene." It was accepted that the earlier the diagnosis and treatment of the child's difficulty, the better the prognosis for the child's later emotional well-being. The dynamic concepts of personality growth and development, from which mental hygiene principles derived, provided the basis for this thinking. Over the years, a growing body of clinical knowledge, theory, and research have continued to bear witness to the validity of this thinking.

The child guidance movement began out of this philosophy and the need thus, to provide therapy for that greater proportion of the population which could not afford private psychiatric help. Started in the twenties with the establishment of a child guidance clinic in each

of a few major cities, utilizing the three disciplines, psychiatry, psychology and social work, the movement has spread rapidly. However, even in this enlightened age, the number of clinics is yet inadequate to meet the needs of the children whose development is thrown out of balance by difficulties which reveal themselves in unhealthy traits, unacceptable behavior, or inability to cope with social and scholastic expectations.  

Not only is there a lack of clinics, but there is also a lack of trained personnel to staff those clinics already operating. For even with sufficient funds available, there just are not enough trained workers from the different fields. This challenge is being met in part by large training centers and working scholarships, but it will be some years before the needed clinics can be properly staffed.

The initial impetus for the movement grew out of two separate lines of research and practice. The first was Myer's concept of psychiatry and psychiatric social work. He stressed the importance of childhood experiences


8. Department of Philanthropic Information, Central Hanover Bank and Trust Company, New York, The Mental Hygiene Movement, p. 29
in the development of emotional problems of individuals. The second was the influence of the mental hygiene movement started in 1909.9

The first systematic, large-scale effort to correct and prevent mental and behavior disorders among children took shape first as an attempt, by clinical study and treatment, to rescue youthful delinquents brought before the juvenile courts. As early as 1909 Dr. William Healy, a notable leader in the movement, pioneered clinics in Chicago, and in 1917 established the Judge Baker Foundation in Boston, now known as the Judge Baker Guidance Center.10 However, though at that time the focus was only on the prevention of delinquency, Dr. Healy's five year study11 of young offenders before the Chicago Juvenile Court, saw the biggest step in the development of modern clinics. His thinking led to the consideration of the individual child, and the importance of physical, psychological and sociological factors in the understanding and treatment of the total child. With this new emphasis, Dr. Healy was instrumental in the establishment of the clinics noted

9. Ibid. p. 33
10. Ibid. p. 47
11. Dr. William Healy, The Individual Delinquent.
above, where experts from the various fields participated in working with the needs of the total child.\textsuperscript{12}

These clinics made recommendations to the court. Later in 1922 the Commonwealth Fund financed a five-year program for the prevention of childhood delinquency. This involved, among other activities, a plan for the establishment of demonstration clinics in selected cities of the country. This latter phase of the program was entrusted to the National Committee for Mental Hygiene, and, as in former attempts, the children's court was seen as the point of psychiatric attack. Among the early demonstration clinics were those in St. Louis, Norfolk, Dallas, Minneapolis, Los Angeles, Cleveland, and Philadelphia. It was soon found, however, that children coming into court were in many cases not responsive to corrective and preventive efforts. The scope of the child guidance clinic was broadened then to include children whose conduct or behavior problems had not developed so far or were not of such a nature as to bring them into conflict with the law.\textsuperscript{13}

A demonstration clinic similar to those mentioned above, but financed privately in connection with the Esek

\textsuperscript{12} Department of Philanthropic Information, \textit{op. cit.}

\textsuperscript{13} Stevenson and Smith, \textit{op. cit.} pp. 23-45.
Hopkins School led to the establishment of the Providence Child Guidance Clinic which is the setting for this study. Since the growth of this clinic from this time on closely parallels that of other clinics about the country, further description of the evolution of the modern child guidance clinic will be portrayed using the Providence Child Guidance Clinic as a guide.\(^\text{14}\)

Senator Jesse H. Metcalf, with the advice of professional people, secured a staff which included a psychiatrist, a psychologist and a psychiatric social worker. The clinic opened in October 1925. The purpose was "to serve all problem cases in normal and superior children between the ages of four and eighteen years."\(^\text{15}\) Although the primary emphasis was on the children within the Esek Hopkins School district, the services of the clinic were also extended to cases referred by the judge and probation officers in the district court, as well as by the rest of the community.

It was soon learned that although many children with problems that could be adjusted through cooperation between home and school, were being helped, there were many cases,


\(^{15}\) *Ibid.*, pp. 121-123.
"where the factors of environment plus the child's emotional states produced personalities so warped that future citizenships and personal happiness are jeopardized."16

The question was then asked as to what are the cases with which the Providence Child Guidance Clinic and any clinic, regardless of method of approach, should be concerned and to which it can give the most effective treatment. To those concerned the answer seemed to lie in those

Children within the wide range of what is called normal intelligence whose difficulties are traceable to emotional imbalance, whether in the child or in the parent; or to a lag between the child's capacity and the demands made upon him, of which educational maladjustment is a common example; or to destructive influences in the social environment.17

In 1923 the Rhode Island Society of Mental Hygiene was requested to assume management of the clinic. The Society then incorporated the clinic together with the Juvenile Court Clinic under the new name of the Providence Child Guidance Clinic. Senator Metcalf continued support until 1933. The clinic is now financed largely through the Providence Community Chest and to a minor degree by fees charged clients on the basis of their yearly income. These are flexible to allow for change where dictated by

16. Ibid., pp. 123-124
17. Stevenson and Smith, op. cit., p. 55
size of the family and unusual expenses.

The present staff of the clinic includes one full time psychiatrist who also acts as the Medical Director and Administrator; a part time Pediatrician in psychiatric training; a part time Psychiatrist from the local private mental hospital; a full time Psychologist; two full time Psychiatric Social Workers, one also acting as Chief of Social Services; and three psychiatric social work students. The clerical staff consists of an office manager and two secretaries.

Up to this point there has been a necessary concern with the historical development of the clinics. Now to clarify the function of this setting, a brief look at the changing concepts, as they apply to the team approach, should be helpful.

Originally, a threefold approach to meeting the child's total needs was not considered necessary. It was felt that the symptomatic behavior was merely a specific deviation from what was considered the normal behavior, and once the deviation disappeared by whatever means, the case was considered cured. Today, behavior is accepted as no isolated phenomenon, but a corollary of a basic reaction pattern. Restraining this external behavior which caused social disapproval without removing
the stresses, might only result in different symptoms.

The team approach in the child guidance clinic is based upon this concept; that the behavior is not alone a symptom of faulty individual integration, but of pressure from the social forces which create the child's environment. The child is part of a family, or of an institution; he lives in a house; he plays on a street; he has companions; he cannot escape both physical and social limitations on his conduct. The child does not exist in a vacuum, but usually inner and outer stresses are intermingled and react on each other so continuously that the individual and his environment must be recognized as an indivisible entity.

It is because of this concept that the three disciplines, psychiatry, psychology and social casework, each with its distinctive training, have been utilized as a team by child guidance clinics. The role of the psychiatrist in the clinic has been fairly well defined since doctors, Adolf Meyer, E. E. Southard and Frankwood Williams encouraged psychiatrists to emerge from mental


19. Ibid., p. 152
hospitals and to interest themselves in less severely ill patients in the community. 20 The psychiatrist with his medical training and therapeutic skill is accustomed to dealing with the patient's own conflicts and his adjustment to the total life situation. The psychiatrist in the child guidance clinic focuses more today on the discovery of the attitudes of parents and the child toward social situations. As psychiatry has contributed more to the understanding of mental disease, nervous disorders, and emotional maladjustment, the psychiatrist learned more about human behavior and treatment possibilities. He has become aware that understanding the patient involved understanding all aspects of his life: physical, psychological, emotional and social. 21

The psychologist also has become an integral part of the treatment team in a child guidance clinic. Through the use and interpretation of psychometric tests, particularly, the projective personality tests, the Rorschach, T & T and Blackie Pictures, a much wider field for clinical analysis and interpretation of personality was opened. The results of these tests have come to play

20. Ibid., p. 152
a most valuable part in diagnosis and treatment plans. It was evident, too, that the psychologist, who understands educational principles and practices, could logically handle contacts with schools and was especially equipped to treat cases of educational disabilities. Although the specific role of the psychologist in the various clinics differs, there has been a significant trend toward actual therapy by specially trained psychologists. In the Providence Child Guidance Clinic, the clinical psychologist is trained in and particularly interested in the treatment of children with the symptom of reading disability. He does treat children with other problems, too.

Perhaps, more than any other member of the clinic team, the position of the social worker has changed. Originally, the social worker's function consisted of acting as an aide to the psychiatrist and gathering factual information, as the social history. She also served as the channel through whom the psychiatrist conveyed advice to the parents, and checked to see whether the recommendations were carried out. For at this point in the child guidance movement the parents were rarely considered except as vehicles to carry out the clinic's recommendations.

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Experience has indicated that often the important advice was not, and could not be heeded.23 Through the psychiatric social worker's increased skill in the application of the principles of dynamic psychiatry, it was discovered that children's problems could often be traced to adverse parental attitudes. As Gordon Hamilton notes:

It is the precariously balanced rejecting or neurotically tied family which is the clinical setting for the behavior problems and the anxiety ridden child.------The severe neurotics and neurotic characters perhaps function least well as parents especially when the 'repetitive core' of their neurosis gets in the way of or actually is worked out through and upon the children.24

The concept followed today in this setting is that in order to be of most benefit to the child, it must be recognized that parents too are individuals. The same general principles should be applied in treatment of their problems as in treatment of the child's problems, if positive help is to be rendered in the situation.

The professional team in child guidance has come to realize that the problem usually is not the child's behavior or his symptoms or the complaints of the parent about him,


but rather is in the nature of the parent-child relationship. In most child guidance clinics today the function is based upon a two-fold relationship; the therapeutic relationship with the child, and the relationship with the parent, in whom change will usually be related to the changing self of the child.

The social worker shares in the task of offering to children and parents service in terms of their individual needs. In addition to being responsible for the study and analysis of the social situation of the child in his relationships with his family; the caseworker also assists directly in the treatment process by helping the parent understand how his attitudes and personality have acted as a bar to better parent-child relationship.

The success of the team approach is determined to a great extent by the staff members and their ability to work together. For to be valid any teamwork concept would presuppose a constant evaluation of diagnosis and treatment goals by the three disciplines together. For all three, the psychiatrist, the psychologist and the psychiatric social worker, are striving toward a common goal:

That of improving the parent-child relationship

25. Greenberg, M. D., op. cit., pp. 170-185
with the maximum amount of participation on the part of the parent and child in seeking new and more satisfactory patterns of behavior in relation to their life situation.²⁶

As noted before, the Providence Child Guidance Clinic includes representatives of each discipline. It takes as its patients any child who in behavior or personality traits seems to deviate in a way that is suggestive of inability to cope with the requirements of his social life. Children are brought to the clinic because of unacceptable behavior; disobedience, stealing, lying, temper tantrums, truancy, and other such aggressive acts; because of personality problems such as nervousness, in-attention, shyness; because of school difficulties, poor work, retardation, indifference, and so forth. Though the referral may be initiated by the school, physician or other agency, the parent must telephone before the child's name can even be accepted for the waiting list. As noted above, the parent's involvement in treatment is essential from the first, if the treatment plans for the child's adjustment and improvement of the parent-child relationship is to have any chance of success. It is usually the chief psychiatric social worker who talks first with the parent on the telephone. Equipped as she

²⁶. Ibid, p. 185
is with knowledge of the resources in the community as well as the specific services the clinic has to offer, she is able to determine whether the clinic affords the type of help the person is seeking.

Intake interviews are handled by each social worker whether she is able to continue with the case herself or another worker will take over. A number of initial interviews are held with the parents and the psychological testing completed, so that the child will be ready to see the psychiatrist as soon as time is available. The parent usually comes alone to the first interview. This time is still used to obtain a social history, an important part of the diagnostic study. However, the parent is also given the opportunity at this time to tell his story in his own way, with the reassurance that he is to be treated with respect as an individual. Also during this first interview, the caseworker attempts to help the parent consider the reality of asking for clinic service; the painful problems leading to application; his feelings about asking for and receiving help; what he can expect from the clinic; and what responsibility he will be expected to assume in the treatment process. For every effort is made to involve the parent in a casework relationship which is positively sought, and through which the parent can be helped to understand how his
own feelings and conflicts may have contributed to the asocial behavior of the child.

Though the social worker makes the decision as to whether a case should be properly seen in the clinic, there is further opportunity for screening at the weekly intake conferences, attended by the Medical Director and casework staff. However, because of the transition period this past year, in which the clinic was considering the enlargement of its training facilities, this latter was not always possible. Intake conferences frequently consisted merely of recording the case in the intake book.

Early in 1953, the clinic, together with Butler Hospital, a private mental hospital, and Bradley Home, a privately endowed institution for the treatment of emotionally disturbed children, embarked on a program of training members of the three disciplines.

Specific cases presenting a problem as to how or whether treatment should continue are discussed with the complete staff at staff conferences held each week. Present, also, might possibly be interested members of other agencies, schools, and so forth. It is at this time that the knowledge and skill of the three disciplines are pooled.

This then is the unique setting for this study. It is unique in that it is the only member of the American
Association of Psychiatric Clinics for Children in Rhode Island, which attempts to treat emotionally disturbed children.
CHAPTER II
REVIEW OF OTHER PERTINENT STUDIES

At the present time almost no matter what the size of the clinic staff and the skill of its personnel, all those children who might be referred for services cannot be treated. This immediately raises the question of policies adhered to or criteria used in selection of cases for therapy. Inherent here is the question of length of treatment which is of obvious importance from the point of view of the clinic pressed for time and by a waiting list. Some attempt has been made by child guidance clinics toward a partial solution by limiting the kinds of cases accepted for treatment and by setting up criteria before a case will even be placed on the waiting list. For example, the clinic may require the parent to call directly for an appointment. Many clinics do not accept children of defective intelligence, those diagnosed as psychotic or psychoneurotic, or with problems resulting from major organic lesions of the brain.

For the clinic to spend its energy most usefully, there must be a carefully thought out plan for the selection of children to be treated, backed by adequate research insofar as possible, indicating the areas wherein the individual clinic can most effectively operate. If through research criteria could be discovered by which
cases that do not yield to present methods of therapy could early be distinguished from the more hopeful cases, the indication would probably be either not to accept such cases, or more constructively to attempt to devise new methods for dealing with them.

Research appears to be particularly limited in this area of study and the writer was able to find but one similar study, that by Mabel Mercer.¹ She found that the parent's attitude toward the child and problem was important in relating outcome to length of treatment. Since other studies indicate the influence of parental attitudes on the progress and outcome of treatment, it might appear that a possible source of clues as to length of treatment would be found in parental attitudes to the child, the clinic and the problem.

A number of pertinent studies have been conducted in an attempt to discover clues which might prognosticate progress and outcome of treatment. With some understanding of the factors involved in the success or failure of treatment, the clinic might then be in a better position to decide how best to utilize its services.

Such a study was that made by Helen Leland Witmer and students.² These investigators reached the conclusion:

The degree of success achieved in treatment and the child's later social adjustment appeared to be related to the degree of his and particularly his parents' emotional adjustment.

They found, too, that the other traits, such as the patient's inherent capacities, the physical environment in which he lived, the type of treatment given to him at the clinic faded into insignificance, and were almost overshadowed by the influence of emotional factors. The findings and implications of such a study are that it may offer some suggestions for a more effective handling of the case; for deciding more specifically on which cases to concentrate; the type and extent of service which seems most feasible for the case; and most importantly which client can use the clinic most constructively.

Other studies concerned with this problem of most effective use of clinic time have been made by students of the Smith College School of Social Work. These have indicated factors in the first interview which appeared to influence successful outcome of treatment. These

studies concluded that there appeared to be a relationship between the attitude of the parent expressed in the first interview and the outcome of treatment. They found that when the attitude of the parent in the initial interview was one of a real desire for help, an awareness of the problems, and understanding of the function of the clinic, and a real concern about the child's behavior, there was generally a successful outcome to the case.

Conversely Jessie Herkimer's conclusions indicated that the parents' initial attitudes in coming to a child guidance clinic could not be used as a prognostic shortcut. She implied that the clues of treatability of parents and children were within the more fundamental areas of a


Dorothy McKay, "Influence of Parents' Attitudes to Treatment on Progress and Results of Treatment in a Child Guidance Clinic," unpublished thesis (1935) on file in the Smith College Library.

parent's real feelings toward himself and the child; that these real feelings could not be determined in the initial interview.

In the previous group of studies, it was found that objective traits of the child such as ordinal position, number of siblings, physical condition, symptomatic behavior, problems, and likewise, objective traits of the parents, such as nationality, religion, marital status, age, economic status, bore little relation to outcome of treatment. The factors which did influence a successful outcome were satisfactory marital adjustments of the parents, a harmonious home atmosphere and the positive behavior of the parents toward the child. It was found also that length of treatment and the number of interviews bore no relation to the outcome of the case.\(^5\)

Another study as to prognostic clues in the first interview with parents was conducted at the Providence Child Guidance Clinic. This writer's\(^6\) findings generally concurred with the other studies. She found:

The greatest likelihood of success in treatment might be expected from those cases in which the parents' attitudes toward the clinic are of a

\(^5\) Helen Leland Witmer and others, op. cit., p. 3

positive nature in that they want help for the child's behavior, his school adjustments, the child and themselves, or themselves alone. Likewise, a favorable outcome is to be anticipated from those cases in which the parents' attitude toward the child is accepting, in which the parents are aware of the problem, although not in relation to themselves, and in which the parents are aware of the problem, feeling some responsibility for it.

These studies, then, generally indicate that the parents' attitudes to the child and the clinic and their marital adjustments, influence the progress and outcome of treatment. Thus, it seemed to the writer that the places to search for factors affecting length of treatment were in these areas. Chapters, three and four, describe, in statistical and summarized form, the case material in which these clues were found. However, while the greater emphasis is placed on the parental attitudes and adjustments, some preliminary investigation will be made and consideration given to such external factors as: age, ordinal position, sex, marital situation, source of referral, problem as referred, economic status, and psychologist's findings.
CHAPTER III
STATISTICAL DESCRIPTION OF CASES

The first section of this chapter is concerned with the total group of cases studied, while the concluding section shows the comparison of the two separate groups.

DESCRIPTION OF THE TOTAL GROUP OF CHILDREN

TABLE I

AGE AND SEX

<table>
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<tr>
<th>Age at Intake</th>
<th>Male</th>
<th>Per Cent</th>
<th>Female</th>
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<td>30.0</td>
<td>6</td>
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<td>10</td>
<td>100.0</td>
<td>21</td>
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In the total group of twenty cases there were twenty-one children seen for therapeutic interviews. In one long term case twin boys, in the age group seven to nine, were seen at the same time. Out of the total group eleven were boys and ten girls which indicates no significant difference; although in a negative way this may be worthy of consideration since the ratio of boys to girls is two to one in the usual experience of the clinic. Again there appears to be no difference in the ages of boys as compared to the girls.
The age range for the total group ran from three to twelve years at opening with a median age of eight years; which compares favorably with statistics showing the most popular aged child seen as eight.\footnote{Clinic Statistics from 1946 to the present.}

TABLE II
ORDINAL POSITION OF PATIENT

<table>
<thead>
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<th>Position</th>
<th>Male</th>
<th>Female</th>
<th>Totals</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>First Born</td>
<td>6</td>
<td>4</td>
<td>10</td>
<td>47.6</td>
</tr>
<tr>
<td>Second Born</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>19.1</td>
</tr>
<tr>
<td>Third Born</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>4.7</td>
</tr>
<tr>
<td>Only Child</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>28.6</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>11</strong></td>
<td><strong>10</strong></td>
<td><strong>21</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

In all of the cases studied, the family's size ranged from an only child to five children. The families with four and five children, including patient, numbered two and one respectively. The composition of the remaining families was as follows: six families with three children apiece; five families with two children apiece; and six families with the patient as the only child.

It is interesting to note in Table II almost half of the children seen were in the first born group. This might indicate another area of study. However, since the median age
is eight, indicating the majority of children seen are of school age, this might possibly be an explanation of why more of these children are seen and make up such an important number of treatment cases. An examination of the referral source which follows might illustrate this or not as the case may be.

**TABLE III**

**SOURCE OF REFERRAL**

<table>
<thead>
<tr>
<th>Source of Referral</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>8</td>
<td>38.1</td>
</tr>
<tr>
<td>School</td>
<td>5</td>
<td>23.8</td>
</tr>
<tr>
<td>Social Agency</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td>Parent</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>Other Clients</td>
<td>3</td>
<td>14.3</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>21</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Most of the children were referred to the Providence Child Guidance Clinic by schools or physicians. A smaller number were referred by other social agencies, by their parents or other clients. The distribution of the children with respect to source of referral is given in Table III. These referral sources appeared to be fairly representative of the total clinic population.
### TABLE IV

**DISTRIBUTION OF SYMPTOMS AT REFERRAL**

<table>
<thead>
<tr>
<th>Problems</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stealing, Lying</td>
<td>4</td>
</tr>
<tr>
<td>Bunking School</td>
<td>1</td>
</tr>
<tr>
<td>Poor School Work</td>
<td>4</td>
</tr>
<tr>
<td>Stuttering, other Speech Difficulties</td>
<td>4</td>
</tr>
<tr>
<td>Reading Disability</td>
<td>3</td>
</tr>
<tr>
<td>Shyness</td>
<td>3</td>
</tr>
<tr>
<td>Nervousness</td>
<td>2</td>
</tr>
<tr>
<td>Enuresis</td>
<td>3</td>
</tr>
<tr>
<td>Aggressive Behavior</td>
<td>4</td>
</tr>
<tr>
<td>Unmanageable</td>
<td>3</td>
</tr>
<tr>
<td>Anxiety Neurosis</td>
<td>1</td>
</tr>
<tr>
<td>Psychosomatic Complaints</td>
<td>2</td>
</tr>
<tr>
<td>Temper Tantrums</td>
<td>3</td>
</tr>
<tr>
<td>Hyperactive</td>
<td>1</td>
</tr>
<tr>
<td>Swearing</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>39</strong></td>
</tr>
</tbody>
</table>

The problems which brought the children to the clinic ranged all the way from minor habit and conduct disturbances to pronounced anti-social acts and behavior symptomatic of severe mental illness. For most of the children more than one problem was reported. Therefore, the number of complaints
will be greater than the twenty cases or twenty-one children studied.

The behavior of many of the children was marked by external hostility and aggression as expressed in anti-social acts. The outstanding parental complaints were the children's uncontrollable or impulsive behavior in the home and with other children; as, stealing, lying, bunking school, and enuresis. This applied to thirteen of the twenty-one children or approximately sixty-two per cent and included children whose behavior at home, at play or school was hostile, quarrelsome, destructive, disobedient, stubborn, abusive, demanding, profane, or irritable and who were given to temper tantrums.

Tables V and VI are compiled from the findings of the psychometric tests administered and interpreted by the clinical psychologist, and the conclusions of the child's therapist, usually the psychiatrist.

**TABLE V**

**INTELLIGENCE RANGE**

<table>
<thead>
<tr>
<th>Classification</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dull Normal</td>
<td>4</td>
<td>19.1</td>
</tr>
<tr>
<td>Normal</td>
<td>7</td>
<td>33.3</td>
</tr>
<tr>
<td>Bright Normal</td>
<td>2</td>
<td>9.5</td>
</tr>
<tr>
<td>Superior Intelligence</td>
<td>8</td>
<td>38.1</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td><strong>21</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
As noted in Table V those children within the normal and above normal range make up seventeen or approximately eighty-one per cent of the total group. This finding would be consistent with a clinic policy of preferring children in these groups for treatment.

**TABLE VI**

**DEGREE OF DISTURBANCE IN THE CHILD**

<table>
<thead>
<tr>
<th>Degree of Disturbance</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Disturbed</td>
<td>2</td>
<td>9.6</td>
</tr>
<tr>
<td>Some Disturbance</td>
<td>12</td>
<td>57.1</td>
</tr>
<tr>
<td>Severly Disturbed</td>
<td>7</td>
<td>33.3</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>21</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table VI summarizes the conclusions as developed by the psychologist from the projective tests, particularly the Rorschach, and the psychiatrist's findings. In five cases the findings were that prognosis for treatment at the clinic was good, while in one case, it was felt that therapeutic treatment would not be helpful. A disturbed parent-child relationship with hostility to one or both parents appeared in the results of twelve Rorschach, while insecurity and lack of confidence appeared in eight. Other areas of difficulty and the number of children involved included: sexual, twelve; neurotic, two; feelings of rejection by one or both parents, five; castration fears, three; oral aggressive drives, one;
inability to adapt socially, one; organic, one; psychotic tendencies, one; and unresolved oedipal conflict, four.

It would appear then that the findings of psychological testing would support the recognized and accepted area of focus in a child guidance clinic, the disturbed parent-child relationship. For it appears in twelve of the twenty-one records or approximately fifty-seven per cent of the children that there was a disturbed parent-child relationship.

As used in the table, the child who is "not disturbed" indicates the child who is developing normally, emotionally but who has been brought to the clinic usually because of the parent's own distress. The child with "some disturbance" may be one who emotionally has not developed normally in all areas, yet does not indicate any neurotic or psychotic traits. This category would encompass many degrees of disturbance but all within normal limits. In the last category are found those children diagnosed as psychoneurotic or pre-psychotic.

**TABLE VII**

THE KIND OF TERMINATION

<table>
<thead>
<tr>
<th>Kind of Termination</th>
<th>Cases</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Planned by Clinic with Parent</td>
<td>13</td>
<td>65.0</td>
</tr>
<tr>
<td>Instigated by Parent</td>
<td>3</td>
<td>15.0</td>
</tr>
<tr>
<td>Instigated by Clinic</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>20</td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>
This table describes the circumstances surrounding termination of treatment for the total group of children.

In thirteen out of the twenty cases, the clinic was able to plan closing with the parent. In twelve cases terminations were on the basis of the improvement in the child's symptomatology and/or internal pressures, and in the parent-child relationship. Eight cases were closed when it was felt the parent and/or child was not responsive to treatment.

**TABLE VIII**

**CLASSIFIED BY ADEQUACY OF PARENTS**

<table>
<thead>
<tr>
<th>Adequacy of Parents</th>
<th>Cases</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two Adequate Parents</td>
<td>8</td>
<td>40.</td>
</tr>
<tr>
<td>One Adequate Parent</td>
<td>5</td>
<td>25.</td>
</tr>
<tr>
<td>Two Inadequate Parents</td>
<td>5</td>
<td>25.</td>
</tr>
<tr>
<td>Psychiatric Disorder Present</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In one or both parents</td>
<td>2</td>
<td>10.</td>
</tr>
<tr>
<td>Totals</td>
<td>20</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table VIII distributes the twenty-one children according to whether they have two adequate parents, one adequate parent, two inadequate parents or one or both parents with a psychiatric disorder present. The term "adequate parent" as defined in this study means that the parent is living at home with the patient and that there is no chronic illness or outstanding economic difficulty existing; with gross marital discord or
emotional disturbance absent. For the purpose of this study a parent was considered severely disturbed and/or psychotic only if clearly stated in the record.

Out of the twenty-one children, thirteen had at least one parent who was inadequate or mentally ill.

TABLE IX
ATTITUDE OF PARENT TOWARD CHILD

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Number of Parents</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptance</td>
<td>14</td>
<td>35.0</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>11</td>
<td>27.5</td>
</tr>
<tr>
<td>Rejection</td>
<td>15</td>
<td>37.5</td>
</tr>
<tr>
<td>Totals</td>
<td>40</td>
<td>100.0</td>
</tr>
</tbody>
</table>

The parent's attitudes toward the child was classified into three categories: rejection, ambivalence and acceptance. The third category is defined as either conscious or unconscious dislike of the child and either shown by verbalized attitude or behavior toward the child. The second category is described as follows: the parent would express affection toward the child on one occasion, and on another would be hostile. The first category is defined as the parent who had affection, warmth, real love and concern for the child and was able to demonstrate these feelings. While the parent here may have become involved in the child's problems, the outstanding element of the parent's attitude toward the child
was positive and sincere.

The results of the table would not indicate any particularly significant information; for about an equal number of parents were rejecting as were accepting. It has been noted in the literature that just coming to the clinic provides trauma for the parent, so that only those with some positive feelings toward their child are likely to seek help.²

**TABLE X**

**INVOLVEMENT OF PARENT IN TREATMENT**

<table>
<thead>
<tr>
<th>Degree of Involvement</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement of Mother</td>
<td>9</td>
<td>45.0</td>
</tr>
<tr>
<td>Moderate Involvement of Mother</td>
<td>4</td>
<td>20.0</td>
</tr>
<tr>
<td>No Involvement of Mother</td>
<td>7</td>
<td>35.0</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>20</td>
<td>100.0</td>
</tr>
</tbody>
</table>

Table X indicates the degree of involvement on the part of the parent in a casework relationship. The term "involvement" as used here indicates the degree to which the parent entered into the casework relationship. There was "no involvement" when the parent merely used the interview for a friendly chat; constantly came late, frequently broke appointments, with or without calling, and consistently resisted all attempts by the caseworker to get her to talk about herself.

² Gordon Hamilton, *op. cit.*, pp. 275-315
and her feelings. Where the parent kept fairly regular appointments, did talk about herself, though superficially, she was considered as being "moderately involved" in the casework relationship. The parent who kept appointments regularly and who spoke of herself, her feelings and their relationship to the child's behavior was considered as "involved" in treatment.

Total involvement and moderate involvement in a casework relationship accounts for thirteen or sixty-five per cent of all the mothers.

**TABLE XI**

**OUTCOME OF TREATMENT**

<table>
<thead>
<tr>
<th>Status of Children</th>
<th>Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved</td>
<td>11</td>
<td>52.4</td>
</tr>
<tr>
<td>Partially Improved</td>
<td>4</td>
<td>19.1</td>
</tr>
<tr>
<td>Unimproved</td>
<td>6</td>
<td>28.5</td>
</tr>
<tr>
<td><strong>Totals</strong></td>
<td>21</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In evaluating the outcome of treatment consideration was given to changes in the child's objective behavior at home, and at school, the changes in his interpersonal relationships and lastly the changes in his symptomatic behavior and internal pressures. Objective manifestations of the disturbance of a person's development would be those which can be observed by others as against the subjective which can only be recognized if the client is willing; in other words, the inner conflicts.
Both objective and subjective factors thus entered into the evaluation of outcome of treatment. Moreover, insofar as possible, the evaluation is a relative one based on the comparison of the child's subjective and objective performance at the beginning and ending of treatment.

Changes in the child's functioning at home, at school and at play included his increased or decreased ability to adjust in normal home and school situations. Changes in interpersonal relationships included some amelioration or aggravation in such relationship factors, as aggressiveness and eccentricities. Changes in symptomatology encompassed reduction or increase in neurotic and psychotic symptoms and in habit and conduct disturbances. Finally, for change in internal pressures, as anxiety, depression, guilt feelings, hostility and personal contentment or happiness, the writer looked to the material recorded by the child's therapist.

The ratings for the two areas, covering the objective aspects of the child's behavior, or symptomatology, and the second covering the subjective aspects, or internal conflicts, were then translated into a final clinical rating of "improved," "partially improved," or "unimproved" in accordance with the following formula. If either the original problems or symptoms and the internal pressures were favorably modified, the condition of the child at the point
of closing was considered "improved." If neither the symptoms nor the internal pressures were alleviated, the condition of the child was called "unimproved." If either the original symptoms or the internal pressures were favorable modified, the condition of the child was called "partially improved."

Fifteen or 71.5 per cent of the total group studied are seen to have "improved" or "partially improved" during the period of treatment; while six or 28.5 per cent showed no improvement at all.

**COMPARISON OF THE TWO GROUPS OF CHILDREN**

This next phase of the study compares the factors as statistically described for the whole group, between the long term and short term cases. Table XII compares the external factors. It should be noted here that no attempt is made to use these figures in a significant way. Instead, their use here is descriptive only, and for the purpose of demonstrating the factors as they appeared in the records.

Generally, all the factors in this objective table exhibit no significant differences and it would appear that it is necessary to look elsewhere for clues as to possible factors which may be of aid in prognosticating length of treatment.
TABLE XII

COMPARISON OF LONG TERM AND SHORT TERM CASES AS TO EXTERNAL FACTORS

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Long Term</th>
<th></th>
<th>Short Term</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Per Cent</td>
<td>Number</td>
<td>Per Cent</td>
</tr>
<tr>
<td>Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>11</td>
<td>100.0</td>
<td>10</td>
<td>100.0</td>
</tr>
<tr>
<td>3-5</td>
<td>3</td>
<td>27.4</td>
<td>2</td>
<td>20.0</td>
</tr>
<tr>
<td>7-9</td>
<td>4</td>
<td>36.3</td>
<td>6</td>
<td>60.0</td>
</tr>
<tr>
<td>10-12</td>
<td>4</td>
<td>36.3</td>
<td>2</td>
<td>20.0</td>
</tr>
<tr>
<td>Sex</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>11</td>
<td>100.0</td>
<td>10</td>
<td>100.0</td>
</tr>
<tr>
<td>Male</td>
<td>6</td>
<td>54.5</td>
<td>5</td>
<td>50.0</td>
</tr>
<tr>
<td>Female</td>
<td>5</td>
<td>45.5</td>
<td>5</td>
<td>50.0</td>
</tr>
<tr>
<td>Ordinal Position of Child</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>11</td>
<td>100.0</td>
<td>10</td>
<td>100.0</td>
</tr>
<tr>
<td>First Born</td>
<td>4</td>
<td>36.3</td>
<td>6</td>
<td>60.0</td>
</tr>
<tr>
<td>Second Born</td>
<td>3</td>
<td>27.4</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>Third Born</td>
<td>1</td>
<td>8.9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Only Child</td>
<td>3</td>
<td>27.4</td>
<td>3</td>
<td>30.0</td>
</tr>
<tr>
<td>Source of Referral</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>11</td>
<td>100.1</td>
<td>10</td>
<td>100.0</td>
</tr>
<tr>
<td>Physician</td>
<td>5</td>
<td>45.5</td>
<td>3</td>
<td>30.0</td>
</tr>
<tr>
<td>School</td>
<td>2</td>
<td>18.2</td>
<td>3</td>
<td>30.0</td>
</tr>
<tr>
<td>Social Agency</td>
<td>2</td>
<td>18.2</td>
<td>1</td>
<td>10.0</td>
</tr>
<tr>
<td>Parent</td>
<td>2</td>
<td>20.0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other Client</td>
<td>2</td>
<td>18.2</td>
<td>1</td>
<td>10.0</td>
</tr>
</tbody>
</table>
### TABLE XII CONTINUED

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Long Term Number</th>
<th>Per Cent</th>
<th>Short Term Number</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Degree of Disturbance</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>11</td>
<td>100.0</td>
<td>10</td>
<td>100.0</td>
</tr>
<tr>
<td>Normal</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some Disturbance</td>
<td>7</td>
<td>63.7</td>
<td>5</td>
<td>50.0</td>
</tr>
<tr>
<td>Severely Disturbed Intelligence</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Totals</td>
<td>11</td>
<td>100.0</td>
<td>10</td>
<td>100.0</td>
</tr>
<tr>
<td>Dull Normal</td>
<td>2</td>
<td>18.2</td>
<td>2</td>
<td>20.0</td>
</tr>
<tr>
<td>Normal</td>
<td>3</td>
<td>27.4</td>
<td>4</td>
<td>40.0</td>
</tr>
<tr>
<td>Bright Normal</td>
<td>2</td>
<td>18.2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superior Intelligence</td>
<td>4</td>
<td>36.3</td>
<td>4</td>
<td>40.0</td>
</tr>
</tbody>
</table>

The lack of any differences between these two groups would appear to correlate with the results of the other studies described in Chapter II. As was noted there, these other studies indicated that the external factors appeared to have no influence upon the length of treatment or outcome of treatment.

Table XIII is a statistical description of factors which have appeared significant in other studies in predicting progress and outcome of treatment.

Helen Leland Witmer and Students, *op. cit.*, pp. 47-55
TABLE XIII
COMPARISON OF LONG TERM AND SHORT TERM CASES
AS TO SUBJECTIVE FACTORS

<table>
<thead>
<tr>
<th>Criteria of Treatment</th>
<th>Long Term</th>
<th></th>
<th>Short Term</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Number</td>
<td>Per Cent</td>
<td>Number</td>
<td>Per Cent</td>
</tr>
<tr>
<td>Outcome of Treatment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Totals</td>
<td>11</td>
<td>100.0</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Improved</td>
<td>2</td>
<td>18.2</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td>Partially Improved</td>
<td>4</td>
<td>36.3</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Unimproved</td>
<td>5</td>
<td>45.5</td>
<td>1</td>
</tr>
<tr>
<td>Adequacy of Parents</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Totals</td>
<td>11</td>
<td>100.0</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Two Adequate Parents</td>
<td>1</td>
<td>9.1</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td>One Adequate Parent</td>
<td>2</td>
<td>18.2</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td>Two Inadequate Parents</td>
<td>6</td>
<td>54.5</td>
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</tr>
<tr>
<td>Psychiatric Disorder Present in one or both</td>
<td>2</td>
<td>18.2</td>
<td></td>
<td></td>
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<tr>
<td>Attitude of Parent toward Child</td>
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<tr>
<td></td>
<td>Totals (Parents)</td>
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<td>20</td>
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<tr>
<td></td>
<td>Acceptance</td>
<td>4</td>
<td>20.0</td>
<td>10</td>
</tr>
<tr>
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<td>Ambivalence</td>
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<tr>
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<tr>
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<td>Totals (Mothers)</td>
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<tr>
<td></td>
<td>Involvement in Treatment</td>
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TABLE XIII CONTINUED

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<th>Criteria</th>
<th>Long Term</th>
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<tr>
<td>Instigated by the clinic</td>
<td>2</td>
<td>18.2</td>
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While these results are interesting, they cannot be considered statistically significant because of the small number of cases studied. The table demonstrates a number of interesting differences. In outcome of treatment, there are nine children or 90.0 per cent who are improved or partially improved in the short term group; while in the long term group, there appears to be little difference between the improved, partially improved and unimproved children.

Adequacy of parents seems to favor the short term group. Seventy per cent of the children in this group have two adequate parents and the remaining 30 per cent have at least one adequate parent. In contrast, in the long term group, 54.5 per cent of the children belong in the group with no adequate parent. The results compare quite closely with the picture of the whole group. This might appear to have some significance.

The greater proportion of the parents in the cases seen
thirty or more times appear to reject their children; while in those cases seen for a briefer time only 15 per cent of the parents rejected their children. This, too, would appear to have some significance as a clue in evaluating prognosis for length of treatment.

The picture of the involvement of the mother in treatment compares favorably with these other subjective factors. Here only 20 per cent of the mothers were involved in treatment in the long term cases; while 70 per cent of the mothers in the short term group were involved in a casework relationship.

In 80 per cent of the case records studied, there was no recorded consideration of length of treatment. In 20 per cent of the records, there was a statement, as part of a staff conference notes, that the staff felt this would be a long case. However, the basis for this thinking was not recorded. Because of the turnover in staff, it was not possible to obtain this information verbally.

The figures for this table were obtained from the closing summary, where the reason for termination and by whom initiated was noted. In both the groups there appears to be little difference in the number of cases closed by mutual planning of clinic and the parent and in those closed accidentally.

It would appear that in those cases where the parent
or parents were mature, adequate (as defined), and well-adjusted in their respective roles as wife, mother, husband, father; were accepting of their children; and able to become involved in a casework relationship, the possibility was that the case would be a short term one and also prognosis for success fairly good.

In another study aimed at discovering what proportion of parents change their attitude toward problem children as a result of child guidance treatment; it was found that the proportion of mature parents making marked improvement in attitudes toward problem children was greater than the proportion of moderately maladjusted parents making that type of adjustment. Also the latter, in turn, was much greater than the proportion found among markedly maladjusted parents even if carried over a long period of time. This would appear to compare favorably with the findings of this study.

Irgens studying the same cases as above attempted to show the extent to which improvement in problem children's


5. Effie Martin Irgens, "Must Parents' Attitudes Become Modified in Order to Bring about Adjustment in Problem Children?", Smith College Studies, 7:17, September 1936.
behavior is dependent upon modification of their parents' attitudes toward them. She found that a change in parents' attitudes usually accompanies improvement in children's behavior.

It would seem, therefore, that parents need help with their own maladjustments which interfere with their ability to modify their behavior toward their child; if the child's progress in treatment is to be furthered. Insofar, as they are able to accept such help and the worker is able to evaluate this ability, will it, perhaps, be possible to speculate on the length of treatment. Length of treatment will depend on an evaluation of all the factors involved, made as carefully and skillfully as possible.
CHAPTER IV  
CASE PRESENTATION

In studying the two groups of cases, one particularly interesting difference seemed to lie in the adequacy of the parents. This difference appeared to be reflected similarly in the other subjective factors examined as: involvement of the parent in treatment, outcome of treatment, and attitude of the parent to the child. In Chapter III, these factors were described statistically. In this chapter, the case material which seemed to indicate these differences in the two group of cases, is presented. The cases have been grouped according to the following categories in the factor, adequacy of parents, because this case material also appeared to point out the other differences:

A. **Long Term Cases**—Eleven Children
   1. Two adequate parents—one child
   2. One adequate parent—two children
   3. Two inadequate parents—six children
   4. Psychiatric disorder present in one or both parents—two children

B. **Short Term Cases**—Ten Children
   1. Two adequate parents—seven children
   2. One adequate parent—three children

As noted in the preceding chapter the term "adequate
parent" was defined in this study to mean that the parent was living at home with the child and that there was no chronic illness or outstanding economic difficulty existing, with gross marital discord or emotional disturbance absent. In one case where the child was living with only one parent and that parent was inadequate, he was put in the "two inadequate parents" group. It seems important to note here that in the cases studied, the degree of adequacy is not always clear cut and there is some overlapping. The writer has selected for presentation those cases that seemed most representative of the group. Because of the limited number of cases, in those categories where a case summary seemed to show the basis for the findings more clearly, all the cases were summarized.

LONG TERM GROUP

1. Two Adequate Parents

Since there was only one case that appeared to fall in the category of "two adequate parents," the writer will present this case in detail.

Case 1, Fanny

Fanny, an eight year old girl, was referred on 5/26/49 by her pediatrician. Her symptoms were nausea, vomiting, difficulty with her mother and poor school work. The pediatrician had been treating her for nausea and vomiting, and for an irritation at the base of the duodenum. When the symptoms persisted, the mother asked if anything else could be done, and the physician suggested the clinic, as he felt now, the problem
appeared psychosomatic. The mother noted at intake, that the doctor felt she was ready to accept the help of the clinic, and that parents had to reach some understanding before they were ready to accept help.

At school Fanny's work was spotty, and the teachers felt she was not doing what she should. F. was withdrawn, spent hours in her room, and the mother said that she could not understand F. and she could not or did not understand the mother.

The mother, forty years old, and F. came for interviews from 5/31/49 through June 1950, interrupted during July and August by vacations. They came regularly except for unavoidable absences because of illness. They came thirty-four times in all. The mother originally paid a fee of four dollars, but this was later reduced to two dollars because of heavy medical expenses for a younger sibling.

The case was discussed in conference before all staff members in early October. At that time F. had established a good beginning relationship with the psychiatrist and the mother with the caseworker. The problem then appeared to be that of an over-meticulous, somewhat heavy, methodical and unimaginative mother, who nevertheless, had great affection for her family; and a child who was very bright, sensitive, imaginative, but reacting to the mother by an aloofness and behavior difficulties, as well as with physical symptoms. The Oedipal relationship had not been worked out. F. still seemed to be in considerable rivalry, both with the mother and an older sister.

The father appeared to be a mature adequate husband and father. He was a professional man whose work kept him away from the family much of the time. However, he tried to spend time with the children. He appeared very interested in them and tried to include them in his plans when free from work.

At the conference, it was the combined feeling of the staff, that treatment should be continued,
and that the case would probably be of longer duration than many of the clinic cases. The staff concluded this, because the mother's meticulous personality, which played such a large role in her attitude toward F., was too basic to permit any radical change. However, with her considerable warmth, through a neutral relationship established at the clinic, she might be able to relax in her attitude to F.

F. was eight at referral, nine, November 1949, the second oldest of four children. B., the oldest sister was thirteen and in the last year of junior high in the public school system. The mother described her as a calm, normal happy girl. D., five, was described as hyperactive and was seen at the clinic upon completion of F's treatment. He was very annoying to F. with his rough ways. The youngest child, a girl, was eighteen months and the mother described her as a petite, dainty little thing.

The mother noted at the time of her pregnancy with F. that the marriage had not been a happy one. F. had been conceived in the hope that the couple would be brought closer together. When the mother was four months pregnant, it was discovered that the father had a hyperthyroid condition and an operation was done. The father became a changed person; less tense, and more even-tempered. Marital relationship from that time was much better.

The birth was normal but the mother was unable to nurse F. long because her breasts were sore. F. was put on a formula after five and a half weeks and ate well. At two and a half years, F.'s appetite became capricious, and continued until this year. The child was well over two years before she started to talk, but then expressed herself in complete sentences. She was shy and hid behind things when she met strangers. By the time she was seven, she was emulating her older sister and had developed a nice way with people.

The mother noted that F. had more imagination than other children and liked to write poetry. She had always read a great deal. The mother indicated a desire to know what F. was thinking
and was in many ways over-attentive to F.'s whims and fancies.

Until the year before coming to the clinic, F. did very well at school, then her work became spotty.

Father was always very fond of F. He and mother came to realize this during treatment, when they discussed some of the things from the clinic. Until, shortly before termination, F. was always wanting her father's attention; getting into his lap and wanting to be near him.

In February 1950, F. had a couple of weeks of great anxiety at bedtime, trembling in bed and crying for her parents. The mother discussed this at the clinic and was advised to go up to F. herself and not father. This cleared up rather quickly.

The mother began her contact with the case-worker in a somewhat guarded way. She apologized for not having read more and went into extreme detail in her description of F.'s behavior and of the details of running the house. As the interviews progressed, the mother brought out more and more about herself and her relationships to people. She told the worker that she had always been friendly with people but never could confide in them. The casework relationship grew slowly but steadily.

Mother was the oldest of three children and the only girl. She noted that she was much closer to her father than her mother. The mother always wished she had a sister and wanted F. to be a girl so the older girl would not be as lonesome as mother had been. Mother often said that the older girl was like herself.

During mother's adolescence her own mother was absorbed in the brother next younger to mother who was ill with polio. Maternal grandmother mourned over her son's illness, became sick herself, and shut herself away from everything and everybody. She was always a model child, the mother noted, and grew up to be very proper,
rather old-fashioned and serious. She thought it was fortunate that father fell in love with her.

The father's parents were quite different. They were not as proper as mother's parents. The couple were married in secret in a civil ceremony but after a few months told their parents and had a religious ceremony.

Mother was active in a mother's club and entertained them in her home. Because of her positive experience in the clinic, she became interested in mental hygiene and would obtain mental hygiene speakers and films for the meetings. She was a hard worker, an excellent cook and apparently very generous, entertaining often. Yet, when she would get a large meal, she would get upset if the children were not hungry. The mother worked very hard in the casework interview. She tried to understand the children and not to intellectualize, and come to relax somewhat with them. She came to some understanding of the feeling life of her children and did not get as tense and disturbed as formerly, realizing that she could not give them all the answers. With her considerable warmth, through the casework relationship, the mother was able to relax with F. which enabled her to give up her symptoms and blossom out in a very conspicuous way.

The psychologist found that test results showed F. to be a child of superior intelligence. They also showed her to be emotionally unstable, with difficulty in relationships with her parents, which appeared to stem from an unresolved Oedipal conflict.

The psychiatrist described her work by noting that the child was somewhat superficial at first but at vacation time had become more thoughtful and showed her desire to continue coming to the clinic. When she returned, she renewed her relationship with the therapist, and brought out her feelings of rivalry with her older sister and mother. Her physical symptoms disappeared fairly early in the contact and the pediatrician's
Medication was left off with no recurrence of physical symptoms. Her academic work at school went up. She became more accepting of her younger brother; more cheerful, happy and outgoing. The therapist felt the child was greatly improved in physical and behavior symptoms and the inner conflict, Oedipal, was resolved.

Although, basically, mother's personality did not change radically, her capacity for warmth and ability to use casework enabled her to become less controlling. In contrast to the other cases in the long term grouping, this case illustrates all the elements involved in the definition of the term adequacy. The marital relationship appeared positive as well as the attitude of the father to the children. Economically the family position was sound. Both parents appeared mature in their relationships with other adults.

2. One Adequate Parent

There were two children who fell into this category. The writer will present in detail one of the cases and will comment briefly on the other one.

Case II, Robert

Robert, a five year old boy, was referred by his pediatrician because of his babyish ways and poorly articulated speech. At school, he was found to be shy, withdrawn and sensitive about his defect. He was not doing as well academically as an older brother in the same private school. At home his behavior was quite similar. Mother felt he was in great competition with his older brother. She felt that it would be hard for him always
to be following along after this older sibling, who would probably always be a leader.

The mother and child came regularly for interviews from 4/6/48 until 10/30/49. The case was reopened briefly on 10/6/50 when the mother requested advice as to having a speech therapist. The psychiatrist felt that the child's personality had matured and his speech improved sufficiently that further treatment was unnecessary. There were interruptions during the summers of 1948 and 1949, because of vacations. The mother paid a fee of five dollars, though she often had the need to mention economic distress.

R. was the middle child of three children, the oldest a boy and the youngest a girl.

The father tended to worry a great deal. He suffered from migrane headaches and had had a nervous breakdown once when sent away from paternal grandparents' home. He was an engineer, in business for himself and spent very little time with the children. He was a dominant, definite person and handled all the financial matters.

The mother was a member of a prominent family and representative of old New England culture. The mother was an extremely conscientious, tense woman, active in many social and community affairs. Her children had to meet upper class standards at all times.

Pregnancy and development was normal until the age of two when the mother noted no improvement in his speech, then, over his speech at one year.

Two caseworkers saw the mother, the first until September, 1948, and the second until the end of treatment the following year. In her first contact the mother presented the family situation, but tended to ask questions and to approach behavior from the point of view of discipline and methods. She became dissatisfied with this and at the point of transfer, both workers clarified with the mother whether or not she wished to continue and placed the problem on an
emotional basis; that is the feelings of R. and the members of the family, especially the mother.

In the second contact the mother was somewhat able to go into her feelings. She brought out essentially her rebellion at the culture in which she had been born. She raised and obtained some understanding of how much she was repeating this for her children, and sensing in them many of the problems that she, herself, felt as a child growing up in private schools. She also saw within her own family many of the problems of reserve, reticence and tradition that had made her and her father before her feel particularly aloof and distant. She brought out her own inability to talk with any member of her family when she was a child. She also brought out considerable feeling around her school experiences, her relations with her own family, and her relations with her children and husband.

She was able to bring out some hostility and during the second contact with the clinic, she became more relaxed and developed a more positive feeling for the clinic and its work. Though at times she retreated from treatment into a consideration of more general problems, on the whole, she appeared to come back to the family relationships. The mother made progress in understanding her children's needs and in being able to meet them more freely than before.

Father's parents too emphasized rigid social behavior. Since paternal grandfather was alcoholic, father had to take over support of the family from an early age. Father was quite indifferent to the children and deliberately kept out of their way.

Results of the psychological tests showed R. to be a boy of probably superior intelligence, with evidences of emotional interference with maximum performance on verbal material. His feelings about his speech handicap and the handicap itself, appeared to inhibit his ability to perform up to capacity when required to respond with words. However, in spite of the handicap,
there was evidence that his language development was at least average. The psychologist felt that the speech difficulty was on an emotional basis, but the tests did not throw any light on why this symptom was chosen.

The psychiatrist found R. to be a well-developed child. Left to his own devices, he would not talk at all, but when questioned, he answered but with indistinct sounds in his speech, especially around consonants. He played in an immature way, seeming to be a child of three. He spoke with great interest of the private school, he was attending and of his younger sister, but never discussed his older brother directly. He used the dolls to show up many of his problems and to work out his aggressive feelings. His growing maturity both physically and emotionally was obvious during the course of treatment.

Basically, the mother was a warm person with the capacity to react as a mature mother but who found it difficult to express feelings because of her own rigid upbringing, and to accept any display of feelings from the children. The mother appeared caught in the dilemma of having many rebellious feelings, herself, against the social restrictions that were placed on her and yet, of enforcing them with the children for fear of their losing out in some way if she did not do this. At the end of treatment, she was able to understand these feelings. She saw how these were affecting the children, so that they felt guilty about expressing what is considered merely normal aggression. She was then able to accept R.'s expressions of aggres-
sion as healthy. Because of this real desire that her children not be denied a good mother-child relationship, she was able to find release with casework help.

While many of the conditions in the definition of adequacy are met in this family, there is some question of the marital relationship where father was not accepting his responsibilities as a mature father and husband, but was still continuing the pattern established in his childhood when he took over his father's role in many ways. He appeared quite rejecting of the children.

Even with one adequate parent, the child was able to give up many of his symptoms and to resolve some of his feelings about his relationship with his mother. This case was closed when improvement in symptomatic behavior and parent-child relationship was noted. It was felt by the team that further contact would be on the basis of diminishing return.

No staff conference was held on this case but the value of such when consideration could be given to diagnosis and treatment plan, is apparent. Certainly then perhaps the time spent during contact with the first worker without any involvement of mother in treatment might have been shortened. The plan to face the mother with the need to place the problem on an emotional, if
the clinic contact was to be helpful, might then have been accomplished earlier in the contact.

In the second case in this group, many of the conditions of adequacy were met; such as, lack of real economic distress or gross marital discord. Mother was seen as a compulsive controlling figure with a great deal of rejection and hostility to the child. Throughout the contact, she spoke of the child in a negative way. The mother of this five year old child, Albert, because of her own deep-seated emotional disturbance, was unable to act as an adequate parent. Father, here, was the mature member of the family and it was his strength and attitude to the child which enabled him to operate within such normal limits as he did. This contact was terminated when the child showed symptomatic improvement. With the mother receiving help privately from a psychiatrist, Albert's therapist felt the clinic had gone as far as it could. It was felt that the child's satisfying relationship with his father would be of sufficient support in his continued adjustment.

3. Two Inadequate Parents.

In the third category six children were treated. This included a set of identical twins seen at the same time, each by a different therapist. Of the total,
three children showed partial improvement in an amelioration of symptoms, without any accompanying change in the basic conflicts. What appeared to the writer to be the most representative case in this category will be presented in detail, with the remainder commented upon briefly.

**Case IV, William**

William, ten, was referred to the clinic, June 1947. His symptoms were stealing, lying and bunking school. Referral was suggested to mother by a public librarian. At school, he was retarded two years and his attitude there seemed to be one of complete indifference. At home, he got along poorly with his siblings and was easily led by the neighborhood boys.

Mother and child came in fairly regularly for interviews from June 1947 until January 1949 when both discontinued. The case was reopened November 1950 with W. being seen by a male therapist in the clinic, and the mother every other week by a male caseworker in the Family Service Agency for supportive help. The mother never was able to come to more than a superficial relationship with the worker. It appeared that she saw the worker as an authoritarian figure to whom she reported on the events of the week. While she complained somewhat of the other children, she constantly came back to a discussion of W.'s behavior. She did little, if any, mature thinking in her casework contacts.

Treatment conference was held November 1947 after the mother had been seen six times. It was felt then that the inadequacy of the environmental conditions was overwhelming and that a possible treatment plan at this time involved environmental manipulation. The staff wondered at that time, too, whether mother would really have the strength to
move out of this environment. It was felt that a better understanding of the mother was needed. The staff considered that because the mother came from quite a restrictive family and never was allowed the normal emotional growth of a little girl, she was still a little girl in many respects. She was easily crushed, unable to take on responsibility or to make a decision. It was felt that with W. this was a pretty crucial point in his life as to whether or not he would turn to crime. In addition to the gangland neighborhood, condemned decaying building in which the family lived, the father drank, encouraged the boy in his stealing and truancy.

W. was seen at the clinic over a period of four years, on and off. He was the second oldest of five children, three boys and two girls.

Father was a taxi driver who was alcoholic, a poor provider, ineffectual in his marriage relationship and as a father. He was the passive one in the relationship, escaping from his responsibilities by drinking.

Mother was the dominant figure in the marriage; was inadequate as a parent, unhappy in her marital relationship, masochistic and immature. She had had few really satisfying relationships and was unable to become involved in a casework relationship which was more than superficial.

Mother noted that W. was born with rickets, was very bony and "funny shaped." The mother lost two babies after W.'s birth. The mother was unable to nurse W. She noted that he was always a "whiney" baby; was hard to train in toilet habits.

The mother had two caseworkers. With the first one, she appeared to establish a fairly good relationship which she used in a supportive way. It appeared briefly as though the mother were able to take on more responsibility for improving the environmental situation and become more accepting of the frustration she
had to meet. However, after her operation, she again withdrew and with the second worker was very superficial. This worker attempted to see the mother as a person apart from W., encouraging her to talk about her own wants, but the mother could not tolerate this. The family continued to live in the same house. The father found a new one at one time, but the mother found it unacceptable. This inability to move out the poor environment indicated a strong degree of masochism, in this woman which caused her to cling to such miserable surroundings.

The mother was from a comfortable middle-class family. She was the oldest of three sisters and felt herself to be the least favored. While the others could go out, she would have to stay home and care for her younger sister. The mother noted that her marriage had been a forced one because her mother restricted all sex knowledge from her. She had not even known that she was pregnant until the father told her there was a baby in her stomach. During the casework contacts, she revealed this immature attitude toward sex.

The father came from a very poor family environment. According to the mother, paternal grandmother was promiscuous and paternal grandfather too neglected the children.

The case was closed January 1949 when the doctor felt that nothing further could be done for W. Because of the poor environment, the mother's deep seated emotional disturbance, and her control of W., the possibilities of change in either seemed remote. When, therefore, W. was again accepted for treatment, it was on the basis that he would be helped by seeing a male therapist, in a supportive way, while the mother would continue with the Family Service Agency. W. discontinued shortly with no change in his behavior and it appeared very possible that he would be sent to the training school.

Test results indicated a boy of bright normal intelligence with emotional disturbances. It was felt that he had sufficient intelligence to
make excellent school progress when and if his emotional adjustment could be improved.

The first therapist, a female psychiatrist, felt the boy related in a fairly superficial manner. The doctor noted the boy's extreme talent in art and obtained a scholarship for him in art school which he used only briefly.

With the second therapist, the boy seemed to want to talk over his problems instead of acting out as formerly. Just why he withdrew when he did was not readily apparent to the staff. Withdrawal did coincide with his birthday. Since he equated money and tangible gifts with love, it might well have been his resentment to the worker for not giving him a gift, which accounted for his withdrawal. It also appeared part of his pattern that he became completely absorbed in a new experience and then did not follow through.

In this case can clearly be seen all the components of the definition of inadequacy; outstanding economic difficulties with gross marital discord and emotional disturbance in both parents. No improvement was noted in this case and any would be doubtful as long as the boy remained in the environment. A treatment goal which might have been considered was eventual removal of the boy from his family to that of his maternal grandparents in a nearby town. With his grandparents, he appeared to have a good relationship.

Five other children fell in this category of two inadequate parents. In all the cases, a poor marital adjustment appeared as well as emotional disturbance in both parents. In case #5, the marital un-
happiness seemed to result from the conflict induced by the union of a weak, immature man to a superficially strong, domineering, but basically anxious woman who was wholly unable to share the father with the daughter, Miriam.

The father of Anna, case #6, was an immature, self-centered, selfish, unstable person, who was always protected by his mother while she lived. From his behavior before and after, he separated from Anna's mother, paranoid tendencies appeared. The mother of Anna unconsciously rejected her because of the father's seeming preference for Anna and because she had experienced so much rejection herself, as an illegitimate child and later as a woman. She was conflicted about sexual matters and immature in this respect among others.

In case #7, Ruth's mother and father had suffered from lack of love in their early childhoods and were now unable to relate heterosexually in a mature way. The parents of the twins too were unable to form a mature heterosexual relationship, but in their case because each was so identified with their own parent of the opposite sex.

Both Miriam and Anna were seriously disturbed and were seen at the clinic over a long period of time, supportively, in the hope that a psychotic break might be
prevented. Ruth was felt by the doctor to be neurotic and treatment was continued in the hope that she might be able to work through her basic hostility to her parents, because of their rejection, through contact with a "good" father, the therapist. However, her defenses remained too strong and her feelings too strongly repressed to permit much movement.

There was some alleviation of symptoms as noted at referral in Ruth and the twins, Allan and Roland. Ruth was no longer swearing, at least not as uncontrollably as at referral. While Allan and Roland had shown some improvement in reading and in their academic efforts. Basically, Ruth appeared to take on even more controlling defenses which made her even less amenable to therapeutic treatment. Her feelings of rejection were not worked through at all. The twins, too, were unable to work through their basic conflict, an unresolved Oedipal, because of the inability of their parents to adjust as mature marriage partners and parents.

Generally, it would appear that where there was gross marital and emotional disturbance in the parents, continuing the case over a long period did not necessarily indicate a positive change in the child and/or parents would be forthcoming.

Termination of cases, five and six, was planned
by the clinic with the parent on the basis that the clinic
did not appear to be the proper source of help in these
situations. At the time of closing, Anna had been re-
ferred and accepted for care at the local home for emo-
tionally disturbed children and the mother referred to
the family service society. Contact with Miriam and her
mother was mutually ended when neither the parent nor
the child appeared able or willing to enter into a rela-
tionship with their respective therapists.

The case of Ruth was closed at the request of the
child and parent. The team felt this was due to the
threat to each of their becoming involved in a rela-
tionship to the doctor and caseworker, respectively.
Contact with Allan and Roland was ended when their
therapists left the clinic and there were no available
male therapists to take over treatment. Also, neither
parent indicated any ability or desire to enter into a
casework relationship.

4. Psychiatric Disorder Present in One or Both Parents

This last category to be considered in the long
term group had two cases. One case will be illustrated
and the other discussed briefly.

Case IX, Theresa

Theresa, age ten, was referred to the clinic
by her family physician, August 1947. She had
recently been involved in two stealing incidents
and the family felt she was sly and unstable. She had been adopted at the age of seventeen months.

The test results showed T. to be a girl of average intelligence. The Rorschach portrayed an insecure, anxious girl who responded to instinctual demands in an immature fashion. She attempted a rigid, constrictive control which often slipped into impulsive outbursts. She had extreme difficulty in forming interpersonal relationships.

She used her interview time with the psychiatrist to chat superficially. The doctor felt her to be a narcissistic, immature girl who was rejected by her mother and constantly reacting to her parents' unhappy marital relationship. Her school marks were always poor and promotion was not expected at the time of termination.

The mother was found to be a seriously disturbed person. She had extreme difficulty in relating to the worker. She had experienced an extremely traumatic childhood. Her father deserted when she was five and and she and a younger sister were brought up by a strict and demanding mother. The mother felt she had been rejected by maternal grandmother because she looked like her father. Both she and her sister were deprived of all material things. The mother knew nothing of sex until her early marriage and was so overcome by the puritanical harshness of her own home that she would not even attend church with her husband.

The father was seen for a period and was found to be a meticulous perfectionist, often a punishing person. He was the youngest of eight children and as a sickly adolescent, was over-protected by his family and had an intense relationship with his mother. His parents were separated. He had wanted his brother to accompany him on his honeymoon and would often spend evenings with his mother rather than return home to dinner with his family. He described himself as a "physically cold" woman. He noted that she had had "an affair" many years ago but he still professed his
love for her. He, like mother, found casework treatment too threatening.

During the Christmas holiday of 1947, the mother became so disturbed that she voluntarily saw a psychiatrist twice, but was unable to continue. She left home then to visit her sister in New York, who was not accepting of her. At this time, mother was diagnosed as being in the depressive state of a true psychosis. She felt that her acquaintances had deserted her. She went on a near starvation diet, carried on with other men, and thought of suicide.

The casework relationship was superficial. The mother always talked in extremely anxious, guilt-laden tones, during the thirty-two times she was seen. She was seen as an extremely narcissistic person who did not love T. All of her adult relationships were poor and she was extremely suspicious and depressed in clinic contacts. A conference in November brought out the feeling of the staff that she had many paranoid trends. Her inability to form relationships, especially with other women, suggested a homosexual component. The goal at that time was to offer supportive help to the mother with the idea of her permitting the child to continue in treatment, and of finally helping her to seek and accept psychiatric help.

However, this goal was not attained at the time it was necessary to terminate because the mother's therapist was leaving. At this time too her paranoid trends were very evident as she even suspected people watching her in the clinic waiting room. Yet her depressive states were so evident that a diagnosis of depressive affective psychosis was made.

In this case there was evidence of psychiatric disorder in both parents. Because of the poor home situation, no improvement seemed possible for the child as long as she remained. Though contact with T. and the mother was terminated because the mother's caseworker
was leaving the clinic, a transfer was discussed with the mother, six weeks before closing. This mother was unable to accept. The team also felt that closing was best since a change in the parent-child relationship seemed improbable due to the mother's disturbed mental state.

In case #10, Donald's father, though he appeared somewhat overbearing and punishing, indicated enough strength, stability and desire to obtain help from a therapeutic contact. The mother, on the other hand, was very guarded, defensive and hostile in the case-work relationship. She was completely negativistic and rejecting of the child, and during interviews would say over and over again that she would never have another child. The mother was diagnosed as paranoid. She was involved in the Oedipal fantasy with her own father who lived with her, and the family. The marital situation was disturbed.

This case was closed after forty-five interviews with no apparent change, though mother was seen for a number of interviews by the psychiatrist. She withdrew when the treatment became too threatening, and after placing the child in a parochial school, though the clinic would have continued to see the child and the mother.
This group of long term cases though brief in number is felt to be fairly representative of the total number of intensive (in time) clinic cases. As such it might be possible to note here that in the long term cases, there appears to be a prevalence of poor parent-child relationships, of marital disturbance and little or no important change in the child and/or parent.

**SHORT TERM GROUP**

A study of these cases appeared to indicate that the parents, involved, fell into only two categories out of the possible four. Again, there would appear to be overlapping. Where the parent or parents appeared to exhibit some strength, maturity and ability to move ahead in their understanding of how their feelings affected the parent-child relationship, they were placed in the more favorable category.

1. **Two Adequate Parents**

   There were seven cases falling into this category and one will be presented, while the others will be discussed briefly.

   **Case II, Rupert**

   Rupert, age ten, was referred January 1947 at the suggestion of his teacher. He was in the fifth grade and the oldest child of three, the others, twin brothers, age three and a half. He
was tested at school and found to be of superior intelligence. However, his work performance at school was poor as was his behavior.

He teased other children in school, had no friends, daydreamed, was pokey and slow at home. R. was always intellectually curious at home and spent a good deal of time reading scientific magazines and like material. This reading presented a realistic problem in that his eyesight was impaired by a muscular weakness for which he was being treated. He was also being treated regularly with hormone injections, because of undescended testicles.

The psychiatrist found R. to be a stimulating, charming, likeable youngster to talk with, but a confused one. He could not understand how twins could be born or how his mother could have two babies. The doctor discussed babies and birth with him, encouraging him to speak of his associations with boys. This was a difficult subject for him as he felt "different" and lonely because of the undescended testicles. He was helped to join the Y.M.C.A., to attend summer day camp, and found a friend, a bright boy in his class, before treatment was terminated. The relationship appeared to be mutually stimulating, intellectually and socially. His adjustment at school was good too at the close of treatment.

Work with the mother was focused on her feelings about her inadequacy, although she had and continued to perform adequately. She was an alert, attractive, interested and interesting young woman. She used her relationship in the clinic to talk over many of her feelings about total family relationships and points of difficulty.

The father, who was seen once for an interview, appeared to be still somewhat involved with his mother. His one act of rebellion was his marriage. While he gave the impression of immaturity, he indicated many potentialities for maturing adequately with the help of his wife's understanding and support. Both were genuinely fond of the children, and the mother was able
to express her ambivalent feelings about them without too much anxiety.

The mother appeared to be the stronger member of the partnership and could easily have been too controlling because of her drive and push for success for the family. However, she came to recognize the presence of this attitude and related it to how best she could use this understanding of her own needs to help the father. She might, thus, avoid falling into the trap of repeating for him his relationship to a controlling mother. In spite of many insecurities, both parents showed evidences of much strength and a wish to work things out for a totally more mature adjustment.

The case was closed when the clinic felt that in view of R.'s better adjustment in school, at home and in the community, and the mother's understanding of the situation, the family was able to work through any further difficulties on their own.

The marital relationship of these two parents appeared satisfactory. The family was economically solvent. The parents' attitude to the child was seen as basically sound. Through her involvement in a casework relationship, the mother recognized the effects of her drive and push for success on the family and to control these. Termination was planned with this mother and child when the team felt they were ready to go ahead independent of the clinic help.

The parents of the other six children in this category, generally, appeared to have the same traits and attitudes as in case #11. Again, in case #12, Margaret
was reacting to pressure from her mother to do more than she was able. Her mother tended to project upon M. her own ambitions. In so doing, the mother was emulating her own strict background as a child, of which she was resentful. At the same time she was concerned about M.'s academic work, she also wished M. to get along well with everyone. With casework, the mother was able to recognize that M. was reacting to her expectations by throwing temper tantrums. The mother was able to accept the need to have M. placed with her own age group in school, and to permit the child more freedom for her own natural expression. Both parents indicated warm affection for M.

In case #13, Edwin, too, appeared to be reacting to parental expectations beyond his capacity. The mother exhibited much warmth and interest in E. She was able, through a casework relationship, to recognize that E. behaved as he did in order to compete for her attention and approval with two much brighter siblings. Though she appeared rather compulsive and inclined to have high standards, there was some modification of this attitude in relation to E., during her clinic contact. Father, too, exhibited a great deal of warmth and interest in E. Though he worked late hours, he always tried to get home in time to help the mother put the children to bed and listen to
their prayers. Sundays, he spent a good deal of time with the children.

Rosilyn, age five, case #14, was in the middle of her Oedipal conflict. Her own father had died when she was two and a half, and she had lived alone with her mother until the mother had remarried a year before coming to the clinic. The mother had intensified R.'s conflict by pushing her toward the stepfather, to assuage her own guilt feelings about remarrying. R., in her contacts, with the male therapist, soon indicated that her Oedipal strivings were close to consciousness. She was permitted to act out these feelings in a permissive atmosphere. Thus, she tended to feel less guilty about her mixed feelings for her stepfather, and was able to carry over the relationship formed in the clinic to the home situation. The mother, too, was helped to feel less guilty about remarrying at the termination of the contact. Termination was planned when the clinic, the mother and the child felt they were able to continue the improvement in the family relationships, independent of the clinic.

The problems of Peggy, age nine, case #15, appeared to lie in a traumatic childhood and an incomplete female identification. Before and after her mother's death, she lived for brief periods with various relatives. When her
father remarried, she reacted to the stepmother with extremely aggressive behavior in school and in the home. The stepmother showed great concern about being a stepmother and afraid of the neighbor's criticism. The team felt that the stepmother was identifying P. with herself as a child and her impulses and difficulties at that time. With casework support and acceptance, the mother was able to relate positively to the clinic and ventilated many of her hostile feelings about P. There was a resulting improvement in the family atmosphere. The case was closed somewhat prematurely because the family did not live in the geographical area covered by the clinic. Though P. had accepted a female identification and her symptoms had disappeared, the team felt the improvement in the mother-child relationship was still tenuous. However, it was hoped that the many positives, of good ego strengths in P. and the stepmother, and the satisfactory marital relationship, would help them to continue independent of clinic help.

In case #16, Marjorie, age ten, too, seemed not to have accepted a female identification completely, as a result of pressures from her mother to do well. Both parents were found to be warm in their affection to the child. The father seemed the more mature and stronger of
the two, though the mother was a warm and sensitive person. During treatment, M.'s symptoms disappeared and she appeared to accept a female identification. Correspondingly, the mother became more understanding and tolerant of M. At the close of treatment, planned by the team and the clients, the mother and the child had joined an art class together.

Esther, age eight, case #17, was referred because of enuresis at night, sibling rivalry, a general sense of insecurity, and nightmares. The psychiatrist felt her basic problem lay in a confused identification. Gradually E. developed a warm relationship with her therapist. There was a resulting steady improvement in her adjustment at school, with other children, her siblings, and acceptance of a female identification. At the end of treatment she was promoted with an excellent report card. The mother was felt to be somewhat confused about her own identification. Gradually, too, during the clinic contact, the mother became aware of her own mixed identifications and appeared willing to make the effort to orient herself to her roles as wife and mother. She was able to relate her different reaction to M. to M.'s considerable progress.

In all but one case, #13, in this group, definite improvement was noted both in the symptomatic behavior and the inner conflict. The boy in case #13 was not felt
by the team, to have worked through his basic feelings of hostility to his mother. Though the mother was told the clinic would continue in the fall, she did not feel it was necessary in view of the disappearance of symptoms.

Termination of cases eleven through seventeen, excepting thirteen, was planned with the parent and child. In view of the improvement in family relationships, the disappearance of symptoms, and resolution of inner conflict, the teams felt these families could continue independent of clinic help. Case #13 was closed when the mother felt there was no need, because of the disappearance of the symptoms.

Generally, it would seem that where the child is living at home, and the conditions for adequacy prevail, prognosis for length of treatment might indicate a comparatively brief period of time.

2. One Adequate Parent

In this last group of short term cases, three boys appeared. In all of these, it was the fathers who appeared to have the more mature and normal feelings for the children, while the mothers were, on the whole, rejecting and fairly narcissistic. One case will be presented and the others commented upon briefly.

Case XVIII, Jerry

Jerry, a seven year old boy, was referred to
to the clinic November 1949 by his physician because of stuttering.

The clinical psychologist found J. to be a very likeable little boy who was functioning at the average level of intelligence. While he showed some tension during the testing, his stuttering was not marked. There appeared to be some difficulty in his relationships with his parents, especially with his mother. The psychologist felt that his response to environmental stimuli was a favorable sign and that he did not appear to be a seriously disturbed boy.

The psychiatrist in summarizing her contact with the boy explained that he was a physically and mentally immature boy who was not retarded. She had noticed a jerky movement at the back of his neck, a peculiar tic, but felt the speech defect was not too apparent. While the relationship appeared superficial, there was some change during the clinic contact. The child, who had skipped a grade, was put back in school with his own age group, where he was actually much happier and more relaxed.

The father showed affection for the children. He appeared much more mature in his role as a father, and tried to help the mother release the boy to play with others and to reduce the pressures for success. He also enjoyed doing things with the boy.

The mother was a very rigid and exacting mother. She consciously recognized that she had some part in John's difficulty and expressed a desire to modify her attitude toward him. However, her resistance was so strong that it was impossible for the caseworker to get at the basis of mother's rigidity and her suppressing attitude towards Jerry.

From what material was revealed, it was felt that the mother's own early family relationships were very unsatisfactory. In addition, she appeared to be quite disappointed in her own marriage. Her early insecurity seemed carried
in her roles of wife and mother. She had a great deal of resistance to the casework relationship, and broke many appointments which did not allow the relationship to become very fruitful.

The mother's satisfaction in J.'s improvement was evident. However, she indicated disturbance when he acted aggressively at home. It was the consensus of the team that the mother was un-treatable, yet, if the mother did not change her attitude somewhat toward Jerry, he would remain inhibited throughout life. On the whole it was felt prognosis for casework treatment was quite negative, and that the change in grades was probably the most that could be accomplished at this time. For this reason, further contact was felt to be unprofitable.

In both cases, nineteen and twenty, the mothers were pregnant. In view of this and the mothers' reluctance, the casework treatment was necessarily limited, though the teams felt the mothers were emotionally disturbed. Bob, case #19, age four, was referred because of difficult behavior and temper tantrums. He was of superior intelligence and appeared "normal" in personality development. It was felt that mother's basic rejection of the child prevented her from accepting any overt behavior on Bob's part. During the supportive casework contact, the mother appeared to obtain some relief from talking about her problems, the boy's aggressive behavior and her dissatisfaction with the father. She became somewhat less protective of the boy.
In case #20, Harry, age seven and a half, was referred because of a reading disability. It was the father who was most active in getting help for the boy, and felt the problem was an emotional one. It was in view of the mother's continued resistance to involvement in a casework relationship and seeming inability to gain insight that the case was closed. The record indicated rejection of the child on the mother's part and conflict about her own identifications. She was jealous of the father's interest in Harry. The team felt that the marriage relationship was not satisfying to her and that she tended to project much of dissatisfaction upon the boy. She also appeared to be repeating with Harry, her own emotional attitudes of competition and identification, experienced during her own childhood. The boy was able to improve his reading in remedial reading sessions with the clinical psychologist. Since it was felt that H. could overcome his reading disability with an accepting tutor, in view of the mother's extreme resistance, the case was closed.

The first two cases in this group indicated partial improvement with some amelioration of symptomatic behavior. However, no real change in the inner conflict, hostility of the mother, seemed possible because
of the mother's own deep-seated conflict, her resistance to involvement in casework treatment, and in case #19, her pregnancy. In the first case the child's relationship with his father appeared good and the environmental manipulation of having him placed with his own age group in school, appeared to provide sufficient relief for a disappearance of the symptoms to a great extent. In the case of Bob, he appeared to be getting a great deal of affection and acceptance from the maternal grandparents and his father, which was helping him to develop quite normally. In both cases, it was felt that the children were not too disturbed.

In case #20, the boy was felt to have a great deal of suppressed hostility to the mother which he was unable to release at all during the clinic contact. While he was able to read better with the psychologist, this improvement did not carry over into school.

In all three cases there was evidence of the mother's rejection of the child, marital difficulties, and indications of a not too well integrated and functioning mother.

Contact with Jerry was ended when the mother became threatened by a possible involvement in a casework relationship and withdrew. However, before this happened, the clinic was able to effect environmental manipulation
by having the boy placed back a grade. The cases of Bob and Harry were terminated because of lack of available staff. Their workers left the clinic and since prognosis appeared poor, no effort was made to continue the cases.
CHAPTER V
SUMMARY AND CONCLUSIONS

The Providence Community Chest Drive, which contributes the major portion of financial support to the Providence Child Guidance Clinic has failed to reach its goal in the past few years. Through the efforts of the present administrator, the amount of clients' fees has reached the largest total collected annually. However, with an increasing number of children requesting its services, the clinic can use more financial support. To this end, the administration at the clinic requested this comparison study of long term and short cases. They felt that such a study might point up factors, which would lend themselves for consideration in prognosticating the length of treatment. This knowledge could be useful to the clinic, pressed for staff and time, in deciding where to put its energies, whether into long term or short term cases. Emphasis, in this study, then, was on possible predictability of length of treatment, not so much for the exclusion of long term cases, but from the point of view of over-all clinic planning so that it would not at a given time, become too heavily loaded with long time cases.

In the twenty cases, randomly selected, the writer took note of the possible influence on length of treatment
of such external factors as age, sex, ordinal position of the child, home situation(economic), source of referral, distribution of problems, and degree of intelligence. Since these factors did not appear to be significant, greater emphasis was placed on the internal structure of the situation; the parent-child relationship and the marital situation. The writer in considering these factors as possibly influencing the length of treatment sought answers to the following questions:

1. How does adequacy of the parents affect length of treatment, if at all?
2. Does the parent's involvement in treatment affect the length of treatment?
3. Were there any significant gains by the parent and/or child in long term cases? In short term cases?
4. Is there any relation between length of treatment and outcome of treatment?
5. Did length of treatment and closing appear to be a planned part of treatment.

There were some interesting findings as the cases were studied for the answer to question one. In the long term cases, there were eight children who had no adequate parents or one or both parents with a psychiatric disorder; while in the short term cases all ten of the children had at least one adequate parent. There were eight children, then, in the long term group, who lived with parents poorly
adjusted, maritally, with gross emotional disturbance present in one or both parents. In the attitude of the parent to the child were found similar results. In the long term group, there were twelve rejecting parents out of a total of twenty, as contrasted with three rejecting parents out of a total of twenty, in the short term group. Conversely, there were eight accepting and ambivalent parents as contrasted with seventeen accepting and ambivalent parents, in the respective groups. It would appear that the parents in the short term group were characterized by a greater incidence of adequacy, and, in general, by a more positive attitude towards the children, than those coming over a very long period.

From the findings, in regard to question two, the involvement of the mother in treatment, there would appear to be no influence on the length of treatment in the long term cases. While, in the short term cases, eighty percent of the mothers were at least moderately involved in a casework relationship as contrasted with only twenty percent who were not involved at all. This might indicate that where the parent or parents were involved in a casework relationship, the contact might not be too extensive.

The answers to questions three and four would appear to compare favorably with the results of other
studies as reviewed in Chapter II. Generally, it would not appear in this or any other study reviewed that the longer the period of treatment, the greater the improvement. In the long term cases, there was an almost equal number of improved and partially improved children as there were unimproved children. While in the short term cases, nine children out of a total of ten showed improvement or partial improvement. However, in view of the brief number of cases studied, these findings cannot be considered as statistically valid, but are used here descriptively. It is interesting to note that where outcome of treatment is related to length, the largest proportion of successful cases is to be found among those involving only approximately twelve interviews, and no less than five.

It might be speculated that the number of clinic contacts was not significant as far as success or failure of treatment was concerned. It would follow, then, that the use of skill and knowledge in closing a case, when it would appear, a point of diminishing return had been reached, might permit more profitable use of clinic time.

Investigation of the cases for an answer to question five was handicapped by a lack of material in the records. The results were culled as objectively as possible by the
writer, largely from staff conference notes and closing summaries. Since only two cases out of the twenty discussed length of treatment, and then not clearly, no findings are possible. However, for purposes of future studies, it might be suggested that consideration of the reasons for continuing cases, particularly over a long period, be given in the record. It would not appear that closings planned by the clinic with the parent and/or the child had any influence on length of treatment. An equal number of closings were planned in long term and short term cases.

Again, it must be emphasized that in view of the limited number of cases, no definitive conclusions can be drawn. However, in the short term group, there would appear to be a relationship between adequacy of parents, outcome of treatment, attitude of parents towards the children, and involvement of the parent in a casework relationship. In view of the fact that a like relationship does not appear in the long term group, early assessment of these factors should be useful in prognosticating the length of treatment. In turn this knowledge could be a consideration in the setting up of criteria for the selection of cases for treatment, particularly, when there is pressure from long waiting lists.
From these findings, it might appear that the main considerations for the length of treatment in this child guidance clinic should be the strength and power of the disturbance of the parents, how much of it is focused in and projected upon the relationship with the child in question; and secondly, how integrated and well-functioning as persons the parents seem to be. The skill of the worker, who will have to work with the resistances put up one by one by the parent against the giving up of the status quo, will play a big role here.

While these findings cannot be considered absolute, it is hoped that they may offer some suggestions for the selection of cases. It is hoped, too, that this study may be a harbinger for other similar studies, which may check on the significance of the findings. The writer would also suggest consideration of a short diagnostic period followed by presentation to the staff of such cases, which might indicate prognosis for long term contact, to precede actual acceptance of the case for treatment. In this way, the situation might be evaluated in light of the pressures of work on the clinic at that time.

Approved:

Richard K. Conant
Dean
Books

Department of Philanthropic Information, Central Hanover Bank and Trust Company, New York, *The Mental Hygiene Movement*.


Periodical Literature


"Can Case Closing be Planned as a Part of Treatment?" The Family, Vol. XII, No. 5, (July, 1931), pp. 135-142.


Pamphlets


Unpublished Material

Burling, Temple, M.D., Memorandum written to Providence Child Guidance Staff and Board of Directors, Unpublished material; exact date unknown (1941–1946).


## Appendix I

### ASSIGNED NUMBERS AND NAMES

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Appendix II

SCHEDULE

External Factors

Age
Sex
Religion
Economic Status
Referral Source
Ordinal Position
Symptoms at Referral
Intelligence
Number of Therapeutic Contacts
Developmental History
Regularity of Contacts

Internal Factors

What the Mother saw as the Problem
Kinds of Persons Parents were
Parents' Attitudes toward the Child
The Child's Attitude toward the Parents
Child's Relationship with others: Siblings, Adults, Friends

Information in regard to the Social Worker's Contact with the Parents:
  Mother's Attitude toward treatment
  Treatment Goal
  Kind of Closing; who, why, how accepted

Psychologist's Report
Psychiatrist's Report