A study of the factors related to the acceptance of treatment as seen in the initial interviews

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A STUDY OF THE FACTORS RELATED TO
THE ACCEPTANCE OF TREATMENT AS SEEN IN
THE INITIAL INTERVIEWS

A thesis

Submitted by
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THESIS ABSTRACT-
A STUDY OF THE FACTORS RELATED TO THE ACCEPTANCE OF TREATMENT AS SEEN IN THE INITIAL INTERVIEWS- SUBMITTED BY JOAN EHRICH

This was a comparative study of seven families that accepted treatment and seven families that refused treatment. The study focused on the relationship of parental attitudes in the initial interviews to the subsequent acceptance of treatment. The following areas were examined in order to understand the dynamics of clinic involvement: descriptive characteristics, family background, history of the problem, source of referral, parental attitudes toward the child, parental attitudes toward the problem, parental attitudes toward the clinic and the nature of termination. This study was conducted at the Providence Child Guidance Clinic in Providence, Rhode Island.

The factors that were found to be most related to the acceptance of treatment were parental attitudes toward the child, toward the problem and toward the clinic. Parental attitudes in relation to clinic involvement tended to form a configuration. The parents who introjected responsibility for the problem, were ambivalent to their children and were either well-motivated or ambivalent to the clinic accepted treatment. The parents who refused treatment tended to project responsibility for the problem, be more rejecting of their children and either poorly-motivated or ambivalent to the clinic. Another factor that was found to be crucially related to the acceptance of treatment was some degree of conscious involvement with their child's difficulty.
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CHAPTER I

INTRODUCTION

This is a comparative study of seven families that accepted the offer of treatment and seven families that refused treatment. The study focused on the relationship of parental attitudes in the initial interviews to the subsequent acceptance of treatment.

The question of initial engagement in the treatment process and what factors are related to resistance to treatment have been of interest to child guidance clinics. Question has been raised about just what are the criteria for initial involvement in the problem-solving process. Of interest also are the implications and issues this raises for casework. The Providence Child Guidance Clinic shares this interest and concern especially since during the period covered in this study about one-sixth of the applications discontinued at the clinic after the diagnostic process although treatment was offered. The clinic feels a responsibility and obligation to try to help those families who need help but are unable to accept it when it is offered to them. The question arises as to what are the dynamics behind the acceptance of treatment. For the social worker, this question points out the need to know what factors are crucial to initial clinic involvement so as to make the most fruitful treatment plan. The social worker is faced with the crucial issue of how to handle families in the initial interviews so that they will be helped to involve themselves in treatment and how to work with the resistant parent around mobilizing them to become engaged in the treatment process.
The study explored the following areas in order to understand the dynamics of involvement to clinic procedure by the client.

1. The parent's attitude toward the problem
2. The parent's attitude toward the child
3. The parent's attitude toward and their expectation of the clinic

The fourteen cases were drawn from the caseload of families who had completed a diagnostic study during the period of September 1958 to January 1960. All of these families were seen for a routine diagnostic study which consists of the child being seen by a psychiatrist and a psychologist and the parents being seen by a social worker. The data were collected from the case records. The attitudes and experiences of these parents were explored to discover what attitudes or feelings on their part were related to the acceptance of treatment. With the use of a schedule the following areas were examined: descriptive characteristics, family backgrounds, history of the problem, source of referral, attitudes toward the child, attitudes toward the problem, attitudes toward the clinic (including attitudes towards help), the nature of termination.

This study was conducted at the Providence Child Guidance Clinic in Providence, Rhode Island. The clinic has as its focus, the study and treatment of children of school age (5 to 17) who have emotional problems.
CHAPTER II

THEORETICAL CONSIDERATIONS

This chapter will consider the factors relevant to clinic involvement by the client. The factors considered crucial to the acceptance of treatment will be examined. The theoretical focus will be mainly on the phenomena of resistance. No detailed study has been made about the factors felt to be related to initial engagement in the treatment process but the following people have indicated what they feel are the crucial factors to predict acceptance of treatment.

Relevant Literature of Criteria of Treatability

Helen Witmer and a group of her students at Smith College feel the most important factors in relation to treatability was the parent's attitude toward the child. She found that most of the failures in clinic treatment occurred when the parents were overly rejecting and markedly ambivalent toward the child.

Pearl Lodgen found that

"Treatment results can frequently be predicted from an analysis of the mother's personality traits and their attitudes toward their children...... The hope of adjusting children of mothers who cannot or do not want to change is not great unless the children have within them unusual strengths and are provided with some form of mother substitute".

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Helen Harris Perlman considers the following issues as important to a client's workability. By workability she means both their "ability to work" and their "responsiveness to therapeutic influence". In trying to identify what seems to be the major attributes for involvement and use of agency help, she finds the following factors crucial:

"Two conditions must hold for the sustainment of the responsible willingness to work at problem-solving: Discomfort and hope. Thus a person must feel more uncomfortable than comfortable with his problem in order to want to do something about it, and this malaise will serve to push him. Accompanying this push from within must be some promise of greater ease or satisfaction and this promise pulls the person to bend his efforts toward the same goal... The existence of either element without the other, or an excessive degree of either, will deplete motivation."

The capacity to use casework help is dependent upon an assessment of the client's emotional capacity (primarily his capacity for relationship), intellectual capacity (meaning the client's social intelligence which includes perceptiveness, capacity for attention, good judgement, know-how, and the ability to communicate both within oneself and to another) and physical capacity.

Pearl Baum in her study stresses the importance of the client's attitude towards the use of clinic services and treatment as a major predictive trait for the outcome of therapy.

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4Helen Harris Perlman: op.cit., pp. 186.
Joan Apurton and Audrey Schoenward in their study found that improvement is more likely to occur when...

1. The mother-child relationship was healthier and in cases in which specific kinds of problems were present.

2. The mothers were more flexible in the use of casework contact and could focus their discussion during the interview on both their own and the child's problems, whereas the other mothers tended to focus almost exclusively on either one or the other area.

3. When the mothers were more able to use the relationship with the social worker to fulfill previously unmet emotional needs and thereby were able to function more adequately in their maternal roles.

Margaret Blenkner in her study was interested in finding what factors might be associated with positive movement. She feels that the factors predictive of the direction of change are related to the source of referral, the problem area, insight, resistance and the degree to which the client was overwhelmed.

She feels that positive movement was most likely to occur when the referral source was from a health or welfare agency or from the advice of a physician and when the problem for which the client sought help was in the same area as that judged to be the child's basic or core problem. She feels that positive movement was unlikely unless the client showed some degree of insight into the problems for which he sought help. If there


was resistance by the end of the first interview to the discussion of the problem with which the client himself sought help, there was little likelihood of positive movement. Resistance to discussion of problems in areas other than that for which the client is seeking help bears no significant relationship to subsequent movement. For example, she feels that the client that seeks help around the child's problem of stealing but is reluctant to discuss other existing difficulties is still capable of positive movement. She feels that the client most likely to show positive movement was the one who was rated as "moderately" overwhelmed by his problem, while a very high or very low rating was associated with lack of positive movement.

Charlotte Towle set up a criteria for determining treatment possibilities. Her criteria of treatability includes:

1. Recognition of the importance of the client's purpose.
2. Capacity for relationship, that is, the nature of the relationship that it is possible to establish with the client.
3. The use which the individual makes of his problem, that is, in the case of child guidance, the emotional value that the child's behavior has for the parents.
4. Duration of the symptomatic behavior.
5. Extent of involvement.
7. The question of related attitudes - a client may present problems in a certain area which have induced attitudes which contribute to, reinforce or further the crystallization of the original problem.

Lilian Ripple feels that

"The client's use of casework service is determined by his motivation (what the client wants and how much he wants this, that is his goals and immediate objectives and the amount of pressure he has towards these goals), his capacity (the use of relationship and activity directed toward problem-solving), and the opportunities afforded him both by his environment and by the social agency from which he seeks help."

Sidney Green feels that an adequate assessment of the ego structure and functioning enables the caseworker to make a reliable early estimation of the client's ability to use an interpersonal relationship. He feels that an estimation of ego functioning offers important cues to the manner in which such a relationship is likely to be used. Dr. Green lists certain criteria to be used as an aid in evaluating the degree of ego maturity and introjection. They include the following: ability to form object relationships, reality testing, judgement, mobility patterns, tolerance for frustration, affectivity, defense mechanisms and basic intellectual capacities.

In a study done at Thom Guidance Clinic Suzanne Taets Van Amerongen felt that

"A review of the case histories indicated that the conscious wish for treatment expressed by the mother and the theoretical treatability of the child has been an insufficient basis upon which to make the decision for clinic treatment."
She feels to get a more complete picture of the treatability of a family, appraisal should be made of:

1. The marital relationship in light of emotional needs and the personality structure of each parent.

2. The emotional balance in the family and the patient's function in this balance.

3. The unconscious fantasies, fears and expectations of the parents concerning psychiatric treatment.

Dr. Van Amerongen found frequently in unsuccessful treatment cases the occurrence of symptomatology in one or both parents suggestive of severe neurosis, borderline states, or psychosis, serious marital difficulties, and pronounced ambivalence and anxiety about psychiatric help, expressed openly or indirectly.

At this point I will focus my discussion on one factor often manifested in the refusal of treatment -- that is the phenomena of resistance.

Relevant Literature on "Resistance"

Resistance is a highly involved and complex term in dynamic theories of personality. Resistance involves the entire concept of the unconscious: the repression by the ego of painful, disagreeable or obnoxious impulses and their conscious associations into the unconscious, the resultant neurotic symptom formation as these impulses remain active and express themselves in altered form, and finally the opposition by the ego, through various psychological defense mechanisms, to the efforts of both the

\[12\text{ Ibid., p. 74.}\]
analyst and the individual to make these impulses again conscious. According to Anna Freud, the defense against the instinct, manifests itself as resistance and that all the material which assists us to analyse the ego makes its appearance in the form of resistance to the analysis of the id. Frederick Allen sees resistance as "the internal struggle of a patient against the emergence of unconscious material, with the feeling directed toward the analyst. It refers to various efforts that the individual makes to handle those negative feelings which are manifested mainly by the antagonism, distrust, dislike and so forth."

If the repressed impulses should reach consciousness, suffering or 'unlust' would result because the impulses were originally repressed because of the pain they were causing. The mind tends to achieve pleasure and avoid its opposite. The organism has the need to discharge tension (pain) and achieve a state of equilibrium. The resultant symptom formation represents a compromise between the opposing forces, an attempt at adjustment or adaptation to these impulses.

According to Freud, the whole psychoanalytic theory is in fact built upon the "perception of resistance exerted by the patient when we try to make him conscious of his unconscious."

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"When we undertake to cure a patient of his symptoms, he opposes against us a vigorous and tenacious resistance throughout the entire course of treatment. The patient exhibits all the manifestation of his resistances." 16

The client may disguise his antagonism and may not even be conscious of having these resistances or hostile feelings. These hostile feelings may be turned against themselves, overcompensated by overprotection of the child, the feeling may be projected onto the environment, or what usually happens, they may be directed toward the clinic or the therapist. However,

"indeed, we understand at last that the overcoming of these resistances is the essential work of the analysis, that part of the work which alone assures us that we have achieved something for the patient." 17

Resistance in social work is based upon the same dynamic concepts. However, the social worker makes no attempt to interpret to the patient the unconscious motivation of his resistances while the psychoanalyst deals with unconscious resistances. Resistance in casework covers "any and all of the client's defenses against treatment which require understanding in order that the case will not be lost in treatment." 18

The social worker is more concerned with preventing resistances from interfering with the casework process and inhibiting the treatment goal.


The resistant client uses energy to resist treatment that can be freed for more positive uses and therapeutic aims. The worker tries to work with the healthier parts of the ego for the purposes of transposing the use of energy from defenses to constructive activities. A long standing resistance pattern often gives the client the assurity and confidence that he has his problems in check so therefore he is invulnerable to anxiety or casework help. The success of treatment then will depend upon the ability of the worker and the client to cooperate to overcome resistances to treatment in whatever manner they may be expressed.

Most psychiatrists and social workers feel that resistance to some degree is present in every case. Resistance is always manifested by parents in various and sometimes extremely subtle ways. Often it is hard to recognize and protean in the multiplicity of the forms that it takes. Rogers disagrees about the universality of resistance in treatment, feeling

"that resistances to counseling and to the counselor is not an inevitable part of psychotherapy, nor a desirable part, but it grows primarily out of poor techniques of handling the client's expression of his problems and feelings, more specifically, it grows out of the unwise attempts on the part of the counselor to short-cut the therapeutic process by bringing into discussion emotional attitudes which the client is not yet ready to face". 19

Resistance is shown in a variety of ways by parents in a child guidance clinic setting. It can be expressed in a negative or hostile attitude toward the whole treatment experience. It may be shown by

tardiness in keeping appointments, broken appointments, the desire to leave the appointment before the time is up, an unwillingness to participate in treatment. Often resistance is expressed in the client's attempt to control the interview. The client will try to do this by such attitudes as the inability to discuss the problem, by discussing only material that they want to discuss and sometimes at such a rapid rate that the worker is unable to follow or to participate in the discussion.

The parent may refuse to give the required social history or will concentrate on present realities and avoid touching upon past experiences saying that they cannot remember or by answering in vague terms. Resistance to treatment might also be expressed in the denial of any problem, or the decision that treatment is no longer indicated. The parents may decide that they feel that the clinic is not equipped to handle the problem and that they want to take it to another agency. Usually this is just an attempt to withdraw from treatment with no intention of seeking help elsewhere.

Deutsch points out that there are three groups of resistance:

a. The intellectual, or, as they are better termed, the "intellectualizing" resistances, corresponding to the intellectual "working through" of the analytic material

b. The transference resistances (especially the "acting-out" which remains so puzzling to us) in many cases the central task of the analytic endeavor.

c. Those resistances which are connected with the recollecting of infantile material.

The reasons behind resistance to treatment are also manifold.

"Parental resistance can be studied most clearly in the case of parents of difficult children. Parents of problem children experience the dread of psychoanalysis as an immediate danger more intensely than others." 21

Through a lack of understanding of just what psychoanalysis means or what involvement in treatment entails, parents often have associations of insanity and fear.

The resistance may be motivated by jealousy. In therapy the parents must share the child with another person. With an insecure parent there might be the fear of what the child will tell the analyst along with the fear that the analyst will replace the parent in the child's affections. The parent may fear the strong emotional tie or closeness that might develop between child and analyst. This fear will probably be particularly intense where the parents are too closely bound up with the child or when the parents have guilt feelings for unconscious rejection or hostility toward the child.

A strong feeling of guilt may develop on the parent's part which makes treatment difficult. They may feel responsible for the child's difficulties because of their handling or mistakes they made during the development of the child. The idea that their child may be disturbed creates feelings of guilt and anxiety as well as dealing a narcissistic blow

to the ego of the parents. Many parents feel that the fact they come to a child guidance clinic for help is an indication of their failure as parents.

"Anxiety, jealousy and a sense of guilt are often the unconscious causes of the resistances of parents to the treatment of their children and to the help that psychoanalysis could give.... Sometimes, the parents feel that the child's disturbance is only a part of the whole disturbed situation at home, and that any change in the child would affect themselves. In that case they defend their own neurosis along with that of the child." 22

Along with defending their own neurosis, the parent is often distrustful of both the analyst who tries to help the child get rid of his difficulty and their own caseworker.

Many of the parents seeking help have feelings of inadequacy and failure. The resistance to treatment can be related to their own feelings of insecurity as parents. These feelings of inadequacy about coping with their problems combined with the stress situation within the family and the anxiety of coming to the clinic may prove to be more than the parents can handle at the particular time. Treatment is so anxiety-producing and threatening that the parents try to escape the situation by withdrawal. Feelings of shame and humiliation about coming to a child guidance clinic may be reinforced by anxiety about mental abnormality of their child.

Resistance may be mobilized when the parent becomes uncomfortable in the treatment situation or when they feel they are uncovering or revealing too much of their feelings.

"Usually these resistances occur because the counseling process has been painful and the material has been brought into consciousness which the client has been reluctant to face." 23

22 Ibid., p. 641.
23 Carl R. Rogers: op. cit. p. 150.
Resistances can also occur if the therapist moves too rapidly in recognizing feelings which the client has not yet expressed. Resistance may also be connected with a previous unpleasant agency experience.

Certain personality patterns and the nature of the casework situation may also contribute to resistance. Resistances show specific ways of reacting of the ego which began as a defense mechanism, which can either become an immovable and positive possession of the mental apparatus or merely a veil over the patient's neurotic fears.

In whatever form it is present, resistance must be dealt with from the beginning of treatment. The opening interviews are crucial for clinic involvement and usually it is a time when the client expresses some form of resistance. Success or failure in involving the parent in treatment on many occasions may be dependent upon the first few interviews. One of the great values of the initial interviews is that the therapist can deal with negative feelings that are expressed as they are felt at the moment and without any urge to stop them. Also in the first interviews the client is helped to see that acceptance of treatment is his decision.

"Resistance develops automatically as soon as the transference is established, when the defenses are laid aside and the therapist approaches the center of the emotional conflict." 24

Resistance continues throughout the treatment involvement, increasing when new topics are approached or when feelings uncomfortable to the client are examined.

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Early Diagnosis

The importance of early diagnosis in the beginning phase of clinic involvement is pointed out by Perlman. She feels that in the beginning the client's "workability" becomes the center of diagnostic attention.

"The diagnosis of a client's workability", then, is a by-product of the work in which he is engaged from the start. The caseworker arrives at his diagnosis through the evolving evidence of the client's functioning in his first steps of problem-solving. 25

The utilization of early diagnosis as a prognostic cue for the acceptance of treatment is evident in many cases. "His responses to this beginning treatment provide diagnostic evidence and guidance of major significance". 26 Many parents who are unable to accept help manifest their resistance or ambivalence to help from the very beginning of clinic contact. This fact will be observable with the families in this study who are unable to accept treatment. The caseworker from the beginning of clinic contact can test and give impetus to the client's motivation and ability to start working around the problem. Also the beginning phase should provide the client with the feeling of being helped.

Along with the importance of an early diagnosis is the reality that the diagnosis might change as new information about the client's personality structure and defenses is obtained or as the worker-client relationship dictates at that particular time in treatment.

The Social Work Issues

The problem of resistance has far-encompassing significance for social

25 Helen Harris Perlman: op. cit., p. 181.
26 Ibid., p. 198.
work. One question is how to reach these resistant parents and help mobilize them towards engagement in clinic treatment. It is important for the caseworker to be aware of the negative attitudes of their client so as to anticipate what may happen in any individual case. Resistance can either facilitate or restrict the social worker in the treatment relationship. Through skillful handling the worker can make a positive use of her understanding of the resistance which can be interpreted in meaningful terms. A skillful interpretation of the dynamics of resistance in a particular case can lead to greater understanding of the client's personality and be of significant help in formulating a meaningful treatment plan.

The worker when faced with expressions of hostility or resistance should consider if there is anything that she has done to bring about these feelings. The worker should try to be sensitive to the fact that perhaps by projecting her own ideals into the treatment relationship, she therefore may be contributing to the blocking of the expression of resistant or hostile feelings. By introjecting our own goals or values we create barriers to the unfolding of the client's real feelings in terms of their own reality.

"Projection of our own ideals blocks establishment of cooperation and gives the patient a chance to express his negative feelings not in terms of his own reality but in terms of resistance to therapeutic attempts." 27

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The social worker should not fall into the trap of becoming overly sympathetic or overidentified with the child, especially if extreme negative or rejecting feelings have been directed against the child. Much of the parent's resistance to the clinic is related to the parent's jealousy of the child-therapist relationship. The worker by becoming oversympathetic with the child can give the parent justification for his feelings. If parents are reinforced in these feelings the gap can be widened between the parent and the child as well as between the parent and the caseworker. This will also make it more difficult for the parent to establish a helping relationship with his worker and for him to gain greater insight and understanding of his negative feelings toward the child. The social worker can be accepting of any expression of negative feelings and at the same time point out that the analyst only spends one hour a week with the child while the parent is with him for the rest of the week.

The social worker can try to create as neutral and permissive an atmosphere as she can for encouraging the expression of feelings. The relationship should be one which is non-judgemental, where there is no assignment of blame, but rather where the individual can feel free to be himself. If such therapeutic setting can be created there would be less of an urge to keep out the expression of negative feelings.

In dealing with the resistant client, the social worker should not try to move too fast in recognizing feelings that the client is not ready to accept. The worker can recognize that the client is opposed to clinic contact and make it plain to him that this feeling is acceptable. There is also the danger of making interpretations before the client is ready for them or to allow our awareness of a problem to direct treatment far beyond
the awareness of those being treated.

This chapter points out the need for more research about what are the crucial factors in relation to initial engagement in the treatment process since there have been no complete studies in this area. The factors found by this writer to be of significance to the acceptance of treatment will be discussed in Chapter V.

Summary

A review of the literature indicates that the following factors are considered important for the initial engagement in the treatment process. This includes source of referral, history of the problem, parental attitudes toward the child, toward the problem, and toward the clinic, their feelings about receiving help, their degree of involvement with the child and his problem, the nature of termination, motivation in seeking help. Since these factors have been considered crucial, they will be studied to see their relationship to the subsequent acceptance of treatment and initial clinic involvement.
CHAPTER III

METHODOLOGY

Selection of the Sample

This study is based on the records of those parents who applied for treatment for their child during the period September 1958 to January 1960. Two groups were selected for investigation. One group or half the sample was selected from the list of families that refused the offer of treatment after the completion of the diagnostic process. The other group in the sample was selected from families that are now in treatment at the clinic. In both groups the data were abstracted from the interviews held during the diagnostic process. The diagnostic process was defined as including the two application interviews and the three diagnostic interviews.

Group I was the group that accepted treatment, while Group II refused the offer of treatment. Treatment was defined as at least ten interviews with a social worker or psychiatrist following the diagnostic study. Sixteen families met the above criteria. From these 16 families selected two groups were set up. One group consisted of 8 families that accepted treatment and the second group consisted of 8 families that refused treatment. These two groups were matched for age and sex of the child. It was decided to drop an adolescent girl from each group since all the other children studied were latency-aged. Therefore the sample was reduced to fourteen cases or two matched groups of seven latency-aged children.

Data Analysis

In this study the following aspects of the treatment situation will be
studied: duration of the problem, referral and informant at application, 
previous attempts to deal with the problem, the waiting period, parental 
attitudes toward the symptom, parental attitudes toward the child, parental 
attitudes toward and expectations of the clinic and the nature of termina-
tion.

This study will focus on those factors considered relevant to the 
acceptance of treatment. Of special focus was the investigation of parental 
attitudes in the initial interviews as they are related to the initial en-
gagement in the treatment process.

One area of investigation was concerned with whether the parents felt 
there was a crisis at the time of application. Crisis was classified in 
two categories - internal and external crisis. Internal crisis was de-
defined as crucial changes within the child related to his feelings or atti-
tudes. Examples of internal crises would include refusal to eat, inability 
to sleep, sudden expression of hostility or destructiveness. External cri-
is was defined as crucial changes in relation to the child’s external en-
vironment. Examples of external crises would include problems around a 
change in residence or of school, pressure from the school in the form of 
refusing to promote the child to the next grade or accidents in relation to 
their environment.

Parental Attitudes

Information about parental attitudes were processed by means of the 
following scales:

1. Attitudes Towards the Child

The parent’s predominant attitude toward the child was rated on a 
three point scale - acceptance, rejection and ambivalence. Acceptance
toward the child was defined as a positive and warm feeling, expressed affection, love and concern for the child. Rejection was defined as either conscious or unconscious dislike of the child. It was shown by either the parent’s verbalized attitudes or behavior in respect to the child. The attitude of hostility is often combined with some expression either overtly or covertly of negative feelings for the child. Ambivalence was defined as an unresolved attitude toward the child, combining feelings of affection and feelings of hostility or negativism.

2. Attitudes Towards the Problem

The parent’s attitude towards the problem was investigated in relationship to two areas, that is, acceptability or non-acceptability of the symptom and responsibility for the problem. The parent’s feeling in relation to acceptability of the symptom was rated on a two point scale: acceptability and non-acceptability. Acceptability of the symptom was defined as the parent’s feeling that they did not find the symptom objectionable. In some cases where the symptom was acceptable, it was fulfilling an unconscious need or fantasy of the parent. Non-acceptability of the symptom was defined as the parent’s feeling that the symptom was totally objectionable and disagreeable to them.

The parent’s attitude in relation to responsibility for the problem was rated on a three point scale: introjection, projection, projection plus some degree of introjection. Introjection of responsibility for the problem was defined as the parent’s feeling that they were entirely responsible for the child’s difficulties. This was often expressed in feelings of self-blame such as "I have always picked on him for everything. I feel that I am at fault for the trouble he is having now." Projection
of responsibility for the problem was defined as the parent’s feeling that sources outside themselves were responsible for the child’s difficulties. Examples of projection of responsibility was the feeling that the school or the other marriage partner was the cause of the problem. Projection plus some degree of introjection of responsibility for the problem was defined as the parent’s feeling that although major responsibility for the problem was placed on a source other than themselves, they felt that they too were in part responsible for the child’s difficulties.

3. Attitudes and Expectations Towards the Clinic

The parent’s attitude in relation to the clinic was investigated around three areas, that is, attitude toward the clinic, who they saw as doing the work about the problem and their feelings about clinic fees. The parent’s feelings in relation to the clinic was rated on a three point scale: well-motivated, poorly-motivated and ambivalent. Well-motivated, was defined as the parent’s feeling that they were anxious to involve themselves in treatment and had a positive attitude as far as clinic policies were concerned. Involvement in treatment refers to the degree to which the parents were willing to use the casework relationship to modify their feelings, attitudes and behavior in the relationship to the child. Poorly motivated was defined as the parent’s feeling that they did not want to involve themselves in a casework relationship and had a negative attitude towards clinic policies. Poorly motivated parents manifested a great deal of resistance to any emotional involvement in the understanding of their child’s problems, their relationship to it and their own feelings and attitudes. Ambivalence to the clinic was defined as the parent’s feeling that they wanted help with their problem but were
afraid to involve themselves in treatment. These parents were conflicted in their desire to get help and put up many resistances to receiving help. The ambivalent parents usually had difficulties in conforming to clinic routine or in carrying through clinic recommendations.

The parent's attitudes toward responsibility for work around the problem was rated on a three point scale: clinic doing everything, clinic doing nothing and the sharing of responsibility. Clinic doing everything was defined as the parent's feeling that the clinic should assume major responsibility for dealing with the problem. Parents with this attitude expected to receive answers to their problems rather than involving themselves in the problem-solving process. Clinic doing nothing was defined as the parent's feeling that they expected to do the major work in dealing with the problem with a minor degree of clinic help. These parents were ready to involve themselves in the problem-solving process and to assume the major role in the helping relationship. Sharing of the responsibility was defined as the parent's feeling that the clinic and the parents would share equally in helping the child.

Parent's attitude toward clinic fees was rated on a three point scale: good, poor and ambivalent. A 'good' attitude toward clinic fees was defined as the parent's acceptance of the amount to be paid, the manner of payment and promptness in payment. A 'poor' attitude toward clinic fees was defined as the parent's feelings of negativism or hostility to the amount of the fee, the manner of payment and either non-payment or lateness in payment. An ambivalence to clinic fees was defined as a combination of acceptance of clinic fees with feelings of hostility or negativism. The ambivalent parent often could not verbalize their negative feelings
about the fees but would consistently forget to pay or would pay late. This ambivalence to clinic fees is often indicative of conflicted feelings to the whole clinic procedure and involvement to treatment in general.

The Setting

This study was conducted at the Providence Child Guidance Clinic, which is the only privately supported child guidance clinic in the state of Rhode Island. Two years ago the clinic faced a reorganization. The previous director resigned as of September, 1957. At this time the clinic obtained a new director, chief psychiatric social worker and an almost completely new staff in all areas. At the time of this reorganization, the clinic reexamined its direction along with a change of philosophy in certain areas. As the clinic now functions at the present time the changes are seen in the following ways. The clinic is more treatment focused while prior to the change the number of diagnostic hours was almost comparable with the amount of actual treatment time. Another change is seen in the fact that the clinic has no waiting list. The idea now is to see everyone who applies as quickly as possible even though extended treatment might not be possible because of the availability of staff time.

Team conferences on every case are usually scheduled at least every two weeks and on a weekly basis when the needs of the case indicated this.

There has been a large increase in staff since the clinic's reorganization. In the early part of 1957 the clinic was functioning with less than one full-time psychiatrist, a full-time psychologist, and three part-time social workers. The staff has increased three-fold over the past two years with the increasing funds made available through the Community Chest.
There has been change from the situation in which short-term cases were most frequent to the predominance of long-term treatment cases at present. Prior to the reorganization there was the tendency not to accept any child when there was any question of organic involvement. New cases in which organic involvement might be present are accepted if it is felt that the emotional factors outweigh possible organic disturbance.

Change is also seen in other areas. The clinic along with its regular long and short-term cases has been doing extended diagnostic studies in which cases are evaluated over a three-month period before a treatment plan is formulated. The clinic as a training center is now one of the important considerations of its operation while this was not as integral a part of the clinic philosophy under the old administration. Certain cases are accepted because of clinic needs and because they will provide good learning experiences.

As part of the new clinic philosophy all fathers must be seen on a routine basis or the family will not be accepted for treatment. The only exception to this rule is when the father is dead and the mother has not remarried. All step-fathers are seen without exception. An Integration Conference, a new aspect of clinic procedure, is scheduled at the end of the diagnostic study at which time the clinic shares its findings and offers treatment to the family if it is felt to be indicated. Regularly scheduled re-evaluation conferences are held six months after the close of every case.

**Intake Policy and Procedure at the Providence Child Guidance Clinic**

At the Providence Child Guidance Clinic the child in most instances is seen by a psychiatrist. A psychiatric social worker with previous
training in work with children may see a mildly disturbed child under the close supervision of the psychiatrist. Conversely if a parent is considered extremely disturbed, he may be seen by the psychiatrist although parents as a rule are seen by the social worker.

The psychiatrist, through the use of play therapy with younger children and conversation and/or play therapy with older children helps the child gain insight into his emotional problems and conflicts. He provides a permissive atmosphere where the child will feel free to express his hostile feelings and anxieties.

The psychologist as a routine part of any diagnostic process gives the child a variety of tests which he feels will be helpful in formulating a diagnosis as well as an aid in the treatment plan. The tests are administered in an attempt to evaluate both the functional and potential level of the child's intelligence as well as to evaluate his personality, its defenses and the adequacy of its current adjustment. These tests provide a diagnostic tool in formulating differential diagnosis and in prognostic statements. The tests administered include the Stanford-Binet 1937 Revision, the Wechsler-Bellevue Intelligence Scale for adolescents and adults, the Rorschach, the Thematic Apperception Tests and the Blacky Pictures. In addition to the administration of psychometric tests, the clinical psychologist with his training in educational psychology, can provide therapy in selected cases involving reading disabilities and also do therapy in other cases.

The psychiatric social worker works with the parents around the area of their relationship with the child and their own needs and conflicts. The worker helps the parents explore their feelings about their
own childhood experiences and their relationship to their parents and siblings. Treatment is undertaken to help the parents as individuals in their own right in addition to their relationship to the child. There is a close interplay between the child's disturbance and the parent's unresolved conflicts from the past. It is these "conflicts that now seek their solution and gratification in motherhood." The dynamics of the parent's personality is of paramount importance for the treatment of the child because of the relationship between parent's conscious and unconscious reactions and the child's problems and conflicts.

The social worker as a therapist in the treatment process helps the parents understand how their feelings and attitudes are related to the child's problems and through casework help to modify their attitudes toward the child. The aim of treatment with the parents is to alleviate guilt and anxiety and to help the parents see the connection between his problems and the child's.

The social worker tries to assist the parent to an emotional acceptance and a greater understanding of himself in relation to the child along with helping the parent to formulate his thinking, feeling and behavior about the child. The worker attempts to work with the healthier parts of the client's ego and at the same time trying to modify and/or remove the more disabling defenses. Through the casework relationship, the


social worker tries to offer the client a new kind of relationship and living experience in which he will feel free and comfortable to express his feelings toward his environment and significant people in it.

"Increased acceptance of hostile feelings, commonly the outstanding progressive development in long time treatment are accompanied by greater freedom in expression of positive feelings in the parent's relationships, including that with the child. It has been observed that when in the course of treatment the mother becomes less guilty in relationship to her hostile feelings towards the child, less anxious and outwardly more sure of herself as a parent, she tends to show her positive feelings towards the child more freely. The general benefit to the child is reflected in the parent-child relationship as a whole."\textsuperscript{30}

It is the client's use of the relationship that forms the basis of any treatment plan. The worker starts where the client is as far as what he sees as the problem, his ability to see his relationship, and part in the child's problems and what he sees as his role in the casework relationship. Through the creation of an atmosphere of acceptance, permissiveness and confidence in the client as an individual, the parent begins to feel freer in involving himself in the problem-solving process.

In the Providence Child Guidance Clinic no case is accepted for treatment unless both parents are seen and are willing to involve themselves in treatment. The clinic, feeling as it does that the child's difficulties are a reflection of parent-child relationships, sees the role of father as equally important as that of mother. Death is the only reason why only one parent would be seen. In the case of re-marriage all step-parents are part of the treatment plan on a routine basis. This emphasis

\textsuperscript{30} Katherine M. Wickman and William S. Langford: The Parent in the Children's Psychiatric Clinic. \textit{American Journal of Orthopsychiatry}. Volume XIV, Number 2, April, 1944; p. 220.
on the involvement of fathers as well as mothers is based on the philosophy that

"child guidance is the treatment of sick relationships of the total situation.... it is our job to understand the total situation and help those who are involved in it to understand it." 31

The initial contact is made between the parent and the chief psychiatric social worker over the telephone. The social worker gathers some face sheet information at this time and informs the parent that she will be contacted by a social worker for an appointment. The first application interview is held with both parents who at this time present what they see as the problem, what led up to the application, previous attempts at dealing with the problem, what they expect from the clinic as far as the type of help is concerned and what responsibility they expect to assume in the treatment process.

"The dynamics of the intake process has as a central theme and objective the involvement of the parents in beginning to consider their own part in the problems presented by the child." 32

A second application interview is held with the mother alone to get the developmental history. After this the worker meets with the chief psychiatric social worker at an intake conference to evaluate the situation to determine if they feel that this is a problem within the functions

31 Dr. Temple Burling: Memorandum Written to the Staff and Directors of the Providence Child Guidance Clinic. Date Unknown.

of the clinic and if it seems that clinic help would be beneficial. Motivation on the part of the parents is also considered. If it is felt that the case does not come within the function of the clinic, the worker after evaluating the situation may make a referral to an appropriate agency. If it is decided to continue with the case a worker is assigned to do the diagnostic study of the parents. The diagnostic study involves at least one interview with each parent with the focus being on their childhood and their relationship with their parents. Concurrent with this, the psychiatrist sees the child twice. Between these two interviews the psychologist administers psychometric tests. The social worker carries the main responsibility for getting familial and social history, for the formulation of the diagnosis and the subsequent treatment plan.

After completion of the diagnostic study, a planning conference is held with all the involved team members to evaluate whether treatment is indicated and if it should be offered to the parents at this time.

At the weekly staff conferences specific cases are presented in which the three disciplines meet to discuss certain cases, to evaluate the effectiveness of treatment, to decide if treatment should be continued. All aspects of the case are discussed and decisions are made about future treatment plans. It is at these staff conferences that the knowledge and skill of the three disciplines are pooled and the team approach perhaps takes on its fullest meaning.

The staff at the Providence Child Guidance Clinic consists of one full-time psychiatrist who serves as director, four part-time psychiatrists, two full-time psychologists, a chief psychiatric social worker, two full-time psychiatric social workers and two part-time psychiatric
social workers. The clinic also serves as a training center and this year there are two social work students receiving their field work training there.

The Child Guidance Movement - Its History and Philosophy

Child Guidance clinics were first established over a quarter of a century ago. The purpose was to co-ordinate available community resources to meet the growing need for treatment of early emotional problems in children. The child guidance movement began to evolve when recognition was given to the philosophy that "childhood was the golden age of mental hygiene." 33

Greater consideration was given to the appreciation of psychiatric diagnosis and treatment at the early stage in the evaluation of the child's difficulties in psychosocial adjustment or adaptation. The child guidance clinic is an attempt according to Stevenson and Geddes to

"marshall the resources of the community in behalf of children who are in distress because of unsatisfied inner needs, or are seriously at outs with their environment.... 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". 34

The Mental Hygiene Movement provided the impetus for the development of child guidance clinics, along with the expressed need and changing community attitudes toward emotional disturbances. The National Committee for


Mental Hygiene was established in 1909 under the leadership of Clifford Beers and Adolf Meyers. Also in 1909, another leader in the mental hygiene movement, Dr. William Healy, pioneered clinics for delinquents in Chicago and later in 1917 established the Judge Baker Foundation now known as the Judge Baker Guidance Clinic. Dr. Healy's focus at that time, through his five year study of young offenders before the Chicago Juvenile Court, was mainly on the prevention of delinquency. Later in 1922, a five year program was financed by the Commonwealth Fund for the prevention of childhood delinquency. This involved the establishment of demonstration clinics in several cities across the country, e.g. St. Louis, Norfolk, Dallas, Los Angeles, Cleveland and Philadelphia. These clinics

"shifted the focus of attention to children in school and home who deviate significantly, but not necessarily in the eyes of the law, from reasonable social expectations, and has broadened its scope to include parents when their problems determine the difficulties of the child." 36

A demonstration clinic similar to those mentioned above, but financed privately in connection with the Esek Hopkins School led to the establishment of the Providence Child Guidance Clinic. The Providence Child Guidance Clinic was the product of several articles promulgated by the Rhode Island Society for Mental Health. It opened in 1925 although several precursors of very short duration existed before that time. The prototype of the present Providence Child Guidance Clinic had its birth in 1916 and offered services that contrasted sharply with those offered


today. It operated once a week in facilities voluntarily given by a school. The staff consisted of four part-time physicians and one full-time nurse trained in working with mentally disturbed cases. It closed after one year mainly because of America's growing absorption and participation in the war.37

The Rhode Island Society of Mental Hygiene in 1928 requested to assume management of the clinic. The Society then incorporated the clinic together with the Juvenile Court Clinic under the name of the Providence Child Guidance Clinic. Until 1933, Rhode Island Senator Metcalf continued to support the clinic. The clinic now is the only privately supported child guidance clinic in the state of Rhode Island being supported primarily by the Rhode Island Community Chest Inc. Although financed largely through the Chest, there is a fee system based on the client's yearly income and number of dependents. There is a guide indicating the fees which range from one dollar weekly for income of $1,800 or less to $25.00 weekly for incomes of $10,000 or over. The sliding fee schedule is flexible and allows for changes when emergencies or unusual expenses occur.

Referrals usually are received from a wide variety of sources. The main referring agencies, however, are schools, physicians and other social agencies. Self-referrals occur infrequently and in most of these instances there is considerable pressure from outside sources. Sources of self-referral include the suggestion of a former client, and newspaper and magazine articles. Social agencies, both public and private as well

as the school departments use the clinic as a place of referral.

One inherent characteristic of the child guidance philosophy of treatment is the use of the teamwork approach. The teamwork type of services consists of a multi-discipline approach including the services of psychiatrists, psychologists and psychiatric social workers. These disciplines all work together with the goal being to help improve the client's social adjustment or adaptation to his environment. Weekly team conferences are held by all team members involved in the particular case to share information and to clarify one's thinking about the dynamics involved. The team works towards the aim of improving parent-child relationships through the participation of both parent and child in the treatment plan.

The team approach in child guidance clinic is based upon the philosophy that the child's problems are a reflection of his familial relationships. It is mainly through this interaction of parent and child during its earliest years that the basic patterns of personality are determined. The child's personality, including his symptoms are formed mainly as a response to parent-child relationships. His symptoms are reactions to both the external pressures of his environment and as well as to his instinctual needs and conflicts.

"There is an awareness on the part of the clinician dealing with children that the behavior of a child is to be understood fundamentally only in the context of intrafamilial relationships. Pathological relationships between mother and father and child play a great role in helping to maintain the distorted and unintegrated tendencies in the child". 38

The shift to the realization of the equal importance of treatment of parents has occurred only in the last decade of child guidance philosophy. At first the child guidance movement centered mainly around the child with the belief that the problem could be solved if the symptom was removed. Little attempt was made to involve the parents in treatment. However, it was found that symptom removal would not be permanent and would usually recur when the child returned to his parents who in no way had received any understanding or modification around their feelings toward the child. With the growth of a body of knowledge concerning parent-child relationships especially the contributions of psychoanalytic psychiatry, a new emphasis on the need of involving parents in treatment was formulated. The new emphasis has been to focus on "changing the attitudes of parents in order to create a more favorable environment for the development of personality in the child".39

CHAPTER IV
ANALYSES OF THE DATA

Description of the Sample

The sample consists of fourteen families with an emotionally disturbed child. Group I was composed of families that accepted treatment after the completion of the diagnostic study. Group II was composed of families that refused treatment after the completion of the diagnostic study. Sixteen families having children ranging in age from six to fourteen were selected. The sample included two adolescent girls while the rest of the children were latency-aged. It was decided to eliminate the two adolescent girls so that the sample would consist only of latency-aged children. The findings then would have significance in relation to our theoretical knowledge of latency as a stage in a child's psychosexual development. With the removal of these two children, the sample was reduced to fourteen families or two groups of seven. The groups were matched for age, sex and presenting problem of the child.

Table 1
Age and Sex Distribution

<table>
<thead>
<tr>
<th>Age at Opening</th>
<th>Group I</th>
<th>Group II</th>
<th>Sex</th>
<th>Sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male - Female</td>
<td>Male - Female</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>2</td>
<td>2</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Total 7</td>
<td>Total 7</td>
<td>6</td>
<td>1</td>
</tr>
</tbody>
</table>

37
Table 1 indicates that all the children in the sample were latency-aged. These children are 12 boys and two girls ranging in age from 6 to 10 at the time of application. One outstanding feature is the high proportion of males to females. The number of families studied is too small to be of significance, however, it does reflect the tendency in child guidance clinics towards the treatment of a predominance of male children.

Table 2
Ordinal Position and Number of Siblings

<table>
<thead>
<tr>
<th>Place in the Family</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oldest</td>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>Youngest</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Only Child</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Number of Siblings</td>
<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>1</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>3</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>4</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>Total 7</td>
</tr>
</tbody>
</table>

Knowledge of the number of siblings and the child's place among them might be helpful in evaluating capacity for acceptance of treatment. Table 2 indicates that the two groups were quite similar in relation to ordinal position and the number of siblings. The majority of children in both groups were the oldest child in the family. This high incidence of the oldest child in the family needing clinic help supports the general conclusion that parents have more difficulty with their first child. Many of the parents reported that their first child came sooner than they hoped.
Some parents expressed the feeling that they were too young or emotionally unprepared for their first child. These emotionally immature parents frequently relive unconscious conflicts and difficult experiences of their own childhood with their first child.

Youngest children were infrequent in both Groups.

In both Groups, the majority of children had three siblings. There were no only children in the sample. The variation between the two Groups in relationship to ordinal position or number of siblings was negligible, thereby having no relation to whether the parents accepted treatment.

Table 3
Psychological Testing

<table>
<thead>
<tr>
<th>Classification</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inferior</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Borderline</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Low Average</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Average</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>High Average</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Superior</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Very Superior</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Not Known</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

Table 3 indicates such a wide range of scatter that no significant conclusion can be drawn. Also, as will be noted in the presenting problem over one-half of the children have some sort of school or learning difficulty. One common factor in the psychological report of these children was the fact that their intellectual functioning on the basis of the I.Q. tests showed that because of emotional factors they were functioning below their capacity.
Most of these children show indications of having I.Q.'s that are higher than their test scores would indicate.

The majority of the children scored within the average range. It is worthy to note that almost half of the children in both Groups are functioning below average capacity although the tests indicate no question of organic involvement.

Table 3

Presenting Problem at Application

<table>
<thead>
<tr>
<th>Problem</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>School</td>
<td>5</td>
<td>5</td>
</tr>
<tr>
<td>Difficulty with Peers</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Temper Tantrums</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>

The presenting problems are those about which the parents are most concerned and for which they seek help at the time of application. In most cases after further exploration it was found that the child was having difficulties in areas other than those presented at application. Often what the parents present as the problem differs from what the clinic feels is the main problem. There may be present many other problems about which the parents may have little concern or awareness. The majority of children in both groups came to the clinic because of school problems in one form or another. Under school difficulties are included repeated grades, special opportunity rooms for emotionally disturbed children, not working up to potential, not getting along with schoolmates or not wanting to go to school.
Table 5

Duration of the Problem

<table>
<thead>
<tr>
<th>Amount of Time</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 to 1 year</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>1 to 2 years</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>2 to 3 years</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3 to 4 years</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4 to 5 years</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>5 to 6 years</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Over</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

In the majority of the families in both groups the problem has been present for at least three to four years. This indicates that it is often difficult for most parents to recognize and accept the fact that they have a problem with their child. This reluctance around seeking help was equally prevalent among both parents who can or cannot accept treatment.

Many of the parents even after they are able to accept and recognize the fact that they have a problem with their child, verbalize their reluctance and anxiety in seeking help. They delay in bringing their child to an outside source of help such as a child guidance clinic. Many of the parents verbalize the rationalization that the behavior difficulties of their child is part of the normal process of growing up and will disappear as the child matures. While this is theoretically true in some instances, these parents usually wait long after they realize that the symptomatology is not going to disappear with age. The parents often feel so guilty and at fault for the difficulty that their anxiety immobilizes their taking action on the problem. Many parents postpone as long as possible the step
of seeking help for themselves and their children. Only after dealing unsuccessfully with the problem for a length of time do they take the initial step of seeking outside help. Even then as seen by the parents who refuse treatment, many of them cannot follow through beyond this first step.

The problems ranged in duration from two months to six years with the average length of time being over three years.

Source of Referral

In attempting to understand what motivates a family to seek help at the time of application, one wonders whether the parents applied because of pressures from external sources (school, family doctor) or because of their own feelings of discomfort with their child's problematic behavior.

In examining the source of referral, it appears that in the majority of cases in both groups it was the family physician who recognized the problem and encouraged the parents to come to the clinic. A number of mothers reported that they had learned about the clinic from a neighbor or former patient.

In those families where the presenting problem was some type of school difficulty, it was felt that there may have been some pressure from the school for them to seek help at the clinic.

The source of referral can be of significance in that it indicates that the majority of parents in both groups resisted or lacked the initiative to come to the clinic independently. This paucity of self-referrals can be indicative of resistance in recognizing a problem and a lack of motivation around seeking help for change.

Although one would expect a greater number of self-referrals from the
parents who accept treatment, it was interesting that there was almost an
equal inability of these parents to come to the clinic on their own. The
degree of non-self-referrals raises the question of whether these parents
were sufficiently motivated to seek help. One would expect a greater
capacity for involvement among those parents who were self-referred. Since
the source of referral was not significantly different for the two groups,
this factor was not related to the acceptance of treatment.

Table 6

<table>
<thead>
<tr>
<th></th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>5</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>2</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

One would expect that a parent's ability to seek help prior to coming
to the clinic would be positively related to the acceptance of treatment.
Those parents who in the past have attempted to deal with the problem
perhaps have a greater recognition of the existence of a problem and have
shown a degree of motivation in seeking outside help. One would suspect
that these parents might be more able to involve themselves in treatment
since they were able to seek help in the past.

This can be seen by a comparison of the two groups in relation to
previous attempts at dealing with the problem. Those parents who were
later able to accept help had in a majority of cases previously attempted
to deal with their child's problem. In Group II however, the majority of
parents had never sought help prior to coming to the clinic. The
evaluation of this factor can be used as a prognostic cue for the later acceptance of treatment. Parents who sought help prior to coming to the clinic accepted help more readily than did the parents in Group II. This factor is seen then to be related to the acceptance of treatment.

Previous attempts at dealing with the problem included private psychological testing, contact at another agency, consulting a private psychiatrist.

Table 7

<table>
<thead>
<tr>
<th></th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>No</td>
<td>5</td>
<td>3</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Crisis was defined in Chapter III where the distinction was made between internal and external crises. The majority of crisis situations that precipitated application in both groups were external crises. The precipitating crisis situation usually involved school pressure in one form or another. There was no significant difference between the types of crisis situations in the two groups. Table 7 indicates that the majority of families in Group II as compared to a few families in Group I applied for help at the clinic because of a crisis situation. The greater tendency of parents in Group II to seek help during a crisis situation might reflect their ability to mobilize themselves for help only when an extreme situation arises. One might suspect that these parents would be less
willing to involve themselves in treatment after the crisis situation has past. Some of these parents denied the existence of any problem before the occurrence of the crisis situation and sought help at that time only in relation to the particular precipitating event.

In some cases the current crises were related to school pressure around the question of promotion to the next grade, pressure to put the child in an opportunity room for emotionally disturbed children to which the parents were opposed or the desire of the school for the child to leave until they received the results of the clinic's diagnostic study. Other current crises include the refusal of a child to attend school, the inability of the child to sleep, the taking of sixty aspirins following a fight with the mother.

An example of an internal crisis is the following:

"David has not been sleeping well and has been afraid for the past year. However, during the past week he has been having terrible nightmares saying that he is going to die. The mother has been upset by his behavior the past week. He says that he is going to die and cries at the drop of a hat. The mother feels at her wit's end because the child has never behaved as he did this past week. She feels that she cannot stand his behavior anymore."

An example of an external crisis is the following case:

"Mrs. L. is quite concerned about the school pressure that she is receiving about her son. The school wants him to leave because of his destructive behavior and his inability to learn. The school has told the parents that they will wait until they have received the results of the clinic's diagnostic study before they take final action. The parents came to the clinic in compliance with the school's request for a diagnostic evaluation and hope that the clinic can be instrumental in persuading the school to let their child remain in his class."

The Waiting Period

The length of time between the date of referral and the initial application interview, the length of time between the application interview
and the beginning of the diagnostic study and the length of time between the diagnostic process and the offer of treatment was studied. The waiting period was not significant, because it was the clinic policy during the period studied to accept all families immediately for the application and diagnostic process. Every effort was made to get the parents involved in the diagnostic process and treatment as soon as possible.

The existence of a waiting period has been thought to be of importance in relation to the acceptance of treatment. However, this study found that it was not related to the acceptance of treatment.

Number of Visits

The number of clinic visits by the children and parents in both groups were identical. For all families the period covered was the application and diagnostic process which routinely has a set number of interviews. All the families completed a full diagnostic study. This factor then is not related to the initial engagement in the treatment process.

<table>
<thead>
<tr>
<th></th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Yes</strong></td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td><strong>No</strong></td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 8

Were There Any Indications That the Parents Would Not Accept Help Prior to the Offer of Treatment

One would expect that those parents who were unable to accept treatment might during the diagnostic process show some signs of resistance to clinic involvement. Table 8 indicates that the majority of parents that
refused help manifested some form of resistance or ambivalence to treatment during the initial interviews. Those parents that accepted treatment had a predominant trend of not manifesting any signs that would indicate they would not involve themselves in treatment. They expressed in a majority of cases a positive feeling of willingness to clinic involvement. Their motivation for help was seen in an increasing involvement with the clinic through the various steps of the diagnostic process. In contrast to Group II, they verbalized at no time any negative feelings which might indicate they would not accept help if it was offered to them.

The majority of parents in Group II expressed negative feelings about various aspects of clinic policies and procedures. Some of them verbalized their fear of involving themselves in the problem-solving process.

Indications of inability to become involved in treatment was manifested in many ways. Resistance and ambivalence about clinic involvement was reflected in the parent's attitudes toward the whole idea of treatment. Resistance was seen in their reluctance about getting off from business for appointments, ambivalence about the payment of fees, expressed difficulties in getting a baby-sitter.

One area that reflected resistance or ambivalence to clinic involvement was around broken appointments. The majority of parents in Group II broke at least one appointment during their clinic contact. In contrast to this there were no broken appointments among the parents that later accepted treatment. The incidence of broken appointments in Group II varied from one to four appointments with an average of two broken appointments per family. The reasons given for breaking appointments were multiple. They included, sickness, inability to get a baby sitter, difficulty...
in leaving work, car breaking down, etc. The parents that frequently broke appointments usually cancelled at the last minute or failed to call to say that they would not be coming in.

Parental Background

Information about the parent's background was obtained to see if there was any relationship between this factor and the acceptance of treatment. This included data on age, occupation, nationality, religion, income, education.

Both groups were quite similar in respect to all the variables investigated and there was no significant difference between the parental backgrounds of the families. This indicates that the parent's background did not influence the acceptance of treatment - (see appendix for chart on parental backgrounds).

Table 9

Marital Status

<table>
<thead>
<tr>
<th>Marital Status</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Together</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>Remarried</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Other</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

Home environment is known to be an influencing factor in the emotional stability of a child, especially in the earliest years. A child living with both parents is perhaps less apt to be disturbed than a child who has lost one or both parents through death, divorce or separation.

The majority of children in both groups were living with their own
parents at the time of the application. This Table does not take into ac-
count whether or not the child has been living with both parents up to the
time of the application.

In the two cases of remarriage, it was a second marriage for both
mates. Since the marital status of the parents is the same in both groups,
this factor does not influence acceptance of treatment.

The marital adjustment of the parents was rated on a two point scale:
satisfactory, unsatisfactory. The dominant finding was that the majority
of marriages were unsatisfactory in both groups.

Examples of two unsatisfactory marital relationships are the follow-
ing:

"We are not happily married and that is all there is to that.
Maybe I should get a divorce. When the patient was a year and one-
half the parents started to have marital difficulties. There were
verbal arguments as well as physical ones. She feels that her hus-
band is too demanding sexually and she has not enjoyed sex since
the birth of the patient."

"With regard to her own marriage, Mrs. L. said that it was a
perfect marriage until she got sick. When I wondered more about
the marriage now, she said that she was not complaining but that
things are very difficult. She hesitantly said that she felt that
her husband has let her down in many ways, perhaps he had tried
to help her throughout the illness but somehow she felt that some-
thing was missing. She was obviously quite tense, crying through-
out when she spoke about some of the disappointments she felt with
her husband. Mr. L. felt that his wife is so different now than
what she used to be. He said that one problem that they do have
is in communication. He is quiet and so is she and although they
make determined efforts to talk things over this just does not
seem to work out very well and silent periods occur most often."

Parental Attitudes

"Why do parents who come to the clinic needing help not
accept this help? What is it that keeps them from see-
ing through an effort that might assist in readjusting
their children's lives or possibly even their own lives in one very important relationship, the relationship to their sons or daughters."

An attempt will be made to focus in this section on parental attitudes in order to determine what relationship, if any, exists between parental attitudes during the initial interviews and subsequent acceptance of treatment. The following questions will be considered in order to understand better the dynamics behind initial engagement in treatment:

1. The parent's attitude toward the problem. This was rated on a two point scale: in the acceptability or non-acceptability of the symptom. Who they saw as responsible for the problem was rated on a three point scale: introjection, projection, projection plus some introjection.

2. The parent's attitude toward the child. This was rated on a three point scale: acceptance, rejection or ambivalence.

3. The parent's attitude toward and expectation of the clinic. This was rated on a three point scale: well-motivated, poorly-motivated or ambivalent. In the area of expectations of the clinic, the writer examined who the parents saw as doing the work around the problem. This was rated on a two point scale: clinic doing everything, clinic doing nothing. However, very little was recorded in this area. Additional information about the parent's attitude toward help was seen in the reasons given for refusing treatment.

Parental Attitudes Toward the Problem

Acceptability of the Symptom

Table 10 indicates that those parents who accept help find the symptom in all cases non-acceptable. In Group II however, the symptom

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Table 10

Parental Attitudes Toward the Problem

<table>
<thead>
<tr>
<th>Mother's Attitude</th>
<th>Father's Group I</th>
<th>Father's Group II</th>
<th>Father's Group I</th>
<th>Father's Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptable</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>2</td>
</tr>
<tr>
<td>Non-acceptable</td>
<td>7</td>
<td>5</td>
<td>7</td>
<td>5</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>Total 7</td>
<td>Total 7</td>
<td>Total 7</td>
</tr>
</tbody>
</table>

is seen as acceptable by a majority of the parents. It might follow that if parents find the symptom acceptable they would be less motivated to do something about changing it. The child's symptom for these parents might be fulfilling some unconscious need or fantasy on their part. One might suspect that the number of parents who find the problem acceptable might be higher in Group II, if you hypothesize about the close connection between the child's symptom and the parent's conscious and unconscious wishes.

An example of a parent who finds the symptom acceptable is the following:

"Mr. L. said that he can be firm with Kenneth and when the mother is out of the house he behaves well. Father says that he has no trouble with Kenneth or with any of the other children. As for Kenneth's behavioral difficulties, Mr. L. thinks that he is just an average boy who does not misbehave any more than the next child. He does not find the way he behaves difficult at all. It seems as if there is a strong element of identification with Kenneth on Mr. L.'s part."

Those parents who find the symptom unacceptable express frustration about their child's behavior. They find their problems anxiety-producing and complain about being made very upset because of them. These parents verbalize the exasperation and intolerance they feel toward their child
when they manifest their symptomatic difficulties. For many parents the child's difficulty is seen as an imperfection. These parents see the symptom as a reflection or extension of their own feelings of inadequacy or failure. The child's symptom is often seen by these parents as the bad or unacceptable part of themselves.

Some of the parents of children who have school difficulties find failure in this area particularly hard to accept. This was especially true with one father who hoped to achieve through his son the scholastic success he never experienced but desired as a child. This was a father who had extreme guilt feelings about letting his parents down by failing out of college.

Mr. and Mrs. A. are parents who find their child's symptoms totally unacceptable. Mrs. A. expressed the feeling that

"they find that March is driving them crazy, is a poor sport, a reflection on themselves, not manly and talks more like a woman than a man. Mrs. A. indicated her feeling that there was a "streak" all through the family that is not sound. In each generation there has been something wrong with one child. She fears now that March has inherited this streak. One of her sisters is diabetic, one brother is in a mental institution. She said that she felt "that the whole family is queer." She expressed her frustration in having to put up with March's temper tantrums and displayed quite a bit of affect as she spoke of this".

Table 11 indicates that those parents who are unable to accept treatment show a predominance of projection of responsibility for the problem. Some degree of projection is present with a majority of both parents. However in Group I, introjection seems to be the predominant trend for both parents. This is significant in that parents who tend to project blame find it more difficult to involve themselves in treatment. It is also interesting that in Group I whenever projection was present
it was combined with some degree of introjection of responsibility.

Table 11

Responsibility for the Problem

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal Responsibility for the Problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Introjection</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Projection</td>
<td>0</td>
<td>5</td>
</tr>
<tr>
<td>Projection plus some introjection</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

When projection was present in Group II it was the predominant attitude. Introjection occurred infrequently and always in combination with a dominance of projection of responsibility.

The parents showed a variety of feelings which could be included under the headings of introjection or projection. Under Introjection, involved feelings of blame for the problem, self-blame for letting things slide so long before coming to the clinic, feelings of guilt for letting the child sleep in the same room and occasionally in the same bed. Other parents who introjected responsibility for the problem expressed the feeling that perhaps they have picked on the child too much, or have been too punitive with him. Two parents felt that it was themselves rather than the child who needed help. One mother recognized the relationship between her emotional tensions and the problems of the child and felt guilty and responsible for the child's difficulties. Another mother
expressed feelings of blame and responsibility for the problem related to the fact that she left him alone so much as a child.

Under the category of projection of responsibility for the problem were feelings that the school was to blame for the child's difficulties or that the child's relationship with the other marriage partner was the cause of the child's difficulty. Often blame was projected on the grandparents who because of their favoritism or excessive attention were felt by the parents to be responsible for the child's symptoms. Parents who projected responsibility tended to express the feeling of not knowing what could be the cause of their child's problems and at the same time denying that it could have anything to do with them. Parents with this attitude saw themselves as doing nothing wrong in the way of handling their children.

An example of a parent who introjected responsibility for the problem is the following:

"Mrs. L. seemed to recognize the relationship between her own tensions and difficulties and those of Christine, probably feeling some guilt and a great deal of responsibility toward helping her. Mrs. L. has been under psychiatric care and has received insulin shock treatment at Fuller Memorial Hospital. The parents are quite willing to accept the supposition that Christine's problem has an emotional basis and feel that the mother's illness and absences from the home might well have contributed to her present immaturity. She is very concerned about Christine, feeling very much to blame for Christine's problems at this time, associating them with her own illness and inability to give Christine what she needed."

The following are examples of projection of responsibility for the problem:

"Mrs. R. said that she did not know how many times he has managed to run a very high temperature. She felt that in some way he was able to bring on this high temperature. It is 105 degrees at night then the next morning he is perfectly well."
He is up and around and perfectly fine. She cannot believe that any child who has had such a high temperature at night could possibly be perfectly well consistently the next day."

"Mrs. A. tends to project any responsibility for the problem. She sees one of the child's problems as being his relationship with his father. Mrs. A. said that the reason the child had trouble in school was because of his teacher who made a spectacle of him in front of the class. Throughout the school year, the mother felt that the other children have been very cruel to him. Last year she insisted on his being transferred to another school. She feels that the conflict with March centers much more with the father than with her."

In only a minority of cases was there any information on whether the parents felt the symptom was alterable or unalterable. Three of the parents were from Group I and one from Group II. All of these parents felt either that the child would outgrow the symptom with time or that maturity plus clinic help would alter the problems for the better. Since the data are minimal in this area no conclusion or further speculation can be made.

Table 12 indicates that parents who can accept treatment seemed to be characterized by an ambivalent attitude toward their children. This seems to be the predominant attitude among the parents of Group I. The trend in Group II indicates that the parents are more rejecting of their children. This dominant attitude is present with both parents. The significance of parental attitudes towards their children and its relationship to the acceptance of treatment will be discussed in the following chapter. The trend seems to indicate that parents that are able to accept treatment seem to be more accepting of their children although the parent-child relationship is characterized by ambivalence. These findings indicate strongly that the parental attitudes toward their children is related to the ability to accept help.
TABLE 12

Parental Attitude Toward the Child

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother's Attitude</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Rejection</td>
<td>1</td>
<td>5</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>Total 7</td>
</tr>
<tr>
<td><strong>Father's Attitude</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acceptance</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Rejection</td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>6</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>Total 7</td>
</tr>
</tbody>
</table>

The following is an example of an accepting parent. The pathology is concentrated around the boy's relationship with his mother who seemed to be reliving her unconscious fantasies through the child.

"Mr. B. spoke with a lot of warmth of the enjoyment he got out of the relationship he had with his son. He seems to be very accepting of the boy's behavior. He is aware that he can get along well with the boy although quite a bit of conflict is evident between mother and son. Mr. B. seems to enjoy Kenneth's growing abilities and derives pleasure from doing things with him."

An example of a rejecting parent is Mrs. A. who says:

"That March and his father are complete opposites. She described her husband as being "all man" saying that March is very artistic and has some mannerisms that "could turn a man". She said that she is disgusted with him and very discouraged.

March was born nine months and three weeks after the marriage. Mrs. A. described this as being quite a blow to them. She felt that he may have missed the warmth he needed in the beginning period because of her immaturity."
Mrs. A. breast-fed him for three weeks but did not continue because it was distasteful to her, "too animal" as she put it. Throughout the entire period she felt she may have been like a machine with March. She repeated that the pregnancy came as quite a shock to her.

The Rorschach of this child reports that the basic and most unconscious conflict is with the mother figure whom he perceives as unyielding and rejecting.

Ambivalence is by far the most dominant attitude the parents have toward their children. This was the major trend among parental attitudes found in this study. One feeling that seemed to be present among the ambivalent parents was their high expectations and verbalized disappointments when their child did not live up to their hopes and aspirations. This might be related to the fact that some of these parents saw the child as a reflection or extension of themselves. In some cases they expected the child to achieve intellectual or social heights they were not able to reach.

The following is an example of an ambivalent parent:

"Mrs. R. seemed to be conflicted and ambivalent in her feelings about her son. She is able on the one hand to speak with a lot of warmth and express many positive feelings to him. While being understanding at times Mrs. R. is apparently unable to accept his being aggressive or showing any hostile feelings."

Parental Attitudes Towards and Expectations of the Clinic

An indication of the parent's ability to use help is reflected in the way they feel about help. The parents' feeling about help as expressed during the diagnostic interviews may provide some indication of their ability to involve themselves in the treatment process. The parents often bring with them many feelings about the problem, the nature of treatment and many preconceived ideas or fears about clinic involvement. Parents who come to a child guidance clinic do so with considerable
resistance or ambivalence. They are conflicted in their feelings around seeking help and involving themselves in treatment. They want help for their child but are fearful of investing themselves emotionally in looking at their feelings and attitudes. The parent may unconsciously derive gratification from their neurotic relationship with the child or be so overwhelmed by guilt that they are blocked in discussing the problem.

**TABLE 13**

**Parental Attitudes Towards and Expectations of the Clinic**

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father's Attitude Toward the Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-motivated</td>
<td>4</td>
<td>0</td>
</tr>
<tr>
<td>Poorly-motivated</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>Mother's Attitude Toward the Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Well-motivated</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Poorly motivated</td>
<td>0</td>
<td>3</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>7</td>
<td>7</td>
</tr>
</tbody>
</table>

One would expect that those parents who are well-motivated towards the clinic would be able to accept help more readily than poorly-motivated parents. This is borne out by Table 13 which indicates the difference between the two groups in relation to their attitude toward the clinic. In Group I the predominant attitude of the fathers was either good-motivation or ambivalence. In comparison the fathers in Group II had a predominant attitude of either poor-motivation or ambivalence toward the clinic. None of the parents in Group II were well-motivated in their attitude.
toward clinic help.

A fairly similar differential was found among the mother's attitude toward help in both groups. The majority of mothers in Group I were either well motivated or ambivalent toward the clinic. The predominant attitude of the mothers in Group II was either poor-motivation or ambivalence.

The parents in Group I as a whole were much more positively motivated toward the clinic and treatment involvement.

The parent's attitude towards the clinic would seem to be related to their ability to accept treatment. Those parents with a more positive attitude toward the clinic were able to a greater degree to involve themselves in treatment.

An example of a well-motivated parent is the following:

"Mrs. L. said that despite some improvement with Christine, they were still very much concerned with her and would like to take advantage of any help that the clinic would want to offer. Although Mr. L. seemed slightly emotionally detached from the situation he was extremely concerned and willing to participate at least overtly in any possible way. He said that he would fulfill any condition necessary and expressed his gratitude for being able to get clinic help. The parents expressed willingness to involve themselves in any way that we saw fit."

An example of an ambivalent parent is the following:

"Mrs. M. expressed the feeling that she is very anxious to get help. At the same time she said that she is a very independent person. She does not wish to lean on people but likes to discuss things with her husband only. At the same time as saying that she was anxious for help, she felt that coming to the clinic was the "lesser of two evils."

The M's were obviously annoyed at the length of time the diagnostic had taken and because they were not immediately given any information as to the clinic's findings. As the time to offer treatment drew near, both parents offered up many resistances to involving themselves in treatment. They seemed quite conflicted about whether or not they wanted help at this time.
Towards the end of the diagnostic they started breaking appointments saying that Mr. M. could not get off from work. They also felt that perhaps Craig's problems were not as serious as they previously thought.

The following are examples of poorly-motivated parents:

"Mrs. T. was resentful toward the clinic because we had not given her any answers as yet. Mr. T. said that he was not very much interested in coming and would only come if it was necessary. The mother brought out quite directly her negative feelings about coming to the clinic and involving herself in treatment. She said that she always avoided "hanging out my daily wash in public" and how painful it was for her to come to the clinic. She said that it was distasteful and unpleasant and she winced and physically grimaced as she described how unpleasant it was.

Mr. T. readily admitted that he did not like coming to the clinic. In relation to the clinic, Mr. T. said that he found it unpleasant but hard to define his feelings. He felt that it was unpleasant that he should have to discuss his home life with a stranger. He was unsure of what questions were going to be "popped" at him. Perhaps, he felt that he would not be able to do a good job in answering them. He said that he does not like his feelings involved with other people."

What little information could be secured about who the parents saw as doing the work about the problem seemed to indicate that the ambivalent or poorly-motivated parent expected answers to their problems. Some of these parents expressed the feeling that they expected the clinic to tell them what was wrong. They were characterized by their expectation of concrete advice in handling situations. The expectation of specific answers was combined with the parent's resistance to involving themselves emotionally in treatment.

The following is an example of parents who project responsibility to the clinic for work around the problem:

"The T.'s said that they were leaving it up to us to decide whether any more treatment was indicated. The mother asked a lot of direct questions about what I thought about the boy and what I thought was indicated. They both seemed uncertain about what they wanted from the clinic. Both parents
wanted advice around handling the problem but showed reluctance about involving themselves in treatment. They wanted the clinic's opinion about the child expressing the feeling of being not quite sure about how to handle the child. They did not know whether they should make him go along with things that they feel are best or whether they should give into him."

**TABLE 14**

<table>
<thead>
<tr>
<th>Attitude</th>
<th>Group I</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Good</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Poor</td>
<td>0</td>
<td>4</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
<td>Total 7</td>
</tr>
</tbody>
</table>

Table 14 indicates that fees can be an area of parental resistance to treatment and further involvement in the problem-solving process. In Group I, none of the parents showed a poor attitude to clinic fees. The trend was toward either a good attitude or ambivalence to clinic fees. In Group II the dominant attitude was ambivalence and negativism to clinic fees. Those parents who were able to accept treatment had a far higher degree of positive attitudes to the payment of clinic fees.

Parents who had a good attitude toward clinic fees paid all their bills on time and did not verbalize any negative feelings either to the amount that had to be paid or the method of payment (weekly). Much resistance in other areas can be displaced on to the area of payment of fees where hostile feelings can more comfortably be verbalized.

There are various ways in which ambivalence to clinic payment manifested itself. One father said that he was lazy about paying, being about six weeks late at that point but paying immediately after a bill was
sent. Many of the parents had to be sent bills once or twice before they would pay. They varied in lateness from anywhere between two to fifteen weeks. These ambivalent parents were not able to verbalize their negative feelings about the fees but would either say that they forgot to pay or would pay at a later date.

Parents who had a poor attitude to the clinic were characterized by a much more hostile and negative attitude to the payment of fees. With these parents a minimum of two bills had to be sent before payment. The parents in this group were able to verbalize their hostility about the fees saying either that they felt the fees were too high or that the clinic was too rigid about how and when the fees were paid.

Nature of Termination

Indications of the parent's feelings about receiving help, the way in which they are able to use help and their degree of resistance to help can be seen by the nature of termination. The nature of termination was investigated around who terminated, did the parents feel the problem had changed, and if so, how, the reasons given for refusing treatment.

TABLE 15

<table>
<thead>
<tr>
<th>Who Terminated</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
<td>2</td>
</tr>
<tr>
<td>Father</td>
<td>1</td>
</tr>
<tr>
<td>Both</td>
<td>2</td>
</tr>
<tr>
<td>Never Called Back</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>7</strong></td>
</tr>
</tbody>
</table>
Table 15 shows that in the majority of cases the mother called back, the parents did not call the clinic back for the final contact or keep the appointment for the Integration Conference where they would find out the clinic's recommendations.

TABLE 16

<table>
<thead>
<tr>
<th>Feeling about the Problem - Had it changed?</th>
<th>Group II</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>2</td>
</tr>
<tr>
<td>No</td>
<td>3</td>
</tr>
<tr>
<td>No Final Contact</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

Table 16 indicates that the majority of the parents felt that the problem had not changed since coming to the clinic. A minority of the cases did not contact the clinic after completion of the diagnostic so there is no definite way of knowing if they felt they had been helped or if they felt there was a change with the child's problem.

An example of a parent who felt there was a change in relation to the child's problem was the following:

"Mrs. L. felt that the symptoms had improved. The parents have moved to their new home and everything is going well. Barbara has found playmates and for the last week has been out of the house every night playing until six o'clock which is new for her. Formerly she would have been afraid to do this. Barbara still throws temper tantrums occasionally, but goes to bed all right, and is not fearful about this as she was before. She sleeps well and the father feels that she has made strides since the move and change of schools.

The other parent who felt that there was a definite change with their
child related this to clinic help. They terminated with the feeling of wanting to try to handle the child by themselves without further clinic help.

"When she arrived, Mrs. P. reported that Norman has been doing much better. He had only wet the bed three times this past month compared with the previously nightly occurrence of this. She feels that she is able to see a reason for wetting each time, such as the arrival of her own mother or her own preoccupation at a Christmas party thereby not paying attention to Norman. She feels that her demandingness has also improved and with this the child is easier to handle. She said that there have not been any serious outbreaks (temper tantrums) since they started coming to the clinic. She has noticed an improvement in Norman's ability to concentrate on a particular thing and will now spend quite a lot of time with a jigsaw puzzle.

She feels that just having come to the clinic has helped them all. Norman is very fond of Dr. Jaso. She feels that her husband now realizes that perhaps there is something more serious to be concerned about and not just that her own feeling that there might be something wrong.

Mrs. P. also feels that she had gained some insight into the connection between her own feelings and the child's outbursts and temper tantrums."

Two parents used the mechanism of denial of the further existence of a problem to withdraw from clinic involvement when treatment was offered. Although concerned at the time of application with what they felt was a problem, the offer of treatment was so threatening to them they denied that a problem any longer existed.

"Mrs. R. said that she felt that John had improved some and that she and her husband are not so concerned about him at the present time. She feels that perhaps she has exaggerated the seriousness of his behavior and feels now that it is probably normal for his age. She feels certain that he will outgrow his difficulties with time. She mentioned that he joined the Cub Scouts. Mrs. R. expressed uncertainty as to whether the boy had a problem and as to whether treatment was something that they really wanted."

Table 17 indicates that the majority of the parents expressed the fear of involving themselves in treatment and felt they wanted to try to
handle the situation by themselves.

**TABLE 17**

<table>
<thead>
<tr>
<th>Reason</th>
<th>Group II</th>
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</thead>
<tbody>
<tr>
<td>Fear of Involving Self in Treatment</td>
<td>3</td>
</tr>
<tr>
<td>Handling Situation by Self</td>
<td>2</td>
</tr>
<tr>
<td>Not Stated Since they did not call back</td>
<td>2</td>
</tr>
<tr>
<td>Total</td>
<td>7</td>
</tr>
</tbody>
</table>

With all the families that refused treatment, resistance and ambivalence could be seen from a review of their stated reasons for not involving themselves further in treatment. Two examples of the underlying ambivalence and resistance to treatment are the following:

"Mrs. R. said that they really felt that they did not have a clear picture of what the problem was with John, as we saw it. Both parents denied that treatment was something that they wanted to avoid and that they would do anything that was indicated for John, but went on to point out that the treatment program made heavy demands on the family. Mr. R. said that they only have one car which he uses for his business which is largely a traveling one. This would mean taking off a total of two half days in order to come here, also they have no regular baby sitter. Mrs. R. would also rather not come for the group sessions because she did not feel that she could put in that much time. She also suggested the possibility of the parents coming in alternative weeks which was pointed out would not be practical.

All in all it seemed that neither parent was especially ready for a treatment program at this time. Both of them wanted information on the level of advice that they could carry out for themselves. There was a noticeable lack of the kind of anxiety and concern which both parents had expressed in the first two sessions. It seemed that it was the mother who was finding more reasons to resist at this point. She expressed a great deal of uncertainty about going on, relating this to their lack of clarity as to the severity of John's problem and mechanical difficulties, e.g., transportation, baby-sitting etc.

Mrs. R. took the position that it was Mr. R. who did not want to come in. Mr. R. said that he could not handle it at this
time but would like to keep the door open so that he could get in touch with us in the future if the problem got any worse. Mrs. R. put entire responsibility for their not coming in with him saying that she felt that John definitely needed help. However, she agreed with her husband that they cannot put in as much time as is indicated. I definitely got the feeling that Mrs. R. is not convinced that she wants to go on with treatment but that she is unwilling herself to take the responsibility for this and it seems that she may be attempting to manipulate her husband into taking a definite stand."

"As soon as treatment was offered, the A.'s expressed a tremendous amount of reluctance to treatment fastening especially on Mr. A.'s work pressures, the amount of time involved, the money involved, etc. Mrs. A. let forth a barrage of negative feelings about the diagnostic complaining that they were given nothing at all and felt that they were paying $30.00 for nothing. Both of them expressed reluctance about entering treatment. Mrs. A. fastened upon two problems in particular as being major stumbling blocks to their accepting treatment viz. the financial burden of treatment and her objection to the assigned therapist. As for the first of these points, she felt that they could only afford $1.00 or $2.00 a week. She pointed out that Mr. A. had given a "ghastly sum" to the United Fund this year. They could not see paying us $5.00 a week now and felt that we should reduce the fee. As to her second point, her objection to the therapist assigned, she said that she thought she could not work with such a young and inexperienced person. She expressed the feeling that she would have to have a more mature and older person.

The basic consideration became her and her husband's ambivalence about the need for treatment, no matter how much they wanted to pay or even with whom they would work. She could not be convinced that treatment would necessarily do any good. She expressed with considerable feeling her fear of getting involved and how she really is not sure she wants to look at things too much.

It was felt that reduction of the fee and the change of workers were symptoms of the parent's underlying resistance to treatment and it was felt that nothing would be gained by giving into their requests."
CHAPTER V

SUMMARY AND CONCLUSIONS

This was a study of fourteen families who applied for help at a child guidance clinic. Seven of these families accepted treatment while seven refused treatment. The aim of this study was to investigate what factors are related to initial engagement in the treatment process. The focus was exploratory: to discover whether there were any specific characteristics of the parents that were related to the acceptance of treatment. This was done by examining the following areas: descriptive characteristics of the applicants, family background, the intake period, the referral, duration of the problem, previous attempts at dealing with the problem, whether there was a current crisis at the time of application, parental attitudes toward the child, parental attitudes toward the symptom and parental attitudes towards and expectations of the clinic, attitudes towards help, and nature of termination. These areas were explored because it was felt that they might be related to the acceptance of treatment.

The characteristics of the parents and their children were examined to determine whether these factors were related to the acceptance of treatment. It was found that the families in this study were a fairly representative cross-section of the clinic population, firstly in their socio-economic status, which was middle class, secondly in their age range, six to ten which represents the majority of clinic cases, and thirdly in terms of the presenting problem.
The presenting problems were primarily learning difficulties in some area and neurotic symptoms. Both groups were matched for age, sex and the presenting problem of the child. Parental backgrounds, ordinal position, number of siblings and duration of the problem were similar in both groups so these factors would not appear to be related to the acceptance of treatment.

The source of referral, informant at application, the waiting period and the number of interviews were examined to determine whether these factors were related to the acceptance of treatment. It was found that there were no significant difference between these groups in respect to this factor.

Investigation around previous attempts at dealing with the problem and whether there was a crisis at the time of application proved to be of significance with respect to the parent's attitude toward clinic involvement. Those parents that were able to accept help in a majority of cases previously attempted to deal with problem by seeking help prior to their contact with the clinic. Those parents that could not follow through on their involvement in treatment did not with few exceptions seek help prior to coming to the clinic. It was found that those parents who previously sought help for their child, tended to bear responsibility for the problem, were ambivalent towards the child and fairly well-motivated to clinic involvement. Those parents who previously did not attempt to deal with their child's difficulties tended to be more projecting of responsibility for the problem, more rejecting of their child and ambivalent as far as clinic involvement was concerned. A parent's ability to take action around their child's difficulties prior to clinic contact.
seems to be positively related to the acceptance of clinic treatment.

Whether the parents applied at the time of a crisis situation differed between the two groups. Those parents who later accepted help tended to apply when there was no immediate pressure while the opposite was true with the group that could not accept clinic treatment. This group tended to be able to mobilize themselves to come to the clinic only when there was immediate external pressure but would then become resistant to further involvement once the crisis had passed and their anxiety level was lowered. The parents that sought clinic help around a crisis situation in most instances tended to be those parents that showed no previous attempts at dealing with their child's difficulties. On the other hand those parents that sought clinic help even though there was no crisis situation evidenced a slight tendency to be those parents that sought help prior to coming to the clinic. Those parents tended to have a more positive attitude toward clinic involvement and were moreintrojective of responsibility for the problem. The parents that mobilized themselves to come to the clinic only when there was immediate external pressure tended to be more resistant to clinic involvement. These were the parents that were ambivalent to clinic policies and fees, would break appointments and tended to feel that the clinic should provide them with advice about handling their child. These parents also tended to project responsibility for the problem on sources outside of themselves.

The question was raised about whether there were any indications that the parents would not accept help prior to the offer of treatment and what was the nature of termination (who terminated, reason given for termination, did they feel that the problem had changed, if so, how).
The majority of cases that were unable to accept treatment showed indications from the very beginning that they might not be able to involve themselves in treatment. This suggests that their ambivalence and resistance to clinic involvement was evident from the first while the opposite findings were true of the group that did accept help. The parents who indicated that they might not be able to accept help tended to be poorly motivated in respect to the clinic and ambivalent about the payment of clinic fees. They were often late and cancelled or broke appointments at the last minute. These findings raise crucial questions for the social worker, that is, how to work with the client who is resistant from the outset in such a way as to mobilize their capacity for clinic involvement.

The examination of the nature of termination showed significantly that the majority of the parents that could not accept help saw their involvement in the problem but their anxiety was so threatening that they terminated even though they did not feel that the problem had changed. Involvement in treatment was so anxiety-producing that they could not mobilize themselves to continue working on the problem for which they sought help. The majority of these parents could verbalize this feeling and were able to say that an important reason for refusing treatment was their fear of involving themselves in the clinic treatment plan. The parents that refused treatment tended in the majority of cases to be parents who were either rejecting or ambivalent of their child, projecting of responsibility for the problem and either ambivalent or poorly motivated to the clinic. These parents in most cases were characterized by an attitude of resistance in one form or another to the entire clinic
procedure. They manifested their ambivalence and resistance from the onset and could not handle their anxiety about clinic involvement in a constructive manner.

The area of investigation that seemed most related to acceptance of treatment or to the question of criteria for initial engagement in the treatment process was the parental attitudes toward the symptom, toward the child and toward the clinic. There were significant differences between the two groups in relation to their attitudes to the above factors. The parents that were able to involve themselves in treatment had the predominant attitude of introjection of responsibility for the problem while the other group tended to project responsibility for the problem on outside sources, e.g., the school or the other marriage partner. Introjection or projection of the responsibility for the problem is often an attitude seen when parents apply to a clinic for help with their child's difficulties. Projection of responsibility for the problem may serve as a defensive maneuver to protect the parents from becoming involved in the problem-solving process. It would seem that those parents that introject responsibility for the problem would be more cognizant of the role they are playing in their child's difficulties and more aware of the sharing of responsibility for help which is implicit in treatment in a child guidance clinic. It would appear that parents who introject responsibility for the problem find it easier to involve themselves in treatment.

In relation to parental attitudes toward the child it was found that those parents that were able to accept help tended to have a predominant attitude of ambivalence to their children with little overt rejection. The group that refused treatment were characterized by a
predominant attitude of rejection in most cases and ambivalence in the remaining ones. It was found in this study that parents who were able to accept help seem to be less rejecting of their children although their relationship seems to be characterized by ambivalence. Those parents who are rejecting of their children found it difficult to accept help with their problems and have in the past not attempted to deal with it although usually the problem was of long duration.

These two groups of parents also differed markedly in their attitudes towards and expectation of the clinic. The parents who accepted help were either well-motivated or ambivalent in their attitude to the clinic. In the other group the parents were either poorly-motivated or ambivalent with no instances of good-motivation. The parent's attitude toward clinic fees was in practically all the cases the same kind of attitude they had to the clinic in general. For example, the parent who was well-motivated to clinic involvement tended to have a good attitude to clinic fees while the parent who was poorly-motivated about clinic involvement tended to have a poor attitude to clinic fees. A negative attitude toward clinic fees is often a prognostic cue to the client's feelings about the clinic or treatment. Negativism toward clinic fees was an avenue of resistance for poorly-motivated parents.

An attempt was made to see if any configuration or cluster of attitudes existed between the three areas investigated above, that is, attitudes toward the symptom, the child and the clinic. The parents who were able to seek help and to accept treatment showed a cluster of attitudes consisting of ambivalence toward the child, introjection of responsibility for the problem and either ambivalence or good-motivation to the clinic.
Their attitude toward clinic fees was usually the same as their attitude toward the clinic. The parents who sought help but were not able to accept treatment showed a cluster of attitudes consisting of a greater degree of rejection toward their children, projection of responsibility for the problem and either ambivalence or poor-motivation to the clinic.

Their attitude to clinic fees was usually the same as their attitude toward the clinic. It was found then that there were distinct differences among the attitudes of parents who apply for help at a child guidance clinic that make it possible for one group to accept help while the other group refuses help.

In conclusion an attempt will be made to answer the questions raised initially in this study. What are the factors related to initial engagement in the treatment process and what makes it possible for some parents to accept help while others are unable to involve themselves in the problem-solving process? In other words, what were the factors found to be related to involvement in clinic procedure by the families in this study? Are there any characteristics that reflect differences between those parents that can or cannot accept help? Of all the factual and descriptive data explored, these two groups did not differ from each other in any significant way other than in the area of parental attitudes. The two groups were comparable in all other areas. Some authors felt that the waiting period had some relation to the acceptance of treatment but this factor was found to be of no influence. Also factors such as duration of the problem, source of referral, and number of visits were found to be of no relevance. It was the parental attitudes to the symptom, the child and the clinic that were crucial for initial engagement in
the treatment process. Interestingly enough, parental attitudes in relation to clinic involvement tended to form a configuration. It was the parents who introjected responsibility for the problem, were ambivalent to their children and were either well-motivated or ambivalent to the clinic who accepted treatment. The parents who refused treatment tended to project responsibility for the problem, be more rejecting of their children and either poorly-motivated or ambivalent to the clinic and clinic fees.

Summary

The generalizations that can be drawn from this study must be understood within the context of the limited design. The limitations concern the size of the sample and certain inadequacies in case recordings. However, the findings of this study point out the need for further research. Certain areas would seem to be especially fruitful for more detailed study and exploration.

It would appear from this study that the factors most related to initial engagement in the treatment process were parental attitudes. It was the parent's attitudes towards the child, the problem and the clinic which were crucial for involvement in the problem-solving process. Since it is parental attitudes which are most crucial to initial involvement, a further area of exploration would seem to be the study of the origins of the parental attitudes. What are the origins of those attitudes which are found to be related to the subsequent acceptance of treatment? The origins of parental attitudes are related to the ability to treat the child and the parents own ability to become involved in the treatment process. The origins of the parental attitudes that are related to
clinic involvement effect then, the treatability of the entire family.

The parent's patterns of relating to helping individuals and their feelings about asking for help are most crucial to their ability for clinic involvement. Of broader concern to the whole question of a family's capacity for clinic involvement is the fact that the ability of the parents to utilize help is related to the child's ability to use help. It is the parents who represent for the child the major model of help. The child's ability to use the helping person is related to the child's ability to use the parents as helping individuals.

It would also appear from this study that parents who cannot involve themselves in clinic treatment tend to be characterized by ambivalence. Their ambivalence and hostility in the area of feelings and attitudes is markedly stronger than those parents who can accept help. Also in the area of further research, it would be worth following up on both those families that did and did not accept treatment. Those families that became involved in the treatment process can be followed up to see their patterns of relating in an ongoing treatment relationship and to look more deeply at the attitudes present during the initial interviews which were related to their ability to involve themselves in clinic treatment. Those families that could not involve themselves in treatment can be followed up to see the outcome of their crises and if they were able to handle their problem without help.

An aspect of the ability to initially engage oneself in treatment appeared to some degree of conscious involvement with the child's difficulty. Those parents that refused treatment tended to withdraw both in the area of feelings of responsibility for the problem and lack of
involvement in the helping process. An area that seems fruitful for further research would be the exploration of the origins of parental involvement in their child's difficulty. This study indicates that those parents involved with their child's problems were more able to engage themselves in treatment. This raises the question of what feelings, attitudes or impulses on the part of the parent and the child lead to parental involvement in their child's problem.

This study has crucial clinical implications for social workers. The crucial issue is the fact that it is the social worker who sees the parent in the initial evaluation of their ability to involve themselves in clinic treatment. The social worker is faced with the problem of distinguishing between all the factors present during the initial interviews in order to determine whether the factors considered crucially related to the acceptance of treatment are present within the family that is seeking help. In her initial evaluation, the social worker would look for those factors found to be related to clinic involvement as part of her diagnosis of the parent's ability to use a helping relationship. Through an initial evaluation of the degrees to which factors found related to the acceptance of treatment are present along with a consideration of all the relevant psychosocial data, the social worker can make a fruitful treatment plan. In assessing a family's capacity for clinic involvement during the first interviews the social worker should look for those factors found in this study to be crucially related to the initial engagement in treatment. That is, the social worker should look carefully at the parent's attitudes towards the child, the problem and the clinic, their attitude toward help and change, and the degree of their involve-
ment in their child's difficulty.

If we are correct in our finding that these are the factors related to clinic involvement the social worker can learn in the early stages to mobilize and work with these factors. In the initial interviews the social worker can try to mobilize some change around the parent's attitudes and their involvement in their child's difficulty. By attempting to mobilize change around the factors related to clinic involvement, the social worker can facilitate the client's ability to initially involve themselves in treatment.
APPENDIX
**SCHEDULE**

**FACTUAL AND DESCRIPTIVE DATA**

1. Case Number
2. Name
3. Age
4. Sex
5. Siblings: age and sex
6. Ordinal position
7. I.Q.
8. School Grade

9. Parents
   a. Mother
   b. Father
   |   a. Marital Status | Satisfactory | Un satisfactory |
   | b. Age |               |               |
   | c. Occupation |               |               |
   | d. Nationality |               |               |
   | e. Religion |               |               |
   | f. Income |               |               |
   | g. Education |               |               |
   | h. Marital Relationship | Satisfactory | Un satisfactory |

10. Application and Diagnosis
   a. Who made the application: Mother, father, doctor, school, other.
   b. Who referred them
   c. Is there a current crisis that made the parents apply at this time.
   d. Presenting problem
   e. Duration of the problem
   f. Previous attempts to deal with problem
   g. Were there any indications that the parents would not accept help. If so what?

11. Appointments
   a. Regularity
   b. Any broken appointments
   c. Reason given for breaking appointment
   d. Promptness

12. Problem as seen by the clinic

13. Waiting Period
   a. Time between date of referral and application interview
   b. Time between application and the beginning of the diagnostic
   c. Time between the diagnostic and the offer of treatment

14. Number of visits
   a. Mother
   b. Father
   c. Child
15. Reasons given by the parents for refusing treatment

16. Who terminated?

17. Did the parents feel that the problem had changed? If so, how?

18. Parent's attitude toward the problem
   a. Acceptability of the symptom:
      Acceptable -- Non-acceptable
   b. Responsibility for the problem
      Introjection -- projection
   c. Can it be altered
      Alterable -- unalterable

19. Parent's attitude toward the child
   a. Acceptance, rejection, ambivalence

20. Parent's attitude toward the clinic
    a. Well-motivated, poorly motivated, ambivalent
    b. Who do the parents see as doing the work around the problem?
       Clinic doing everything -- Clinic doing nothing

21. Parent's attitude toward clinic fees
    a. Was the fee actually paid
    b. Who paid it
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<tr>
<th>GROUP I</th>
<th>PARENTAL BACKGROUNDS</th>
<th>GROUP II</th>
<th>PARENTAL BACKGROUNDS</th>
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Burling, Temple. Memorandum Written to the Staff and Director of the Providence Child Guidance Clinic, date unknown.


Periodicals

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