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# Factors effecting families' response to a treatment offer by a child guidance clinic

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BOSTON UNIVERSITY  
SCHOOL OF SOCIAL WORK

FACTORS EFFECTING FAMILIES' RESPONSE TO A TREATMENT  
OFFER BY A CHILD GUIDANCE CLINIC

A thesis

Submitted by

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## CHAPTER I

### INTRODUCTION

This is a study of factors in the initial contact related to families' handling of a treatment plan offered by a child guidance clinic.

When a clinic considers cases for treatment plans it is important to know as closely as possible that the family can and will use such help. The needs of the community for the helping services of the clinic as shown, in part, by the waiting lists are a charge to the clinic to offer treatment wisely. The nature of many of the problem situations presented for consideration is such that the decision can be a crucial one in the lives of whole families. Clinics do not offer a simple remedy, but a complex problem-solving process which involves two or more members of the family in a new kind of experience with the combined efforts of the clinic team. Each clinic has objective criteria to consider in making its selection of cases and each has a vital interest in broadening this objective base for a more scientific procedure. This study of factors relating to acceptance of treatment is pertinent to that interest.

Two groups of twelve cases presenting similar problems have been compared. One group consists of cases which did not accept treatment when it was offered. The other is a group of cases which accepted and entered into treatment. The application interviews as recorded in the case records were examined by means of a schedule. The schedule was constructed to examine factual data and the attitudes of both parents toward help, toward their child and toward the problem. The information from the two groups was then contrasted in an attempt to identify any significant differences.

The cases in this study were taken from the files of the central clinic of the Judge Baker Guidance Center. This clinic offers treatment services to children and parents for help with the child's problems of personal adjustment where physical illness is not an important factor. As part of the intake procedure the clinic also offers referral help and short-term services. Each request for help may be disposed of in any of a variety of ways. Those considered possible treatment cases are presented to the intake committee which makes the final decision to offer treatment. The committee also decides which cases are to be offered diagnostic studies and sometimes uses the diagnostic study to aid in selection of a case for treatment. Cases accepted for treatment are notified that they are on the waiting list and after assignment to a clinic team are offered their first treatment appointment.

## CHAPTER II

### REVIEW OF RELATED STUDIES

In the fields of psychiatry and social work there has been much thinking about the people we can help among the people who need help. In 1953 it was estimated that 9,000,000 people in the United States are suffering from some form of mental illness, and 2,400,000 are subnormal mentally.<sup>1</sup>

It has long been recognized that only a limited number of persons with psychiatric problems are interested in psychiatric treatment; and it might also be said that of those who do come to the psychiatrist for help, only a relatively small percentage are able to benefit from the treatment experiences they are offered.<sup>2</sup>

Studies of the community and its needs can be made by the sociologist, but the clinician is confined to appraisal of his contact with the people who have appealed to him for help. He must use these appraisals to try to understand more fully the differences in people with problems so that he can use his helping abilities more effectively.

Probably because external, objective factors are easier to see and thus to study, this was the area to which attention was first directed. In 1933 Witmer and students published findings of a study.<sup>3</sup> Witmer later

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<sup>1</sup>Iowa Mental Health Authority, Third Biennial Report Ending June 30, 1954. Published by the State of Iowa, Des Moines, p. 6.

<sup>2</sup>Coleman, Jules, Janowicz, Ruth, Fleck, Stephan and Norton, Nea, "A Comparative Study of a Psychiatric Clinic and a Family Agency: Part I, Journal of Social Casework, vol. 38 (January, 1957), p.3.

<sup>3</sup>Witmer, Helen Leland, and Students, "The Outcome of Treatment in a Child Guidance Clinic: A Comparison and an Evaluation," Smith College Studies in Social Work, vol. 3 (June, 1933).

referred to that study when she said

Most of the objective traits of the patients and their families--sex, age, ordinal position, number of siblings, religion, nationality, physical condition, symptomatic behaviour problems, economic status,-- bore little or no relation to the outcome of treatment.<sup>4</sup>

Though these findings didn't mean that external facts are of no importance they did free the investigators to look at other factors which seemed to be more significant. The same study found that in "more intangible ways the successfully adjusted cases differed from failures," and suggested a study of parental behaviour.<sup>5</sup> Such a study was soon carried out by Witmer. She examined parental behaviour toward the children for hostility, warmth or over-protection, and contrasted the father's and mother's behaviour. She also examined their relationship with the worker. From her findings she concluded: "It would seem, then, that in parental behaviour is to be found a clue both to the probable outcome of treatment and to the attitude that the mothers are likely to take toward treatment."<sup>6</sup>

Hubbard and Adams in a study of 100 cases of a child guidance clinic concluded in 1936 that treatment of the parents was one factor of success in their cases.<sup>7</sup> Hammer's study in 1951 presented a well-documented theoretical discussion of reasons why both parents should be included in what

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<sup>4</sup>Witmer, Helen Leland. "Parental Behavior as an Index to the Probable Outcome of Treatment in a Child Guidance Clinic," American Journal of Orthopsychiatry, vol. 3 (October, 1933), p. 432.

<sup>5</sup>Witmer and Students, op. cit., p. 43.

<sup>6</sup>Witmer, op. cit., p. 443.

<sup>7</sup>Hubbard, Ruth M., and Adams, Christine F., "Factors Effecting Success of Child Guidance Clinic Treatment," American Journal of Orthopsychiatry, vol. 6 (January, 1936).

he coined as "trinity treatment."<sup>8</sup> Some of the factors which have apparently influenced the therapeutic results seem to center in the father's role in the family. He wrote that "any change in the role of one member of the family has a decided effect on the entire group," and these dynamics must not only be seen in diagnosis but also used in treatment.

Perlman includes in her recent book a chapter on "workability." She chooses that word

. . . in some effort to identify that combination of motivation and capacity that enables a person to engage himself (with greater or lesser degrees of effort and effectiveness) with the persons and means of solving his problem.

Her discussion is an attempt to help workers put into practice some of the knowledge about factors entering into treatability. In a footnote she refers to current study of motivation from which she got some of her basic ideas. This study is also reported on by Werble. The factors found important for continuance in the completed studies have been the appropriateness of the request for help, the degree of discomfort and the pressure of external authority. "If one of the three factors can be said to be most important, it is 'discomfort'."<sup>10</sup>

As we attempt to identify some of the factors of differences between those who can or cannot benefit from a treatment experience we have a definite purpose in mind.

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<sup>8</sup>Hammer, Emanuel, "A Study of Cases Known to the Quincy Child Guidance Clinic from February, 1950 to February, 1951 in Which Both Parents and the Child Were or Were To Be Included in Intensive Treatment," p. 10.

<sup>9</sup>Perlman, Helen, Social Casework: A Problem Solving Process, p. 183.

<sup>10</sup>Werble, Beatrice, "Current Research on Motivation," Journal of Social Casework, vol. 39 (February-March, 1958), p. 126.

The question of prognosis in child guidance work is obviously of importance from the point of view of both intake and methods of therapy. If criteria could be discovered by which cases that do not yield to present methods of therapy could early be distinguished from the more hopeful cases, the indication would probably be not to take such cases (most clinics being pressed for time) or, more constructively, to attempt to devise new methods for dealing with them.<sup>11</sup>

The "early" phase in social agencies is usually referred to as "intake."

The initial phase starts at the moment the client presents himself to the agency, whether by telephone, by proxy, through the intercession of someone else, or in his own person. It ends, as phase, when a kind of pact has been arrived at in the nature of a "trial engagement" between client and caseworker to go forward together in their problem-solving efforts.<sup>12</sup>

Many writers have given special attention to the intake process. Weinburger and Gay label it "one of the most difficult and challenging problems of the clinic" because it includes "selection and disposition of patients who come . . . for help."<sup>13</sup> Scherz feels that we should "continue to examine the content of these interviews in the light of the skill of the caseworker and increased understanding of the client."<sup>14</sup> Anderson and Keisler would designate the intake interview as "helping toward help," and suggest that the patient has the same problems of selec-

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<sup>11</sup>Witmer, op. cit., p. 431.

<sup>12</sup>Perlman, op. cit., p. 106.

<sup>13</sup>Weinberger, Jerome L., and Gay, Eleanor, "Utilization of Psychiatrist and Social Worker as an Intake Team," American Journal of Psychiatry, vol. 106 (November, 1949), p. 384.

<sup>14</sup>Scherz, Frances H., "Intake: Concept and Process," Journal of Social Casework, vol. 33 (June, 1952), p. 239.

tion and disposition.<sup>15</sup> The factors related to his handling of these problems is the interest of the present study.

Freudenthal thinks that the basic job of the intake process is "to ascertain whether services rendered are wanted and can be used, as such, by an applicant." He further feels that "intake contributes essentially to an effective utilization of clinic services . . . by filtering out those presumably unable to benefit from psychotherapy and conditioning those believed ready for treatment."<sup>16</sup> Because this "filtering" exists most actively during the intake contact the investigator has limited his present study to this period.

With the demonstrated importance of the intake process and the suggestion that factors differentiating hopeful from difficult cases might be identified early the investigators turned to a closer examination of the first interviews. Witmer edited studies by Mills<sup>17</sup> and Ritterskampf.<sup>18</sup> In referring to the latter she writes:

By and large the study substantiates Harriet Mill's finding that treatment is successful only when parents have some real desire for it. It appears that lack of desire for treatment can usually be identified in the first interview if the parents are left free to

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<sup>15</sup>Anderson, Delwin M., and Keisler, Frank, "Helping Toward Help: The Intake Interview," Journal of Social Casework, vol. 35 (February, 1954), p. 73.

<sup>16</sup>Freudenthal, Kurt, "The Contribution of the Social Work Intake Process to the Psychiatric Treatment Situation," Journal of Psychiatric Social Work, vol. 19 (September, 1950), p. 26.

<sup>17</sup>Mill, Harriet, "The Prognostic Value of the First Interview," Smith College Studies in Social Work, vol. 8 (September, 1937).

<sup>18</sup>Ritterskampf, Louise, "The First Interview as a Guide to Treatment," Smith College Studies in Social Work, vol. 8 (September, 1937).

express their feelings about coming to the clinic and to decide whether they want the kind of service the clinic has to offer.<sup>19</sup>

Blenkner, Hunt and Kogan<sup>20</sup> have studied interrelationships of factors in first interviews with new clients, including attitudes toward their situation, and toward exploring the problem with the worker. They found that disposition seemed to be made according to attitudes shown. Blenkner in a later study has separated factors which might have prognostic value into two groups. Some factors were found significant in whether a client had more than one interview. These were the type of problem, the client's response to the suggested plan of treatment and the client's conception of the worker's role at the beginning and end of the interview. Other factors were found significant for some success of treatment. These were the referral source, the problem area and the relation of the presenting problem to the "core" problem, the client's ability to look at himself objectively, his resistance to discuss his problem and the degree to which he was "overwhelmed".<sup>21</sup>

Mitchell, Preston and Mudd studied first interview records in marriage counselling and found two factors which seemed important. One was the picture of spouse presented to the worker and the other was the way

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<sup>19</sup>Witmer, Helen Leland, "Comments in Conclusion," Smith College Studies in Social Work, vol. 8 (September, 1937), p. 82.

<sup>20</sup>Blenkner, Margaret, Hunt, J. McV., and Kogan, Leonard, "A Study of Interrelated Factors in Initial Interviews with New Clients," Journal of Social Casework, vol. 32 (January, 1951), p. 29.

<sup>21</sup>Blenkner, Margaret, "Predicting Factors in the Initial Interview in Family Casework," Social Service Review, vol. 28 (March, 1954), p. 69.

blame is handled.<sup>22</sup>

With all the studies of the intake process the complaint is still heard that we have not had "any reliable knowledge of the factors that influence patients to reject the treatment offered to them in the clinic."<sup>23</sup>

Burton has tried to describe some of the differences in groups of mothers who accepted or refused treatment.

It was found that the mothers in both the groups displayed anxiety concerning the child, themselves, or the referral. The mothers who accepted treatment, however, seemed to have a better understanding of the problems' emotional components, as well as their own involvement in it. They were eager for help and reached out for it. The study further revealed that the over-protective parent was more likely to accept treatment than the rejecting parent. The extent of the parent's understanding of the clinic's function and services also determined to some extent whether or not the treatment plan was accepted.<sup>24</sup>

Anderson studied forty cases of mothers who withdrew after the intake interview. She found that the mother-child relationship seemed to be most significant as well as the mother's personality and relationships with others. She found that blame was scattered, but that the mothers' concept of the seriousness of the problem seemed significant.<sup>25</sup>

Our review has shown the course of studies as the profession has investigated the problem of whom we can help. We've found that the obvious

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<sup>22</sup>Mitchell, Howard, Preston, Malcolm, and Mudd, Emily H., "Anticipated Development of Cases From Content of First Interview Record," Marriage and Family Living, vol. 15 (August, 1953), p. 228.

<sup>23</sup>Coleman, op. cit., p. 4.

<sup>24</sup>Burton, Eleanor, "Acceptance and Rejection of Treatment of a Child Guidance Clinic," Smith College Studies in Social Work, vol. 20 (February, 1950), p. 105.

<sup>25</sup>Anderson, Elizabeth C., "The Characteristics of Mothers Who Withdraw after the Intake Interview in a Child Guidance Clinic," p. 29.

external factors which differentiate people seem not to affect their use of clinic services significantly. The more intangible attitudes and relationships have been the focus of many studies and their significance has been established in relation to length and success of clinic contact.

There have been some attempts to relate these factors to handling of treatment plans. This study furthers those attempts by combining elements of other studies and focussing on those areas previously found especially significant. An added dimension is the inclusion of fathers. Evidence has shown that they are important in consideration of treatment plans so it was felt necessary and pertinent to include them in this study. This gives us an opportunity to examine the whole family group in relation to the problem and marks this study as different from those previously completed.

## CHAPTER III

### SCOPE AND METHOD

The importance of understanding how clients will handle a treatment offer becomes sharpened in a child guidance clinic where several factors arise which are peculiar to this type of agency: The problem is presented by a parent on behalf of the child; the child's decision to enter treatment is imposed upon him by the parent(s); the treatment plans usually involve two or more family members; there is often a time lapse between the original contact and the application interview because people are customarily seen only by appointment; and there is usually a waiting period after the application during which consideration for treatment is made by a clinic intake committee. Not only do these factors give us a more pointed reason for making this study, but imply that by their absence in other settings our findings might apply only after modification.

This is a case record study and the limits of such studies are well established. A recent article points out that subjective data abstracted from case records has been colored three times; once in the telling by the client, once in the recording by the worker and once in the abstracting by the investigator.<sup>1</sup> The abstracting is sometimes made more reliable by the use of two or more judges and it is a definite limitation that this investigator was the only judge in this study.

The size of the sample is another limiting factor, as is also the

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<sup>1</sup>Preston, Malcolm G., Mudd, Emily H., Peltz, William L., and Froscher, Hazel B., "Abstracting the Content of Social Case Records," Journal of Abnormal and Social Psychology, vol. 45 (October, 1950), p. 630.

fact that records by several different workers were used. Since many of these workers have since left the agency, there was no attempt to obtain more information from those workers who were still present. The study was confined to an examination of the actual data revealed in the case records. There was no attempt to consider the worker's role and its effect.

The Judge Baker Guidance Center is one of the oldest child guidance clinics in the country. Originally conceived as a resource for the juvenile court, its services have been offered for children in the 5-17 age groups of both sexes. Currently, the work with delinquency is being conducted chiefly in three project offices and the central clinic has a wide range of problems on its caseload beyond those that are court referred.

Through the years Judge Baker has maintained a high reputation as a treatment service and training center for the geographical and professional community. At present, four disciplines are using the central clinic as field work training; nursing, social work, psychology and psychiatry. Inherent in the training procedure is an active part in the intake program, which means, in practice, that trainees sometimes conduct the application interviews and present cases to the intake committee. They also sit in on the committee meetings as consideration is given to the cases presented. Experienced staff members representing the three professions of social work, psychology and psychiatry make up the committee which meets for one hour weekly. As well as accepting cases for treatment the committee accepts cases for diagnostic study, makes recommendations to refer cases, and sometimes refuses cases. Quite often the committee postpones decision on a given case until the intake worker secures more information relating to the case; usually in regard to physical condition or to previous contact

with other helping persons.

Application interviews may be held by those staff social workers designated as intake workers, or they may be assigned to other staff members or trainees. There is no prescribed framework for conducting these interviews, and aside from certain face sheet information, there is no specified manner of recording. Usually the interview is held with at least one parent and, from time to time, there is varying emphasis on the advisability of seeing both parents.

When a client is accepted for treatment he is informed immediately by the intake worker that he has been accepted and that he will be contacted by the clinic sometime in the future as to when he can come for his first appointment.

After the intake committee has accepted a case it is put on a waiting list to be assigned. The assignment committee, made up of department heads, considers the case in relation to the workers available. There are several factors that might affect the assignment: The needs of the client as to urgency, sex of worker, complexity of problem, number in family to be seen and whether members can keep appointments scheduled at different hours; the needs of the clinic for balancing the caseloads of trainees and staff as to sex, age, family role and type of problem. Because of the multiple considerations at this stage there is apt to be a great difference in the length of waiting period before a client is offered a treatment interview.

For the purposes of this study, it was felt that a group of twelve cases would be of sufficient size to show significance when compared with another group of twelve. This sampling would remain small enough to be workable within the time limit. The cases were selected from the current

files searching back chronologically.

Refusal of treatment may have been implied by the withdrawal as in one case in which the family moved and left no forwarding address. Or refusal may have been made after as many as four contacts in which attempt to initiate a treatment relationship was made. Acceptance of treatment plans was presumed if the case had maintained a treatment contact with the clinic for at least one clinic year.

After the initial group of twelve cases which had refused treatment were selected, the matching twelve cases which had accepted treatment were chosen from the same general time span. In matching the cases particular attention was given to the sex and age of the child and the type of presenting problem.

There were several criteria imposed by the purpose of the study and care was taken that each sample case met these criteria. None of the sample cases came to the clinic as a result of a court referral. It was felt that court referrals introduced an authoritative factor into families' handling of treatment plans which might be strong enough to overshadow other factors. None of the families were foster parents of the child and there were no adoptive homes included.

Each sample case was making its first clinic contact and did not have a prior diagnostic study. It was felt that when either of these conditions exist, the intake committee already has a much broader and sounder basis for offering treatment plans and a fuller expectation of how the offer might be handled.

When the sample selection was completed, the data from each case was

examined by the use of a schedule<sup>1</sup>. All the recorded information which was available to the intake committee was used as a source. This included the face sheet, recorded 'phone calls, interviews and referral or other letters. Information pertaining to the stated cause for discontinuance was taken from later entries in the record.

The data gathered consisted of two types. There were the identifying external factors relating to the child, the parents and the clinic contact. There was also subjective data regarding the families' attitudes toward help, toward the child and toward the problem. These were examined separately for the father and mother.

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<sup>1</sup>See appendix.

CHAPTER IV

RESULTS OF THE COMPARISON

In our description of the two groups of cases under study we will look first at the objective, external characteristics. Then we will turn our attention to the subjective factors. For ease in reference, that group which handled the treatment offer by refusal will be called "refuse" and the group which accepted will be called "accept".

Both groups included ten male and two female children. Their ages ranged from 6 to 12 with the distribution being fairly proportionate as indicated in Table 1. This same kind of distribution held also for their school grade as can be seen in Table 2.

TABLE 1  
COMPARATIVE AGES OF THE PROBLEM CHILDREN OF THE  
TWO GROUPS

Age in Years	Refuse	Accept
6	1	1
7	2	1
8	2	3
9	0	1
10	2	1
11	1	5
12	3	0

The families these two groups of children come from are also similar. Most of them are homes with both parents present. The one exception occurred in "accept" in which the father had died the year before application by the mother. The two families where this was the second

TABLE 2  
SCHOOL GRADES OF THE PROBLEM CHILDREN

School Grade	Refuse	Accept
1	2	2
2	3	1
3	0	3
4	1	2
5	2	0
6	1	3
7	3	1

marriage were in "refuse". One of these was the second marriage of the father and the other of the mother. Table 3 indicates the similarity of the ages of the two groups of parents.

TABLE 3  
COMPARATIVE AGES OF THE PARENTS

Age in Years	Fathers		Mothers	
	Refuse	Accept	Refuse	Accept
28-31	1	1	0	3
32-35	2	3	5	4
36-39	1	1	2	0
40-43	3	3	3	4
44-47	4	2	1	1
48	0	1	0	0
Unknown	1	0	1	0
Deceased	0	1	0	0

A look at the sibling groupings among these families produces another similarity as can be seen in Table 4. The usual family in both groups consists of the child, his two parents and one or two siblings.

TABLE 4  
NUMBER OF SIBLINGS IN THE FAMILIES

Number	Refuse	Accept
None	1	2
One	5	6
Two	6	2
Three	0	2

There was insufficient data to give a picture of the nationalities represented in each group, but the information on religious affiliation indicates a fair balance in each group. See Table 5. The fathers' employment was quite varied and seemed to be well balanced as to category

TABLE 5  
FAMILY'S RELIGIOUS AFFILIATION

Religion	Refuse	Accept
Jewish	5	5
Catholic	2	3
Protestant	3	3
Mixed*	1	1
Unknown	1	0

\*One family Jewish-Catholic and one Catholic-Protestant.

of occupation between the two groups. This is further borne out in the amount of annual income as shown in Table 6. Only three mothers worked full time and two part time. One full time and one part time working mothers were found in "refuse" with two full time and one part time working mothers in "accept". Thus, the groups were very similar as to religious affiliation, parental employment and income.

Although the education and health of the parents was included on the schedule there was not enough data on these subjects to give significant findings.

TABLE 6  
FAMILY'S INCOME

Income in Thousands	Refuse	Accept
\$3 to 4	3	4
to 5	3	2
to 6	2	1
to 7	3	2
to 8	0	0
to 9	1	1
to 10	0	1
Unknown	0	1

We turn to the nature of the chief complaint given by the parents in asking for help. As stated above, this was originally chosen as a criteria for matching the sample groups. Table 7 shows the array of problems and their distribution. It should be noted that other problems were usually mentioned by the parents during the application procedure. Some parents mentioned only one or two while others mentioned as many as six

associated problems. The total of other problems was 34 for "refuse" and 30 for "accept".

TABLE 7  
PRESENTING PROBLEM

Problem	Refuse	Accept
Fearful	2	0
"Different"	1	0
Pre-delinquent fighting	1	1
Stealing	1	0
School phobia	2	5
Behaviour problem in school	1	1
Learning problem	2	4
Demanding show-off	1	0
Withdrawn	1	0
Behaviour problem	0	1

We now look at the referral sources. In four cases, two in each group, there were formal referral contacts from other agencies. It was more usual for these cases to come by themselves, often with a recommendation or suggestion from a friend, a doctor or the schools. Again, the source of referral was not an area in which any marked differences between the two groups could be distinguished.

When a person makes an original contact with the clinic, as was described above, there is sometimes a lapse of time before he is seen in an interview. As Table 8 shows, this lapse can sometimes be measured in weeks and sometimes in months, but there is no great observable difference in the two groups.

Another time lapse occurs after the application interview and before

TABLE 8  
 TIME LAPSE BETWEEN DATE OF FIRST CONTACT AND DATE OF  
 APPLICATION INTERVIEW

Length of Lapse	Refuse	Accept
None	2	3
1-4 weeks	3	3
2-4 months	3	4
5-6 months	1	2
7-8 months	2	0
Unknown	1	0

the first treatment appointment is offered. This is usually called the "waiting period." Table 9 shows that both groups were subject to this waiting and that the length of waiting time was similar for those in each group.

TABLE 9  
 WAITING PERIOD BETWEEN APPLICATION INTERVIEW AND  
 OFFER OF FIRST TREATMENT APPOINTMENT

Length of Waiting Period	Refuse	Accept
None	0	1
Less than 3 months	2	4
3 to 7 months	4	3
8 to 12 months	3	3
13 to 16 months	1	1
Unknown	2	0

The last external factor of similarity shown by this study was the number of parents seen in the application interview. The two groups to-

talled 24 families with 47 parents living and present in the home. In each group, four sets of parents were seen for the application interview. All the other cases were represented by mothers alone.

One external factor of difference appeared in our data. We were interested in the family group composition including others living in the home besides parents and siblings. There were two grandparents living in the homes of "accept" and reference made to others who had previously shared the home in three cases in "accept". In "refuse", there was only one reference to a grandparent who had lived in one home, but had been gone for four years before the application.

In securing data concerning the families' attitudes toward help, the child and the problem it was more usual to get responses applying to the mothers. In no instance were there fewer than 18 responses for a given item pertaining to mothers. The responses for items pertaining to fathers were considerable fewer ranging from six to sixteen. The total number of responses were about equally proportioned between the two groups. This study included responses pertaining to fathers in all cases, whether father was present in the interview or not.

Our first area to explore was the attitudes the families had toward help, and first whether they wanted to come to the interview. Five families did not and they were all from "refuse". In one family this was a joint attitude of both father and mother. Families showing ambivalence to coming numbered six in "refuse" and five in "accept" with two families in each group in which both parents shared this feeling. There were fifteen families who wanted to come and two families in each group in which both parents wanted to come. The families in which only one parent wanted

to come were more numerous in the "accept" group. There were no fathers among this group. Table 10 summarizes the attitudes the families had toward coming. We next looked at what they had done to handle their problem, both as to number of things done and whether outside help was sought.

TABLE 10  
FAMILIES' ATTITUDES TOWARD COMING

Attitude	Refuse		Accept	
	One Parent	Both	One Parent	Both
Didn't want to come	4	1	0	0
Ambivalent	4	2	3	2
Wanted to come	3*	2	8*	2

\*These figures represent only mothers.

"Accept" mothers tended to have done more and sought outside help more frequently. Only one instance was recorded of a father seeking outside help. He was from the "accept" group. In addition to calling the clinic, he had sought help elsewhere. We now look at the expectations families had of the clinic. There were none who felt that the clinic would be of no help. Realistic expectations were shown by eleven parents in "accept". They represented eight families. Four mothers in "refuse" had realistic expectations but four fathers in "refuse" gave the clinic the full responsibility for helping the child.

Perhaps the most definite alignment of the groups was in the nature of the relationship the families made with the interviewer. This was

taken as positive or negative. In three "refuse" families both the father and mother made a negative relationship with the worker, and in three "accept" families both the father and mother made a positive relationship with the worker. Among the "refuse" mothers there were seven negative and five positive. This was reversed among "accept" mothers where there were four negative and eight positive. Among the fathers, the alignment was more striking with the four fathers from "refuse" making a negative relationship and the four from "accept" a positive one. See Table 11.

TABLE 11  
RELATIONSHIP PARENTS MADE WITH WORKER

Group	Positive	Negative
"Refuse" families	0	3
"Refuse" fathers	0	4
"Refuse" mothers	5	7
"Accept" families	3	0
"Accept" fathers	4	0
"Accept" mothers	8	4

An examination of the families' attitudes toward the child shows there is but one describable difference between the two groups. Only one mother of each group seems to have warm relationships with their children. The others are hostile or over-protective with more of the latter in "accept". This does not hold true for the fathers whose relationships with their children tends to be warmer. As to supervision and discipline the distribution seems similar for each group of families. There are more

responses to "rigid" and "lax" than to "appropriate" and more to "inconsistent" than to "consistent."

The remaining area to examine was the families' attitudes toward the problem. Seven families in each group did not involve themselves in blame at all while five in each group did. Of these, the "accept" parents tended to blame themselves a bit more.

Six families, three mothers and five fathers of "refuse" did not feel that the problem was serious, but there was no such response among "accept" families. Eleven of the latter parents thought it somewhat serious and five thought it very serious. In "refuse", five thought the problem somewhat serious and six thought it very serious. The greater number of responses of each group indicated that the problem was thought to be of long range rather than emergency in nature.

The last area to examine is the discomfort the problem causes the families. The fathers were distinguished from the mothers of both groups in that the source of their discomfort seemed to be within themselves. The amount and source of discomfort caused the fathers by the problem was very similar in each group. The difference as to discomfort the problem caused the families centers in the mothers. Eight "accept" mothers had great discomfort as compared to only two "refuse" mothers. Ten "refuse" mothers and only four "accept" mothers had some or slight discomfort. In both groups the source of discomfort was about evenly split between selves and the community with each having one instance in which the family was the source of discomfort.

## CHAPTER V

### SUMMARY AND CONCLUSIONS

This study examined factors in the first interview relating to families' handling of the treatment plans offered by a child guidance clinic. Two groups of twelve cases matched for presenting complaint, age and sex of child were compared. One of these groups were those who refused treatment and the other were those who had accepted treatment.

The first part of the study looked at external, objective, factual data revealed in the record and pertaining to the child, the family group and the clinic contact. As we reviewed this data it was seen that there were no significant differences and the two groups in respect to age, sex, school grade, ordinal position and numbers of siblings were remarkably alike. This similarity persisted when we reviewed the data as to family religion, income and employment and parental age. Again, the sameness continued in regard to referral source, lapse of time between original contact and interview and length of waiting period. Only one difference was evident in the first part of our study. This was the occurrence of more grandparents in the homes of the group which accepted treatment. From this, there is a suggestion that the extended family group may be of some importance as a factor in families' handling of treatment plans. Perhaps this is an area which might be more fully explored during the initial contact.

Since the two groups were so similar in the external characteristics it can be said that we must look elsewhere for clues as to how they might handle the offer of treatment plans. It is thought that these clues must be in the more intangible areas of attitudes and relationships.

The second part of this study looked at the attitudes of the fathers and mothers of the two groups. Mention should be made of the over-all deficiency of data for the fathers. Only eight of the twenty-three fathers were interviewed and where not physically present in the interview data on father was generally quite sparse. Within the limitations of this study, it can be said that, generally, the father's part in treatment plans is not considered fully enough. Whether present or not, it would seem that this key family member should be involved more closely by the clinic in treatment plans for any one or more members of the family.

There were considerable differences revealed in the attitudes of the two groups toward help. Those differences were revealed in the first item and accentuated in later items. Six parents, representing five families who refused treatment did not want to come to the interview. Lack of desire for treatment was present in a substantial number of those who later refused the offer. This lack of desire was not shown by any family which later accepted though there were mixed feelings about coming for help in many of those cases. This is an area which intake workers might easily explore more thoroughly during the initial contact. Our findings indicate that such exploration would yield pertinent data for the clinic in making treatment plans.

Whereas families who accepted treatment tended to have a realistic expectation of the role the clinic would play in helping the child, the families who refused were much more apt to throw full responsibility for the care of the problem onto the clinic. They did not tend to conceive of the helping process as something in which they would be called upon to participate in by making decisions and expending time and effort. The

efforts they made toward solving the problem before coming to the clinic were fewer suggesting that they had not involved themselves as much in the past.

Data revealed only one father who had sought outside help prior to coming to the clinic. Fathers more often tried to correct the situation themselves. In our culture, fathers are, at least nominally, the head of the family and our findings would suggest that they want to believe that they still have the family and its problems under their control. It would seem that fathers want to believe that when a problem arises they, personally, can effect a change. It is felt that clinics and workers should give deference to father's role as the head of the family and consider the wisdom of including him in treatment planning.

The striking difference in the kinds of relationships made by the two groups of families seems to indicate that our strongest clue as to how the treatment offer will be handled is within the nature of the relationship in the interview itself. Where fathers were present and both parents were seen together this difference of relationship was even sharper. We may feel, then, that our best clue could be obtained from the nature of the relationship in the interview where both parents are seen. This seems to re-emphasize the arguments in favor of seeing the parents in the application interview. Such interviews can provide much more valuable data for the use of the clinic in making consideration of treatment plans. They could greatly reduce the number of refusals after treatment was offered.

Among family attitudes examined those that seemed least fruitful

for this study were attitudes toward the child. The investigator thinks that the mothers did not tend to give such accurate data in the area of the fathers' relationship with the child. One can see how this area in particular might be colored by mothers' own feelings toward the fathers. It might also be observed that the very fact that the child has a problem considered at a child guidance clinic implies that there has been some sort of imbalance in the parent-child relationship and our finding of few warm mother-child relationships could have been anticipated. The occurrence of more over-protective mothers among those who accepted treatment seems to show that these mothers, in line with their over-protectiveness, are more apt to accept treatment.

The family attitudes toward the problem showed no significant differences. We looked at whether parents involved themselves in blame for causing the problem. Most of each group did not blame themselves. And there was only a slight difference in the amount of self-blame with the families who accepted treatment also assuming more blame. Since the groups were so similar in the extent they tended to blame themselves, this does not seem to be a significant factor in how they handle treatment plans.

The families who accepted treatment saw the problem as serious more often than those who refused. Again, this was more obvious in the fathers' responses, so that we might generalize that if the father sees the problem as serious the family is more apt to accept treatment plans. One apparent paradox occurs in the responses of mothers in families who refuse treatment. This was the group which more often described the pro-

blem as "very serious." The investigator does not think that this lessens the significance of parental attitudes toward the seriousness of the problem. Rather, it tends to reinforce our generalization of the particular importance of the fathers' attitudes on this point.

There was a slight predominance of parents who accepted treatment who felt that the problem was long-range rather than emergency in nature. This taken alone is not significant but seems to delineate somewhat further the attitudes of the two groups.

The discomfort the problem caused the parents seems to be most noticeably different in regard to the mothers. Those who accepted treatment were more discomforted by the problem and slightly more often the source of this discomfort was the community.

To recapitulate, this study has examined background characteristics and attitudes of families who accepted and refused the offer of treatment plans. It was found that the background characteristics were very similar and apparently had no significance as to whether the family accepted or refused the offer of treatment. It is felt that the difference in attitudes could be considered the crucial determinants in accepting or refusing treatment. The families' attitudes toward help are significantly different for the two groups and it is felt that this whole area is one that should be explored more fully by the worker in the initial contact. The inclusion of fathers in such interviews can be most important as a source of pertinent data and it is felt that clinics must make every effort to involve the fathers in treatment plans. Such a source of valuable data must not be foregone.

The relationships that the parents make with the worker in the interview are the most important single clues shown by our study, and it is felt that the worker must be more able and ready to evaluate this in considering the offer of treatment.

*accepted 5/26/68*  
*Marcell Schleifer*

APPENDIXSCHEDULE USED TO EXCERPT CASES

The Child: Sex, Age, School Grade

The Problem: Presenting Complaint, Other Complaints

The Contact: Referral Source, Lapse, Waiting Period, Those at Interview

The Family: Religion, Income, Marital Status, Siblings, Others

Father: Age, Occupation, Education, Health

Mother: Age, Occupation, Education, Health

Parents' Attitudes Toward Help  
Desire to Come to Clinic  
Prior Attempts to Help  
Expectations of Clinic  
Relationship to Worker

Parents' Attitudes Toward Child  
Relationship  
Supervision  
Discipline

Parents' Attitudes Toward Problem  
Involvement of Selves in Blame  
Seriousness  
Discomfort Caused Parent

Stated Reason for Discontinuance

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