

1962

A follow-up study of families referred from a child psychiatric clinic

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BOSTON UNIVERSITY
SCHOOL of SOCIAL WORK

A Follow-up Study of Families Referred
from a Child Psychiatric Clinic

A thesis

Submitted by
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(B.S. University of Rhode Island, 1960)
In Partial Fulfillment of Requirements for
the Degree of Master of Science in Social Service

1962

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CHAPTER I

INTRODUCTION

This is a follow-up study of ten families who did not comply with a referral, after a diagnostic study, from the South Shore Guidance Center, a child psychiatric clinic, to other agencies in the community.

The diagnostic evaluation at the Guidance Center is to determine suitability of a case for treatment or referral to other community agencies. Treatment plans evolve from a problem-solving process in which the problem and the family's motivation for help is mutually explored by the parents and clinic personnel.

The client's attitude toward and involvement in the problem are important determinants with regard to motivation for help. It was felt that understanding these attitudes will provide an opportunity to understand the referral service at the clinic with regard to clients who evidence little involvement in their children's problems and low motivation for help.

Families who were seen at the Guidance Center for diagnostic Study and referred to other agencies in the community were interviewed by the author. These families did not comply with the clinic referral.

The data for this study was obtained from case records at the clinic and from interviews with the sample families. The agency to whom the client was referred was contacted for information regarding the

outcome.

The South Shore Guidance Center offers as one of its services consultation study of a child's emotional problems. When it is deemed necessary psychiatric treatment is offered for the child. If the child is accepted for treatment one or both parents are seen regularly by another member of the staff.

When a case is appropriate to the clinic's treatment policies the intake process involves helping the client use the Guidance Center's services. If the case is not appropriate for treatment at the clinic the client is directed to a service in the community which is more suited to his needs.

Cases are presented to the intake committee after the initial request for help. The committee determines which cases will be offered diagnostic study and which are to be referred to other agencies in the community. Cases are reviewed for a second time, after the diagnostic study is completed in order to determine which ones will be accepted for treatment and which are referred to other agencies. Treatment cases are either assigned immediately or put on a waiting list until service can be offered. If a referral is indicated parents are encouraged to seek help from the referred agency.

CHAPTER II

HISTORY and LITERATURE

Social work has long recognized that no single social agency can adequately meet all the psychosocial needs and problems of a community, of a family, or even of one human being. ¹

A network of social services have developed, in many communities, to meet these needs. As agencies become more specialized there is an increasing demand for inter-agency communication and cooperation in order to facilitate referrals.

The primary goal of a referral is to help a person find and utilize the appropriate service. The question of a referral arises when a client applies for help at an agency that cannot treat certain aspects of his problem. ² Consequently, a social worker must have the diagnostic competence required to analyze the need for a referral, a comprehensive knowledge of community resources, skill in communicating the client's need for service, and the ability to help the client carry out the referral. ³

Few studies have attempted to look at the client's use of a referral service. Joseph J. Parnicky, Ph.D., David L. Anderson, Charles M.L.S. Nakoa, and William Thomas in their study of the Effectiveness of Referrals printed in the December 1961

1

Joseph J. Parnicky, Ph.D., David L. Anderson, Charles M.L.S. Nakoa, William Thomas, "A Study of the Effectiveness of Referrals," Social Casework, Vol. 42 No. 10 (December 1961), p. 494

2

Ibid.

3

Ibid.

Social Casework raised some questions about referrals. The authors were interested in the following:

How effective are referrals in terms of clients actually going to the agency to which they have been referred? How appropriate are referrals in terms of matching the needs of clients with the services of agencies? What other variables, such as age, nature, of illness, type of problem, or motivation are related to successful referrals?

What method or methods are most effective in terms of the client carrying through with the referral?

The findings of the study indicated that a high degree of successful referrals can be achieved by professional workers who recognize the client's needs and have knowledge of community resources. ⁴

The study also pointed out that clients are more likely to apply to the referral service if preliminary contact with the service has been made by the referring social worker. The findings of this study suggest that further exploration dealing with the procedures for self-referral as opposed to other types of referrals and the relationship of the length of the contact with the referring social worker to success, would prove worthwhile.

In 1950 the Philadelphia Jewish Family Service published the results of a study of 86 cases who were seen for one interview and referred elsewhere. The following statements are the major findings of this study:

There is strong evidence that many clients need a casework service before they are ready to utilize other community resources of which they already may be aware.

4

Ibid., p. 499.

A formal referral in which the caseworker initiated contact with the receiving agency was found to be much more effective than an informal referral (or steering) in enabling the client to apply to other resources.

Clients who initially accepted referrals were, not unexpectedly, somewhat more likely to follow through than those who were undecided or refused.

Clients who presented problems in addition to those on the basis of which the referral was made were somewhat more likely to get in touch with the other agency.⁵

At the conclusion of this study, it was noted that two thirds of the clients who were formally referred contacted the new agency. On the other hand, only one third of the informal referrals contacted the referral service.

Kogan, as well as the previously mentioned studies, indicated that a formal referral is generally more effective than steering in ensuring client contact with the other resources and may possibly affect acceptance for service.

Wilson and Bartlett suggest some specific factors relating to the referral process. Although their article deals with referrals from hospitals some of the principles are appropriate for social agencies as well. The suggested steps to a referral are "helping the patient accept the referral, preparing the referral agency to be receptive to the patient, and seeing that the patient actually gets to the referral agency."⁷

⁵
Anne W. Shyne, "What Research Tells Us About Short-Term Cases in Family Agencies," The Short-Term Case In the Family Agency, New York: Family Service Association of America, 1957, pp. 6 & 7.

⁶
Leonard S. Kogan, "Short-Term Case in a Family Agency: Part III," "Social Casework, Vol. 38 (July 1957) p. 369."

⁷
Harriett M. Bartlett & Eunice W. Wilson, "Referrals from Hospitals to Social Agency: Some Principles and Problems," Social Casework, Vol. 34 No. 10 (December 1955), p. 495.

We can anticipate that the first step, helping the patient accept the referral, may involve the use of casework services before a client recognizes the problem, is motivated toward help, and can accept the referral. Preparing the referral agency to be receptive to the patient would be especially important when low motivation or little involvement in the problem is indicated. It is evident that the first two steps would be influential in getting the patient to the referral agency.

Wilson and Bartlett suggest, as do other authors, that "sound casework practice involving careful psychosocial diagnosis and integration of basic casework principles is essential to successful referral, and that the referral process cannot be isolated from casework itself.⁸ This implies that the referral service is not an automatic giving of information about community facilities, but an opportunity to refocus the problem and the client's desire for help through casework services and in preparation for the referral. The length of casework service, in preparation for a referral, would depend upon the problem, the client's view of the problem and involvement in it, motivation for help, and policy of the agency recommending the referral.

Alexander and Ripple point out that the "client's use of case-work service is determined by his motivation, his capacity and the opportunities afforded him both by his environment and by the social agency from which he seeks help."⁹

8

Ibid., p. 465

9

Ernestine Alexander and Lillian Ripple, "Motivation, Capacity and Opportunity as Related to the Use of Casework Service: Nature of the Client's problem," Social Service Review, Vol. 30, (March, 1956), p. 50.

Conversely, a client who is poorly motivated, lacks capacity for change and opportunities will not make use of the casework relationship. As with the poorly motivated client, the non-voluntary client "has not taken the preliminary steps of identifying a problem which he cannot solve alone and deciding that he can and will ask for help."¹⁰ The development of motivation is usually needed in the non-voluntary client and in the client who exhibits low motivation for help. Casework services may be helpful in developing motivation for a referral service. On the other hand, Henry wrote:

It is, indeed doubtful that it is possible to convince a person that he needs help if he does not already have some conscious feeling of need, however reluctant he may be to acknowledge it.¹¹

Margaret W. Miller, in her Commentary in the February, March 1953 Journal of Social Casework, stated that motivation can be developed in clients by confrontation, reduction of fear, use of cultural expectations, and use of emotional support. This would appear to add structure to casework services given in preparation for a referral.

10

Charlotte S. Henry, "Motivation in Non-Voluntary Clients," Social Casework, Vol. 34 (February, March 1953), p. 131.

11

Ibid., p. 132.

As indicated by the literature, client's who exhibit low motivation and lack of involvement in the presenting problem will be less likely to carry through with a referral. This finding is of particular importance to a child guidance center where parents are often referred to the clinic by other members of the community. Parents who are referred by other community members do not necessarily recognize the meaning of the problem or their involvement in it. Parents coming to a child psychiatric clinic have an opportunity to project the responsibility for the problem on to the child, their marital partner, school, or the community. We can speculate that these parents would have additional problems accepting a referral which involved recognition of their own problems or their role in the child's problems.

It seems evident that these poorly motivated clients could be helped to accept a referral through preliminary casework service. This casework service should ideally be focused toward clarifying the problem and motivating the client toward help.

This present study was undertaken to find out what parents, who had been unable to comply with a referral, had done about their child's presenting complaint, status of the complaint, and attitude toward the diagnostic study and help in general.

CHAPTER III

METHODOLOGY

This is a follow-up study of clients referred from a child guidance clinic, after a diagnostic study, to other community resources but who did not comply with the referral. In order to find out the status of the presenting complaints and the families' attitudes toward and motivation for help the parents were interviewed.

SELECTION OF THE SAMPLE

The cases were selected from the closed index files at the South Shore Guidance Center, searching back chronologically. The author reviewed the index files and those cases which seemed useful, in relation to the study, were examined.

The number of sample cases were limited because a large percentage of referrals are made after the initial application interview. Such cases would not meet the criteria of the study. Also the index cards and case records did not always specify the agency in the community to which the client and/or family was referred.

Certain criteria were deemed essential for these cases. All the sample cases included the diagnostic study, for it was felt that this phase of the intake process would expose the clients to a relationship with a helping person. None of the sample cases had been referred by the court because this would introduce authoritarian factors.

All of the sample cases were selected from the closed file and dated back from six months to three years. It was felt that the six months minimum would give the clients ample opportunity to carry through with the referral or to seek other types of help. Also, it was felt that behavioral changes would be reflected during this designated time period.

DATA COLLECTION

The data for this study was partially obtained from the intake and diagnostic records at the South Shore Guidance Center. The referred agencies were contacted in order to determine the status of the referral and the sample parents who had not carried through with the referral were interviewed by the writer.

The case records were examined and data collected according to a schedule which included external factors related to the parents, child, problem, and clinic contact. The Sample parents were interviewed in order to gather data dealing with the current status of the problem, activity with the problem, motivation toward help, and attitudes toward the clinic. Although the client's attitude toward the worker and the diagnostic study was examined no attempt was made to examine the worker's role and its effect upon the referral.

THE SOUTH SHORE GUIDANCE CENTER

Several demonstration clinics were formed, in 1922, by the National Committee for Mental Hygiene through the Division for the

Prevention of Delinquency and financed on a five year plan, by the Commonwealth Fund.¹ Dr. Douglas A. Thom, recognizing the need of psychiatric work among young children, directed the establishment of "habit clinics" throughout the state. These "habit clinics" were conducted especially for psychiatric therapy.

The South Shore Guidance Center, first called the Quincy Clinic, was opened in October of 1926. During its first few years, the clinic carried on work concerned with the correction of emotional maladjustment and certain physical habits. During its first full year the clinic was opened part-time, held forty-seven sessions, treated fifty-four cases and 273 visits were made by social workers.² In the following years the clinic expanded its facilities and personnel.

The South Shore Guidance Center is a community clinic designed to provide a mental health program for children and their families. The clinic is sponsored by the Massachusetts Department of Mental Health, through the Division of Mental Hygiene, in partnership with the South Shore Mental Health Association. Financial assistance is received from the Quincy Health Department, the Quincy United Fund and the seven South Shore towns in the Association which it serves.

1

Reba I. Osgood, The South Shore Guidance Center, Quincy, Massachusetts: President Press, 1958, p. 17.

2

Ibid., p. 18.

The clinic is open five days a week and there is no charge for services. The clinic's staff includes psychiatrists, psychologists, social workers, and mental health consultants. Children between the ages of three to seventeen residing in Quincy, Milton, Braintree, Weymouth, Hingham, Hull, Cohasset and Scituate are accepted at the clinic.

The clinic reflects the development of an increasing emphasis upon the community nature of mental health services. The South Shore Guidance Center, with the cooperation of the South Shore Mental Health Association, promotes a program of mental health for the prevention of emotional disturbances in children, through clinical diagnosis and treatment services, mental health consultation, and mental health education.³ The clinic works in close cooperation with family physicians, schools, court and other social agencies.

Approximately 5,000 interviews are conducted yearly and the clinic serves as a training center for social work students from Boston University and Simmons College, as well as for the Harvard School of Public Health.⁴ The consultation services are offered to nurses, doctors, clergy, school and court personnel in the community. Several research projects are being carried on at the clinic, including a study of retarded children and a study of juvenile delinquents who come to the attention of the Court.

³
Ibid., p. 10.

⁴
Ibid., p. 20.

INTAKE PRACTICES OF THE CLINIC

The intake practices of the South Shore Guidance Center attempts to determine and provide the most effective service to the applicant and community. This is in keeping with the overall philosophy of the clinic.

Application to the clinic is made most often by parents seeking help for their child or for information about the nature of the clinic's services. Parents are generally referred to the clinic by people or agencies in the community including the school, family physician, clergy, social agency, relative or the court.

The intake worker gathers information such as name, age, residence, income, referral source, the child's problem and its duration. The intake committee reviews the case at the intake conference which is held weekly. The intake committee is composed of experienced staff members including a psychiatrist, psychologist, and social worker. An appropriate case for the clinic is then assigned to a staff member, usually a social worker, for an application interview, which ideally includes both parents. At this point the intake committee may decide to refer the case to a more appropriate agency or may accept it for further diagnostic study. The appropriateness of a case would depend upon the nature of the problem and previous contact with other agencies.

The diagnostic study usually includes two interviews with the mother, one with the father, and two with the child. The parents are most often interviewed by a social worker while the child is seen by a psychiatrist or psychologist. Psychological tests are often indicated

before the diagnostic study is completed. After the diagnostic study, the case is again reviewed, this time by the clinical director or a consultant. Members of the three disciplines are present at the diagnostic conference. It is decided at this time, whether a case is appropriate for treatment at the Guidance Center or if other resources in the community would be more suited to the needs of the family. The staff members involved in the study and both parents attend a post-diagnostic conference. At this conference the committee's decisions are discussed and recommendations are made. Recommendations may include a referral to another agency. If a referral is indicated the post-diagnostic conference is geared to help the parents accept such recommendations. Referrals are made when the applicant's residence is outside the area which the clinic serves, when the annual income is above the maximum which a family may have and be accepted for treatment, and where a child may have physical as well as emotional needs. If severe marital difficulties are present, which would interfere with treatment directed toward the mother-child relationship, the parents are referred to a family agency until such conflicts are lessened. Placement is recommended if the child is too severely disturbed for treatment on an out-patient basis or if the home environment is considered pathological.

After the problem has been discussed and a recommendation for referral made it is usually left to the parents to decide whether they want to think over the findings before making a decision or whether they want the worker to proceed and initiate the referral. If the latter

decision is made the worker will contact the referral service and forward data in accord with that agency's policy. If the parents are undecided or wish to think the recommendation over, they are encouraged to call the clinic back for further help with the referral. The parents may decide to contact the referral agencies and this may be supported as a means of encouraging motivation in the client for help. Recommendations and findings are, many times, rejected during the post-diagnostic conference. Parents who initially reject a referral usually have evidenced little involvement in or recognition of the problem during the diagnostic study. Consequently, they consider the referral unnecessary.

CHAPTER IV

DATA and FINDINGS

In the description of the sample group, first the external, objective characteristics gathered from the case records will be examined; secondly, the internal, subjective factors gathered from interviews.

The ages of the parents ranged from twenty-four to forty-eight years. The preponderance of mothers fell into the thirty-five to forty age group, while the majority of fathers were between forty and forty-five.

TABLE 1

<u>COMPARATIVE AGES of the PARENTS</u>			
<u>Age</u>	<u>Father</u>	<u>Age</u>	<u>Mother</u>
25-30	2	24-30	2
35-40	3	35-40	5
40-45	4	40-45	2
Deceased	1	45-50	1
TOTALS	10		10

Seven of the couples in the group were married and are biological parents of the sample children. One set of parents are divorced and the child resides with the mother. There was also one step-mother, the child's biological mother being father's first wife, and a widow in the group.

Within the group of ten mothers seven were full-time housewives. Two women were employed as saleswomen; one on a part-time basis. Another mother was employed as an attendance officer in a school. Table 2 compares the mothers' occupation with their marital status. Only one of the married women worked outside of the home and this was on a part-time basis.

TABLE 2

COMPARISON of MOTHERS' OCCUPATION and MARITAL STATUS

<u>Occupation</u>	<u>Marital Status</u>	<u>Number</u>
Housewife	Married	7
Part-time Saleswoman	Married	1
Full-time Saleswoman	Divorced	1
Attendance Officer	Widow	<u>1</u>
Total		10

There was some variation as to the fathers' employment although the eight occupations of the sample fathers fall into the skilled category. One father is deceased and one is divorced and his whereabouts is unknown.

The annual family income ranges from the \$3-4,000 category to \$10,000. Table #3 indicates the income for these ten families.

TABLE 3

ANNUAL FAMILY INCOME

<u>Income</u>	<u>Number of Families</u>
3-4,000	3
5-7,000	5
10,000	1
Unknown	<u>1</u>
Total	10

Of the three families found in the lowest income group, \$3-4,000 range, one consisted of a father employed as a rigger, the second of a widow working as an attendance officer, the third was a divorcee employed as a saleswoman. Thus the two single mothers, employed on a full-time basis, with the major responsibility for family income, fell within the lowest economic group. The professional army man, mechanic, welder, salesman, and service station owner fell into the \$5-7,000 category. The \$10,000 annual income belonged to the department head. The unknown category of annual family income consisted of a father employed as a salesman and mother working as a part-time saleswoman.

The majority of the families in the sample group were Protestant. There were an equal number of Catholic and Jewish families in the group. The two families in which divorce had occurred were of the Protestant faith. The religious affiliation is illustrated in Table 4.

TABLE 4

RELIGIOUS AFFILIATION

<u>Religion</u>	<u>Number of Families</u>
Protestant	5
Catholic	2
Jewish	2
Mixed*	<u>1</u>
Total	10

* Catholic-Protestant

Table 5 shows the various presenting problems given by the parents in contacting the clinic. In these ten cases, the other problems

which the parents presented were closely related to the chief complaint.

TABLE 5

PRESENTING COMPLAINTS

<u>Presenting Complaints</u>	<u>Number of Children</u>
Learning and Emotional Problems	2
Emotional Problems	3
Learning and Behavior Problems	1
Behavior Problems	1
Learning Problems	1
Emotional and Behavior Problems	1
Learning, Behavior, Emotional Problems	<u>1</u>
Total	10

The presenting problems indicate behavior, learning, and emotional difficulties or some combination of the three. Behavior problems indicate destructive, acting out behavior, and learning problems indicate lack of or low level of school achievement. Emotional difficulties cover acute anxiety, confusion, and tics. Five of the children were referred specifically for learning problems, while seven of the group are classified as poor achievers.

The sample group includes six males and four female children, ranging in age from five to seventeen years as indicated in Table 6.

TABLE 6

AGE of the SAMPLE CHILDREN

<u>Age</u>	<u>Number of Children</u>
5-10	4
11-13	3
14-17	<u>3</u>
Total	10

The twelve year range in age among the children in the sample group corresponds to the range in school grade. However, the grade and level of achievement does not correspond to the chronological age of the majority of these children.

TABLE 7

COMPARATIVE AGE and ACHIEVEMENT

<u>AGE</u>	<u>LEVEL of ACHIEVEMENT</u>		
	<u>Poor</u>	<u>Good</u>	<u>Excellent</u>
5-10	3		
11-13	2		1
14-17	2	1	
TOTAL - 9 *			

* one child not in school

Three of the sample children, the five and a half, ten, and seventeen year olds, are in grades appropriate for their age. However, the first two children mentioned, are doing poorly in school while the third's achievement is considered good. The twelve and a half year old child, who is achieving excellent work, is approximately a grade ahead of what is expected for his chronological age. The remaining five children, who are in school, are approximately a grade behind what is appropriate for their chronological age.

The majority of the children in the sample have one sibling. Table 8 indicates that there is no appreciable difference between the

number of children in the sample and the corresponding number of siblings.

The oldest children did, however, have the oldest parents.

TABLE 8

COMPARATIVE NUMBER OF SIBLINGS AMONG THE SAMPLE CHILDREN

<u>Number of Siblings</u>	<u>Number of Study Children</u>
0	2
1	4
2	3
<u>4</u>	<u>1</u>
TOTALS 9	10

Table 9 illustrates the source of the original referral to the clinic. Only one referral was made directly by the parent. The remaining referrals made by parents were at the suggestion of the school, physician, and a social agency. However, there appears to be no correlation between the presenting problem and the person who suggested the referral to the clinic. For instance, physicians referred children to the clinic for learning difficulties as well as emotional and behavior problems. Conversely, school personnel referred those children with emotional and behavior problems as well as learning difficulties. Big Brother Association of Boston referred a child with the presenting problem being behavior, learning, and confusion. The referral made exclusively by the child's mother was with the presenting problem of acute anxiety.

TABLE 9

SOURCE of REFERRAL

<u>Referral Source</u>	<u>Number of Children</u>
Parent directly	1
Parent suggested by	
School	5
Family Physician	3
Other Agency *	<u>1</u>
Total	10

* Big Brother of Boston

The clinical staff, in all cases, attempts to make a referral, when necessary, that is consistent with the needs of the family. Consequently, there is a direct relationship between the various agencies families are referred to, and the reason for the referral as is indicated by comparing Table 10 and Table 11.

TABLE 10

PLACES the FAMILIES WERE REFERRED TO

<u>Agency</u>	<u>Number of Families</u>
Private Psychiatrist	1
Family Agency	5
Placement	3
Other Psychiatric Clinic	<u>1</u>
Total	10

TABLE 11

REASONS for the REFERRAL

<u>Reason</u>	<u>Number of Families</u>
High income	1
Marital conflict	3
Promote one stable adult	2
Child seriously disturbed	3
Ineligible because of age	<u>1</u>
Total	10

Three cases were referred to family agencies because of marital discord. It was felt by the clinical staff that these severe marital problems would interfere with attempts to concentrate on problems concerning or related to the parent-child relationship. However, the parents were free to return to the clinic for help with their children whenever the marital problem had sufficiently decreased. Two other cases were referred to family agencies for the purpose of promoting a stable adult in the family. Because the main focus of treatment in the clinic is on the child, it was felt that these parents would best benefit from an agency which could meet their own needs. The three families to whom placement was recommended contained children who were seen by the staff as too disturbed to be treated on an out-patient basis. In addition, the home situation in these three cases were too pathological for the children's well being. It should be noted that in one out of the three cases where placement of the child was recommended a letter was sent to an agency in

order to facilitate the referral. The referrals to a private psychiatrist and to another psychiatric clinic were decided upon largely because of agency policy. In the first instance, the annual income was above the maximum which a family may have if they are accepted for treatment at the clinic. The latter was concerned a child who was above the maximum age which the clinic, by its policy, could accept.

Nine of these cases were informed about the referral during a post diagnostic conference. One family was told about the referral by the psychiatrist involved in the diagnostic study. Of these ten cases, having a referral as the disposition, three accepted, five were undecided, and two rejected the referral.

When asked how they felt about the original referral to the clinic the mothers, who were interviewed, stated that they felt it was necessary at the time. Table 13 illustrates the families' attitude toward the diagnostic study.

TABLE 12

ATTITUDE TOWARD the DIAGNOSTIC STUDY

Attitude	Number of Families
Disagreed with findings	1
Not helpful	3
Helpful	<u>6</u>
Total	10

Two of the three families who did not find the diagnostic study helpful rejected the referral during the post diagnostic conference. The

family who disagreed with the findings did, however, verbally accept the referral. Of the five families, undecided about the referral, four felt the study was helpful and one thought it was not. The two remaining families had accepted the referral and considered the diagnostic study helpful.

Table 13 represents a comparison between the presenting complaint and the status of the presenting complaint. Six families reported the presenting complaint had slightly improved, three reported great improvement, and one indicated no improvement. Interestingly, the families noting the greatest amount of improvement had indication of a relatively severe problem at the time of referral to the Guidance Center.

TABLE 13

COMPARISON of PRESENTING COMPLAINT and ITS STATUS

Presenting Complaint	S_t_a_t_u_s		
	No Improvement	slight	great improvement
Learning and emotional		2	
Emotional		1	2
Learning and behavior			1
Behavior	1		
Learning		1	
Emotional and behavior		1	
Learning, behavior, and emotional		1	
TOTAL - 10	1	6	3

The families who denied having current problems noted a great improvement in the status of the presenting complaint. The current

problems are directly related to the corresponding presenting complaint.

Four families reported no activity with the presenting complaint following the diagnostic study. Two of the previously mentioned cases reported slight improvement, one indicated great improvement concerning the presenting complaint, and the other no improvement. Table 14 indicates activity with the presenting complaint and the current status of the complaint.

TABLE 14

ACTIVITY WITH THE PRESENTING COMPLAINT AND ITS STATUS

Activity	S_t_a_t_u_s		
	No Improvement	Slight	Great Improvement
Special class		2	1
No activity	1	2	1
Other methods of discipline		1	
Private tutor		1	
Psychiatrist and tutor			1
Total - 10	1	6	3

Five cases reported activities concerned with some aspect of the learning process. This corresponds to the five children who were referred to the clinic, solely or partly, because of difficulty with learning. The one family who had further contact with a private psychiatrist reported great improvement and slight improvement was reported from the family using other methods of discipline.

The six cases reporting activity with the presenting complaint viewed the activity as directly related to any changes in behavior. One

family initiated no activity and reported no change in behavior. The remaining three families, not having initiated activity with the original complaint, presented the changes in behavior as directly related to the child's outgrowth of a difficult stage of development. Within the limits of this sample there appears to be no appreciable degree of improvement due to activities on the part of parents.

Five mothers expressed positive attitudes toward the people they had contact with at the clinic. Four people expressed ambivalent feelings and one was negative about the study, social worker, and findings. Three of the five mothers expressing positive feelings toward clinic personnel remembered the name of the social worker they had seen and one mother described the worker she had contact with. In the remaining six cases the name of the social worker and/or psychiatrist involved with the family was not remembered. There appears to be a relationship between the mother's feeling toward the clinic and personnel and whether or not they could recall the people they had contact with during the diagnostic study.

Three families reported that they did not understand the referral from the Guidance Center or the reason for the referral. These same families accepted the referral at the time it was made. Seven cases in the sample group understood the reason for the referral and the function of the agency they were referred to. Five families from the group of seven who understood the referral were undecided about seeking further help. The remaining two families in the group rejected the referral at the time it

was made.

The writer has eliminated from Table 15 the two families who rejected the referral at the time of the post diagnostic conference. These families reportedly discussed the referral at the family conference. Table 15 indicates people the disposition was discussed with, among the families accepting or undecided about the referral.

TABLE 15

COMPARISON of PEOPLE INVOLVED IN DISCUSSION of THE REFERRAL and ATTITUDE TOWARD THE REFERRAL

Involved in Discussion	Attitude	
	Accepted	Undecided
Principal	1	
Psychiatrist, physician	1	
Husband	1	2
Sister		1
No one		2
Total - 8	3	5

Three mothers discussed the referral only with their husbands. In this group two families were referred for marital counseling and the other disposition was a recommendation for placement of the child. The mother who discussed the referral with her sister was also referred to another agency because of the intensity of marital conflict. The cases, in which referral had not been discussed included a widow and divorcee. The sample family who reported discussing the referral with a private psychiatrist and family physician was noted in the record as very

disturbed and placement of the child was recommended. The mother who discussed the referral with the principal had been referred to the clinic by the school.

When asked why they had not complied with the referral four families stated they felt it would not be helpful. Only one family, however, rejected the referral, one family having accepted, and two were undecided. Of the four cases not complying with the referral because the husband was against it two were referred to family agencies and two cases placement of the child was the recommendation. Here again, one family rejected the referral, one accepted and two were reportedly undecided. One family did not comply with a referral to a family agency for marital counseling because "they never got around to it". This family also reported no activity with or improvement of the presenting complaint. The case referred to another psychiatric clinic, because of the discrepancy between the child's age and clinic policy, was not complied with because the child was unable to apply to another clinic herself. This case was reported as greatly improved.

The six families who expressed indecision about the referral from the clinic all stated, when asked by the interviewer, that the referral was necessary. Of the two families that rejected the referral one felt it was a good plan and the other viewed the referral as unnecessary. The two families who accepted the referral never-the-less felt "upset" about the recommended disposition. Another family who accepted the findings felt the referral had been necessary at that time.

Table 16 indicates the parents' attitude toward the presenting complaint.

TABLE 16

PARENTAL ATTITUDE TOWARD THE PRESENTING COMPLAINT	
Attitude	Number of Families
Alterable	7
Doubts ability for change	<u>3</u>
Total	10

The three mothers who doubted the ability for change with regard to their children's problems did not initiate activity with the presenting complaint other than clinic contact. The fourth mother who reported no activity with the presenting complaint felt the problem was alterable and had been greatly improved through the child's own efforts. It appears that activity with problems, initiated by parents, is related to parental attitudes toward the problem.

The last area to be investigated was parental attitude concerning responsibility for the problem as indicated in Table 17.

TABLE 17

PARENTAL ATTITUDE CONCERNING RESPONSIBILITY FOR THE PRESENTING COMPLAINT

Responsible for problem	Number of Families
Late development	2
parental handling	2
Unknown	3
Resentment toward step-mother	1
Conflict between parents	1
Death of father and close relative	<u>1</u>
Total	10

Four of the sample group recognized some aspect of parental behavior as directly related to the children's problems. Another three families denied having any knowledge concerned with the origin or background of the presenting complaints. All of the parents in the group lacked understanding of the dynamics involved in their children's problems and their, the parents, relationship to these problems.

Many of the current problems reported were directly related to the presenting complaints. Consequently, the majority of the sample families still have the problems that existed during their contact with the clinic. Activities with the presenting complaints, in all instances, had failed to take into account the total dynamics of the problems.

It appears that motivation for change and/or treatment, in the same group, is in general low. Nine out of the ten families in the sample group were referred to the Guidance Center by other people in the community. In some instances, such as school referrals to the clinic, there was additional pressure for these families to seek help. For various reasons, none of the sample group complied with the clinic's referral.

CHAPTER V

SUMMARY and CONCLUSIONS

This is a follow-up study of parents with emotionally disturbed children who did not comply with a referral by the South Shore Guidance Center for service elsewhere in the community. As the attitudes of clients are important factors in determining whether or not they will continue to seek help, it was felt that this study would provide greater understanding of the attitudes of people unable to comply with a referral and the significance of these attitudes to the referral system. Since these parents were able, in many instances, to seek out and utilize services other than that which was recommended in the referral, this was noted and examined.

The first part of the study was an examination of the external, objective data obtained from the case records and related to the family, child, and their contact with the clinic. The reviewed data revealed that the majority of fathers were between 40-45 years while the majority of mothers fell into the 35-40 year old category. Seven of the couples were married and are biological parents of the sample children. Two fathers are absent from the home and one child has a step-mother. These latter situations, fathers absent from home and step-mother, may focus the problem, particularly on the mother-child relationship. While this may serve as a motivational factor for treatment it may, on the other hand, be too threatening and anxiety producing for the parent to continue.

There is no direct relationship between the age of the parents and the number of children in the family. The sample family having the largest number of children contained a couple twice married and having children from the previous marriages. The oldest parents, however, had the oldest children.

The occupations of fathers in the group were limited to skilled work. Three of the sample mothers worked outside of the home; two, on a full-time basis, and one, on a part-time basis. The two families where the women were working full time the fathers were absent from the home. The absence of an authoritative parental figure may have been an important factor in the mothers coming for help at the clinic.

Annual salaries ranged from \$3 - 10,000. The families with fathers absent from the home fell into the lowest economic group. This suggests that these mothers had responsibility for the total family income, as well as child and home care. This total responsibility would again appear to be a motivational factor for these mothers to seek outside help, although the anxiety and guilt producing aspects of a treatment situation is still present.

The majority of families in the sample group were Protestant. There were an equal number of Catholic and Jewish families.

The ten presenting problems indicated were behavior, learning, and emotional difficulties, or a combination of the three. The children ranged in age from 5 to 17 years, with the corresponding school grades being between kindergarten and the 12th grade. The majority of children

were doing poorly in school although one family reported excellent work and another's achievement was considered good. The prevalence of poor school performance appears to be directly related to the five children who were referred because of learning problems.

The majority of sample children had one sibling. The largest number of siblings of a sample child was four. There was no direct correlation between the age of the parents and number of siblings in a family.

The sample families were interviewed in order to determine the more subjective factors and status of the cases. The majority of these families were undecided or negative about the referral to another agency at the time of the post diagnostic conference. These families needed preparation before they would be able to comply with a referral. Ideally this group should have been offered preparation for a referral through casework service at the time of the post-diagnostic conference.

Referral to an outside agency calls for additional motivation and responsibility from the parents. Referrals to other agencies involves recognizing problems above and beyond the child and related, in many instances, directly to the parents and the home life. These parents, who came almost exclusively because of community pressures, did not have the motivation to follow through with a referral. The reasons stated for not carrying through with the referral were, in the majority of cases, vague and unrealistic. Although a degree of improvement with regard to the presenting problems was noted in nine of the cases the current problems

reported were directly related to the presenting complaint.

The findings indicated that further preparation for referral is indicated especially with families who evidence little involvement and low motivation for treatment. Clarifying the problem and recommendation for referral is not sufficient in all cases as the sample group has indicated. Preparation for a referral through case work service might help clients to recognize the problem, involve themselves and follow recommendations for specific service at other agencies. A more lengthy relationship with a helping person might also increase the possibility of families carrying through with referrals.

Only four of the sample parents saw themselves directly involved with the child's problems. The remainder of the group projected the responsibility on to developmental factors or denied any knowledge of causation. None of the families clearly recognized their own involvement in the child's difficulties. It seems evident that these families are less apt to involve themselves in treatment as this necessitates careful exploration of the parent-child relationship. The parents' inability to become involved in the child's problems, with the corresponding anxiety and sense of guilt, would certainly nullify plans for treatment. These parents, on the other hand, did not exhibit the anxiety concerning their involvement which is used as an indicator of motivation and "treatability".

The majority of sample parents did, however, feel that the presenting problem was alterable. The remaining three families doubted the

ability for change with regard to the child's problems. Attitudes regarding alterability of the problem would appear to be related to motivation for change. However, it is important that parents view alterability in terms of a realistic change oriented program. The majority of activity initiated because of the presenting complaints revolved around the learning process. The parents' activity appears to be appropriate when one recalls the preponderance of learning problems and low school achievement in the sample group. On the other hand, activity with some aspect of the learning process fails to take into account the corresponding behavior and/or emotional difficulties. The other activities reported, short term treatment with a private psychiatrist and other methods of discipline, again, failed to take the total dynamics of the problem into consideration. Lack of parental involvement and understanding of the child's problem is evident in the four families who did not initiate activity with the presenting complaint.

The sample parents appear too poorly motivated to follow a referral and enter a treatment situation. They lack understanding of their children's problems and fail to see parental involvement in these difficulties. Consequently, the families tended to project responsibility for their children's problems. There were primarily negative responses toward the referral recommendations. The writer is under the impression that these families saw the clinic as a service through which their children could be helped without parental participation.

Although referrals corresponded to the needs of the case, the attitudes and lack of understanding among the sample families made use of the referral service impossible. The recommendations for marital counseling and placement would necessitate recognition of responsibility on the part of the parents. Where placement is recommended, the parents are faced with the reality of a poor home environment and must face the guilt and possible condemnation of a separation.

A follow-up study of these families was aimed at finding out what type of help these people could accept, the status of the problem, and why they were unable to accept the referral. Because many families are unable to follow through with a referral for service, this was felt worthy and in need of investigation. The findings of this study have important implications for a social worker utilizing his role in the referral process as the attitudes and abilities and limitations of parents have significance in terms of their use of referral services.

It appears that casework service was indicated for the sample families so that they could be helped to utilize the referral services. Casework service was needed to assist the parents in recognizing the problem and some of its dynamics as well as their own involvement in the children's difficulties. Although casework cannot guarantee that a referral will be followed, it should be extended, in most instances, as part of the referral, so that the client can be helped toward use of the referral and ultimately to a solution of his problem.

This study has been limited by several factors. The small sample is one factor. A larger sample would provide such a study with greater range and validity. The use of case records imposes the factor of the subjective judgements of social workers gathering data during the diagnostic study. Interviewing the sample families open for question the validity of the responses. In some instances the responses did not sufficiently answer the investigators question. The objectivity of the data is again limited by the judgement of the investigator.

It is hoped that this study will initiate further exploration in the area of referral process and service and the implications for case-work service.

*accepted by
Maxwell Goldwater
5/62*

A P P E N D I X

SCHEDULE for DATA COLLECTION

General Characteristics of the Parents

1. Age
2. Occupation
3. Income
4. Marital Status
- 5 Religion

General Characteristics of the Children

6. Age
7. Sex
8. Number of Siblings
9. School grade
10. Achievement in school
11. Presenting problem
12. Other problems
13. Original source of referral
14. Places the families were referred to
15. How the families were informed about the referrals
16. Reasons for the Referrals

Data From The Interviews

17. Attitudes toward the original referral to the clinic
18. Attitudes toward the diagnostic study
19. Current problem or problems
20. Status of the presenting complaint
21. Activity with the presenting complaint
22. Changes in behavior
Reasons for changes in behavior
23. Attitude toward people at the clinic
24. Understanding of the referral and agency referred to
25. Who the referral was discussed with
26. Why didn't the families comply with the referral
27. Feelings about the referral from the clinic
28. Attitude toward the presenting complaint
29. Responsibility for the presenting complaint
30. Attitude toward the child
31. Attitudes toward help
32. Motivation for treatment

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