Parents who reapply to a child guidance clinic

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Boston University
PARENTS WHO REAPPLY TO A
CHILD GUIDANCE CLINIC

A thesis

Submitted by
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CHAPTER I
INTRODUCTION

This is a study of thirteen families with an emotionally disturbed child, who reapplied to the Douglas A. Thom Clinic for Children after the termination of a treatment contact. The study explored (1) factors which might reflect that these parents will reapply; (2) factors existing at termination of the first contact which might relate to the bases on which these cases were reaccepted for further treatment, if this occurred; and (3) factors relating to the use of help when they reapplied.

Reapplicants have been of interest to child guidance clinics in past years. Questions have been raised about the characteristics of reapplicants, their attitudes toward treatment, whether changes in attitudes have occurred, and criteria from the initial contact that is prognostic of success upon reopening. The Thom Clinic has a similar concern. The Clinic feels a responsibility and obligation to these persons who again seek help where they have been helped before. With increasing caseloads and the large number of parents reapplying each year, the question often arises about how the reapplicants use help, and whether they benefit from further treatment.

The thirteen cases studied were drawn from the caseload of reapplicants in the years 1954 through 1957. These parents
had been in treatment during their initial contact with the
same child for whom they reapplied. Four of the cases reapplied
twice and two reapplied a third time. Data was collected
from the case records. The attitudes and experiences of these
parents in treatment were explored to discover whether any
pattern or characteristics emerge in the way these parents
have used help. With the use of a schedule, the following
areas were examined: descriptive characteristics; presenting
problems; source of referrals; length of time in treatment;
nature of termination; outcome of reapplications; attitudes
toward the child; attitudes toward help; and involvement in
treatment.

This study was conducted at the Douglas A. Thom Clinic
for Children, a community child guidance clinic in Boston,
Massachusetts. The Clinic focuses on the study and treatment
of families with children of grade school age having emotional
problems.
CHAPTER II
REVIEW OF THE LITERATURE

Little attention has been paid to the question of reapplications in child guidance literature, but numerous studies have explored various aspects of this issue. Price and Feldman¹, in a study at the Jewish Board of Guardians, examined reopened cases with the aim of determining whether the decisions to terminate or reopen a case were sound. In answer to these questions they state:

Baffling cases always deserve another trial. Although increased maturity and changes in the life situation were some reasons for another attempt, for the most part, reopening seemed sound because our original contact had not demonstrated the client's inability to profit from case work service. Instead we had failed, for various reasons, to offer help.

Other studies of reapplications were concerned with changes in the parent's attitude toward treatment or toward the child, and whether these factors were prognostic of success at reopening. In comparing changes in attitudes and motivations shown at intake, McGinnis² found that most of the mothers had in common the fact that they did not want to get involved in treatment and had no insight into their involvement in the child's problem. In the reapplication interviews,

²Patricia A. McGinnis, "Attitudes Shown at Intake by Clients Who Reapply to a Child Guidance Center."
she noted an increased rejection and hostility on the part of the mother toward the child, with increased severity in the child's symptom. In concluding, she suggests that these attitudes may have contributed to the refusal of appointments by many of these parents after they reapplied. Beatrice Smith found that the attitudes at the time of first termination were prognostic of later co-operation.

The conclusion drawn was that if the clinic needs to be very selective at intake, the cases most likely to show progress after reopening are those in which the mothers have shown an intelligent understanding of the clinic's work or were fearful of treatment at the time it terminated.

In her study on changes in attitudes toward treatment at reapplication with a second child, Patricia Ball noted that while the attitudes seemed to be quite similar in both contacts, there was less ambivalence about treatment when they returned. Further, most of the parents and caseworkers made comments showing an awareness of changes in the mother's attitudes toward the problems. They seemed to be integrating some of the understanding they had gained in their first clinic experience. Jameson explored differences between the two


4 Patricia A. Ball, "The Mother Returns to the Clinic."

5 Mary Elizabeth Jameson, "A Study of Mothers Who Return to a Child Guidance Clinic."
contacts in regard to the attitudes and problems at intake, the mother's relationship to the clinic, the mother's understanding of treatment, and facts about termination. She found that the half of the cases that were able to use their first clinic experience profitably assumed more initiative in seeking help, had a better idea of what help the clinic offered, and had a better attitude toward the clinic. The status at termination was not prognostic of their improvement with further treatment.

Changes in attitudes toward treatment was also explored by Sadie Goldstein. She concludes that

... the favorable changes in attitude and the continued positive relationships of the mother in over half of the cases can be attributed to the skill of the case-worker in meeting the needs of the mothers. Those who showed change had been helped to a better understanding and appreciation of treatment.

Pearl Baum, in her study, "When Is It Worthwhile to Reopen a Case for Child Guidance?" concluded:

... in considering reopening a case much importance should be attached to the parent's attitude toward the use of clinic's services. Logic would sustain that conclusion, for these parents have already had an opportunity to see what a clinic has to offer.

In reviewing other aspects of the first treatment period, she

6 Sadie Goldstein, "A Study of Maternal Attitudes to Treatment in a Group of Reopened Cases in a Child Guidance Clinic."

found that neither the mother's attitude toward treatment at termination, the extent of the child's participation in treatment at that time, nor the degree of change in the mother's attitude toward the child were predictive of results in the second treatment period.

At the Thom Clinic in 1954, Suzanne Greenberg\(^8\) studied clients who terminated their first contact with the clinic before they became involved in treatment, and reapplied a second or third time. After exploring many factors, including attitude toward the problem, source of referral, expectations of treatment, reasons for termination, she concluded that there was no single factor which would indicate the client's ability to complete his application or to follow through on clinic's recommendations.

Other studies of importance to the present investigation are those dealing with criteria of treatability. Helen Witmer and students in the study, "The Outcome of Treatment in a Child Guidance Clinic"\(^9\) felt that the parent's attitude toward the child was a good index of results of treatment, since most of the failures occurred when parents were overtly rejecting

\(^8\) Suzanne B. Greenberg, "Repeated Applications to a Child Guidance Clinic."

and markedly ambivalent toward the child. Pearl Lodgen, in her study, "Some Criteria for the Treatability of Mothers and Children by a Child Guidance Clinic"\(^\text{10}\) concluded:

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

These studies concur on the need to understand when it is "worthwhile" to reopen a case. Some of them focused on the prognostic value and criteria of a previous contact in considering whether to reopen a case, while others explored whether and what kinds of changes occurred. All of these studies sought to determine what factors are significant in accepting a client for further treatment. This study assumes the same quest.

This study differs from those described in that the sample is smaller (thirteen cases) and the cases are drawn from a different setting. Since the focus at the Thom Clinic is on intensive treatment, the investigator sought to determine why these families felt the need to reapply for further help, and whether they were better able to use the help available in subsequent contacts. Furthermore, the aim here is descriptive:

to discover whether there are any characteristics or patterns which emerge in the way these families use help. In contrast to some of the other studies, this sample includes only those families which were in treatment during their first contact. This provides a basis on which to evaluate how they used this contact in the interim period and when they reapplied.

This study was undertaken with the aim of discovering:
(1) factors which might reflect that these parents will reapply; (2) factors existing at termination of the first contact which might relate to the bases on which these cases were reaccepted for further treatment, if this occurred; and (3) factors relating to the use of help when they reapplied.

The findings that emerge from previous studies indicate that the parent's attitude toward treatment and toward the child are important factors in successful treatment. Among other areas suggested for further exploration are: the reasons for termination; expectations of treatment; pressures to apply; presenting problems. With these suggestions, the following areas were explored in this study:

1. Characteristics of the reapplicants
2. Presenting problems
3. Source of referral
4. Length of time in treatment
5. Nature of termination
6. Outcome of reapplications; comparison of accepted
with non-accepted (for treatment) cases

7. Attitude toward the child at first and reapplication contacts.

8. Attitudes toward treatment at the time of referral and at reapplication.

9. Involvement in treatment in first and reapplication contacts.
CHAPTER III

METHODOLOGY

This study was conducted at the Douglas A. Thom Clinic for Children, "a community psychiatric agency for the study and treatment of children with emotional problems and their parents."¹ As a "modern teaching child psychiatric clinic," the program consists of study and treatment, of professional training, and of clinical research.²

The Clinic was founded in 1921 (then named the Habit Clinic for Child Guidance) as one of the pioneering clinics in this country and in the world. At that time the program consisted of diagnostic studies of the child in his social milieu, and treatment in the form of advice and suggestions to the parents. Under the influence of psychoanalytic work with children, the newly organized Thom Clinic began to apply psychotherapeutic techniques to the child himself.³ With this new interest in dynamic psychology, caseworkers began to treat parents for their own problems. Caseworkers questioned the wisdom of this approach, however. They maintained that parents should be accepted in the role in which they present

²Ibid.
³Ibid.
themselves to the clinic: not as informants, nor as patients, but as individuals who are troubled about a relationship in which they are involved. The child guidance worker then took as his task the fostering and enhancing of the parent's strength in deciding to help the child, and helping the parent to support the child's psychological growth as it received fresh impetus from psychotherapy. Thus, in the 1940's, there evolved the traditional child guidance pattern of weekly psychotherapy for the child and casework for the mother.

While this continues to be a major part of the clinic's program, the clinic has extended its function by providing consultation services to other agencies in the community (i.e. nursery day care centers). Furthermore, as other agencies in the community began to treat children with mild neuroses and situational upsets, the clinic began to absorb in its caseload an increasing number of seriously disturbed children, and multi-problem families, which required years of intensive treatment. Through the stimulation of these difficult cases, the clinic developed its emphasis upon the "family diagnosis," and experimented with new types of treatment for these families. The psychiatric family study is now used in assessing

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the treatability of more disturbed families, and in guiding treatment plans and techniques.

The "chronic problem family" which is a current concern of many community agencies, precipitated the clinic's research study on families of antisocial children. This reflects the clinic's concern in providing optimum service to its families, and also, perhaps, lending assistance to other community agencies in their work with these difficult-to-treat families.

**Intake Policy and Procedure at the Douglas A. Thom Clinic for Children**

All of the procedures at the Thom Clinic, from the time of referral to final disposition have the two major aims of acquiring a most thorough understanding of, and to give optimum service to each family. Recognizing that psychotherapy is not a panacea, the clinic attempts to select only those families who can benefit from and utilize the services available.

We consider the Thom Clinic to be primarily a study and treatment center for emotionally disturbed children. Of the children referred to us, we treat all whom we believe we can treat from the standpoints of our estimate of their pathology and of the willingness and ability of their parents to permit change in their child and, from that of the capacity of our clinic facilities.

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The selective and therapeutic process begins at the point of the telephone referral, the first step in the intake process at the Thom. As the parent approaches the child guidance clinic for help, he is confused, fearful, and yet strong in taking this step toward changing the situation.\(^8\) Often by the time he takes this step he is in a state approaching despair, has lost any perspective he may have had, and feels angry, baffled, and guilty. He believes that he is in some way inadequate or he would not need help.\(^9\) The caseworker, accordingly, seeks to counteract this anxiety by the establishment of rapport with the client, through a meeting of minds on the problem, and by a direct and confident approach. This definiteness of approach on the part of the worker serves to clarify the situation, to gain the necessary information, to consider disposition, and to allay some of the client's confusion and anxiety.\(^10\) Although these initial calls usually last only ten or fifteen minutes, a skilled and sensitive worker can make a significant beginning in understanding the family structure, the areas in which breakdown of functioning have occurred, and

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the strengths of the situation. Having elicited enough information, the worker begins to formulate a tentative diagnosis, and gives consideration to whether this client is at the appropriate agency.

If it is obvious that the client is not eligible for the services of the clinic, the worker can direct the referral to a more suitable source at this point. The intake policy includes the following principles:

1. Age: generally, children between the ages of five and twelve are accepted. However, the child younger than five years and the child in early adolescence are also eligible.

2. Residence: generally, the family must live in the Greater Boston areas which are members of the United Fund. Families residing outside of these areas and in communities where psychiatric clinic services (state or private) are not available, are also eligible.

3. If the problem is principally a physical one, the case is referred to a hospital setting.

4. Severely disturbed children (e.g. certain psychotics) may be referred elsewhere, i.e. to a private psychiatrist, residential treatment center, psychiatrically-oriented day school, etc.

5. Persons with sufficient financial resources available, and

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who are also not willing to wait for a clinic appointment, are encouraged to seek private treatment. The determination of fees is based on a "sliding scale" fee schedule.

The worker taking the intake call records the information in the Intake Book. Each referral that is not referred elsewhere, is presented in the Intake Committee meeting, with enough information to formulate a tentative diagnosis and prognosis. The Associate Director presides over these meetings and the members include the clinic social workers and a staff psychologist. The worker who took the call has the responsibility of conveying to his colleagues the tone of the client, his feelings about help, as well as the nature of the problem. The decision of the Intake Committee is then recorded in the Intake Book. If the referral is accepted, the worker who took the call will notify the parent or referring agency of the decision. If the parents of the child have not yet contacted the clinic (in the case of an agency referral) they will be encouraged to do so, since it is important that the parents show a genuine interest in getting help for the child.

At this point, the name is placed on the appropriate waiting list for assignment: application interview, reevaluation, or research study. The application interview is a joint interview, and the worker's initial contact with the two parents. The joint interview is an important step in the process of securing first-hand knowledge of the parents' attitudes toward
help, their complementary strengths and frailties in their interrelationships, what part each has in the child's problems, and what resources are present in the family with which to work. Following this initial appraisal of the total family unit, the diagnostic study is initiated, with the mother ordinarily seen by a social worker while the child is seen by a psychiatrist in three interviews. The father is then seen at least once by a social worker or psychiatrist. The purpose of the diagnostic study is to formulate a diagnosis of the parents and the child and to assess the family members' motivations and abilities to involve themselves in the helping process.

To cope with the increasing number of disturbed families that were referred to the Thom Clinic in the early 1950's, the psychiatric family study was devised. In this, an attempt is made to appraise the personality of each parent and the disturbed child, with particular emphasis upon their dynamic interrelationships. The psychiatrist sees both parents together (and at times, in separate interviews), and spends a few sessions with the child alone. The aim of this study is to re-establish a balance in the family unit and to facilitate optimum functioning for all the members. While the family study is applied principally to the more disturbed families referred


13 Ibid.
to the clinic, this focus on the dynamics and equilibrium of the family unit is at the core of the diagnostic thinking at the Thom.

It was found that all children in emotional trouble do not profit from psychiatric treatment, that treatment for one or two members of a family may so change the family psychic equilibrium that the child's improvement cannot long be maintained in the face of increasing stress for other family members.\footnote{Ibid., p. 15.}

Consultation is another form of treatment at the clinic. Intensive treatment cases have been followed by consultations at regular monthly or bimonthly intervals when it was felt that a child and parent have reached a plateau level of progress, and yet require continued guidance, observation, and support to stabilize the progress they have made. This may also serve to prepare a family for later intensive treatment, or for referral to another agency for a different kind of help. The consultations discussed in this study are requested by clients who have already terminated. They again seek help in a stressful period; in the face of difficulties with the child and/or in the family situation.

A reevaluation is made when a client reapplyes to the clinic. The clinic feels a responsibility and obligation to these families, who seek help where they have been helped before. On the basis of information gained from the intake call, together with the reapplication, the clinic may decide to see
the family on a consultation basis for supportive help, or in a reapplication interview to explore the need for further help. In the latter instance, the worker assesses the situation in light of the way things were at termination, whether they were able to follow through on clinic recommendations, and the nature of the present situation and problem.

A fuller understanding of the reapplicant is of interest to the clinic, since it is often confronted with the need to evaluate whether to resume treatment. Although the situation is usually reevaluated, the reapplicant is given priority in treatment and consultation. It would appear that the Intake Committee has a monumental task in deciding whether a reapplicant can use and benefit from further help. This decision may be simplified by a study which would indicate how these clients related to treatment in their previous contacts, and whether they benefited from further treatment.

Selection of the Sample

This study is based on records of those parents who reapplied for treatment for the same child during the years 1954 through 1957. The cases were selected from the Intake Book, which notes those cases which are reapplications. Having obtained the names of clients who reapplied during this period, the investigator examined the case records to determine whether they were in treatment during their first contact with the clinic. Treatment was defined as at least three interviews
with a worker or therapist following the diagnostic study. The cases which were referred to another agency for further help for the parent or the child, following their first contact at the Thorn, were eliminated. It was felt that these cases may not have been ready for treatment when they first applied. Furthermore, at reapplicantion, another treatment experience would have to be taken into consideration, the information of which is not available. Since this study is focused on the parent's attitudes and experiences in treatment, another criteria was that the same parent had been seen in both contacts. Only those cases having had at least one reapplication interview when they reapplied were considered. Thirteen cases met the above criteria. Two of the families were in treatment at the time of this study.

Processing of Data

In this study, the following aspects of the treatment situation will be considered: length of time in first treatment contact; status at termination; source of decision to terminate; attitudes toward treatment at termination; basis of clinic's decision to resume treatment; attitude toward the child in first and second contacts; involvement in treatment in first contact and in reapplication contact.

This study will focus on the treatment experiences and attitudes of the mothers. In all except one case (in which both parents were treated together), the mother was the only
parent involved in treatment.

Six of the thirteen mothers reapplied more than one time. In these cases, the "reapplication contact" refers to the most extensive period in treatment after reapplication. In the cases in which a reapplication was made shortly after the first termination, this refers to the final treatment period.

The sample was divided into three groups in regard to the status at termination: Improved; Further help indicated; Little improvement. Judgments about the status at termination were made on the basis of changes in the parents' attitudes and handling of the child, the family's relative adjustment to the problem, and their need for help.

The status "improved" is defined as those situations in which the presenting problem or symptom has been somewhat alleviated, there had been some modification of attitudes and handling of the child, and at termination the family had made an adequate adjustment so that they could carry on without further clinic help.

By "further help indicated" is meant that the parent has begun to think about her role in the problem and some of her attitudes, as well as better ways of handling the child, but can use further help to solidify these changes.

"Little improvement" is defined as some changes in the parent's handling of the child, with little modification of parental attitudes or deeper understanding of the problem.
Information about parental attitudes were processed by means of the following scales:

1. **Attitudes toward the Child**

   The parents' predominant attitudes toward the child were classified into six categories: Rejection; Some rejection; Ambivalence; Overprotection; Some overprotection; Acceptance. Rejection is defined as either conscious or unconscious dislike of the child, and is either shown by verbalized attitude or behavior toward the child. Ambivalence is an unresolved attitude toward the child, seen by the expression of affection on one occasion, and hostile expressions on another. Overprotection is defined as an attitude of indulgence toward the child, in which the child is highly protected from the ordinary hazards of life. Acceptance is defined as a positive and sincere warm feeling, expressed in affection, love, and concern for the child. When rejection or overprotection is accompanied by some acceptance, the attitude of the parent was rated as: Some rejection, or Some overprotection.

2. **Attitude toward Help**

   Attitudes toward help were rated in terms of how much responsibility the parent was willing to assume in the helping process. Judgments regarding these attitudes were made on the basis of the parent's statements on the source of the problem, and where they placed major responsibility for change. These attitudes were rated on a five-point scale: Projection; Some.
projection; Sharing of responsibility; Some introjection; Introjection.

Projection is defined as the parent's feeling that complete responsibility for helping to solve the problem situation should be taken by some other source, such as the clinic, the school, or the spouse. Parents who placed the responsibility on other sources, but recognized their need for help in handling the child had attitudes rated as some projection. Sharing of responsibility is defined as parent and clinic sharing equally in helping the child. Introjection is the attitude in which the parent accepted the entire responsibility for the child's problem and helping him. This is often expressed in such terms as: "What can the clinic do? . . . I have always spoiled him!" Parents who felt that they, themselves, should take most of the responsibility for solving the situation had attitudes rated as some introjection.

3. Involvement in Treatment

Involvement in treatment refers to the degree to which the parent entered into the casework relationship with the goal of modifying her attitudes and behavior in her relationship with the child. The degree of involvement was rated on a five-point scale: Positive; Positive-Ambivalent; Ambivalent; Resistant-Ambivalent; Resistant.

Positive involvement refers to the parent's ability to gain intellectual and emotional understanding of the problem,
to use clinic recommendations and suggestions, and to conform to clinic routine, such as keeping regular and punctual appointments. The parent who is ambivalent in treatment is one who gains some intellectual understanding of the problem with little emotional involvement, has a supportive relationship with the worker, but is unable to conform to clinic routine or to carry through on clinic recommendations. The parent who frequently comes late or cancels appointments, who consistently resists any emotional involvement of herself in understanding the problem, and who has a poor relationship with the worker, is considered resistant. Positive-ambivalence and resistant-ambivalence refers to a combination of predominantly positive or resistant elements with ambivalence to treatment.
CHAPTER IV

ANALYSIS OF DATA

A. CHARACTERISTICS OF THE REAPPLICANTS

Description of the Cases

The group consists of thirteen families with an emotionally disturbed child. These children are ten boys and three girls, ranging in age from five to eleven at the time of the first application, and from eight to sixteen in subsequent contacts. The cases studied include five parents who reapplied one time, six who reapplied twice, and two who made a third reapplication.

At the time of the first application, most of the children were between the ages of five and six. This is consistent with the Intake Policy. Thom has set a lower age limit at five years, and an examination of the Clinic population in these years showed a predominance of children in the five to six age range. At the time of the second application, most of the children were between the ages of eleven and twelve, a period when many pre-puberty problems arise.

Eight of the children are first-born, three are second-born, and two are the only child. Over half of the group is Jewish, five are Catholic, and one is Protestant. One child in the group is adopted.

TABLE 1
AGES OF THE CHILDREN AT EACH APPLICATION

<table>
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<th>Age</th>
<th>First</th>
<th>Second</th>
<th>Third</th>
<th>Fourth</th>
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<tr>
<td>5-6</td>
<td>9</td>
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<td>7-8</td>
<td>2</td>
<td>4</td>
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<td>9-10</td>
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<td>11-12</td>
<td>1</td>
<td>5</td>
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<tr>
<td>Above 13</td>
<td>-</td>
<td>1</td>
<td>3</td>
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The parents are a low-middle class group. Most of the fathers have a high school education, and a job of a white-collar variety. This is characteristic of the clinic's case-load. In 1953, the socio-economic background of the families at the Thom Clinic was predominantly lower-middle class. The fee schedule shows that this is a good sample of the clinic population economically. Most of the parents in the Clinic were paying between 25¢ and $1 prior to 1952 (when the fee schedule was revised to higher levels), and $1 to $2 after 1952. The parents in this group who were paying more than $1 applied after the revised fee schedule.

In terms of the religious composition of the group, this

2Ibid.
3Douglas A. Thom Clinic, Study of Fees (1953).
is fairly representative of the total Clinic population, too. In 1953, 43% of the clinic population were Jewish, 30% Protestant, and 21% Catholic. 4

### TABLE 2
**DESCRIPTIVE DATA OF THE PARENTS**

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<tr>
<td>Protestant</td>
</tr>
<tr>
<td>Catholic</td>
</tr>
<tr>
<td>Jewish</td>
</tr>
<tr>
<td>Mixed Marriage</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fathers’ Occupations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Workman</td>
</tr>
<tr>
<td>Salesman, Storekeeper</td>
</tr>
<tr>
<td>White Collar</td>
</tr>
<tr>
<td>(Executive, Advertising)</td>
</tr>
<tr>
<td>Professional</td>
</tr>
<tr>
<td>(Engineer)</td>
</tr>
<tr>
<td>Unknown</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Fee (1949-1954)</th>
</tr>
</thead>
<tbody>
<tr>
<td>50¢</td>
</tr>
<tr>
<td>$1, less than $2</td>
</tr>
<tr>
<td>$2, less than $3</td>
</tr>
<tr>
<td>$3 and above</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Marital Status</th>
</tr>
</thead>
<tbody>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Divorced</td>
</tr>
</tbody>
</table>

Seven of the thirteen parents were familiar with casework. 4

---

or psychiatric help prior to the initial contact. Of this seven, three had psychotherapy for themselves previously, two had been involved in group therapy, and two had a previous contact at the Children's Center for the child who was now being seen at Thom.

Thus, this group shows the same diversity of characteristics, and the same socio-economic background as is found in the Clinic population. This implies that these reapplicants represent a cross-section of the Clinic caseload.

**Presenting Problems**

The presenting problems are those about which the parent is most concerned and for which he seeks help at the time of referral. There may be present many other problems about which the parent may have little concern or awareness. The problem may be presented as a neurotic symptom: fear of the dark, of animals, of being left alone; or as rituals of tapping, folding, etc.; or poor eating habits; enuresis, etc. The problem may be centered about relationships in the home and with peers, such as aggressive, defiant, or negativistic behavior; or it may be manifested in the school situation, taking the form of a learning problem, inability to concentrate, or disruptive behavior. In late latency, aggressive behavior may be manifested in delinquent acts, such as stealing, fire-setting, sexual promiscuity. Passive behavior may be manifested in a severe learning problem.
The presenting problems were classified into the following categories used in the Thorn Clinic Annual Report, 1953, in order to compare them with those of the Clinic caseload: Behavior, aggressive; Behavior, passive; Learning difficulty; Delinquent acts (fire-setting, stealing, etc.); Neurotic symptoms (tics, fears, nightmares, etc.). In some cases, more than one category was used since the presenting problem could exist in more than one area.

TABLE 3

COMPARISON OF PRESENTING PROBLEMS OF REAPPLICANTS AT REFERRAL AND REAPPLICATION WITH PRESENTING PROBLEMS OF CLINIC CASELOAD

<table>
<thead>
<tr>
<th>Presenting Problem</th>
<th>Reapplicants</th>
<th>Clinic Caseload</th>
<th>Per Cent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Referral</td>
<td>Reapplication</td>
<td></td>
</tr>
<tr>
<td>Behavior, aggressive</td>
<td>4</td>
<td>3</td>
<td>42</td>
</tr>
<tr>
<td>Behavior, passive</td>
<td>1</td>
<td>2</td>
<td>16</td>
</tr>
<tr>
<td>Learning difficulty</td>
<td>4</td>
<td>6</td>
<td>48</td>
</tr>
<tr>
<td>Delinquent acts</td>
<td>1</td>
<td>3</td>
<td>22</td>
</tr>
<tr>
<td>Neurotic symptoms</td>
<td>7</td>
<td>4</td>
<td>79</td>
</tr>
</tbody>
</table>

It is apparent from Table 3 that the problems presented by this sample are a cross-section of those problems seen in the Clinic caseload. It is also evident that there is no referral problem particular to these cases. It is noteworthy

5Ibid., p. 8.
that there was little change from the first application to the second or third application in the way the problem was presented (see Appendix), and many parents merely stated that the situation was "the same" at the time of reapplication. The noticeable change from the first to the second application is the increase in delinquency and learning difficulties, with a decline in neurotic symptoms. This, however, may be a reflection of the increased age of the group.

While there is no unique pattern to the presenting problems, many of the cases present the same problems in subsequent contacts. This raises two possibilities: (1) the parents' attitudes or handling of the child changed as a result of their first treatment contact, producing changes in the child's problem, only to be later exacerbated when a new crisis or problem arose; or (2) the parents' attitudes did not change sufficiently to maintain the changes which may have occurred in treatment. The latter aspect will be explored in the following section.

Source of Referrals

In attempting to understand what precipitated their re-applications to the Clinic, one wonders whether these parents applied because of pressures from external sources (i.e. the school, neighbors, pediatrician, etc.), or because of their own discomfort with the problematic behavior.

In examining the sources of referral, it appears that most
of the mothers recognized a problem, and contacted the clinic independently. (See Table 4.) A number of the mothers reported that they had learned of the Clinic from a neighbor or relative, or had called a hospital seeking help for their child, and the Thom Clinic had been suggested as the appropriate agency. While seven of the mothers were self-referred, three of the mothers were referred by the schools, and three by other agencies, two of the latter being referred from the Children's Center where the upper age limit is five years.

**TABLE 4**

**SOURCE OF REFERRAL AT EACH APPLICATION**

<table>
<thead>
<tr>
<th>Referring Source</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>I</td>
</tr>
<tr>
<td>Mother</td>
<td>7</td>
</tr>
<tr>
<td>School</td>
<td>3</td>
</tr>
<tr>
<td>Agency or hospital</td>
<td>3</td>
</tr>
<tr>
<td>Doctor or minister</td>
<td>-</td>
</tr>
</tbody>
</table>

Although one would expect a greater number of self-referrals at the time of reapplication, since these parents were familiar with the Clinic, it is interesting that again six parents were referred by other sources. This raises the question of whether these parents were sufficiently motivated to seek help independently at the time of reapplication. To
determine whether there is any relationship between the source of referral and the attitude toward treatment, the involvement in treatment of those who were self-referred was compared with those who were referred by other sources.

**TABLE 5**

COMPARISON OF INVOLVEMENT IN TREATMENT OF PARENTS WHO WERE SELF-REFERRED WITH PARENTS NON-SELF-REFERRED AT INITIAL APPLICATION AND REAPPLICATION

<table>
<thead>
<tr>
<th>Involvement in Treatment</th>
<th>Initial Application</th>
<th>Reapplication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Self-Referred</td>
<td>Non-Self-Referred</td>
</tr>
<tr>
<td>Positive</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Resistant</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Totals</td>
<td>7</td>
<td>6</td>
</tr>
</tbody>
</table>

At the time of the initial application the attitudes of those who were self-referred and those referred by other sources were quite similar. However, at the time of reapplication, there was a more positive involvement among those parents who were self-referred. The non-self-referred group tended to be more ambivalent about treatment. Because of the small size of the sample, one hesitates to make any generalizations. There is the suggestion here of a difference in attitude toward treatment between the self-referred and those
who reapplied as a result of pressure from external sources.

Length of Time in Treatment

That certain clients reapply suggests the possibility that they have terminated prematurely and hence, need further treatment. This raises the question of whether the length of time these parents spent in treatment was considerably shorter than the treatment periods of other clients at the Clinic. Whether this may be a factor characteristic of reapplicants was explored. The reapplicant's initial treatment period was compared with the treatment periods of the caseload at the Clinic. During those years, the trend at the Clinic was toward more extended periods of treatment.

### TABLE 6

NUMBER OF MONTHS IN TREATMENT OF REAPPLICANTS DURING FIRST CONTACT AS COMPARED WITH CLINIC CASELOAD

<table>
<thead>
<tr>
<th>Time in Treatment</th>
<th>Clinic Caseload</th>
<th>First Contact of Reapplicants (1949-1954)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 6 mos.</td>
<td>14</td>
<td>5</td>
</tr>
<tr>
<td>6 - 11 mos.</td>
<td>27</td>
<td>17</td>
</tr>
<tr>
<td>12 - 17 mos.</td>
<td>11</td>
<td>21</td>
</tr>
<tr>
<td>18 - 24 mos.</td>
<td>3</td>
<td>7</td>
</tr>
<tr>
<td>Over 24 mos.</td>
<td>-</td>
<td>5</td>
</tr>
</tbody>
</table>

---

Most of the reapplicants were in treatment for less than a one-year period, while it is evident from Table 6 that the average time in treatment at the Clinic was from one to one-and-one-half years. Among the group of reapplicants, only one case was seen for more than sixteen months. This would suggest the possibility of premature termination in some cases. This then raises questions about the nature of termination after the relatively shorter time in treatment.

Termination of Treatment

Of importance in the way people are able to use help and the degree of their resistance to future help is the nature of their termination of the previous contact: by whom it was initiated and the status at the time. In attempting to evaluate whether treatment should be resumed with a client who already had a treatment contact with the clinic, there is concern about whether the client had terminated prematurely, i.e. against the clinic’s recommendations, or whether the clinic had terminated treatment on the basis of sufficient improvement.

The issue of termination is a complex one, raising questions of whether the client is able or willing to make further changes, whether the difficulties in adjusting to a new worker will be offset by sufficient additional gains, whether the child or parent can benefit from further treatment, and so on. All of these factors were taken into consideration in termi-
nation of the cases under consideration.

In attempting to understand what factors existed at termination of the initial contact, of interest is the status of these cases at termination, the source of the decision to terminate, and how this reflects their past contact and subsequent disposition. Thus, the attitudes toward treatment at termination of the initial contact and the disposition at reaplication were examined in terms of the status at termination. It should be noted that the status of the case at termination is not always made explicit in the record. Consequently the investigator attempted to define it in its operational use.

The cases were classified into the following categories: Improved; Further help indicated; Little improvement. There was no case in which "no improvement" was shown.

TABLE 7
STATUS AND SOURCE OF DECISION AT TERMINATION OF FIRST CONTACT

<table>
<thead>
<tr>
<th>Status</th>
<th>Source of Decision</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved................6 Clinic..................8</td>
<td></td>
</tr>
<tr>
<td>Further help indicated..3 Clinic and parent.....2</td>
<td></td>
</tr>
<tr>
<td>Little improvement.......4 Parent....................3</td>
<td></td>
</tr>
</tbody>
</table>

It is evident from Table 7 that in most of the cases the mother and child had "improved" at the time of termination, and in these cases, this improvement was the basis of the
decision to terminate. Factors contributing to termination of the other cases included the parents decision to withdraw from treatment (three cases), the child's having "improved" and the parent feeling confident to continue without further clinic help, and the necessity of transferring to a new worker or therapist which precipitated termination in two cases.

In examining attitudes toward treatment at the time of termination, it is noteworthy that among the eleven parents who were "ambivalent" or "positive," five continued to telephone the worker for some time thereafter, requesting further advice or support, and two other parents expressed their desire to continue treatment although the child had terminated. This suggests at least two possibilities: that these parents were thus expressing their need for further help although the clinic had decided to terminate; or that these parents, although somewhat ambivalent about treatment throughout, had become quite dependent on the worker for support, and had not adequately worked through their feelings about termination.

In examining the relationship between attitudes toward treatment at termination and status at termination, it appears that the attitudes may have contributed to the degree of improvement shown in treatment. It is evident from Table 8 that in those cases which were not classified as "improved" there is a predominance of "ambivalent" attitudes. This raises the possibility that the "ambivalent" attitude toward treatment
TABLE 8
RELATIONSHIP OF ATTITUDE TOWARD HELP TO STATUS AT TERMINATION

<table>
<thead>
<tr>
<th>Status at Termination</th>
<th>Attitude toward Help</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Positive</td>
</tr>
<tr>
<td>Improved</td>
<td>6</td>
</tr>
<tr>
<td>Further help indicated</td>
<td>-</td>
</tr>
<tr>
<td>Little improvement</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>7</td>
</tr>
</tbody>
</table>

may have precipitated the termination in those cases not designated as "improved." This is illustrated in the case of Samuel Yaffe. 7

Samuel was brought to the clinic at the age of five as a transfer from the Children's Center where he had been in treatment for a year. The presenting problems were intense sibling rivalry, fearfulness, enuresis, and numerous physical ailments, including asthma. Samuel was adopted after Mrs. Yaffe had four miscarriages, but mother later gave birth to another child. This mother was oversolicitous of Samuel, and feeling ambivalent toward him, was unable to discuss the issue of adoption with him.

In the eleven-month period treatment, Mrs. Yaffe was highly ambivalent about treatment; cancelled half of her appointments, and focussed on the boy's problem in a reporting fashion. She was helped to discuss the issue of adoption with the boy. When the issue of termination arose, she stated that she "was not eager to return but reluctant to leave." When she was to return in the fall, she called to say she could con-

7The names used in this thesis are fictitious.
tinue on her own, and that the situation had improved.

Usually, the clinic makes the decision regarding termination, based on an understanding of the needs of the family and its ability to benefit from further treatment. It is hoped that the parent will share in this decision. In the case records, however, it is not always made explicit whether the decision to terminate was shared with the client.

Termination may be handled in a variety of ways, depending on the parent with whom one is dealing. Some parents will passively accept the clinic's decision with the same ambivalence that they have shown in treatment. Other parents may be able to actively share in the decision, recognizing both the changes that have occurred and their increased ability to continue independently. Others, fearing the worker's rejection, may precipitate termination by withdrawing from treatment prematurely.

Eight of the cases were terminated by the clinic, and two others by mutual consent. (See Table 7.) Of the three cases which terminated against the clinic's recommendations, two had shown the "need for further treatment," and one had shown "little improvement." In the latter case, the mother withdrew her next application, thereby again expressing marked resistance to treatment. The two other cases were later accepted for further treatment. It appears from this that only one case in the group had expressed resistance to treatment by with-
drawing from treatment. On the other hand, it is interesting that in eight of the cases, there is no indication of the parents having shared in the decision to terminate. This may reflect their passive and ambivalent way of relating to treatment, which in turn, may have contributed to their reapplying for further help at a future time.

Since the cases are evaluated at the time of reapplication, partly on the basis of their status at termination, one may wonder whether the status was related to subsequent disposition.

TABLE 9

STATUS AT TERMINATION IN RELATION TO DISPOSITION AT REAPPLICATION

<table>
<thead>
<tr>
<th>Status at Termination</th>
<th>Disposition at Reapplication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Acceptance</td>
</tr>
<tr>
<td>Improved</td>
<td>1</td>
</tr>
<tr>
<td>Further help indicated</td>
<td>7</td>
</tr>
<tr>
<td>Little improvement</td>
<td>1</td>
</tr>
<tr>
<td>Totals</td>
<td>9</td>
</tr>
</tbody>
</table>

It should be noted that since some families made more than one reapplication, there was more than one disposition in some cases. The findings indicate that the status at termination is related to future disposition. Of the six cases that
had "improved" during their first contact, four were referred for treatment elsewhere. In these, the attitudes had changed during their first contact, but at reapplication, it was found that the child was sufficiently disturbed to warrant more intensive treatment. In one case the family situation was so disturbed that Family Service help was recommended. Only one of these cases was accepted for further treatment, after having been seen in consultation.

The four cases which had shown "little improvement" continued to be markedly ambivalent about treatment when they reapplied. This is reflected in the fact that two of these applications were withdrawn. One of these cases was seen on a consultation basis and later accepted for treatment. This family had to modify their attitudes and handling of the child before they were ready to resume treatment on a more realistic basis.

In the four cases in which "further help" was indicated, three were accepted for further treatment when they reapplied, and another was seen on a consultation basis and resumed treatment at the next application. Since these cases were again evaluated at the time of reapplication, this would tend to confirm the Clinic's original evaluation, namely that these families could use help at a future time when their motivation had increased. These were the families, too, that were highly ambivalent in their first contacts, but made considerable
progress in subsequent contacts.

Outcome of Reapplication

The thirteen families made twenty-one applications, nine applications of which resulted in resumption of treatment. (See Table 9.) Six families were subsequently accepted for further treatment at the Clinic, while the remaining seven were either referred to a more appropriate resource or withdrew the application. The bases for the resumption of treatment of the accepted cases were examined. To determine whether there are any differences between the accepted and non-accepted cases, the attitudes of these two groups were compared. The next question that arises is whether the families which were accepted for further treatment really benefited from the renewed contact. This will be discussed in the following section.

It is evident in Table 9 that of the seven cases which were not accepted for further treatment, three withdrew their applications, and four were referred to other resources, namely, residential treatment centers, Family Service, and private psychotherapy. Thus, those who were not accepted for further treatment can be divided into two groups: those who withdrew their applications, thereby reflecting their ambivalence about help; those who were referred elsewhere, indicating their wish for further help.

Among the non-accepted cases who withdrew their applications, the following statements were made by them about their
feelings toward help:

"Edna will outgrow the problem... I only came because I mentioned at the hospital that she was still enuretic and had been treated here before." Mrs. Shorr felt that no one had given her the answers in her previous contact at the Clinic, nor had they cured her daughter, and she could not see how the Clinic could help now.

Mrs. Williams reapplied when her child was again daydreaming and not concentrating in school. She spent the whole reapplication interview in talking about her marital problems, and concerns about her husband's impending return from overseas where he had been for one year. In regard to her feelings about treatment, she said she had had enough treatment, and "couldn't my son come in alone." She had made many gains but was "afraid of slipping back and becoming less of an individual." She called the following week to say she had decided to get a tutor for the boy.

In both of these cases, it is apparent that the mothers were not willing to become involved in further treatment, and were able to arrive at the decision to withdraw their applications independently. In the latter case, this mother had made considerable progress in her first contact, gaining much understanding and insight into herself and the boy. Having become very dependent on the worker, she was reluctant to terminate in her previous contact. She reapplied when an impending crisis situation arose but was reluctant to again become involved in treatment. She was "afraid of losing the independence and ability to make decisions as a result of being on my own this past year."

Of the cases that were referred, the Clinic felt that three of the children needed more than one hour of therapy a week, and it was on this basis that they were referred else-
where. All of these cases had "improved" during the first contact. In the fourth case marital difficulty was the central complaint, and consequently, this mother was referred to Family Service. All of the referred families were able to follow through on the Clinic's recommendations, after some preparatory interviews at the Clinic.

Among the cases that were accepted for further treatment, the following reasons were given:

1. The child needs further help.

Steven Farmer was brought to the Clinic at the age of five and one-half because of fearfulness, aggressive behavior, and enuresis. During the twenty-six months of treatment in the first contact, mother was highly ambivalent about treatment, imparting little information, and asking for advice, which when given, she was unable to implement. At the end of this extensive contact, the child had improved, but mother remained ambivalent about treatment. When Mrs. Farmer reapplied three years later, she continued to be concerned about the boy's masculinity and aggressive behavior. It became apparent that if this boy was to be helped, Mrs. Farmer would have to allow him to grow up and separate from her. The child clearly needed further treatment, and mother needed to recognize her involvement in the problem and to modify the nature of their relationship. It was on the basis of her becoming more involved, this time with a psychiatrist, that this family was accepted for further treatment.

2. The mother's motivation had increased; she had recognized her involvement in the problem, and wanted help for herself in relation to the child.

Mrs. Cobb reapplied a second time with her daughter Patricia, now age sixteen, who was manifesting delinquent behavior: stealing, sexual activities, school truancy, all of which was similar to but more intense than her previous problems. Mrs. Cobb had gained considerable understanding in her previous contacts, and
was able to modify some of her restrictive and protective behavior with her daughter. At this point, she was unable to cope with her defiant daughter although she seemed to understand the problem. She expressed a desire for help for herself and in her relationship with the child.

3. The parents had used help well in the previous contact.

Seymour Rabb was first brought to the clinic at the age of nine because of aggressive behavior and a violent temper, directed mainly toward his father. Both parents were seen for an eleven-month period, during which time they were helped to become more consistent in their handling of the boy. As mother's attitude toward her husband changed, Seymour's attitude toward his father improved. When they reapplied two years later because of poor peer relationships, the parents were again unable to come together in their handling of Seymour. Mother was overprotecting the boy, and father sadistically provoking him to act out. Since they had both related so positively to treatment before, and now expressed a willingness to begin to examine their feelings and experiences more intensively, they were accepted for further treatment.

4. The parents were able to follow through on both the Clinic's recommendations and their understanding gained from the previous contact.

When Mrs. Yaffe applied the fourth time, after having had one period in treatment for eleven months, and two consultation contacts, some changes were noted in her handling of the ten-year-old adopted child. Previously, the parents had difficulty in disciplining the child because of their ambivalence toward him. Now they were more consistent in their disciplining, and there was less splitting of the two children into the "bad son" and the "good daughter," but rather a recognition that both children were involved in their teasing behavior. Mrs. Yaffe was also more clear in her feelings about the adoption, recognizing that it was more their strong feelings on the matter which were affecting the boy, not the issue of adoption itself. The therapist felt that "they want to use help. I think mother can see her own involvement and is not completely projecting onto him."
This diversity of bases for reacceptance is consistent with the Clinic's policy of reevaluating each case in light of the individual situation.

In a comparison of the accepted cases and the non-accepted cases, one wonders whether there is any significant difference in the way these two groups were involved in treatment during the first contact. The involvement in treatment of the parents who were accepted for further treatment was examined to determine whether this had any relationship to the fact that they were reaccepted. The non-accepted cases were grouped into the referred cases and the withdrawal (of applications) cases, since these represent different attitudes and needs.

**TABLE 10**

INVolVEMENT IN TREATMENT DURING FIRST CONTACT OF CASES ACCEPTED FOR FURTHER TREATMENT AS COMPARED WITH NON-ACCEPTED CASES

<table>
<thead>
<tr>
<th>Involvement in Treatment</th>
<th>Accepted Cases</th>
<th>Non-Accepted Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Pos-Ambivalent</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Res-Ambivalent</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Resistant</td>
<td>-</td>
<td>1</td>
</tr>
</tbody>
</table>

It is apparent from Table 10 that there is a similarity in the attitudes of the referred parents and those of the
accepted parents, both groups showing "positive" and "ambivalent" attitudes toward treatment. Moreover, the withdrawal cases appear to be the only ones which were "resistant" to treatment. The investigator examined the parents' attitudes toward the child to determine whether the act of withdrawing an application or accepting a referral to another agency for a different kind of help reflected any difference in these attitudes. One wonders, too, whether the parent's attitude toward her child preclude her ability to accept further help, help that involves so much investment of her own feelings.

TABLE 11

COMPARISON OF ATTITUDES TOWARD THE CHILD AT THE TIME OF REAPPLICATION OF ACCEPTED CASES WITH NON-ACCEPTED CASES

<table>
<thead>
<tr>
<th>Attitude toward the Child</th>
<th>Accepted Cases</th>
<th>Non-Accepted Cases</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Referred</td>
<td>Withdrawals</td>
</tr>
<tr>
<td>Acceptance</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Some overprotection</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Ambivalence</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>Some rejection</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>

From Table 11 it is evident that there is a similarity in attitudes toward the child of the referred cases and the accepted cases. However there is a difference (seen also in the attitudes toward treatment), between the referred cases and the withdrawal cases. It is interesting that the referred
cases are more accepting of the child than those cases which were accepted for further treatment at the clinic. This may reflect the fact that most of the referred cases were terminated as "improved", while the accepted cases had indicated the "need for further help". The two cases which evidenced "rejecting" attitudes withdrew their applications. In only one case was there a withdrawal of application although the parent was "accepting" of the child, and in this case, a crisis situation had precipitated the application. This strongly suggests that the parent's attitude toward the child affects her ability to seek further help. Thus, in the cases that were referred, the child needed further help while the parents' attitudes may have changed previously. In the cases that were accepted for further treatment at Thorn, the parents needed further help in their relationship with the child.

B. PARENTAL ATTITUDES

Attitudes toward the Child

Basic to the understanding of parent-child interactions is the recognition that the parental capacity to meet a child's needs may vary greatly in his different phases of growth. Inadequate parental responses to the child at any level may vary from over-indulgence and the excessive permissiveness of prolonged earlier satisfactions to the overly ambitious and premature stimulation of more grown-up behavior in anticipation of a later stage of development. For normal growth the child needs to exact the appropriate satisfactions to be derived from each stage of development in order to proceed to the next. At the same time the mature gratification of the parents in helping the child at each step serves as a foundation for a continuing
mutually beneficial relationship.\textsuperscript{8}

Out of this concept in the child guidance movement, there developed the therapeutic philosophy of the modification of both the environment and the child in ways most favorable for the child's psychological growth.\textsuperscript{9} One of the questions raised in this study is whether the parent was better able to use help when she reapplied. One of the indications of a more effective use of help is whether the mother was able to develop a more "mutually beneficial relationship" with the child, and to modify her attitudes in ways which fostered the child's normal development. It is also of interest to know whether there is any predominant parental attitude toward the child seen in these cases, which may reflect the need for further help at a later stage of development.

The attitudes toward the child were rated on a six-point scale: Acceptance; Some overprotection; Overprotection; Ambivalence; Some rejection; Rejection. While the "first contact" refers to the parent's first actual contact with the clinic, the "reaplication contact" refers to the next major contact: the second contact if that was the only reapplication; or the final contact of treatment with the clinic, in


\textsuperscript{9}Group for the Advancement of Psychiatry, \textit{Basic Concepts in Child Psychiatry}, Report 12, April, 1950.
the case of more than one reapplication. Since in many cases
the second contact represented an extension of the first, oc-
curring shortly after the first termination, it was felt that
the final contact would indicate the most change in the par-
ett's attitude. In some cases, the reapplication contact con-
sisted of only a few interviews. There were noticeable changes
in attitude during this time, particularly, when the parents
were helped to clarify some of their feelings.

TABLE 12
COMPARISON OF MATERNAL ATTITUDES TOWARD THE CHILD AT
THE FIRST CONTACT, REAPPLICATION, AND
TERMINATION OF CONTACT WITH CLINIC

<table>
<thead>
<tr>
<th>First Contact</th>
<th>Reapplication</th>
<th>Termination</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Ac</td>
<td>So</td>
</tr>
<tr>
<td>Acceptance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Some Overprotection</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Overprotection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambivalence</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Some Rejection</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rejection</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Totals              | 4  | 4  | 1  | 3  | 2  | 0  | 8  | 1  | 0  | 1  | 1  | 0  | 2  |

*Unknown - currently in treatment.

Table 12 reflects marked changes in attitudes from the
time of the first contact to termination with the clinic.
Initially the attitudes were characterized by a predominance
of "overprotective" attitudes, five parents being "overprotective" and two showing "some overprotection." There were no "accepting" or "rejecting" parents at that time.

From the first to the reapplication contact, five parents showed no change in attitudes. Eight parents showed changes toward greater "acceptance" of the child. Thus, in most of the cases, some positive change occurred from the time of the first contact to reapplication.

At termination of final contact with the clinic, all of the parents, save one, had changed their attitude toward more "acceptance" of the child. The parents showed the most dramatic changes in attitudes from the time of reapplication to termination of contact, with eight parents now being "accepting" of the child. The only parent showing no change in attitude was one who withdrew her application when the clinic "would not cure her child of enuresis." In comparing the changes that occurred, the diversity of attitudes shown at reapplication is replaced by a predominance of the "accepting" attitude at termination.

In six of the cases, the major change in attitude occurred during the first contact, since for these parents, the first contact was the most extensive. These cases include the ones which were referred for more intensive help when they reapplied. However, in those cases which were accepted for further treatment at the clinic, the major changes occurred in the
subsequent contact, being reflected in a more "accepting" attitude toward the child at termination. Thus, those cases in which the parent's attitude had not changed in the initial contact, and which were accepted for further treatment at reaplication, did show positive change in the reaplication contact.

**Attitude toward Help at Initial Application and at Reaplication**

An indication of the patient's ability to use help is reflected in the way she feels about help, and where she places the major responsibility for the helping process. One of the questions raised in this study is whether these parents are better able to use help when they reapply. As was indicated earlier, other investigators have observed that the parent's feeling about help, as expressed in the application or reaplication interviews, may provide some indication of her ability to involve herself in the treatment process.

The client often brings with her many feelings about the problem, the nature of treatment, and where the responsibility for help lies. She may project the responsibility onto the clinic, expecting the child's therapist to "treat" or "cure" the child, or may place responsibility onto the school, hoping that the clinic will bring pressure to bear on the school authorities. In light of this attitude, the parent may see her role at the clinic as a reporter of the child's activities, and in turn, expects the worker to tell her what is "wrong"
with the child and to give her advice on how to change the situation. At the other extreme is the attitude of introjection, in which the parent assumes all responsibility for the problem, feels "guilty," and then uses this self-blaming attitude as a defense against becoming involved in treatment. One would hope that through the course of treatment, the parent will begin to recognize that neither is she expected to relinquish her maternal role in the process of helping the child, nor is she totally responsible for the development of the problem. The reapplicants' feelings about help were examined to determine whether these changes occurred.

The attitudes toward help were classified on the basis of how much responsibility the parent was willing to assume for the helping process. These were categorized on a five-point scale, ranging from projection to introjection: Projection; Some Projection; Sharing (of responsibility with clinic); Some Introjection; Introjection.

It is apparent from Table 13 that the attitudes at the time of initial application were predominantly "projecting," and this existed to a lesser extent at the time of reapplication. The major source of responsibility for helping the child was placed on the clinic. In many cases, a combination of sources was mentioned, including the spouse, the school, grandparents, and even close living quarters. There were no parents who were aware of the "sharing" aspects of the treat-
ment process at the time of initial application. The parents who held the attitudes of "some projection" or "some introjection" recognized in part their involvement in the problem, and indicated a desire for help.

**TABLE 13**

COMPARISON OF ATTITUDES TOWARD HELP AT INITIAL APPLICATION AND REAPPLICATION

<table>
<thead>
<tr>
<th>Initial Application</th>
<th>Reapplication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Some Proj.</td>
</tr>
<tr>
<td>Projection</td>
<td>2</td>
</tr>
<tr>
<td>Some Proj.</td>
<td>-</td>
</tr>
<tr>
<td>Sharing</td>
<td>-</td>
</tr>
<tr>
<td>Introjection</td>
<td>-</td>
</tr>
<tr>
<td>Some Introj.</td>
<td>-</td>
</tr>
<tr>
<td>Totals</td>
<td>2</td>
</tr>
</tbody>
</table>

From the time of the first application to reapplication, nine of the thirteen parents changed their attitudes in a positive way. The investigator considered a change from "some projection" to "some introjection" as a positive one, in that the parent in the latter instance is willing to recognize her own involvement and responsibility, and is therefore more accessible to help. It is noteworthy, that from the first to the next application, the attitudes shifted from predominantly "projecting" ones to "sharing" of responsibility, while still
maintaining some of the former elements.

It is apparent from Table 13 that there was a positive change in the attitude toward help. One wonders if this is reflected in the parents' involvement in treatment, and whether these expressed attitudes truly reflect the parent's subsequent involvement in treatment.

**Involvement in Treatment**

It has been stated earlier that the parent who comes to a child guidance clinic with her child does so with considerable resistance. She wants help for her child who has a problem, but is reluctant to change her own behavior or attitudes. She may derive some unconscious gratifications from the child's problem or their relationship, or may be so overwhelmed with guilt that she is unable to discuss the problem. One of the major tasks of the worker in the early stages of treatment is to enable the parent to overcome some of this resistance, and to recognize that the child cannot be helped unless the parent is willing to change. In a study of reapplicants, one is concerned with whether these parents have overcome this resistance in their previous contacts, and at the time of reapplication, are more able to involve themselves in treatment. It is also of interest to know how resistant these parents were in their first contact, and whether they were better able to involve themselves in treatment in their subsequent contacts with the clinic. Involvement in treatment refers here to the degree to
which the parent entered into the casework relationship, with the aim of understanding herself in her relationship with the child.

The degree of involvement was rated on a five-point scale: Positive; Positive-Ambivalent; Ambivalent; Resistant-Ambivalent; Resistant.

The changes in involvement that occurred from the first to the reapplication contact are described in Table 14. In the first contact, most of the parents were "ambivalent" in their involvement. Of the three parents who were "positively" involved, one had had psychotherapy previously and another was initially "ambivalent" but became more "positive" in the second year of her contact.

**TABLE 14**

COMPARISON OF INVOLVEMENT IN TREATMENT IN THE FIRST AND REAPPLICATION CONTACTS

<table>
<thead>
<tr>
<th>Involvement in First Contact</th>
<th>Involvement in Reapplication Contact</th>
</tr>
</thead>
<tbody>
<tr>
<td>Positive</td>
<td>2</td>
</tr>
<tr>
<td>Pos-Ambivalent</td>
<td>-</td>
</tr>
<tr>
<td>Ambivalent</td>
<td>3</td>
</tr>
<tr>
<td>Res-Ambivalent</td>
<td>1</td>
</tr>
<tr>
<td>Resistant</td>
<td>-</td>
</tr>
<tr>
<td>Totals</td>
<td>6</td>
</tr>
</tbody>
</table>
In the reapplication contact, the degree of involvement tended more toward the poles of attitudes: i.e. "positive" or "resistant," with no parent showing clear "ambivalence." Furthermore, there is a marked increase in "positive" attitudes, with nine of the parents being "positively" involved. In the first contact, the parents had rather mixed feelings about treatment. At the time of reapplication, however, they had clearer feelings about treatment, the predominant attitude being "positive."

Only four parents maintained the same attitude in both contacts. This suggests that the first contact does not necessarily reflect the nature of involvement in subsequent contacts. Since the predominant attitude toward treatment in the first contact was "ambivalent," and the predominant attitude in the second contact was "positive," it would appear that much of the resistance (as reflected in the "ambivalent" attitude) was worked through in the first contact.

The next question that arises is whether there is a relationship between the attitudes toward help as expressed in the application interviews and the degree of involvement in treatment. Thus, the expressed attitudes toward help were examined in terms of the parent's involvement in treatment.

Table 15 suggests that the attitude toward help (as reflected in where responsibility for help is placed) does not necessarily reflect the parent's involvement in treatment.
TABLE 15
COMPARISON OF ATTITUDES TOWARD HELP AND INVOLVEMENT IN TREATMENT AT REAPPLICATION

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Projection</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Some Proj.</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>4</td>
</tr>
<tr>
<td>Sharing</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>6</td>
</tr>
<tr>
<td>Some Introj.</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Introjection</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>0</td>
</tr>
<tr>
<td>Totals</td>
<td>6</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>13</td>
</tr>
</tbody>
</table>

The parents who expressed a "sharing" attitude responded to treatment in very different ways, ranging from "positive" to "resistant." Similarly, the parents who were "positively" involved in treatment had expressed attitudes of "projection" as well as "sharing" of responsibility.

From these findings, it is evident that this group of reapplicants became more "positively" involved in treatment and expressed a more "sharing" attitude toward help at the reapplication contact. However, on an individual basis, the parent's attitude toward help was not necessarily reflected in the parent's actual involvement in treatment. In their initial involvement in treatment, there tended to be a predominance of "ambivalent" attitudes, and a predominance of "positive" attitudes in the reapplication contact. In the case of parents
who were referred to other resources at the time of reappli-
cation, a "positive" attitude was reflected in their ability
to follow through on the clinic's recommendations and to active-
ly participate in the preparatory planning contacts.

Changes in the Use of Help

In examining the nature of involvement in treatment at
each contact, three patterns emerge. The major pattern is
evident in eight of the cases. These mothers were rather am-
bivalent about treatment at first, and unable to involve them-
selves emotionally in the first contact. Their relationship
with the worker was characterized by their expectations of
concrete advice in handling situations, and their positive re-
sponse to the worker's support. They saw help as support in
coping with a difficult situation, and were able to gain both
understanding of the problem and ways of handling it. After
termination, many of these parents continued to telephone the
worker as various crises arose, and in this way, maintained
the supportive relationship. Some of them reapplied and were
seen on a consultation basis. When they again reapplied for
further treatment, the clinic confronted them with the re-
sistant side of their ambivalence, and recognized with them
the need for their becoming more deeply involved in a change
of attitude. When treatment was resumed, they were more able
to involve themselves, gaining deeper understanding, and in
some cases, insight into themselves and their relationship with
the child. Many of these parents, with a deeper emotional investment, used this second treatment experience to solidify the understanding gained previously. Three of these parents sought further help for themselves when the case was terminated.

The case of Steven Farmer illustrates this pattern:

Steven was brought to the clinic by his mother at the age of five and one-half, with the presenting problem of fearfulness, overactivity, enuresis, and frequent erections. Mrs. Farmer was an anxious woman who was closely identified with Steven. She could not discipline him nor treat him as a little boy, most often reverting to oversolicitous behavior. She was preoccupied with his sexuality and had him cicoscoped four times. Although she felt that the problem was "all her fault," she was unable to gain any understanding of the problem and her relationship with Steven in order to change her handling of him during her first contact. Father was seen as an anxious hypochondriacal person. In addition, he had had 13 rectal operations for an injury incurred while in the service.

Mrs. Farmer was seen by a case worker over a period of twenty-six months, during which time she was a difficult person with whom to work. Characteristic of her attitude was hostility and belligerency. She gave little of herself and with infantile passivity, expected to be given direct advice and information. At termination, she indicated that she would like to continue after Steven had terminated, and it was apparent that she had become rather dependent on the supportive relationship with the worker.

From June, 1954, until Mrs. Farmer reapplied in December, 1955, she called the Clinic several times because of persistent difficulties with Steven. At the time of reapplication, Steven presented the picture of the aggressive child, being overtly aggressive and belligerent with his parents and friends, hyperactive, having learning problems, etc. Mrs. Farmer had begun to set limits but was unable to carry them through with any consistency. Mr. Farmer continued to be involved in his own problems and was again seen as untreatable. Mother still projected the responsibility for the problem onto the school, and expected the clinic to work its "magical cure" on Steven as it had before.
Treatment with mother was resumed with a male psychiatrist. It was felt that Steven could not be helped unless his mother changed her attitudes and the nature of her relationship with the boy. During the reevaluation it was established that Steven represented Mrs. Farmer's father who died nine months before Steven's birth. Mother had had a very close relationship with her father, her mother having died when she (Mrs. Farmer) was quite young. Mother had to keep Steven a castrated male; totally dependent upon her, so she would never lose him, as she had her father.

Mother was in treatment for a nine-month period during which time she came regularly and punctually. Initially, she tried to manipulate the therapist as she had the case worker. She soon learned that this would not be tolerated and settled down to carry much of the burden herself. Remarkable progress was made during this contact, with mother gaining some understanding and insight into her relationship with Steven. As a result, she was able to modify her behavior with Steven. As she improved, Steven also improved noticeably, but at this time, father began to have some somatic difficulties and experienced an anxiety attack. He was able to see, with the improvement in Mrs. Farmer and Steven, that psychotherapy may have value for him. He sought help and obtained treatment at the VA Outpatient Clinic. After Steven had terminated at the Clinic, Mrs. Farmer wanted further help for herself, and was referred to an Outpatient Psychiatric Clinic.

In another pattern that emerged, evident in three cases, the mother became deeply involved in the first contact, gained understanding and even insight into the problem, and modified her attitude toward the child. These cases were closed as "improved." When they reapplied, since the child continued to manifest disturbed behavior, the parents were seen in a brief contact, preparatory to referral for more intensive help for the child. The case of Sam Gavin illustrates this pattern:

Sam was brought to the clinic by his mother at the age of six and one-half because of negativism, frequent tantrums, ritualistic behavior, and a learning diffi-
cully (although his I.Q. was 140). Mrs. Gavin was an intellectual, methodical, and domineering woman who had difficulty in freely expressing warmth for this child. She tended to isolate her feelings by discussing the problem in an intellectual manner and with a wry sense of humor. Mr. Gavin was a neurotic eccentric man, who strongly identified with the boy in a passive defiance of his domineering wife. Seeing many of his own anxieties and problems in the boy, Mr. Gavin felt threatened and was opposed to treatment.

Mrs. Gavin was seen in treatment for four months during which time she made considerable progress. She became more relaxed, freer in expressing her warm feelings for the boy, and became less demanding of him. As Sam also improved, becoming less belligerent in school and less defiant at home, the father's attitude toward the clinic became more positive, and he made attempts to spend more time with the boy as the clinic suggested.

Sam was diagnosed as a disturbed child with a schizoid personality, who had held together rather well. Since father was quite disturbed, and mother had arrived at a better equilibrium, it was felt that treatment be terminated at this point, since much improvement had been made.

Three and one-half years later Mrs. Gavin reapplied as many of Sam's problems persisted. She was then seen on a consultation basis. The parents were encouraged to be more consistent and less indulgent of the boy since he tended to have superior ideas about himself and had difficulty in conforming to his peers. It became apparent at this time that the parents had made many strides since their last contact with the clinic. Father had recognized his tendency to identify with the boy, and was now supporting mother in her firmness with Sam. Mrs. Gavin was able to relate in a warm, relaxed manner, and was more affectionate with the child. Sam, too, had maintained some of his gains, being less belligerent at home, and doing somewhat better in school. The clinic suggested that the family consider a private boarding school for him.

Mrs. Gavin reapplied again two and one-half years later, when Sam was thirteen. He presented many of the same problems: ritualistic behavior, perfectionism, and poor peer relationships. The situation was again reevaluated, and Sam was seen as a borderline psychotic
who was in need of more intensive treatment. The parents were able to carry through on the clinic's recommendations for placement of the boy. Both parents expressed their willingness for further help in planning for the boy's placement. They were able to come together in supporting Sam and each other through this difficult period. Mrs. Gavin felt very positive about her past contacts with the clinic, and felt she had been helped in being more affectionate, and being more accepting of her son's and husband's eccentricities. Father was encouraged to seek help for himself, and indicated a desire to do so.

The third pattern which emerged was apparent in only two cases. These were the parents who were resistant to treatment in their first contact, focusing on their own personal problems and expecting the child's therapist to help the child independently of the parent. At reapplication, these parents continued to be resistant to treatment, and one of these parents withdrew her application after verbalizing her willingness to become involved. One of these cases is that of Edna Shorr.

Edna was referred to the clinic at the age of eleven, by Family Service, where Mrs. Shorr had requested help because of the continual fighting between Edna and her younger brother. Mrs. Shorr sought help at the clinic for Edna's chronic enuresis, stating that she is tired of washing sheets and was concerned because Edna would soon be menstruating. Mrs. Shorr was described as a volatile, naive woman, who revealed little understanding of emotional factors. She had been divorced the previous year, and was now living in her parents' home, supported by ADC. She described her former husband as very irresponsible (frequently changing jobs and being fired), a chronic liar, and one who made many futile protestations of reform. During her contact with the clinic, Mrs. Shorr was considering remarriage to a more stable man. She tended to identify Edna with her former husband, and was quite rejecting of her.

Mother was seen by a worker for a six-month period, during which time she was preoccupied with her
ambivalence regarding her impending marriage and her repressed sexual desires and guilt. In addition, she attempted to cope with her domineering mother, with whom she had a hostile-dependent relationship. She saw the clinic as a source of help for her daughter and her enuresis, and thus, did little to change her relationship with Edna. Although it was felt that Edna could benefit from treatment, having some capacity for insight, little was accomplished with her because of mother's inability to change. Treatment was discontinued shortly before mother's remarriage in order to give mother and Edna time to adjust to the new situation.

Edna was again referred to the clinic at the age of fourteen, this time by the Boston Dispensary, because of her persistent enuresis. Mrs. Shorr had remarried, had another child, and was now living in her own home away from her mother. Her relationship with Edna had not changed very much, except that she was now more irritated with her, both because of her adolescent defiance and mother's continued hostile feelings toward her former husband.

Mrs. Shorr expressed marked ambivalence about her former contact, with the clinic, feeling that no one had given her the answers. She recognized some positive changes in Edna such as more sporadic bed-wetting, but did not attribute these to the clinic. It was quite apparent that again Mrs. Shorr's expectations of the clinic were unrealistic in that she expected a single magical answer which would explain Edna's problems and the appropriate remedy. When she was confronted with this, she recognized that she did not want the kind of help that was available to her, and withdrew her application.
CHAPTER V
SUMMARY AND CONCLUSIONS

This was a study of thirteen parents who reapplied for further help after termination of the treatment plan. The aim of this study was to help better assess initial treatment plans. The focus was exploratory: to discover whether there were any characteristics which reflected that these parents would reapply; and to determine whether these parents were better able to use help when they reapplied. This was done by examining the following areas: descriptive characteristics of the reapplicants and their problems; the nature of termination and acceptance for further treatment; and parental attitudes toward the child and toward treatment. These areas were explored because they were found pertinent to assessing a treatment contact.

The characteristics of the reapplicants and their children were examined to determine whether these were related to the reapplication. It was found that this sample represented a cross-section of the Clinic population, first in their socio-economic status, low-middle class, and secondly, in terms of the presenting problems. These problems were mainly neurotic symptoms, and secondarily, aggressive behavior and learning difficulties. This strongly suggests that the attitudes of the reapplicants is the crucial factor in the reapplication.

The source of referral was examined to determine whether
these parents applied as a result of internal or external pressures, and whether this affected their attitude toward treatment. It was observed that over half of the group were self-referred at the time of first referral and at reapplication. While the source of referral did not reflect involvement in treatment during the first treatment period, in the reapplication contact, those parents who were self-referred were more positively involved than those who were referred by other sources. The latter group were more ambivalent in treatment during the second contact.

The question was raised about whether these reapplicants were terminated earlier than other cases at the Clinic. It was found that the reapplicants were in treatment for shorter periods than was characteristic of the total Clinic population during those years. This would suggest the possibility of premature termination in some of these cases.

It was found that in most of the cases, the Clinic was most active in the decision to terminate. In only three cases was the decision to terminate made by the client herself. Slightly less than half of the cases were terminated as "improved." This indicated their ability to carry on without further clinic help. In the cases which were not terminated as "improved" the parents were either ambivalent or resistant toward treatment. This suggests the possibility that these ambivalent and resistant attitudes may have precipitated
termination before the case had "improved."

It was observed that there was a relationship between the status at termination and the subsequent disposition at reaplication. Those cases which were terminated as "improved" were referred elsewhere for a different kind of help, usually more intensive treatment for the child, and those indicating a need for "further help" were subsequently accepted for further treatment. The cases terminated as "little improvement" shown, continued to be ambivalent about treatment at reaplication, with some of them withdrawing their applications after they reapplied. Thus, it would appear that those cases showing "little improvement" in the first contact continued to be resistant or ambivalent about treatment at reaplication. Those cases showing some ability to use help (i.e. in the status "further help indicated") but ambivalent about treatment in the first contact, were later accepted for further treatment, and were more positive about help when they reapplied.

Six of the thirteen cases were subsequently accepted for further treatment. Of those not accepted, four were referred elsewhere and three withdrew their applications. In both the referred cases and those accepted for further treatment, there was considerable similarity of attitudes toward treatment and toward the child. The cases which withdrew their applications when they reapplied, however, continued to be resistant to treatment as they had been in the first contact. They were
also more rejecting and highly ambivalent toward the child than the other cases. This concurs with Helen Witmer's findings that most of the failures occurred when parents were overtly rejecting or highly ambivalent toward the child.

The outcome of reapplications suggests two ways in which reapplications were used: in cases closed as "improved," the parent reapplied for further help for the child because of the severity of the disturbance or a familial crisis; in cases closed as "further help indicated," the parent is now less ambivalent about treatment, and more able to use the help available to make further changes or to solidify previous changes.

The parents' attitudes toward the child showed considerable variation in the first contact, with a predominance of overprotective attitudes. At the time of reapplication, there were some changes to more accepting and less protective attitudes. When the parents terminated the reapplication contact, all of the attitudes had shown dramatic changes in a positive direction, with the predominant attitude being acceptance. It was found that the greatest change in attitudes occurred during the parent's most extensive period in treatment: for the "improved" cases, during the first contact; for those accepted for further treatment, in the reapplication contact. Those

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parents who were resistant to treatment in both contacts showed no change in attitudes.

Projection or introjection of the responsibility for the problem is often seen when parents apply to a clinic. This may serve as a defensive maneuver, preventing them from becoming involved in the process of change. It would appear that when parents reapply for further help, they would be more cognizant of the sharing of responsibility for help which is implicit in treatment at a child guidance clinic. It was found that the predominant attitude toward help at first referral was projection, while at the time of reapplication, most of the parents expressed their willingness to share the responsibility with the clinic. Thus, most of the parents showed marked change in their attitude towards help from the time of the first application to the second. However, in relating these attitudes to the parent's involvement in treatment, it was found that these attitudes expressed at the time of reapplication did not necessarily reflect the parents' actual involvement in treatment.

It was found that most of the parents were markedly ambivalent in treatment during the first contact. At reapplication, the parents were more clearly positive or resistant, with the predominant attitude being positive. It would appear from this, that much of the resistance or ambivalence to treatment expressed in the first contact had been worked out by the
time these parents reapplied. Most of the parents were able to become more positively involved in treatment when they reapplied. This is borne out in the trends which emerged in the way these reapplicants used their contacts with the clinic. Three patterns emerged: (1) Most of the parents used their second contact to solidify the intellectual understanding gained from the previous contact, with more emotional involvement and even insight into the problem. While they were rather ambivalent in the first contact, they became positively involved, and were able to use help profitably in the subsequent contact or contacts. (2) The parents who had been initially terminated as "improved" reapplied when the child continued to manifest disturbed behavior, or there were problems in the home situation. The reapplication contact served to prepare the parents and/or the child for referral to another agency, for a different kind of help. (3) The parents who were resistant to treatment in the first contact reapplied, with the expectation that the clinic would "cure" the child. These parents were unwilling to use the help that was available and withdrew their application.

In conclusion, an attempt will be made to answer the questions raised initially in this study. Are there any characteristics which would reflect that these parents will reapply? With regard to background characteristics and the nature of the presenting problems, these cases did not differentiate
from the Clinic caseload. However, most of these parents were ambivalent about treatment during the first contact. At referral, they tended to project the responsibility for help on to other sources, particularly the Clinic. In their attitudes toward the child, they showed predominantly overprotective attitudes. One would hesitate to generalize on these attitudes, however, since they tend to be characteristic of many of the parents seen at the Clinic. The source of referral was not significant during the first contact, but it was found that those parents who were referred by other sources at the time of reapplication were more ambivalent and resistant to treatment during the reapplication contact.

What factors existed at termination? There is a suggestion that these parents were in treatment for somewhat shorter periods than other parents at the Clinic, and that, perhaps, they were terminated prematurely. Those who were terminated as having begun to think about their problems but in need of further help, were ambivalent about treatment when they terminated, and in need of further help when they reapplied. As Beatric Smith indicated in her study, it would appear that the parents having ambivalent attitudes toward treatment at termination, and an increased appreciation and understanding of help when they reapply, are better candidates for treatment when they reapply. The cases which had made little progress during the first contact continued to be
resistant when they reapplied.

The bases for resumption of treatment of the accepted cases was examined. The decisions to reaccept some of these cases were based on: (1) the parent's increased motivation or willingness to use help, as manifested in their ability to carry through on clinic recommendations; (2) their ability to use help well previously; and (3) the child's need for further help and the parent's willingness to change her own attitudes in light of this. In the cases in which the parent had been markedly ambivalent to treatment previously, the parent was confronted with the resistant side of the ambivalence, and had to affirm their willingness to become more actively involved in order to be reaccepted. The fact that they were reaccepted indicated their increased motivation and willingness to accept a sharing of responsibility for helping the child. Thus, it would appear that these parents return with increased anxiety about the problem, and consequently, are more willing to invest of themselves in treatment since this is the condition for reacceptance.

Were these parents better able to use help when they re-applied? In terms of their attitudes toward help, involvement in treatment, and attitude toward the child, this can be clearly answered in the affirmative. Most of the parents had a greater understanding and appreciation of the sharing process in help, and were more positively involved in treatment when
they reapplied. Their attitudes toward the child changed from predominantly overprotective to accepting attitudes. They could now allow and help the child to grow up and could express more acceptance of the child through this. The patterns described previously also reflect this increased appreciation of help. Furthermore, many of the parents who reached a higher plateau in their reapplication contact recognized their need for further help after the child had terminated, and sought further help for themselves. The parents who were referred elsewhere when they reapplied were more receptive to help, in that they were very willing to follow the clinic's recommendations and to use the preparatory interviews constructively.

In terms of intake policy, the findings reveal that a thorough reevaluation of the cases at reapplication can provide a large measure of success with the cases accepted for further treatment. This evaluation should consist of a study of the family's needs and ability to use help, their expectations of treatment, their feelings about the previous contact, and the meaning of treatment to the total family unit. An examination of factors in the previous contact does not reveal any single one as crucial to success upon reopening. However, those persons who were accepted for further treatment, following an intensive reevaluation, showed marked improvement during the subsequent contact. It was found that the pressures that lead persons to reapply is a factor to consider. Those parents who
were referred by other sources at reapplication were more am-
bivalent about treatment than those who were self-referred. It was also found that what a parent expresses as her attitude toward help at the time of reapplication is not necessarily indicative of her involvement in treatment.

Other areas are suggested as worthy of further exploration. The nature of termination may be an important clue to the reapplicants use of help. These cases appeared to have been terminated after shorter periods of treatment than those of the Clinic's caseload during the years under consideration. Further, the Clinic was most active in the decision to terminate. This suggests both the reapplicant's passive acceptance of the decision to terminate, and the possibility of premature termination. This raises further questions about how and why termination of the initial contact is planned in the cases of reapplicants. The parents' expectations of treatment appears to be another significant area, since the resistant parents were primarily those who expressed unrealistic expectations of treatment, and who subsequently withdrew their applications.

Another interesting finding is that almost half of these parents had been in treatment previously. Although these parents did not show any markedly different attitudes from the other cases studied, this implies something about the reapplicants' use of help. They appear to be ambivalent about treatment, project much of the responsibility for help onto the
clinic and other persons, and relate to treatment in a passive-
receptive manner. The cases which were successful at reappli-
cation were able to use help when confronted with their am-
bivalence, and when demands were placed upon them for a more
active involvement.

accepted by

[Signature]

5/59
SCHEDULE

Factual Data

1. Number of applications: _________________
2. Dates of applications: _______________________
3. Intervals between contacts: ___________________
4. Time (mos.) in treatment: (1)______ (2)______ (3)______ (4)______
   Number of interviews: (1)______ (2)______ (3)______ (4)______
5. Age of child: (1)______ (2)______ (3)______ (4)______
6. Sex of child: _______________________
7. Religion: _______________________
8. Parents occupations: Father_________ Mother_________
   Ages: ___________ ___________
   Siblings: _______________________
9. Source of Referral: (1)_______________ (2)_______________
10. Presenting problems:
   (1)
   (2)
   (3)
11. Precipitating factors:
   (1)
   (2)
12. Requests for help:
   (1)
   (2)
13. Past experiences with helping agencies:
14. Parent(s) seen in application: _______________________
   in treatment: _______________________
15. Termination of contacts:
   Source: (1)_________ Status: _________
   (2)_________ Status: _________
16. Outcome of reapplication:
   (1)
   (2)
   (3)
DESCRIPTIVE DATA

1. Description of parent and child.
2. Mother's attitude toward the child.
3. Mother's expectations of treatment:
   a. Where responsibility for help is placed
   b. Attitude toward previous contact
   c. Reasons for discontinuing previous contact
4. Attitude toward the clinic, at referral and at reappli-
cation.
5. Involvement in treatment, first contact and reapplication.
   a. Conformity to clinic routine
   b. Relationship with worker
   c. Major concerns and preoccupations in treatment
   d. Areas of progress or change in treatment
6. Changes noted at the time of reapplication.
   a. Ability to carry through on clinic recommendations
   b. Changes in attitudes toward the clinic, the child, or
treatment.
### PRESENTING PROBLEMS

<table>
<thead>
<tr>
<th>Case No.</th>
<th>First Application</th>
<th>Second Application</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Fearful, overactive, enuresis</td>
<td>Overactive, aggressive</td>
</tr>
<tr>
<td>B</td>
<td>Enuresis</td>
<td>Enuresis</td>
</tr>
<tr>
<td>C</td>
<td>Stealing, stubbornness, enuresis, school problem</td>
<td>Stealing, school problem</td>
</tr>
<tr>
<td>D</td>
<td>Negativism, stubborn, school problem</td>
<td>Stealing, school problem</td>
</tr>
<tr>
<td>E</td>
<td>Belligerent with peers, infantile, negativism, school problem</td>
<td>Tension</td>
</tr>
<tr>
<td>F</td>
<td>Rituals and obsessions, negativism, tantrums, school problem</td>
<td>School problem, unhappy</td>
</tr>
<tr>
<td>G</td>
<td>Rituals and obsessions, daydreaming, twitchy</td>
<td>School problem, daydreaming</td>
</tr>
<tr>
<td>H</td>
<td>Fearful, enuresis, sibling rivalry, somatic symptoms</td>
<td>Aggressive and defiant behavior, asthmatic attacks, sibling rivalry</td>
</tr>
<tr>
<td>I</td>
<td>Violent temper, demanding</td>
<td>Tense, unhappy, few friends</td>
</tr>
<tr>
<td>J</td>
<td>Shyness, poor eating habits</td>
<td>More retiring</td>
</tr>
<tr>
<td>K</td>
<td>Fearful, nightmares, somatic symptoms</td>
<td>Fearful, worries constantly</td>
</tr>
<tr>
<td>L</td>
<td>Fearful, temper, poor peer relationships</td>
<td>Stealing, fire-setting, poor peer relationships, school problem</td>
</tr>
<tr>
<td>M</td>
<td>Aggressive, belligerent (at school and at home)</td>
<td>School problem, not aggressive enough</td>
</tr>
</tbody>
</table>
MATERNAL ATTITUDES TOWARD THE CHILD AT THE TIME OF FIRST AND SECOND CONTACTS AND TERMINATION OF CONTACT WITH THE CLINIC

<table>
<thead>
<tr>
<th>Case</th>
<th>First Contact</th>
<th>Second Contact</th>
<th>Termination with Clinic</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Overprotection</td>
<td>Some Overprotection</td>
<td>Acceptance</td>
</tr>
<tr>
<td>B</td>
<td>Some Rejection</td>
<td>Some Rejection</td>
<td>Some Rejection</td>
</tr>
<tr>
<td>C</td>
<td>Some Rejection</td>
<td>Ambivalence</td>
<td>Acceptance</td>
</tr>
<tr>
<td>D</td>
<td>Overprotection</td>
<td>Acceptance</td>
<td>Acceptance</td>
</tr>
<tr>
<td>E</td>
<td>Ambivalence</td>
<td>Acceptance</td>
<td>Acceptance</td>
</tr>
<tr>
<td>F</td>
<td>Some Overprotection</td>
<td>Some Overprotection</td>
<td>Acceptance</td>
</tr>
<tr>
<td>G</td>
<td>Ambivalence</td>
<td>Acceptance</td>
<td>Acceptance</td>
</tr>
<tr>
<td>H</td>
<td>Overprotection</td>
<td>Overprotection</td>
<td>Unknown*</td>
</tr>
<tr>
<td>I</td>
<td>Overprotection</td>
<td>Some Overprotection</td>
<td>Some Overprotection</td>
</tr>
<tr>
<td>J</td>
<td>Overprotection</td>
<td>Acceptance</td>
<td>Acceptance</td>
</tr>
<tr>
<td>K</td>
<td>Some Rejection</td>
<td>Ambivalence</td>
<td>Ambivalence</td>
</tr>
<tr>
<td>L</td>
<td>Ambivalence</td>
<td>Ambivalence</td>
<td>Unknown*</td>
</tr>
<tr>
<td>M</td>
<td>Some Overprotection</td>
<td>Some Overprotection</td>
<td>Acceptance</td>
</tr>
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</table>

*currently in treatment
MATERNAL ATTITUDES TOWARD HELP AT REFERRAL AND REAPPLICATION AND INVOLVEMENT IN TREATMENT IN FIRST AND REAPPLICATION CONTACTS

<table>
<thead>
<tr>
<th>Case</th>
<th>Attitude toward Help</th>
<th>Involvement in Treatment</th>
<th>Reapplication</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Referral</td>
<td>Reapplication</td>
<td>Contact I</td>
</tr>
<tr>
<td>A</td>
<td>Projection</td>
<td>Projection</td>
<td>Res-Amb.</td>
</tr>
<tr>
<td>B</td>
<td>Projection</td>
<td>Projection</td>
<td>Res-Amb.</td>
</tr>
<tr>
<td>C</td>
<td>Some Introj.</td>
<td>Sharing</td>
<td>Ambivalent</td>
</tr>
<tr>
<td>D</td>
<td>Some Introj.</td>
<td>Sharing</td>
<td>Positive</td>
</tr>
<tr>
<td>E</td>
<td>Projection</td>
<td>Some Proj.</td>
<td>Ambivalent</td>
</tr>
<tr>
<td>F</td>
<td>Some Introj.</td>
<td>Sharing</td>
<td>Positive</td>
</tr>
<tr>
<td>H</td>
<td>Projection</td>
<td>Sharing</td>
<td>Ambivalent</td>
</tr>
<tr>
<td>J</td>
<td>Some Proj.</td>
<td>Some Introj.</td>
<td>Ambivalent</td>
</tr>
<tr>
<td>K</td>
<td>Projection</td>
<td>Sharing</td>
<td>Resistant</td>
</tr>
</tbody>
</table>
BIBLIOGRAPHY

Books


Articles


**Pamphlets**


**Unpublished Material**


