PREMATURE WITHDRAWAL FROM TREATMENT IN A CHILD GUIDANCE CLINIC

An Exploratory Study of the Factors Which Underlie Clients' Decisions to Withdraw From Social Work Treatment at the Provincial Child Guidance Clinic, North Burnaby, B.C.

by

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Thesis Submitted in Partial Fulfilment of the Requirements for the Degree of

MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the standard required for the degree of

Master of Social Work

School of Social Work

1957

The University of British Columbia
This is an exploratory study of the problem of clients' discontinuation in a child guidance clinic. The problem is considered first in terms of its therapeutic and administrative implications for clients and social workers. Reference is made to the professional literature which suggests the multi-causative factors which operate in a client's decision to withdraw from social work services. The problem is also related to social work principles and concepts. This is done to demonstrate that, by their continued efforts to understand the meaning of behaviour, to study the client in as much of his total life situation as possible, and to refine and enrich methods of family diagnosis, social workers can sharpen their diagnostic skills and their ability to select effective treatment goals. A brief discussion of the history of child guidance together with a more detailed account of the Provincial Child Guidance Clinic in North Burnaby gives a broad perspective to the problem of discontinuation.

The problem is illustrated in five selected cases in which clients withdrew themselves and their children from Clinic services. The case records are examined, highlighting both dynamic patterns within the individual families and also their attitudes towards the child's problems and their Clinic experiences. These areas are thought to be significant factors relating to the parents' decisions to withdraw.

Five follow-up interviews are conducted and recorded which indicate the clients' verbal reactions to the Clinic, including their conscious reasons for withdrawal. An assessment is made of the degree of Clinic help which the five families were able to employ.

Common patterns are elucidated in the five cases and are designated as "withdrawal indicators". These indicators may, in the future, have prognostic value in determining which cases are likely to withdraw. The indicators are applied to six additional cases (tabulated in Appendix D). The results show that two-thirds of the indicators are present in each of the six cases. A further study is recommended in which the indicators would be applied to a larger number of discontinued cases, thus determining their reliability as predictive tools. The clients' reasons for withdrawal are discussed together with the recommendation that an additional study be done both to validate these reasons and to demonstrate new ones.

In light of the findings various recommendations are made which the Clinic social work staff might implement in an attempt to decrease the rate of discontinuation. The withdrawal indicators should be recognized as forms of resistance and should
be handled by the workers in early interviews. Increased skills in the areas of family diagnosis and a more discriminating system of recording will help to expedite the workers' recognition of the indicators. Also, greater skill by the workers in recognizing brief service cases, in handling reassignment, in their interpretation of the Clinic and its functions, and in their choice of words, will help to strengthen the clients' motivation to a continued Clinic contact. Recommendations are also made whereby the waiting-period, which emerges as the strongest reason for discontinuation, might be utilized as a therapeutic tool in treatment.

Withdrawal must, in nearly all cases, reflect the clients' dissatisfactions with the services of the Clinic. To attain their goals for their clients, the agency, and themselves, the Clinic social workers must strive to understand and decrease the rate of discontinuation.
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Date 30 April, 1957
ACKNOWLEDGEMENTS

The writer wishes to express appreciation to Dr. U. P. Byrne, Director of the Child Guidance Clinic for permission to use Clinic records as case material for this study; to Miss Katherine Daly, Supervisor of the Intake and Brief Services Section for the warm interest in the project and for her suggestions and constructive criticisms which reflect her faith in the principles of Social Work.

Special acknowledgement is made to Miss Muriel Cunliffe of the School of Social Work for her consistent helpfulness and guidance which facilitated the writing of this thesis and which enhanced the writer's theoretical and practical knowledge of Social Work as a whole; to Mr. Adrian Marriage of the School of Social Work for his support and stimulating criticism which contributed greatly to the writer's continuing interest in the study.
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CHAPTER I

The Problem of Discontinuation in a Child Guidance Setting

"The goal of treatment in casework is to stabilize or to improve the functioning of the client in terms of social adaptation or adjustment, especially in the balance of inner and outer forces." Treatment goals are selected on the basis of study and diagnosis which occur in the natural progress of each case. To be helpful all treatment must be based on this study and diagnosis in which psychological, physical, economic, and social factors are considered as interacting in various proportions in the total life situation of a client. This is termed the psychosocial approach to study, diagnosis, and treatment.

An anomalous situation arises in child guidance when clients discontinue treatment. This means that treatment goals are not realized. The clients' problems, which have been studied and diagnosed, do not reach the level of improvement which the professional worker recognized as being realistically possible. In short, both the client and the worker emerge from an incomplete experience or relationship. The client may often wonder why he sought help and may continue to find unhealthy ways of handling his problems; the worker, in the light of discontinuation, may tend to question both his own skills and the original diagnosis.

What, it may be asked, are the causative factors

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underlying withdrawal? A moment's reflection will indicate several possible answers. The entire area of client resistance to treatment must be considered—an area which constitutes sufficient material for numerous research projects. Gordon Hamilton suggests that a client will sometimes displace his own failures on the behaviour of a child or spouse. The clients will resist treatment by withdrawing "as soon as they take in how they themselves will be involved in treatment."

A change in workers can be a traumatic experience to the client and thus instrumental in his withdrawal from treatment. This involves the complex phenomenon of transference. "When we consider the transference and its essentially dependent, irrational nature, it is immediately evident that the disruption of the casework relationship can be of the utmost significance to the client." In other words, some clients who have a frustrated dependence on workers will break contact with the agency at the point of reassignment. In effect, they are rejecting the agency in the same way as their worker rejected them. Miss Flesch says that "such behaviour may conceal a deeper request for service, the client's wish to be pursued and given assurance of his worth and the worker's affection."

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1 For one aspect see Beck, Dorothy, Resistance of the Adolescent to Casework Services, University of British Columbia MSW Thesis, 1954.
4 Flesch, Regina, Ibid, p. 16
Lawson Lowrey suggests another ramification of reassignment: "Changes in and absence of staff for whatever reasons often lead the client to doubt that he and his problems are regarded as important." Such a belief by the client would seemingly militate against continuation in treatment.

In addition to the complex psychological aspects of client-discontinuation there may well be the more practical reasons which can not be predicted at the outset. Geographic accessibility to the treatment service may change; sickness may prevent the client from continuing in treatment; or the client may consciously and sincerely believe that he has been sufficiently helped to the point where he can cope satisfactorily with his problem.

Withdrawal from treatment is of concern to child guidance staff in terms of both its services and skills. A service to a client must include help. This help is lacking when clients discontinue for psychological reasons. This recognition of lack of help by the staff will naturally cause them to question their skills as professional workers. Here, the first consideration might be the original diagnosis and treatment plan. Was it sound and realistic in terms of a dynamic diagnosis? A dynamic diagnosis is necessary before accurate treatment goals relating to the individual needs of the client can be established. Diagnosis and treatment goals do change, and rightly so, as the client's strengths and weaknesses become defined. The worker, nevertheless, needs to be certain that all aspects of the client's amenability

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to treatment are recognized and considered during the diagnostic evaluation period.

Social work staff at the Provincial Child Guidance Clinic in Burnaby, British Columbia, have expressed concern with the effect which the waiting-period might have on clients. The length and position of the waiting-period will vary from clinic to clinic. At the Burnaby Clinic there is usually a short wait after referral and a more prolonged one between diagnostic and continued services. Could this more prolonged wait be a factor in withdrawal from treatment? This would seem reasonable, particularly with those clients who have strong, unmet dependency needs. To them, a long waiting-period could seem intolerable - a rejection of their problem by the agency. A long wait could also be particularly disturbing for the client to whom making the decision to seek help was crucial. "The result of such frustration is often lack of impetus to proceed."  

The discussion this far would suggest that the problem of discontinuation has both therapeutic and administrative implications: therapeutic in so far as treatment goals based on diagnosis are not realized; and administrative in that the workers' time and skills are perhaps not being utilized to the most desirable degree of effectiveness.

In this study, it is proposed to examine several cases in which clients have discontinued treatment in a child guidance setting. It should be stressed, however, that the problems of discontinuation or withdrawal from treatment are not isolates but

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have evolved with the history of child guidance clinics as a whole. To provide the reader with a broader perspective, some discussion of the historical aspects of the Child Guidance Movement is necessary, emphasizing the evolution of the social worker's role in the treatment of children and parents. This will also give the reader a better understanding of social work treatment in child guidance and a clearer impression of what clients are withdrawing 'from', when they discontinue.

The child guidance clinic owes its origin to such men as Adolf Meyer, William A. White, Thomas W. Salmon, and other social psychiatrists who, at the beginning of the century "were insisting on a study of the whole individual, his environment and his reactions to it." Meyer's basic contribution was his emphasis on the uniqueness of each individual patient and the consequent necessity of studying his total life history as well as his intellectual and physical equipment if one is to understand the nature of his present disorder. This point of view assumes that mind and body are in a state of constant interaction and that mental activity and behaviour represent the adjustment of the individual as a whole. "From Freudian theory came the concept of the dynamic influences of the emotions (the individual's own and those of the persons with whom he is in contact) on human behaviour." Freud showed behaviour to

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1 For supplementation, see: Chave, Estelle, The Pre Clinical Conference as a Diagnostic Screen in the Child Guidance Setting, University of British Columbia MSW Thesis, 1952.
be purposive. Its purpose, however, may be in response to the needs of the unconscious and will therefore appear to be irrational. The work of these men resulted in our present child guidance approach, the essence of which is the multi-causation concept of behaviour.

William Healy, early in the century made an outstanding contribution to the growth of this idea. He insisted on a concentrated study from the medical, psychological, and social points of view upon youthful offenders "with the aim of searching out the causes of their misbehaviour and finding ways of preventing them from developing into adult criminals." The Chicago Juvenile Psychopathic Institute, founded by him in 1909 was unquestionably the pioneer in this field and provided the pattern on which the later child guidance clinics were partially modelled. Eight years later, under the name of the Institute for Juvenile Research, the Chicago Institute was taken over by the state and extended to cover the wider field of child guidance.

Under this broader policy an increasingly large number of cases were referred from other sources in the community. "Among these were many from family agencies, child placing agencies, and agencies concerned with health, as well as from the public schools and from the parents." While parents comprised the smallest percentage of referrals at this time it is noteworthy that by 1934 they referred 25 per cent of the cases, being second only to schools with 27 per cent. This was a logical development since

2 Stevenson, & Smith, Ibid., p. 322
"under any conception of psychiatry, parents are involved in the treatment of children for they initiate the action and carry out many of the therapeutic measures."

The first child guidance clinics (so named) were set up in 1922 in St. Louis and Norfolk as demonstration units by the National Committee for Mental Hygiene and the Commonwealth Fund. They worked wholly through the courts but soon discovered that the most effective preventive work was to be done with children whose misconduct had not yet been accounted legal delinquency. Later clinics were therefore established in connection with hospitals or schools, and referrals were sought from parents, teachers, and social workers.

Child Guidance clinicians early realized that parents as well as children were their patients. Stevenson and Smith write:

"It has been recognized from the early days of child guidance that the close involvement of the child with its parents, and especially with its mother, make treatment of the mother an almost inevitable concomitant of treatment of the child."

Service to parents assumed increasing importance and 'child' guidance seemed at one time to be near the point of losing its identity to 'parent' guidance.

What effect did this shift in emphasis have on the social worker in the clinic? It entailed a greater responsibility in diagnostic and treatment skills for most of the work with parents was left to him. The rationale of this was that parents were a critical

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2 Stevenson, George & Smith, Geddes, Op. Cit., p. 91
part of the environment of the child and the social worker worked with the environment. Various methods for the treatment of parents were slowly evolved, most of them proceeding from a desire to alter the parents' attitudes in order that the patients would have a more favourable emotional environment. It was believed that some parents could accept and profit from advice and suggestions. Others seemed to need education - a kind of tutorial instruction regarding the emotional needs of children in which their own children's motives and desires were interpreted to them. Again it was held that certain parents could best benefit from gaining insight into their own personal problems. It was also recognized that some parents could be helped by what was called "supportive treatment, which aimed not so much at changing them as at lessening their anxiety about their children or diverting some of their attention."^{1}

The above description of techniques over-emphasizes the social worker's planning, not acknowledging that, in practice, she tried to involve the patient in his planning and to adapt her methods to his needs. It was this process, in fact, which clarified that parents could not be changed to order, nor could another person plan for them how they should think and act toward their children.

"The present trend seems to be toward a clarification of casework and the kind of help it can offer, and of its distinction from psychiatry."^{2} In other words some child guidance

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2 Witmer, Ibid., p. 348
clinics still plan the handling of a case in terms of whether or not the attitudes of the parents need changing and, if so, what methods can best be employed to effect the desired change. Other clinics state their function more specifically as child 'guidance', the social worker providing a helping situation in which the parent may express his feelings about his child and mobilize his capacities for deciding what he will do about the problem. "This help is offered — in the belief that the child will benefit if his parents can become more comfortable in their feelings about him."

Regardless of emphasis (that is, strictly 'child' guidance and/or personality problems of the parents), the original conception of the function and role of the social worker has changed. The worker today is not the aide but the colleague of the psychiatrist in a diagnostic and treatment undertaking that usually involves work with several people in any one case.

The foregoing discussion has briefly surveyed the evolution of the role of social workers in child guidance in relation to their treatment of children and parents. As members of a profession social workers must assume responsibility for the results, favourable and unfavourable, of their contributions to the diagnostic thinking and treatment recommendations of the clinic team. This will include a genuine concern with the problem of clients who withdraw from treatment, and a continued refining of methods and skills in an effort to combat the problem.

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Principles

The evolution of the social worker's role in child guidance was not, and is not, isolated from the growth and change of professional Social Work as a whole. With the development of our theory and practice have come working principles and concepts upon which all social work can be based. The basic philosophy of social work is belief in the worth of every individual, in his potential for growth and change and in his right to find his most satisfying social adjustment for himself and the community. We also believe that the community has responsibility toward the individual in assisting him to make this optimum adjustment. The compatibility of this philosophy and child guidance is evident. The latter, by existing to help children and parents attain more healthy and happy relationships within the family and community, presupposes their potential for growth and development. Community responsibility is fostered by child guidance clinics through educational programs which both recognize the need for a positive community attitude toward mental health preservation and aim to make people aware of clinic services and the emotional needs of children.

While the above principle relates to the broad field of social work as a whole, it is perhaps desirable to include additional principles which focus more directly on this study in terms of the problem of discontinuation in child guidance. Once such concept is that all behaviour has a purpose and a meaning. This purpose and meaning are frequently not recognized by the person and not wholly under his conscious control. Thus, the client who discontinues treatment is prompted to this decision by reasons of

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which he is both aware and unaware. Social workers must continually strive both to understand these causative factors and to improve their skills in handling them, if their efforts to eliminate the problem of discontinuation are to meet with any degree of success.

Another concept to which Social Work adheres and which is pertinent to this study is the desirability that as much as possible of the total person and his life history be taken into consideration to explain his behaviour. This reaches a highly developed degree of professional expression in the team approach, (the team consisting of psychiatrist, psychologist, social worker, and nurse), of child guidance clinics. The writer will have the advantage of this specialized approach in the cases selected for study in this thesis. These cases have been selected from a large group in which the clients have discontinued treatment. It is not believed that discontinuation is always due to circumstances which develop after referral; often, it tends to result in response to long established patterns which are constituents of the client's total personality. Thus, to arrive at an understanding of why a client discontinues, it is necessary to see him, as far as possible, in relation to his total life situation.

Perhaps the most helpful way in which to approach an understanding of the client in his total life situation is to study him in relation to his interaction with other members of his family. It is recognized that one of casework's distinguishing characteristics has been its concern with the welfare of the family. The child guidance field with its continued concern with families in distress has been a major contributor to the emergence
of "family-centered" casework. Again, this is relevant to the problem of discontinuation because the intra-familial components affecting diagnosis and treatment will also be operating in withdrawal from treatment.

The goal of family centered casework represents a "return to the fold" for many social workers. "Today, there is increasing recognition that the mental hygiene and psychoanalytic movements led many social workers away from the concern with the family which had been emphasized by Mary Richmond, toward a pre-occupation with individual psychopathology and intra-psychic problems." However, Miss Richmond's basic principle that the family is the unit of social diagnosis and treatment sounds particularly fresh today and has been an influencing factor in the development of concepts of family diagnosis and treatment, notably in the child guidance field.

Ideally, "family-centered" casework is "casework that is based on an understanding of the needs of the family as a unit, for the purpose of helping family members attain their best personal and social satisfactions, and to help improve the social functioning of the family group as a whole." Further refinements of "family-centered" casework and family diagnosis will perhaps shed new light on the problem of discontinuation to which the interaction of the family members as a whole has not yet been related. The idea, however, has been suggested: "The nature and

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quality of the interaction between significant members of a family are vital factors in the prognosis for any one of the members seeking a more effective personal or family adjustment." In this quotation the meaning of the word 'prognosis' might include those clients with an ability to continue in treatment as opposed to those with a tendency to discontinue before treatment can reach a satisfactory conclusion.

The efforts of social workers toward the development of a true "family-centered" casework are an indication of the maturation of social work. Continued exploration and discovery in its development will sharpen our diagnostic skills and, particularly in the child guidance setting, will assist in selecting those treatment goals most conducive to family participation and client-continuance. Perhaps one of the most significant of these goals is to keep the client in treatment.

Some attention will now be given to the agency which constitutes the setting of this study and from whose treatment services the clients in question withdrew.

Setting of the Study

The history of the Child Guidance Movement in British Columbia has been discussed in detail in earlier theses to

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1 Gomberg, M. Robert, & Levinson, Frances T., Diagnosis and Process in Family Counseling, New York: F.S.A.A. 1951, p. 22

2 See Coyle, Phyllis, Travelling Psychiatric Services, University of British Columbia MSW Thesis, 1955

which the reader is referred. The setting of this study is the
major unit of the British Columbia Provincial Child Guidance
Clinics which is located in North Burnaby. The Clinic is a com-
munity agency in which specialized professions combine their
knowledge and skill and attempt to employ the resources of the
community to meet the problems of children who are poorly adjusted
to their environment and have unsatisfied inner needs. The Clinic
team attempts to study the child as he is at referral and in his
present environment; to get the family and community interested
in understanding the behaviour of childhood and the basic needs
of children; and to treat the particular patient according to his
needs.

The purpose of the Clinic is to detect and treat child-
ren's difficulties at a stage when actual help in the home and the
community is still possible and when community resources - edu-
cational, social, and medical can be used most effectively.

The contribution of the social worker is to explore
with the parents and child the nature of the problem and to help
them find methods to deal with it. The psychologist studies the
child through tests of intelligence, ability, interests, and per-
sonality, and may give remedial help of various kinds. The psy-
chiatrist's contribution is in the area of diagnosis and treatment
of underlying emotional problems and, with the nurse, he is re-
sponsible for the medical aspects of the problem.

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1 Hereafter, the Provincial Child Guidance Clinic in North
Burnaby, B.C. will be called "Clinic".
2 The New Westminster "British Columbian", article by Dr.
U. P. Byrne, January 11, 1956.
Functions

The primary function of the Clinic is that of study and treatment of children who have problems. In addition to this broad function the Clinic has responsibility in:

1. **Orientation** of individuals such as nurses, social workers, doctors, teachers, and mental health co-ordinators who are interested in the work of the Clinic and in learning about mental health principles. The Clinic also takes responsibility for the orientation of medical, nursing, psychological, teaching, and social work students.

2. **Community Education**. Through such media as lectures, talks, films, and case presentations the Clinic staff carry out a function of promoting mental health principles with such groups as Parent-Teacher Associations, parent's groups, service clubs, and institutes.

3. **Professional Education**. At present, Clinic staff give lectures or case presentations to students groups at the University of British Columbia, schools of education, medicine, social work, and nursing. Clinic staff also give lectures as well as orientation to affiliate nurses from various city hospitals.

4. **Student Placements**. At present the Clinic offers student placements for 4-8 social workers, 3 psychologists-in-training, and 1 psychiatrist-in-training.

5. **Community Organization**. Clinic staff participate in other agency committees concerned with the development of services and also participate in executive or advisory boards of other groups such as the Canadian National Institute for the Blind; Cerebral Palsy Committee of the Children's Hospital; Children's Aid...
Society of Vancouver (Family and Child Care Committee); Crippled Children's Registry (Medical Advisory Panel); Greater Vancouver Health League; University of British Columbia School of Social Work; Advisory Committee on Research, and others.

6. **Research Participation.** The Clinic at present conducts operational research along such lines as case flow, extent of services, and quality of services. The Clinic staff participates in research conducted by the University of British Columbia Neurological Research Department, social work students, psychology students, Crease Clinic, Department of Neurology, and the Community Chest and Council.

**Types of Services**

1. **Diagnostic.** The Clinic offers a diagnostic service to children up to 18 years to social and health agencies working with him and his family or guardians. This service involves full clinical examination of the child, followed by formulation of recommendations for treatment, which is part of the continuing responsibility of the agency presenting the case. "Re-examination" is essentially the same as the diagnostic service and is available where repeated or supplementary examination is indicated.

2. **Consultative.** Like the diagnostic service, the consultative service involves discussion of diagnosis (and may include treatment considerations) at a conference between the agency presenting the case and the Clinic team, where the agency has continuing responsibility for the case. Unlike the diagnostic service, however, such consultation is not immediately preceded by clinical

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A description of a "full clinical examination" is given in the concluding paragraph, page 14
examination, though the patient under discussion may or may not have been examined on a previous occasion.

3. **Direct Service.** (a) The Clinic offers direct services to children up to 18 years of age, and their parents, on the application of the family, or on referral of professional individuals or organizations. This service involves full clinical examination. Treatment is the responsibility of the Clinic alone. (b) Co-operative or Joint Service occurs when simultaneous services of the Clinic and another resource are indicated, and may involve joint diagnostic and treatment services. Responsibility is carried jointly, the Clinic or the other agency being determined as the major one by mutual agreement.

The Clinic is prepared to deal with many types of problems. These include almost any behaviour which is disturbing to the parent or child and which, if continued, might handicap the child's general adjustment in life. They may be such outward problems as lying, stealing, chronic enuresis, truancy, and defiance. Also, there are problems of withdrawal as manifested in excessive shyness, fear of attempting new goals, setting too high standards, overdependency on parents, and reluctance to mix with other children. All children may show some of these symptoms to some degree. Cause for concern is when their behaviour swings beyond 'normal' limits.

There is also the problem of the retarded child. The Clinic aims to determine the extent of his deficiency and helps the parent to deal with this slow child so that he will develop to the maximum of his own ability.

**Diagnostic Evaluation Period**

In this study of clients who have discontinued treatment
the writer will examine only cases in which the Clinic team assumed full responsibility in treatment services. The cases to be studied will have completed the diagnostic evaluation stage of treatment, and have accepted the Clinic recommendations for continued casework services which would be available after the waiting-period. Some discussion of the diagnostic evaluation period will be beneficial to the reader's understanding of the services received by these clients up to the point of their discontinuation.

At referral, which is usually made by the parent, the duty worker obtains a statement of the problem. The case is passed to a worker of the Intake and Brief Services Section when his caseload permits. This may involve a wait of up to three months. This worker performs the preliminary intake study, usually one or two interviews with the parents in as many weeks, after which the case is presented at an intake conference. At this point a decision is made whether or not the case can benefit from Clinic services. If it can, it proceeds through the diagnostic evaluation period. A planning conference provides an opportunity for planning based on the needs of each case. At this time appointments are set for a future date when the psychologist will see the child and when the psychiatrist will interview the parents and child. During the interim period the social worker will have regular interviews with the parents exploring with them the nature of the problem and their feelings and attitudes around it. He also prepares a social history which is completed by the time the psychiatrist

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1 Refer to description of "Direct Service (a)", p. 17
has his first interview with the family. A diagnostic conference is held following this clinical examination of the child. Here, the multi-disciplined approach is employed to arrive at a psychosocial diagnosis of and treatment plan for the child based, to as great a degree as possible, on his total needs in relation to his total environment. Treatment may consist of various recommendations including brief or continuing services. The latter means treatment of relatively greater length, usually from two months to several years in some cases. In practice, most of these services are currently given by social workers. A great deal, however, depends on the appropriateness of the case and on the time available among staff of other disciplines to give treatment. This marks the end of the diagnostic evaluation period which, as noted, will have been completed by all the clients forming the subject matter of this study.

**Social Service Department**

For clarification purposes a brief mention of the Clinic's social service department might be helpful to the reader. It is divided into two main sections as far as direct services are concerned; the Intake and Brief Services and the Continued Service sections. Cases which are recommended at diagnostic conference for continuing casework services are transferred from Intake to the Continued Service Section. While routine transfers are not considered desirable in themselves, they are made inevitable by the sectionalizing of the social service department staff. This structuring was made to adapt to overall developments in the Clinic's program. One of the several factors leading to changes in the program was that the demand for services increased out of proportion to the number of staff available to give these services.
This resulted in the development of a waiting period for services. Prior to the creation of the two sections in 1954, applications were received by duty workers, following which each case was assigned to a social worker, who would be responsible for all social services required by the case until its termination. As the volume of clients increased a substantial waiting period developed between application and assignment. This was considered undesirable because some cases needed attention immediately: referral to other agencies could be more accurately determined if further exploration was done while other cases seemed more amenable to treatment at the point of initial application. The Intake section was therefore created to augment the clinic's efforts to provide uninterrupted service from application to the end of the diagnostic period, and treatment service of a brief duration. Thus, the waiting period, originally at the outset, was moved progressively forward until it remained stationary at the point following the diagnostic conference and prior to continued service. This meant that only cases recommended for long term treatment (about fifteen per cent of all applications) were obliged to wait. The length of the waiting period varies from virtually none to one and one-half years, depending partly on staff numbers and on priority of cases.

The Intake caseload has increased to the point that another 'wait' has developed at the outset. Priority of assignment is essentially chronological but is also given on the basis of problem and of the intake worker's evaluation. It is the intake worker's responsibility to prepare the client for the waiting period and for reassignment to the continued service caseworker.
The client should also be psychologically prepared for the treatment, including the reasons for it.

Focus of the Study

The purpose of this study will be to explore the problem of client-discontinuation from treatment at the Clinic. Although it may occur at various points in a case withdrawal or discontinuation in this study is defined as the parents' severance of contact with the Clinic at the point when continued services are offered following the diagnostic evaluation and waiting-periods. "Treatment" is defined as beginning at the first contact between the client and the Clinic.

Administrative implications of the problem will be discussed, including an evaluation of the waiting-period and some suggestions as to how it might be utilized in a therapeutically significant way. Reference will also be made to the importance that Clinic workers recognize resistive clients at the beginning if the problem of withdrawal is to be effectively handled.

The study will also hopefully elucidate hypothetical "indicators" which, when applied to future cases, might have prognostic value in determining which of those cases are likely to withdraw. Once alerted to this danger, the worker can prepare for it, adapting his skills to help a particular client continue through treatment to termination. This is a step toward a more effective refinement of treatment goals and a more accurate prediction of treatability. The goal of all research is ultimately prediction, and an exploratory study such as this is an imperative prelude to a more refined method of prediction.
In Chapter Two the problem of discontinuation will be examined in five case studies and five follow-up interviews conducted by the writer. It is hoped that this limited exploration will facilitate a greater understanding of the problem as it operates in withdrawal cases as a whole.
CHAPTER II

The Reasons For Discontinuation

A total of forty cases were examined as potential material for this study. These were cases in which parents and children withdrew from treatment during the period January 1, 1954 to December 31, 1956. Many of the cases were eliminated because their points of withdrawal differed. Others were disregarded because the recording of the interviews during the diagnostic evaluation period was not sufficiently detailed to illuminate the problem areas which are under scrutiny by the writer. To have used the latter would have entailed so many assumptions on the part of the writer as to make the study invalid.

Many of the forty cases scanned did not state precisely that discontinuation had occurred contrary to expectation. In other words, no assessment was recorded of the client's capacity to continue treatment. A large percentage indicated that the workers did not verbally suggest to the clients the value of continuation. It is recognized, of course, that the recording is often summarized and does not include the subtle but meaningful content of the clients' responses when contact for continued services was made.

There was a variety of responses from the clients to the suggestion of a follow-up interview by the writer: two were agreeable when the first telephone contact was completed; two were quite
resistant and it was necessary to call them three times each over an interval of three weeks; one mother requested that a second call be made so that she might rearrange her schedule in order to accommodate the interview. The writer thought it worthwhile to expend this amount of time arranging the interviews because, if at all possible, it was desirable to interview those clients whose case records were most suited to the study.

Methodology

The research methodology used in this study included summaries of five cases in which parents withdrew from treatment at the Clinic. The selection of the five cases was based on richness of recording and on accessibility of the clients for follow-up interviews. The purpose of the case summaries was to elucidate and identify factors or indicators in the diagnostic study interviews which might constitute the basis of a prediction of withdrawal from treatment. This was accomplished by using a schedule focused on the parents' relationships with the Clinic, their responses to and conception of the child's problem, and significant events in their background which seemed relevant to the problem.

Five follow-up interviews were held - four with mothers, and one joint interview with a mother and father. The interviews demonstrate the clients' verbalized reasons for discontinuation. The results were achieved by means of a schedule upon which the interviews were structured and which focused on the attitudes of the clients to their total Clinic experience. This was related to whether or not the Clinic had, in their opinion, been helpful, their feelings about the waiting-period, and their suggestions as to how the Clinic services might be more helpful.
The cases in this study are not intended to represent a cross-section of all cases which have withdrawn from treatment at the Clinic. It is suggested, however, that associations detected in these five cases may and probably will be found also in others. This is based not on their statistical representativeness but on the fact that the associations discovered are consistent with pre-existent bodies of theory which it might be assumed will apply in comparable measure to the cases not studied. Further study is required to determine the validity of this assumption.

In this chapter the reader is introduced to the cases used in the study. Each case is presented separately in the following sequence: case summary and interview, followed by a discussion of the implications of the interview for the study. The chapter concludes with an assessment of the help received by the clients as a result of their Clinic contact.

The focus in Chapter Three will be on the elucidation and illustration of "indicators" or patterns which are common to the cases as a whole and which, if applied to additional cases, might serve to predict withdrawal from treatment. The last half of the chapter will include a discussion of the clients' reasons for withdrawal from treatment, based on the five interviews.
Mrs. Anderson, at the suggestion of the family doctor, referred her eight year old son Billy for Clinic help. She described him as a high strung, nervous child who rolled his eyes, cried excessively, and acted out by lying and stealing. It was evident from the beginning that Billy was reacting to extreme overt rejection by his mother.

She attacked Billy viciously during her eight interviews with the social worker. Such denunciations as "he's been a miserable kid since the day he was born," "I certainly didn't plan on having a boy," and "if I'd given in to him I would have killed him," illustrate her intense hostility. Guilt feelings would seem to have prompted the referral, for mother said, "I sometimes wonder and worry about what I am doing to Billy." Her understanding of the situation remained at this intellectual, superficial level without the motivation required to involve herself in the examination of her own feelings so that her behaviour toward Billy might be modified.

Father's role in the house was a subordinate one. He admitted spending little time with his family owing to pressures of work and community activities. He acquiesced in his wife's assuming the role of disciplinarian although he sometimes "felt" she was too strict. He thought his wife exaggerated Billy's problems but realized his almost detached position.

Both parents spoke fondly of the younger sibling, Teddy, aged four. He was described as appealing and loveable.

Mrs. Anderson's childhood was marked by an intense, unresolved hatred for her father. She wondered fleetingly at one point if she were destined to treat Billy in a manner which rehearsed her father's treatment of herself and her siblings. Particularly vivid in her memory was her father's cruel attitude toward her only brother, (her favourite sibling). It would appear, therefore, that Mrs. Anderson's treatment of Billy was related to her feelings about her father. This becomes more conclusive when we discover that Mrs. Anderson's father, "strangely enough, thought the world of Billy." With the exception of the two instances already cited, mother saw Billy's behaviour as a calculated attack upon herself, separate and apart from her own personality, and controllable only by aggressive, punitive punishment.

Both parents indicated acceptance but little real understanding of the diagnostic evaluation period. Father was a co-operative, unenthused participant. It would seem that mother made the decisions and he went along to keep the peace. Mrs. Anderson herself related positively to the worker but used the relationship solely to verbalize her hostility toward both Billy and her father.

Her affect was markedly aggressive and negative, with some distress around her guilt feelings. She missed two appointments without explanation. Although the writer noted that the first cancellation followed the interview in which Mrs. Anderson had a "glimmer" that she might be acting like her father.
She asked the worker for help in interpreting the Clinic to Billy: "I don't see how I can tell him that the Clinic will help because I don't think he feels he is unhappy." She was unable to follow the worker's suggestions. Mr. Anderson finally had to assume responsibility for discussing the Clinic with Billy.

Mrs. Anderson brought Billy for his first Clinic appointment explaining to him that he "was going to meet a new friend." After he had gone with the psychologist she again described his miserable behaviour to make sure the Clinic people would not be fooled by his "act" today.

At diagnostic conference Billy was described as reacting to his parents' (largely mother's) controls and rejection. Continued casework services were recommended for mother and Billy with less frequent contact with father. Mother required interpretation of Billy's needs, child behaviour, and also needed help to recognize and understand her own hostility. Further exploration was recommended into Mother's relationships with her own parents and brother. Father was to be encouraged to give more attention to Billy. The team members considered the prognosis to be good.

Clinic findings were interpreted to the Andersons separately, first with father and then with mother. Little is recorded of Mr. Anderson's comments except that he appreciated the help received and would try to give Billy more attention.

Mrs. Anderson was restrained and anxious during her last interview. She asked what was meant by "treatment", and expressed doubt that she could ever behave differently with Billy. The waiting period was explained as was the change in workers. Mrs. Anderson's reactions to this, if any, are not recorded. A tentative appointment was arranged for another interview prior to the waiting period. She did not seem anxious for this and did not keep the appointment.

Mrs. Anderson refused to continue treatment when the Clinic worker called her after a waiting-period of thirteen months.

Telephone Contact

I called Mrs. Anderson this morning. I said I was calling in respect to the letter she had received earlier this week from the Director. She said, "Oh yes." I wondered if she felt she would be able to have an interview with me as the letter had suggested. With some hesitation she replied, "that all depends on whether or not I have to come out to Burnaby." I assured her that we had not considered this and that I would be pleased to come around to the house if that were convenient. She thought that would be fine but she really didn't think she'd be able to help me as the only person she had seen at the Clinic was Mrs. J. I could understand that and knew there may be things I would ask that she would feel she was unable to answer. There would be no obligation involved and we would just discuss things that she felt she could in relation to what she remembered of her Clinic contact. She seemed to relax somewhat and said, "in that case you can come anytime." I suggested today but wanted it to be at a time when
she was conveniently at home. She told me of having some shopping to do this morning before Billy came home for lunch. I wondered if this afternoon would be agreeable around 2 o'clock. She said that would be fine. I thanked her and said I'd be calling on her later.

Comment: There was some anxiety in Mrs. Anderson's tone and hesitation. This lessened when she was assured that the contact was definitely to be geared to her convenience and that she would not be pressed to discuss things that would embarrass her, either from lack of knowledge or, I assumed, in relation to personal involvement.

Interview with Mrs. Anderson

At the beginning of the interview Mrs. Anderson seemed anxious and found it difficult to converse spontaneously. She relaxed, somewhat, after I had described the purpose of my visit. I hoped, from her past experience with the Clinic, that she might criticize it in the light of her reactions and impressions. When I mentioned that our interview would be confidential, she indicated that it didn't affect her one way or the other.

Mrs. Anderson, at first, said the Clinic had helped her. In this connection she referred to her fondness of the social worker. She then mentioned the waiting-period; "They told me I'd hear from them in December, but no one called until July." By this time, Mrs. Anderson continued, "the Clinic moved way out to Burnaby." She stated that to take Billy out there would have meant his missing a day of school. To summarize her thoughts about the waiting-period she said: "it was far too long and made me lose interest."

I mentioned that, had she returned to the Clinic after the waiting-period, she would have had a different social worker. She acknowledged this. I asked if this was a reason for her discontinuing Clinic contact. She had not given the matter much thought. She did suggest, however, "that it would be nice to have the same person right along" as she had thought so highly of her worker.

I still didn't have a clear picture about whether she had been satisfied with the Clinic. She replied, "well, Billy stopped stealing". Did this, I asked, occur about the time she was coming to the Clinic? She couldn't remember -- but she'd told him once and for all that he could either quit stealing or get out. She would not tolerate a thief in the house. "I meant it too -- either he quit or he got out". "So, he quit." She then tended to dwell on Billy's personality. "He has been miserable since the day he was born -- and still is; he bawled from morning till night when a baby and he's still a cry baby. He's also still stuttering" (for which she took him briefly to a speech therapist after being at the Clinic). He also had developed hay fever which she thinks is turning into a chronic sinus condition. "I did one thing you (the Clinic) told me --
I gave in and started doing up his shoe laces for him and still do most of the time." She elaborated, saying that she always had to fight with Billy to tie his shoes -- her worker suggested to her that she might give in occasionally.

I wondered if anything else came into her mind beside the shoe laces. She was disappointed in the psychiatrist in as much as she never did find out what he thought or what he'd said to Billy. He "whisked Billy away and brought him back and that was the last I ever heard." She looked at me intently, asking, "What does the psychiatrist say to the kids?" I thought perhaps his findings were included in what her worker had told her after the diagnostic conference. She couldn't remember. In fact, she really didn't find out anything. I suggested she think of her own interview with the psychiatrist and she could then perhaps remember some of his thinking. She couldn't recall seeing the psychiatrist. Then, lost in thought for a moment, she said, "Oh yes -- I did talk to someone, but I think it was a woman. Mrs. Anderson then asked me questions about the Clinic along procedural lines.

I questioned her about her understanding of parental involvement in Clinic services to children. She and her husband understood this -- then she said, "I told my worker that I was probably to blame for Billy's troubles, and I suppose I still am." I changed the subject and wondered if, on the whole, she felt she had not received what factual information she had hoped for in order to get at Billy's problems. She said that was about it. "Billy is still a baby and won't let me out of his sight -- in fact I have two babies, Billy and his Dad. Young Stevie, age 6, doesn't let anything bother him and is no trouble at all. She did feel sorry for Billy and wished he was a happier boy.

I thought Mrs. Anderson had been most helpful and thanked her for talking to me. She was pleased to do so -- then asked if we were still as busy as ever at the Clinic? I commented we had lots to do to keep us out of mischief. She laughed, calling to me, "thanks for coming."

Implications of Interview with Mrs. Anderson.

It would appear that Mrs. Anderson's attitudes toward the Clinic in terms of her total Clinic experience are predominantly negative.

On the telephone Mrs. Anderson stated that she would see me providing she did not have to come to the Clinic. It is not so much "what" she said as "how" she said it. In effect, she would resist any contact which involved her coming back.

At the beginning of the interview her rather flippant
attitude toward my discussion of confidentiality connoted a "don't care" attitude which, it would appear was dilute hostility. Although she said she was helped at the Clinic, she proceeded in a fairly direct way to show me exactly the reverse.

Mrs. Anderson complained of the waiting period, which we can reasonably assume was a conscious factor in her decision to withdraw. She spoke emphatically and negatively of the distance to Burnaby and remarked, that to bring Billy, would have deprived him of a day in school. She spoke positively of her social worker although she hadn't thought much in terms of reassignment: i.e. she presumably had decided to discontinue regardless of worker.

With reference to Billy's problem she stated it had changed in as much as he was stealing no longer. At that point she went on to demonstrate carefully that it was she, and not the Clinic, who was instrumental in this "improved" behaviour. Aside from this she described the boy as being "as miserable as ever" and still a "cry baby." His problems have increased with the onset of hay fever and a sinus condition. The writer interpreted her remark about the shoe lace to be of a snide nature; a hostile rebuke.

She showed a general lack of understanding in the area of Clinic procedures and seemed to expect a list of rules with which she might re-mould Billy. Such a modification, it would seem, would be more in line with her own needs. Her ability to use the Clinic findings was reduced to the question of whether she should tie Billy's shoe laces or make him do this for himself.
The writer felt she did grasp some significance of our stress on parental participation. This, no doubt, produced anxiety which she distorted into a hostile threat to herself and which soothed the guilt aroused by her rejection of Billy. Thus, her ego was left well defended. Her sadistic need to keep Billy dependent on her so that she can repulse him remains unchanged. Her verbalized wish that Billy be happier bespeaks an unchanged attitude since Clinic contact.

She expressed her conscious feelings that the Clinic could improve its services by providing more factual information as a means of correcting problems.

Summary: Mrs. Anderson was not helped by the Clinic. Her discontinuation would seem to be consciously related to the waiting-period, distance to the Clinic, and the lack of presupposed factual help but basically reflects the threat to her ego and the resulting resistance to any personal involvement which would have to precede internal growth and change.

Case No. 2 - Larry BENNETT

Mr. Bennett took the day off from work to contact the Clinic about his seven year old son, Larry. Both parents were seen the same day. They described Larry as having a "twin-complex", being resentful and jealous of his twin brother. He felt unwanted. They were also concerned about such nervous habits as nail-biting and a "mean" attitude in play.

The twins' Sunday School teacher had recommended the Clinic two years ago. The parents felt, at that time, that they could continue without help as they weren't desperate.

Mr. & Mrs. Bennett both impressed the worker as intelligent but essentially cold people. They appeared willing to look into their handling of Larry as they verbalized the belief that the child's behaviour stems from the treatment he receives. "They were able to intellectualize and use psychological terminology but it was difficult to know how superficial these were."
Mrs. Bennett had nine interviews with the worker. Throughout, she expressed an "understanding" of what Larry's behaviour actually meant. She could not, however, tolerate it unless he could adapt it to her code of acceptable rules of conduct. Larry would act out to attract her attention when she was busily engaged in some activity with the brother. To cope with this mother would push Larry away, rejecting him completely until he could apologize. When this failed she could "try something else". Her methods were inconsistent, devoid of any warmth or attempts to talk through the difficulties with Larry. She was fearful of helping him through his behaviour difficulties lest she appear "condoning".

Mr. Bennett, intellectually inferior to his wife, attempted to convince the worker that he knew all about child behaviour. He was unable to carry over his "knowledge" into the realm of application. Rather, he adapted his parental role to the rigid mould expected by his wife.

Both parents described Larry's traumatic car accident when he was two and which involved months of treatment as well as intense suffering for the boy. They feared, however, that he might use this as a crutch for the rest of his life as a justification for misbehaviour. They spoke much more fondly of the twin sibling -- a more appealing boy, not so intelligent as Larry, but a beautiful looking child who always received first attention from friends and acquaintances.

Mrs. Bennett's childhood "couldn't have been happier". She seemed particularly close to her father who was intelligent, a high school headmaster, and "a very progressive thinker" "He was a strict disciplinarian but always fair". Her mother "did not have father's intellect but was more his passive supporter". Mrs. Bennett had a sister and two brothers. She also had nursemaids until her eleventh year. Her family were firm believers in "co-education". She studied for a year at an outstanding University and, during the war, held responsible positions in one of the armed forces. She met Mr. Bennett overseas and came to Canada after the war to marry him. She was very lonely at first and there are indications of early marital difficulty. (Social Service Index recorded two contacts with a family agency. Mrs. Bennett would not give the worker permission to investigate these contacts which she described as "help through an initial period of adjustment"). She said the people at the family agency were kind and that she needed someone to take the place of her mother over here. Since her marriage, Mrs. Bennett has continued with her profession. She admitted the tremendous "drain" of the twins on both herself and her husband. Although it was a planned birth, they did not expect twins.

Mr. Bennett from an early age, separated himself from his home and school to pursue sports in Canada and the United States. He was one of eight children; he told the worker he was "unable to recall much about his parents". During his three
interviews he conveyed his feeling that he wanted "advice" from the Clinic -- "new ways of handling situations." He thought that some "new methods might help Larry to change his attitudes." The worker recorded: "it is my impression that Mr. Bennett expects a greater change in Larry than he is prepared to make in himself."

Both parents were ambivalent about coming to the Clinic. Mrs. Bennett wondered how Larry would feel when he grew older and knew more about his contact at the Clinic. She was adamant in her refusal to tell him the purpose of the visits.

Mrs. Bennett's discussions were intellectual and controlled, with little affect. She seemed inhibited and fearful of showing any emotion. She was also inclined to think carefully before speaking as if she feared that the meaning behind her words might be "significant."

At diagnostic conference Larry was seen as insecure, dependent, and jealous. He saw his twin as being more favoured than himself. He showed many compulsive traits and was thought to be reacting to the mechanistic handling of his mother in her relentless emphasis on perfection and on good behaviour. Treatment would include a "de-emphasis" on Mrs. Bennett's perfectionistic expectations. The team recommended that the twins be placed in separate rooms at school. Continued services were recommended for Larry and the parents while the home situation (concerning the other boy) was to be watched from a preventive standpoint.

Clinical findings were interpreted first to Mrs. Bennett who "wrote everything down" as the worker talked. She was apprehensive of "treatment" and expressed concern about her own role in it. She agreed to continue after the waiting period and hoped her husband would increase his participation.

Mrs. Bennett refused to continue when contacted after a six month waiting period. She said she had learned a lot and that they "could now cope quite adequately with the situation."

**Telephone Contact**

I telephoned Mrs. Bennett and explained that my purpose in calling was in connection with the Director's letter. She said that when she received the letter she realized she would be away when I called but that there was no way to let me know. I appreciated the situation and wondered now if it would be possible for me to see her as outlined in the letter. Quite quickly she stressed her busy schedule -- working five days a week, with only Saturdays and Sundays at home. Things are additionally complicated at the moment because they are house hunting. I said I could well visualize how rushed she was. She asked me what I really wanted to find out in the interview, I mentioned the Clinic's interest in gearing it services to the needs of the
community. We thought it would be particularly helpful to talk to a few people who were, at one time, in contact with us. It was difficult selecting people but we had thought Mrs. Bennett could be very helpful.

She told me she had some knowledge of the Clinic through professional contacts. Then too, she could remember a little of her own Clinic experience, although it was a long time ago and she "quit early" because she felt "there was no necessity to carry on." I thought her comments would be especially helpful to us, both in the light of personal and professional experience. She wondered if she might suggest a tentative date now for some Saturday and call me to change it if necessary. I thought that would be fine and wondered if she would rather think about a time over this weekend and call me next week. Mrs. Bennett was pleased with these arrangements. She presumed "an hour" would take care of the interview to which I agreed readily. I thanked her and would be expecting her call.

Comment: Mrs. Bennett had a refined, European accent. She was apprehensive and resistive at the beginning, but mellowed when I was able to appeal to her vanity, i.e. "she" could be especially helpful.

Interview with Mr. & Mrs. Bennett.

Mr. and Mrs. Bennett welcomed me with a slight reservation. I could hear the chatter of boys' voices behind a closed door. While Mrs. Bennett went in to "settle them down" I chatted to her husband. He was clad in a dressing gown and hoped I didn't mind. He'd had a busy day and felt like relaxing tonight.

Mrs. Bennett joined us in the living room and I explained the purpose of my visit. The Clinic, always anxious to adapt its services to the changing community, was interested in the suggestions and feelings of people who had come for help in the past. Mr. Bennett asked if I were interviewing a cross-section of our former clientele. I told him that was pretty much it -- I hoped to get a broad range of ideas and criticisms.

Looking directly at me, Mrs. Bennett said, "I presume you wish us to be perfectly frank." I assured her of this. She then told me the Clinic hadn't at all given them the kind of help they wanted -- "or needed, for that matter". Of course, "we just came to the Clinic to see what it had to offer." Mrs. Bennett continued, explaining her contention that the Clinic never did get to the "core" of the problem. "They concentrated on us instead of on Larry."

Mr. Bennett spoke up saying that their problem with Larry was not "cut and dried" like he supposed many family problems were. If a child were mentally retarded, or had a "hate" complex, or some other gross personality disturbance, he thought
the Clinic might be able to do something about it. Mrs. Bennett added, too, that "if the problem was with the parents, rather than the child" it might be suited to the Clinic's way of "treating". Both felt their problem did not fit into any of these categories.

Mrs. Bennett continued: "and I certainly didn't approve of the way they planned to treat Larry; I just don't believe in it". I asked if she would elaborate. "Well, the worker told me someone would see Larry for an hour a week or every two weeks ("or whatever it was"); during this hour he'd be given complete freedom of expression. If he felt like writing on the walls or being destructive ("not that I think he ever would, mind you"), the behaviour would be perfectly acceptable. "Just think what I'd have had to put up with - you people letting him do exactly as he chose, then he'd expect to do the same thing at home - I don't believe in it at all".

I accepted this and wondered if this was the interpretation of "treatment" as given to her by the worker. She thought so. She remembered the worker's emphasis on a "relaxed, permissive atmosphere". I said this might possibly include a re-directing or unacceptable behaviour. She replied, "now, I do believe in that". Here, Mr. Bennett told me how he attempts to distract Larry's attention when he is acting out in a destructive way. He thought this was a good "rule to follow" but it was just as easily done at home as at the Clinic.

Mrs. Bennett, waiting impatiently for her husband to finish, said, "mind you, we knew what was at the core of Larry's problem. He was terribly injured when he was two. Mr. Bennett interrupted and told me of the traumatic ordeal which Larry had suffered - excruciating pain, weeks of hospitalization, skin grafting, and months of dressings and anguish. "He emerged a complete nervous wreck". His wife supported him, saying that the doctor ("who was a lovely woman") warned them it would take years for Larry to outgrow the severe damage he had suffered. "Of course there were other smaller things". Larry's twin brother was a "beautiful baby", endowed with charm and appeal. From the very beginning people took to him first. Even babies, she felt, can sense how others feel toward them. "Larry has always had a twin-complex and had felt in the background where his brother is concerned". I noticed Mrs. Bennett spoke warmly and proudly of the other boy, and more mechanically of Larry.

"At the time we came to the Clinic I was desperate-not knowing how to handle Larry". I asked whether or not the problem had changed since their Clinic contact. She said he is improving slowly, and looked to her husband for confirmation. She quoted a friend who made the following observation of the boys when they were five years old. "Larry will get to the top, regardless how he does it or on whose toes he may tread: the other boy will get to the top too, but it will be because of his simple, pleasant, sincere and appealing personality". Mrs.
Bennett said she couldn't bear to think of Larry going through life without scruples.

I said they might have some additional thoughts about the Clinic to give me. I wondered if they'd felt any reaction to the waiting period. Mrs. Bennett replied instantly: "I meant to bring that up - "it's a terrible thing - why, when I was phoned after all those months it was like a bolt out of nowhere." She thought most people had to "get up a lot of nerve to ask the Clinic for help in the first place -- to her, the waiting period just added insult to injury." Mr. Bennett confirmed this saying the wait caused their final decision not to continue. He said, "if you'd get rid of that, you probably wouldn't lose so many people."

Mrs. Bennett said she enjoyed her two visits with the psychiatrist, "not that she helped me but our talks were interesting." She rather liked talking to the caseworker too. "But, I went for interview after interview, time after time, and we talked and talked -- mostly about me and what Larry had done the week before. All mothers, I presume, enjoy talking about their children, but this wasn't solving our problem." She knew it was absolutely impossible for anyone to give a true picture of how one member of a family behaves. I said she felt an individual could not be isolated from the family as a whole. "That's it exactly."

Mr. Bennett expressed his feeling, saying he spoke for his wife as well, that the Clinic wasted hours going into their backgrounds. "If we had been part of the problem, then O.K. "As it was, they could have learned all that was necessary about our childhoods in half an hour." His wife said she understood the Clinic's concern with finding out whether "our childhoods were happy and our parents maladjusted"; but, she felt, the worker should have sensed that she was "overdoing it" and not getting anywhere.

When I asked about improvements in our services, they visualized as desirable, Mrs. Bennett said, "Well, if you are going to pursue this long term treatment you need a home where the children can "live in" and are exposed to your kind of treatment-atmosphere twenty-four hours a day. She repeated that an hour a week was, in her opinion, little better than nothing. I talked a little about the need for a home for emotionally disturbed children in the Vancouver area and stressed the need for community support. I also wondered if Mrs. Bennett thought that all children who came to the Clinic needed this type of home. She thought so, if our treatment was to be effective --
otherwise, the parents would undo "any good" the child might derive from the weekly appointments.

She thought a moment, then said, "and another thing -- the worker made a home visit which I thought was alright but a complete waste of my time and hers." The worker wanted to "see where Larry lived, his room, and I suppose, how he fit into the family. Well, "you can't learn all that in one visit -- the children were naturally on their best behaviour. In some cases I think such a visit would be desirable, but in ours, there was no point to it, (not that I minded, of course)." I said social workers quite often visited homes and also schools if the class room was a part of the problem. This prompted Mrs. Bennett to talk about the problems which she had heard discussed at P.T.A. She asked what the Clinic does with children referred by the schools? She then described their principal, a family man of wide vision who arranged panel discussions regularly on child behaviour to help the parents in the district. Mr. Bennett said this was a good idea as parents came to feel they were not alone with their problem children. Mrs. Bennett felt she got more help from the panels than she had any other place.

We chatted pleasantly for a few moments. When leaving, both Mr. & Mrs. Bennett followed me to the door and thanked me for coming. Mrs. Bennett said she had "quite enjoyed our talk and she hoped our paths would cross again sometime."

Implications of Interview with Mr. and Mrs. Bennett

Both parents demonstrated great hostility toward and a complete rejection of their Clinic experience. This, the writer suggests, reflects their basic personality patterns, or at least, the interaction of these patterns. Mrs. Bennett's great need since youth has been to be intellectually superior to all males. While the case history points out her attachment to her father, the writer felt there was also an undertone of competition and hostility. She was compelled to be his intellectual equal and felt disdainful of her mother who was his "passive supporter". She is basically narcissistic, tolerating nothing which threatens her own strivings toward perfection. She married a man who is intellectually inferior to herself and whom she can manipulate. Larry, who is strong-willed and intelligent, threatens her position as a superior female and reactivates basic childhood
conflicts of dominant male figures. She can accept the other child who does not threaten or question her superiority. Also, because of his fine looks and appealing, pliable personality, he is a near perfect production of her own need to nourish and strengthen her narcissism.

In direct response to the schedule, Mr. and Mrs. Bennett stated that they were not satisfied with the Clinic's services. They strongly condemned the waiting period in terms of our "losing clients". The wait was, for some reason, intolerable to them. The writer felt that the change in social workers following the waiting period was not a factor in their withdrawal. This assumption is based on the fact that the initial resistance to help was still operating strongly at the end, and that both parents did not involve themselves in the relationship with their worker. Hence, a change would not seemingly be too disturbing to them.

Larry's problem, they stated is gradually improving. The improvement is due to their own versatile disciplinary methods rather than to any help received from the Clinic. The Clinic did not help - which, it would appear, is precisely what the Bennetts' wanted. They could not tolerate any suggestion of their own part in creating the problem and so wished to reassure themselves that no outside help was available and that only "they" were equipped to deal with the problem. They strongly resisted personal involvement and appeared to have no conscious appreciation of the need for parental participation. This is substantiated by Mrs. Bennett's feeling that the worker's home visit was a waste of time, and that her interviews, by focusing on herself, never did approach the "Core" of the problem.

Their suggestions for Clinic improvements were geared
toward a greater awareness needed by the staff in deciding "how" to help people. Mrs. Bennett also suggested a "home" for the "Clinic children" which seemed to exemplify her rejection of Larry. She might have been saying, "if I can't do anything with him at home, I would rather not have him around."

Both parents responded to the writer's acceptance of their hostility and criticisms. They were pleased at having the opportunity to ventilate their feelings. Because of their strong defence mechanisms, particularly those of Mrs. Bennett, they consciously believe that the Clinic was entirely at fault and the only determining factor in their discontinuation.

There is also, it would seem, a cultural factor in this case. Mrs. Bennett was reared in a particular stratum European society which emphasizes the dominant, intelligent parent and the obedient, conforming child. Larry's problems and her own appeal for help would immediately create a conflict. With her status and competency as a parent so obviously threatened, it is not difficult to assume this as being a contributing factor to her withdrawal from treatment.

Case No. 3 - Jimmy COOK

Dr. M. referred Jimmy, age eight years, and accompanied Mrs. Cook to the Clinic to give statistical information. Mrs. Cook described Jimmy as an inordinately aggressive child who was without playmates for this reason. At home Jimmy was particularly jealous of his older brother and when teased, would "fly into a frenzy" and become destructive. Although a stoic where pain was concerned, he continually whined and cried when frustrated by his parents or siblings. "He occasionally has periods when he wets the bed every night, and also messes his pants". His mother also complained that he ate rebelliously. "Mrs. Cook", recorded the worker, "made it clear that she is very much disgusted by messy eating and toilet habits". The symptoms of Jimmy's disturbance were evidently in areas which had special meaning for his mother. During the first interview she was, at one point, on the verge of
recognizing her rejection of Jimmy - "life would be so easy if it weren't for him". She asked the worker for "guidance in handling Jimmy".

Mr. Cook was not cooperative with the Clinic and did not come for an interview before the social history was written. The worker deduced from Mrs. Cook's remarks that her husband had a more "straight forward relationship with the children than she", with less ambivalence. His attitude toward Jimmy's problem was entirely detached and uninvolved as indicated in his interview with the psychiatrist. He said he was away from home alot, but "tried" to play with Jimmy when it was possible. He expressed rigidity about all the children "eating everything that was on the table". He was more inclined to direct the psychiatrist's attention toward himself, for he said "Jimmy understands me better than my wife". It was recorded, "Mr. Cook is somewhat opposed to the Clinic, feeling that his wife is exaggerating her troubles with Jimmy".

Mrs. Cook was raised in a "very loveable" family in which she was the oldest child. She had one brother eight years her junior. She said little of her father but described her strong tie to her mother for whom she quit school and whom she nursed when she suffered a nervous breakdown at menopause. There were indications of strong sibling rivalry for her mother's attention. "My brother was a strange child who still lives with my widowed mother and finds it hard to make friends." "My doctor told me one time that I was too close to my mother - but I tell her all my troubles - you have to tell them to someone". Her father, now dead, seemed to play a minor role in the family constellation.

Mr. Cook had a deprived childhood, being raised by housekeepers and nurses because of his mother's chronic ill health from the time of his birth until her death eighteen years later. His father was away most of the time operating a fleet of trucks. At the present time he has a good job and provides well for his family. He is gregarious and "loves to entertain". This it seems, is for self-glory.

The biggest problem and the one which seemed to concern Mrs. Cook primarily was her marital troubles. Her husband "ran around" after their marriage and "drank heavily". "The only time he has ever showed any concern for me is when I am sick and unable to do the work". She was very ill during her five pregnancies (the third child died at the age of eight weeks). After the fourth was conceived, Mr. Cook threatened to leave his wife unless she got rid of it. "However, he said the same thing next time but he grew to like the two youngest children - especially the baby girl". Jimmy, the second child, was conceived "to draw us closer together". The marriage has been a series of disputes, allegations, separations with Mrs. Cook going home to mother, and reconciliations. She resents her husband leaving to her the major responsibilities for the children, yet rebels when he makes suggestions. As a result, he undermines her authority with the children.

The worker described Mrs. Cook as "an extremely immature person who finds it difficult to meet the demands placed upon her as a wife and mother and who projects the blame for this upon her
husband who fails to meet her immature dependency needs. She is affectionate and patient with small babies but cannot tolerate the frustrations imposed by growing children with their multiple demands. During the intake study, she talked unhesitatingly. Her affect was expressed through grimaces and expressions of dejection. She was apprehensive about bringing Jimmy lest the school or neighbors find out.

Jimmy was very fearful when seen at the Clinic, refusing to let the psychiatrist approach him. Clinic findings showed him to fear rejection, have few inner strengths, and desiring to identify with father and be dependent upon mother but experiencing extreme frustration in both.

"Intensive treatment of Jimmy and both parents" was recommended at the diagnostic conference. Mrs. Cook came for the reports at which time the worker emphasized the need for consistency and parental cooperation in handling the children. Jimmy's need for approval and dependency was also stressed. Mrs. Cook showed little or no appreciation of the findings but tended to discuss her own poor health. She planned to have an operation which would hopefully improve her health and help her to meet her husband's "standards of housekeeping and to be more interested in Jimmy". She accepted the waiting period and said that by autumn she would be able to play a more effective part in helping Jimmy.

After a waiting period of nine months Mrs. Cook declined to continue treatment, saying that Jimmy had improved in many ways although he still "has tempers and cries without reason". Also, her dentist discovered an abscess on one of Jimmy's teeth and he thought this might have been causing the behavioural disturbances.

Telephone Contact

When I called Mrs. Cook she, unfortunately, had not received the letter and was thus caught quite 'off guard'. I explained the purpose for the contact relating it to the study I had undertaken. She said, "do you want to talk to me about Jimmy?" I reiterated that the purpose underlying the suggested interview was to find out what she thought about the Clinic based on her experience with it some time ago. We were concerned about what we might do to be more helpful. Mrs. Cook described the Clinic with some degree of pleasure, but added: "I guess it did me more good than Jimmy". She said she had been helped to understand Jimmy although he is still subject to "fits of bad behaviour". Later, she stated, "they made me wait for a year". I said these were the things that would be helpful to us.

She told me of being in poor health - she never knew ahead of time when she might be confined to bed for the day. Then, she asked abruptly, "when do you want to come?" I told her that Tuesdays and Thursdays were my days for these visits. She wondered if I could call back a week from today. She might be feeling better by then and she would think about it in the meantime.

Comment: Mrs. Cook spoke smoothly and fluently and was well in control. She resisted my suggestion of an interview. It
was thought that the arrival of the letter might help to alleviate any anxiety which the telephone call produced.

One Week Later

I called the Cook home again. Mr. Cook answered and told me his wife was not well and was spending the day in bed. He had a pleasant, friendly manner. He wondered who was calling and seemed interested. He suggested I call back in a few days as he thought Mrs. Cook would be better by then.

Three Days Later

I spoke to Mrs. Cook today. She said her health had not improved and that she preferred not to have visitors. I understood and said I should perhaps not plan to have the interview. This relieved her; she felt it was such a long way for me to come and told me how difficult it was to locate their home. Also, "I'm sure I wouldn't be able to help you - I told you everything last time on the phone". I remembered she had mentioned the Clinic. She said as far as she was concerned Jimmy wasn't helped at all. "All they did was give him a few tests like putting beads on a string. There's never been anything wrong with his intelligence - he does alright in school". I appeared interested so she continued: "They told me there was a problem behind his behaviour - but instead of doing something, they let us wait nearly a year". I said the waiting period seemed to be a major factor in her decision not to return to the Clinic. She said it certainly was. "The Clinic didn't have either the staff nor the facilities to handle our problem".

I asked if Jimmy's problem had changed since the time he was seen at the Clinic. Mrs. Cook replied: "he is changing very slowly - but he's still miserable a lot of the time, cries, and thinks nobody loves him". Here, Mrs. Cook sighed as if the whole thing were just too much for her.

I wondered if she had any thoughts about her own experience at the Clinic. She thought a moment, then said, "They should have spent less time going into my background and concentrated more on Jimmy - especially when we were going to have to wait so long". She concluded by saying Jimmy was still a real problem, and with her feeling sick most of the time and having to look after a large family, it was very difficult for her. I could understand that it was hard and hoped she would be feeling well again soon.

Discussion and Implications of the Cook Case

Although the writer was unable to interview Mrs. Cook personally, it was felt that sufficient material was gained by telephone to warrant using the case in this section of the study.

Mrs. Cook clearly demonstrated that she was not helped at the Clinic. She complained bitterly about the waiting period
and seemed to interpret it as rejection — "They made us wait a year". There were no indications whatever in the record that she was personally involved in Jimmy's problems except in so far as they were of constant annoyance to her. She also gained no awareness of her role in the Clinic procedures or of the need for parent participation; "they should have spent less time going into my background". She was not helped by her husband who, according to his pattern, allowed her to assume the responsibility of coming to the Clinic. Jimmy's problem has, apparently, changed very little which might be expected in view of his mother's persisting attitudes.

The main problem in this case at the time of Clinic contact would seem to have been the marital area. While Mrs. Cook openly denounced Jimmy's behaviour, it was on her relations with Mr. Cook that she tended to dwell. Jimmy seemed caught in the conflict and was reacting almost appropriately. The situation, of course, was aggravated because of his dependent tie to his mother.

It is interesting to recall Mrs. Cook telling her worker that the only time her husband took any notice of her was when she was ill. When the writer called recently on three different occasions, she was in bed and, on one of these, Mr. Cook was home from work. This was in the middle of the day. She intimated that she was chronically ill which would seem to point out a persistence and intensification of the pattern she demonstrated at the Clinic two years ago.

Discontinuation would seem to reflect the waiting period and a feeling of not being helped, on the conscious level, but also a lack of motivation and resistance to change and personal involvement on the unconscious.
Mrs. Davis called the Clinic to refer her nine year old daughter, Judy. The call was made after she and her husband had discussed the problem with a social worker friend. Mrs. Davis expressed concern about Judy's nervousness and discontent and about several incidents of stealing. She also described the mother-daughter relationship as tense and uncomfortable. Judy was showing intense sibling rivalry with her three year old sister. Both girls were born with congenital eye defects which required surgery.

Mrs. Davis said, "Judy does not confide in me" and she "gets along much better with my husband than with me".

It was not possible for the writer to ascertain the exact number of interviews held with each parent because they were incorporated into the social history directly. An estimate would be six interviews with mother, one with father, and one joint interview. Both parents voiced interest in continuing with the Clinic when procedures were explained.

Mrs. Davis verbalized concern about telling Judy of the Clinic and felt "there was nothing that Judy was concerned about at the moment". She seemed very concerned that Judy was not showing "penitence nor any regard for her wrong doings". She related well to the worker, talked easily and intelligently about the problem, and showed her main anxiety in the area of being a failure as a mother to Judy.

She grew up in a family of three boys and two girls in which she was the youngest sibling by ten or twelve years. Her mother died when Mrs. Davis was fifteen and her sister "took over" the family. Although the mother was "kind-hearted and happy", she was a domineering person and imposed restrictions on her daughter which made her feel that mother lacked confidence in her. "Both in relationship with her mother and sister, Mrs. Davis idealized their abilities and tried to emulate them". Yet, she was tortured by fears of inadequacy and of not measuring up to their expectations of her.

She mentioned her father only briefly, stating that he played a subservient role in the family and was not a success in a business sense. Her childhood memories were chiefly those of "not being able to please her mother" and of feeling "belittled" by her brothers who teased her a great deal.

Mr. Davis grew up in a family which placed success in life solely in terms of business enterprises. His father had high moral standards for himself and his family, and demanded hard work from his three sons in the family business. One of the sons was "wild" and died in his late twenties, while another boy, next to Mr. Davis, was his father's favourite. His mother was an outspoken but understanding woman and "she made up for the lack of sympathy in father".

Mr. Davis is driven to "do well at everything" and is very intolerant of his limitations. In view of this, it is possible
to speculate on the serious impact which congenital eye defects
in both children would have on him. (This was traced back to the
paternal grandmother). This prompted the Davis' to decide against
having more children.

At the time of Clinic contact Mr. Davis was suffering
from a blood condition for which he had been treated by eminent
specialists. He strongly denied any need for restricting his
activities.

Mr. and Mrs. Davis appeared to have a very compatible
marital relationship. She, never having had close friends, idealized
this man who lavished so much attention upon her. She told the
worker that her "best endeavours do not come up to his worst". He,
in turn, felt that his wife's "attitude and understanding" made
his success possible. He needed her dependency and admiration.
The worker recorded: "There is a deep affection and understanding
between this couple and a great dependency on each other in their
complementary attitudes and abilities".

Both parents seemed to see Judy in a detached sort of
way - almost as if she threatened their mutual gratification of
each other's needs. During Clinic contact, Mr. and Mrs. Davis
broke an appointment because they wanted to get away for a holiday.
This seems to have been a pattern by which Mrs. Davis escaped
periodically from the children. Her sister had been living with
them for several years. Mrs. Davis appeared to turn to her as a
continuing mother-figure for guidance and consultations concerning
the children.

At diagnostic conference Judy was described as aggressive
and hostile with limited satisfactions in inter-personal relation­
ships. She indicated antagonism toward dominant mother figures and
saw her role as trying to outsmart the mother. She was seen as
identifying with her father because of her feelings toward mother
and because of common attributes with father such as aggression
and determination.

It was recommended that continued services be given to
mother and child. "Mrs. Davis needs reassurance and support to
alleviate her feeling of failure with Judy. Her own efforts to
emulate her competent mother and sister play into her feeling that
she should be in control of Judy at all times".

The parents were accepting of the Clinic findings and
said that they helped to clarify the problem. Mother agreed to
continued services for herself and Judy following the waiting
period.

When Mrs. Davis was contacted thirteen months later, she
felt the problem had improved greatly and did not warrant addition­
al Clinic help. She said she would feel free "to contact the
Clinic if help were needed in the future".

Interview with Mrs. Davis

Mrs. Davis came to the Clinic for the appointment. She
was pleasant and participated intelligently in the interview. She
said the visit here had served a two-fold purpose; both to see me and also to have lunch with a friend in the neighborhood. I referred to our telephone conversation and her mention of attending lectures at University. She responded enthusiastically, describing one of her classes - anthropology - and her interest in that subject. I then told her my reasons for seeing her - that I was doing a thesis and that the findings would be of special interest to the Clinic. I hoped that she would be able to focus directly on her reactions to her Clinic experience and I wanted her to feel comfortable and to be as frank as she felt she could. She replied positively, saying that she would do her best but that she didn't have many criticisms to offer.

I asked her to begin, if she would, by talking about her satisfaction or dissatisfaction with the Clinic. She felt she was pleased with the experience and that it was valuable not only to herself but to Judy and her husband as well. It was difficult for her to highlight any specific thing but she felt she was helped to better understand Judy's behaviour. She thought that her fears of not being able to trust Judy had been dispelled. When they first came to the Clinic she and Judy were not comfortable together and she felt her daughter was not to be trusted. Now, she has been able to relax with her and allow her more freedom and self-expression.

We discussed, at my suggestion, the waiting period. She regarded it as highly undesirable - almost as though it negated the whole problem. "It was alright with us because our problem was not a serious one". She and her husband did wonder why they weren't contacted for nearly a year. However, when the Clinic did call they decided the problem had improved sufficiently so as not "to warrant subjecting Judy to the experience all over again". I asked if Judy had difficulty accepting the Clinic. This, she said, wasn't exactly what she meant. When they first brought Judy it was difficult to explain to her "why". They handled it by saying it was a good opportunity "to talk over our problems - everybody has problems". Had there been no waiting period Judy would have thought her regular Clinic visits as "routine" and quite "the usual thing". After the wait, however, "it just wasn't worth starting all over again".

She told me about coming out to the Clinic a few weeks ago to talk to a gentleman about "continuing". It was at this particular time they decided against it. I asked if she had any particular thoughts about seeing another worker (i.e. a different worker). "It would have been just like starting all over again and would have been hard on us all". She liked Mrs. P. so much - who was a friendly, dainty little person". I wondered about her reactions to the interviews themselves. She admitted being "very disappointed at first" and thinking that she was getting nowhere. She finally decided it was a situation which permitted "a catharsis for the mother" and it was then that she had some "feeling" of being helped.

I asked about her husband and whether or not he had been satisfied with the Clinic. She thought so and "he cooperated well". She recalled him saying, "if the Clinic can help us, I'll go and
am all for it". Mrs. Davis went on to explain that she and her husband had been interviewed "privately" and she really couldn't elaborate too much on his feelings because she didn't know. I accepted this.

She wondered if her children might be getting a very idealistic impression of marriage. I didn't quite understand what she meant. She stated that she and her husband have always got along together in perfect harmony. The children have never heard them speak a cross word to each other. Mrs. Davis expressed her feeling that many problem children were reacting to trouble or conflict between the parents but that this was just not the case in their family.

I asked if Judy's problems had improved. Her "nervous manifestations" still persist although they change in form. Here, Mrs. Davis demonstrated Judy's latest habit which is a twitching of the nose. "She is very high strung and will, I imagine, always need more guidance from us than our younger daughter". The latter, it seems, is more relaxed and less complicated. I asked about the sibling interaction. "They are sometimes loveable, but usually are at each other's throat". Her chief worry about Judy now is her dependence on her friends for making decisions and seeking support. She knew some of this was natural but wondered if Judy hadn't started a little younger than most. She then described a recent incident in which Judy was willing to assume responsibility for making excuses for a friend to her teacher regarding absence from a class. Mrs. Davis did not allow this and told Judy she must not assume these responsibilities for others. "Do you think I did right?" I suggested that only she and Mr. Davis would know best how to deal with individual situations as they arose. She accepted this.

She said there was something which had bothered her slightly during her interviews at the Clinic. I expressed interest and she told me of her feeling that the worker let her "talk too much without direction". She felt as though she didn't know where she was going or what was actually "supposed to happen". She felt perhaps she had talked alot and she was worried at the time about giving the "wrong responses". I asked if this feeling continued through to the end. She thought it decreased somewhat although "she did wonder". She recalled the interview when Clinic findings were interpreted. They helped her to understand Judy better. "Apparently, she was copying her father more than was usual". She added that this situation had changed a great deal. Judy is now very much an Elvis Presley fan and is interested in dancing and likes to be with her girlfriends. "They have elected her president of one of their clubs".

Mrs. Davis asked suddenly if I knew Mrs. B. I replied negatively which prompted her to explain that this lady was a friend of hers who came to the Clinic about the same time as Mrs. Davis was coming. This lady was dissatisfied, felt she wasn't being helped and desired to terminate. Also, her doctor disapproved of the Clinic. She asked Mrs. Davis for advice.
Mrs. Davis advised her to continue on the basis that she would not, for a time, realize the help she was getting, but it "was" there. "She took my advice". Her waiting period was not nearly so long as ours so we thought our problem couldn't be as severe as theirs. I said I didn't know the case and would be unable to evaluate it in terms of theirs.

Regarding suggestions for improvement, Mrs. Davis said, "all I can think of is what I mentioned about the interviews". I wondered about her feeling toward the Clinic professional team as a whole. She couldn't recall seeing any person other than the social worker. "Oh yes - I did see the psychiatrist but she just asked me a few direct questions. It wasn't really an interview".

I thanked Mrs. Davis for her help. She felt she hadn't contributed much to my study but she was glad to do the best she could.

Implications of Interview with Mrs. Davis.

This case represents an unusual situation in which the parents, so mutually dependent upon one another, tend to exclude the child and her needs from their private world. Mrs. Davis, who tried so unsuccessfully as a child to please her mother and sister, is now, at last, able to please someone - her husband. He, in turn, has found in his wife someone who understands him - who is not only sympathetic but dependent. Being intelligent people, they were concerned when Judy began to show emotional disturbances. When the situation intensified they discussed the problem with a social worker friend and, on the basis of this discussion, sought help from the Clinic.

Mrs. Davis tended both to negate and intellectualize Judy's problem, worrying more in terms of her own failure as a mother than of Judy's unhappiness. In effect, by her distrust of and need to control Judy she was undermining her daughter in much the same way as she herself was undermined by her mother and sister. It would appear that the real conflict lay in the fact that Mrs. Davis herself desired to be controlled rather than to control. Thus, her husband filled this need while her sister, who lived
with them, acted as a mother-figure to the children. Still, Mrs. Davis was uncomfortable because in terms of her own identifi cation with mother, she knew she ought to be dominant.

Neither parent could involve himself sufficiently with Judy to continue treatment. During the intake study they went on a vacation which necessitated the cancellation of Clinic appointments.

In response to the schedule Mrs. Davis stated that she was satisfied with the help she received from the Clinic. She felt the waiting period was a deterrent to continuation and, together with reassignment, would have made her feel as though she were "starting all over again". Judy's nervous manifestations still persist, which indicates that the problem has not been resolved. Mrs. Davis' ability to use psychological terminology (e.g. catharsis) demonstrates an intellectual understanding of and the desire to have been helped by her Clinic experience. She thought her Clinic worker was essentially helpful, although she allowed her to "talk too much" without providing a guide-post to indicate "where" she was going or "what" her responses should be.

The writer's impression was that Mrs. Davis never felt a personal involvement in Judy's problem; "she needs guidance from me". She states that she has been able to allow her a greater measure of freedom and self-expression. This, in light of her personality, would seem to indicate something of a rationale rather than any change or modification of her own attitudes as they affect Judy.

Mrs. Davis' suggestions for improved services would include the removal of both the waiting period and reassignment
after contact had progressed. She also worried about "floundering" in her interviews and whether or not she talked too much or gave the "correct" responses. This would seem to exemplify her need to please rather than any real involvement with the problem.

Discontinuation would, therefore, seem to reflect the parents' "conscious" intellectualized belief that they were helped but, more deeply, suggests a lack of motivation toward personal growth and change.

Case No. 5 - Betty SMITH

Mrs. Smith referred her seven year old daughter Betty for help at the suggestion of the family doctor and a social worker friend. She described Betty as feeling "left out of things" and deprived of the privileges enjoyed by her twin brother and younger brother, age four years. Mother, after describing Betty's temper tantrums, felt she was not close to her daughter and that both of them needed "help and advice".

After a three month initial waiting period Mrs. Smith phoned to say Betty had improved "now that summer holidays have come". She withdrew her application saying she would reconsider, if necessary, in the fall.

Mr. Smith called the Clinic three months later. He stated that Betty was insecure and "no one likes her". She also refused to go to school. Her problems, he said, were generally the same as when his wife called previously.

During the diagnostic study interviews with the social worker Mrs. Smith revealed her tendency to intellectualize Betty's problems. "We have been more lenient with her because she is the less favoured of the children". "I tell Betty that if I don't chastise her for the things that are bad, other people won't like her". Mother thought Betty craved affection, yet could not accept it. She did not think children could "love" - they can only "like". "We are not demonstrative but we have always picked our babies up and given them lots of love". Throughout, Mrs. Smith objectively verbalized what was wrong and what they had done as corrective measures. Lacking, however, was any tone of real feeling or warmth in Mother for Betty. She isolated Betty's problems, then applied a prescriptive treatment. She could not see why this mechanical treatment did not produce human results.

At the time of her last interview prior to diagnostic conference Mrs. Smith came closer to showing an understanding of the problem. This was precipitated because her husband had accused her of being concerned only about Betty's anger. She said,
"I'm concerned about the feelings Betty can't express -- she can get as angry as she likes at me, that's natural, but it is the feelings inside I'm concerned with". Again, however, these were "Betty's feelings", and there was no awareness as to her role in creating the feelings.

Mr. Smith came in admittedly at his wife's insistence. He felt that Betty had problems but that she would outgrow them. He talked about the problem areas only in a descriptive way - what Betty did and how he dealt with her. He revealed himself to have a very limited understanding of child behaviour; "boys can be spanked and they won't hold a grudge - women and girls are thin-skinned". He firmly believed that girls and boys have separate needs and characteristics which should not overlap. He was a "holy terror in his day". But, we assume, this perogative belongs only to the male, hence his more comfortable relationships with his two sons.

Mrs. Smith suffered from an insecure, deprived childhood. Her mother died when she was four and she spent the next five years under the care of housekeepers. She was bedwetting at six. At that time her father "surprised" her by remarrying and re-establishing the home. She indicated feelings of great hostility toward her step-mother although "she tried to unspoil me for my best welfare". Her father died when she was fifteen, leaving her "terribly alone". She was the youngest sibling by sixteen years. Her two older sisters often made her feel unwanted. One is now an alcoholic and the other suffers from chronic nervous headaches.

There were suggestions of marital disharmony between Mrs. Smith and her husband. At the beginning of Clinic contact she requested the social worker to interview them separately. At one time "he used to be terribly jealous and would accuse me of terrible things". She felt his need was that she be totally dependent on him, which "I'll never be". The worker interpreted Mrs. Smith as being very dependent on her husband, yet rebelling against it. She also said her husband was a heavy drinker.

Mother was described as being "most accepting" of Clinical procedures. It would seem that father never became involved enough to discuss the purpose and function of the Clinic. Mother's affect was "calm" - her speech was "reservedly spontaneous". Father had an off-hand manner, and unsuccessfully tried to appear casual and comfortable. He would only consent to one interview.

Betty was brought to the Clinic by her mother who interpreted the visit as a means of finding out "why they got so cross at each other". Team findings revealed Betty to be insecure and unhappy. She had extreme fears of being left by her parents and felt she could not please them. It was felt that Mrs. Smith's unresolved hostility toward her step-mother and female siblings was distorting her relationship with Betty. The child was also being subjected to her father's hostility to all women. Continued service was recommended for Mother and Betty with an effort to enlist Father's participation.
Clinic findings were interpreted to the parents together. Mother was critical of Father and accused him, before the worker, for not cooperating in her efforts to help Betty. The waiting period was explained and both parents indicated a desire for continued services.

Mrs. Smith declined the offer of continued services after an eight month waiting period. "Betty is much better and it helped to talk over our difficulties at the Clinic."

**Telephone Conversation**

I called Mrs. Smith mentioning that the Clinic had dispatched a letter to her yesterday and wondered if she had received it. She told me it came this morning and she would certainly be agreeable to me coming to the house for an interview only she was afraid she didn't have any "constructive criticisms" to offer. She was pleased with the help she had received and that was about all she could say. I said I'd be interested to hear about how she was helped and that she wasn't necessarily confined to stating criticisms. She thought it would be fine for me to come and asked what days I was allotting to this part of my work. She suggested I come Tuesday afternoon next at 2 o'clock.

**Comment:** Mrs. Smith spoke intelligently about the purpose of my visit. I thought she seemed pleased that she was to be included in the study and there were no indications of anxiety or resistance.

**Interview with Mrs. Smith**

Mrs. Smith greeted me pleasantly. Throughout she was friendly and spontaneous and seemed to enjoy our conversation. I did not sense that she felt in any way anxious or disturbed by my visit.

We spoke of pleasantries at first -- then I mentioned my purpose in coming and hoped I had made myself explicit in our telephone conversation. She smiled, saying that she understood what I was attempting to find out and hoped she could help.

She was very pleased with the Clinic services to the point at which she withdrew. It was just what she needed -- "you know, it was Mother therapy more than Child." She thought her worker was a real "professional listener" who helped her to look at her problems and do something about them. Mr. Smith only came for one interview "and he never would admit it helped, but it must have at least started him thinking." She explained her husband's aversion to anything "psychiatric" since the time he was removed from combat by the army during the war.

She supposed the new Clinic was a great improvement. I wondered what thoughts she had around this. She has not seen it but the old building where she and Betty had gone was certainly not attractive -- especially the first time or two. She thought it would make a great difference to people who come to a Clinic that really looks like a Clinic.
I mentioned her withdrawal following the waiting period and wondered if the two were connected. Mrs. Smith thought for quite some time, then said "yes, I suppose they were; but the wait wasn't a bad thing for us. I wasn't quite sure that I understood. She proceeded slowly: "I used the waiting period to think about what had been going on during my Clinic interviews." "Although it was my intention to return to the Clinic I discovered, while waiting, that I could manage without further help." She felt her improved relationships with Mr. Smith and Betty began to take real form at this time.

She again mentioned the worker and described her in terms of an "excellent caseworker", asking me if she were using the correct terminology. I asked Mrs. Smith if she were aware that, had she returned to the Clinic, a different worker would have seen her. "Yes -- she was told something about this." She expressed doubts about the desirability of this procedure, thinking it would be best if the same worker continued with the case. She thought, however, that we might find it helpful to get another worker's opinion of the case. I said we tried to accomplish this with the multi disciplined or team approach. This started her thinking and she expressed dissatisfaction about her contact with the psychiatrist. "I only saw him for five minutes and I couldn't tell him anything in that time." She remembered feeling very "cheated" at the time. She had also wondered what the psychiatrist had said to Betty. "He must have calmed her troubles and answered her questions because she didn't ask me anything afterward about why I had taken her."

I asked if Betty's problems had changed since the Clinic contact. "She is no trouble at all now; she gets cross at me and says exactly what is bothering her and I know where I stand." She used to brood and sulk but this has all changed. I wondered if Mrs. Smith attributed this change to any specific thing. She thought it was due partly to her age but mostly because "we've all changed." The most helpful aspect of her Clinic experience was being allowed "to get things off my chest. After the first two interviews I was disappointed and cross -- I felt I wasn't getting any help at all. Then, as time went on I realized the worker was helping me to look at my own problems so I could do something about them."

I said she had, in essence, already answered my next question which was whether or not the Clinic had conveyed the need for parent participation as well as child. She thought this was something she realized gradually as the interviews progressed. "In my case Mother needed help so that Child could be helped." She wished her husband had cooperated more. He had, however, ceased in his verbal objections to the Clinic after his one interview.

I wondered how and in what ways she thought the Clinic might improve its services. "That's a hard one." She thought I might get more help with this from people who had come to the Clinic with more severe problems than they had experienced. She saw their problem as one which was ready to be helped. She suggested that the Clinic could do a greater service to the community by "talking itself up and by explaining what it does for parents and children." She has told many of her friends all about the Clinic. Most of them knew little or nothing about it. One person asked if the social
workers there had given her the "run around" because they did at the agency in Vancouver. Mrs. Smith said she quickly rectified this misconception.

I thanked her for being so cooperative with me. She hoped she had been of some help but felt her "constructive criticisms" were few and far between.

Implications of the Interview with Mrs. Smith

In the Smith case we are confronted with something of an anomalous situation. The case analysis shows a deprived mother who, never having achieved feelings of worth and adequacy as a woman, is unable to transmit these characteristics to her daughter. In one way Freud's classical clinic picture of "penis-envy" might be suggested as we visualize mother and daughter struggling to attain a sense of identity with their own sex.

We must postulate, however, that the problem was not so severe as the record would suggest. The worker, apparently, was not only able to feel the need but also to meet it with the appropriate level of casework. A note of concern rises in the fact that nowhere in the recording has the worker intimated the significant movement which the writer's interview suggests took place. This highlights another point, which is the lack of a diagnostic hypothesis or statement upon which the worker operated both to explore the facts of the case and to formulate her casework approach.

With these thoughts before us we must accept the interview with Mrs. Smith at face value together with its implications. She was completely satisfied with the Clinic services to the point at which she withdrew. She was able to recognize and make use of the help offered. The waiting period, although a factor in her decision to withdraw, was utilized constructively as a period of crystallization in which Mrs. Smith mobilized her inner resources on the strength of the casework help already received. She doubtless would have continued
for a longer period in treatment had there been no waiting period. Fortunately, however, she had been helped to the degree that she was able to carry on comfortably without additional Clinic services.

Betty's problem is much improved, a fact which her mother attributed to the Clinic's services. She recognized it as an indirect process during which she was helped to examine and work through her own difficulties, thus diminishing her need to find fault with Betty and Mr. Smith. This in turn relieved much of the tension in them and their relationships improved with strengthened feelings of good will and understanding.

The writer would alert the reader to the same flavour of intellectualization by mother in the interview as permeates the case analysis. It is almost as though she had incorporated exactly what the worker had said. We might also speculate that the social worker friend who was instrumental in the referral, was also, in some degree, responsible for the mother's succinct explanation (and understanding) of what transpired within herself as a result of her Clinic contact.

Mrs. Smith's only criticism was her brief contact with the psychiatrist which, to some clients, seems to represent the focal event of the Clinic experience.

The reasons for discontinuation in this case would seem to be that either continued help was received from another source, that is, the social worker friend who was instrumental in the referral; or, that the case was erroneously diagnosed as requiring continued casework services when only a "brief service" contact was necessary.
Was the Clinic Helpful?

The reader, having been freshly introduced to the five cases will perhaps find it both appropriate and interesting if a collective assessment is now made of the actual help enabled by the Clinic. It is the writer's opinion that one was helped, while four were not.

In the follow-up interviews the Mrs. Anderson, Bennett, and Cook were openly negative and hostile toward their Clinic experience. There was almost a complete lack of insight into either the purpose or the nature of their relationships with the worker. This, together with their contentions that the problems were unchanged, (or, if some improvement had occurred it was the result of the mothers' endeavours), would seem to substantiate the writer's assessment that Clinic help was neither realized nor used in the three cases.

Mrs. Davis was able to give an intellectualized statement that help was received. There are indications, however, that the referring problem has not changed appreciably. For example, Mrs. Davis said that Judy's nervous mannerisms have not disappeared. Instead, there are now a greater variety of them. Secondly, in the interview she proudly described the ideal marriage which she and her husband are experiencing. This, the reader will recall, was noted with some concern by the original case worker who felt that Mr. and Mrs. Davis were so dependent upon each other that Judy felt herself to be playing the role of an intruder. At the present Mrs. Davis is worried because Judy is "more than 'normally' dependent upon her friends". Such a situation would seem to be a logical recourse for Judy when her own needs are excluded by the neurotic interdependency of her
parents. Thus, it would appear that, in essence, Judy's problem was not helped at the Clinic.

The Smith case, as already indicated, seems to be one in which the mother was able to use the brief Clinic contact positively to examine and work through her own difficulties, thereby decreasing her need to withhold warmth and love from Betty. According to Mrs. Smith even the waiting-period was therapeutic. There was no indication in the case record that a particular casework technique was used by the worker to help Mrs. Smith use the waiting-period beneficially. Betty's problem has improved appreciably which her mother attributed to "mother-therapy" at the Clinic.

The cases to this point have been discussed separately with the emphasis on their individual implications for the study. In Chapter Three an attempt will be made to locate patterns or responses which are common to the case-summaries and to the follow-up interviews as a whole.
CHAPTER III

The Common Denominator

In this chapter an assessment will be made of the case studies as a whole to reveal patterns, indicators, or characteristics which are common to two or more of the five cases; and which might have prognostic value in determining cases that are likely to discontinue treatment.

The second portion of the chapter will deal with material obtained in the five follow-up interviews which the clients consciously recognize as being the causes of their withdrawal. The validity of this material as well as its implications for the study will be discussed.

"Withdrawal Indicators"

(1) The Kind of Referral

It seems of interest to this study that professional people were involved in five of the referrals. Both Mrs. Smith and Mrs. Davis consulted social worker friends before coming to the Clinic. An attempt will therefore be made to assess the role of these workers in relation to the problems of their friends.

Social workers generally accept the statement that clients must experience a particular crisis or reach a certain intensity of anxiety before they are mobilized to seek help. A relationship begins to form when the problem is shared with a worker. This, in turn, usually stimulates some emotional involvement of the client which the worker can utilize in helping her to some awareness of her contribution to the problem; (in Clinic cases, the child's problem).
If however, the client (parent) discusses the situation with a social worker prior to referral, it seems reasonable that much of the emotional involvement may remain attached to the friend from and with whom help was first sought and feelings ventilated. Thus, in accordance with the theory of transference, the parent would conceivably come to an agency (in this case, the Clinic) to please the friend. This would enable her to experience the Clinic relationship more on a superficial level. She might be free to intellectualize an understanding of help she was getting but, at the same time, essentially remain uninvolved and so be able to withdraw at an appropriate time thinking she had been helped. By thinking she was helped the client would be giving pleasure to the original person (the professional friend) to whom the problem-evoked transference elements were still attached.

While both Mrs. Smith and Mrs. Davis did not come back to the Clinic there is some evidence from the interviews that they had received help to understand their problem from their two friends. This, in fact, might have been the "continued help" which the Clinic offered but which the two mothers declined on the basis that they had already been helped sufficiently.

The other three cases studied were referred by doctors who might conceivably play a similar role to that of the social worker friends described above. It would perhaps be advisable in the future for Clinic workers to be on the alert for cases which are referred by or in which there have been previous contacts with professional persons with whom the clients have discussed their problems. It may be necessary in such cases to
involve the client in a discussion of her relationship with the referral person. This would help the client to assess the situation more on a reality level, while the involvement would encourage a transfer of her feelings from the referral person to the worker.

It is suggested, therefore, that referral sources may be indicators of withdrawal and that Clinic workers should be aware of their significant ramifications. This would require further study in itself to establish its reliability as a predictive tool.

(a) Who Brought the Child

In the cases studied the lack of father-participation in the Clinic experience of mother and child is impressive. Mr. Anderson was described as "co-operative but unenthused" and he thought his wife was exaggerating Billy's problems. Mr. Cook did not come for an interview prior to the completion of the social history. Mr. Smith admitted coming at his wife's insistence, while Mr. Davis was probably seen only twice in all. The need of the latter was to placate his wife which would not suggest any real involvement with the Clinic.

This lack of support from the husband would appear to be a devaluing situation for the mother and tends to create in her a feeling that she is carrying the responsibility alone. It is acknowledged that this lack of father-participation probably appears also in cases which continue through treatment. However, the situation would possibly be most harmful when the mother herself has a strong resistance to treatment. A negative or disinterested response from the father would therefore tend to discourage the mother and might, in these cases, be predictive of withdrawal.
(3) **Sex of the Child**

It is interesting that in all of the cases studied the mothers had unresolved hostility toward the parent of the same sex as the child displaying the behavioural disturbances. Mrs. Anderson admitted hating her father, but remarked about his affection for Billy.

While Mrs. Bennett admired her father's intellect, it would appear that she was competitively driven to be his equal which created angry, hostile feelings although, at the same time, enhanced her status. She married an intellectually inferior man whom she could manipulate. Thus, Larry's strong will and superior intellect both frustrate and threaten her.

Mrs. Cook's hostility to her father must be, to a large extent, surmised. It does, however, seem significant that she all but denied his existence. Her entire childhood centered around mother to whom she was still dependently tied at the time she was coming to the Clinic. She did voice anger toward her brother who was "strange" and "could not make friends". Jimmy, she said, had the same difficulties.

Mrs. Smith's mother died when she was five. We get a clear picture of her growing up without identification, angry at her mother for "leaving" her, and bitter toward her stepmother who "unspoiled me for my best welfare". Understandably, we see Mrs. Smith unable to communicate a feeling of warmth and identity to Betty.

Mrs. Davis vividly recalled spending her childhood and adolescence trying unsuccessfully to please her mother and older sister. She was frustrated by fears of inadequacy and a sense
of being alone against a domineering mother and sister. Mrs. Davis has attempted to emulate her mother's pattern with Judy and has succeeded in creating in her similar feelings to those she experienced as a child. In her turn, Judy, is now "antagonistic to dominant mother figures".

It is not within the scope of this study to present a theoretical exposition of the dynamics operating in these cases. Rather, the writer's purpose is merely to identify, where possible, patterns common to a majority of the cases. The underlying dynamic pattern described above would seem to suggest a displacement of the hostility felt by the mother towards her "bad" parent on to one of her children of the same sex as the parent.

It may be prognostically valuable, therefore, for workers to recognize cases in which the mother has unresolved hostility toward the parent of the same sex as the child whom she brings for Clinical examination.

(4) Parents Responses to the Problem

An examination of the parents' responses to the child's problems was thought to be worthwhile in terms of establishing a 'pattern-response' which might alert workers in future cases to the possibility of withdrawal.

Mrs. Anderson regarded Billy's problem as a hostile attack upon herself. Her response was to fight back in order to maintain her status-quo. Unconsciously, it were as though she had to justify her rejection of Billy by making him act out.

Larry's behavioural problems prompted Mrs. Bennett to push him away - open rejection. This was her method of showing him that his behaviour was unacceptable to her. Both parents stressed conformity and tried various disciplinary approaches,
hoping one would 'fit'.

Mrs. Cook saw Jimmy's problem as an endurance test for her and worried about what others might think. Her complete inability to cope is summed up in her statement: "When he was a baby I tried to love him when he was bad; as a little boy I tried to talk him out of it; now I tell him to shut-up".

Mrs. Davis' response was largely anxiety about failing as a mother and concern that Judy did not show "penitence nor any regard for her wrong doings". Both parents sought some way of responding to Judy which would satisfy her, and yet not encroach on their mutual dependence.

Betty Smith caused her mother to fear the opinions of others in regard to her daughter's problems. This, of course, meant fear lest they might seem to be a reflection on herself. Parental responses were in terms of a preconceived prescriptive treatment which would, hopefully, cure the problem.

While it is difficult to suggest a definite 'common response' in the five cases, there does seem to be a significant trend. The five mothers responded as though the child's behaviour problems were a threat to themselves. These responses varied from fears as to what other people might think, to overt hostility wherein the mother felt compelled to compete with the child for mastery in order to preserve her own self-image as the controlling, omnipotent parent. These responses seem to suggest both an insecurity of mother-role and a basic lack of self-worth.

It may be that withdrawal is imminent in cases where the mother expresses more concern for herself than for the child and where she aligns herself against him and responds to his problems in a manner which protects her from herself and from the
critical opinions of others.

(5) Parents' Concept of the Problem

It is the writer's opinion that the parents' concept of the child's problem will perhaps provide some of the most significant factors in this study which may be predictive of discontinuation. One area which might be considered is that of awareness on the part of the parents as to whether or not they are playing a role in the problem.

An examination of the five cases studied failed to provide any indications that such awareness existed. There were two fleeting references which are now recalled for the reader's convenience: Mrs. Anderson said at one point, "I wonder what I am doing to Billy"; while the Bennetts verbalized the belief that "a child's behaviour stems from the treatment he receives". The worker did not pick these up for discussion which might have led to an exploration of feelings and some insight for the parents as to their contribution in creating the problem situations.

The interviews in the five case records were highly flavoured with parental intellectualization which usually indicates or suggests a resistance to personal involvement. Without any real involvement parental anxiety would soon decrease and could provide a basis for withdrawal. Such intellectualization, including the usage of psychological terminology, would seem to be a defence mechanism by which the parent detaches himself from the real problem, thus avoiding any involvement which might expose his true feelings.

The writer postulates, therefore, that parents who have an intellectual approach to the child's problem may have a marked tendency to withdraw. This could be due either to a
decrease in anxiety with no real involvement, or, as Gordon Hamilton suggests: "In cases where mothers do not indicate at the outset some awareness that they are playing a role in the child's difficulty, when this is recognized, finally, the mother may be thrown into a panic and withdraw because of guilt, unless very carefully handled."

There was also a noticeable pattern in the five cases where one of the parents either underestimated the child's problem or verbalized a belief that the problem had changed. Mr. Anderson, for example, "thought his wife exaggerated Billy's problems"; Mr. Cook was "somewhat opposed to the Clinic, feeling that his wife is exaggerating her troubles with Jimmy"; Mrs. Davis said, "there was nothing that Judy was concerned about at the moment"; Mrs. Smith withdrew after Betty's first referral before the Clinic had seen her saying that she had improved. After the second referral Mr. Smith contended that "Betty had problems but she would outgrow them".

This pattern would seem to verify Guise's findings that many "parents who withdrew tend to underestimate the child's problem, claiming either that it is not a problem or that it has diminished."

(6) Parents' Reactions to Clinic Findings

An examination of the parents' reactions to Clinic

findings was thought to be pertinent to this study and to have some predictive significance. They will now be examined to determine whether or not they can contribute to prediction about withdrawal from treatment.

Mrs. Anderson was "restrained and anxious" while the worker interpreted the results of the diagnostic conference. She asked "what was meant by treatment and expressed doubt that she could ever behave differently toward Billy".

When Clinic findings were explained to Mrs. Bennett she "wrote everything down, was apprehensive of 'treatment', and expressed concern about her own role in it."

Mrs. Cook showed little or no appreciation of the Clinic findings. She tended to evade the issues by attempting to draw the worker into a discussion of her own poor health. She felt a change in her ability to help and understand Jimmy was dependent upon the success or failure of an operation she planned to have during the summer.

Mrs. Smith reacted to the Clinic findings by projecting the blame for Betty's problems on to her husband. "She was critical of him and accused him, before the worker, of not cooperating in her efforts to help Betty".

Little was recorded by the worker of the Davis' attitude toward the Clinic findings. They were described as being "most accepting" and that Judy's problem had been "clarified" for them.

It would appear quite conclusive that in four of the five cases the parents were threatened by the findings. Their reaction was either to express direct concern about treatment and their own involvement in it, or to deny their own responsibility...
bility in the problem by a projection of it.

It may be that withdrawal is indicated when parents cannot accept the Clinic findings positively as a further step in helping them to understand the problem, including their participation in it.

(7) Parents' Preparation of the Child for the Clinic

The writer noted that the parents in four of the cases studied expressed difficulty with or asked for help in interpreting the Clinic visits to the child.

Mrs. Anderson said, "I don't see how I can tell him (Billy) that the Clinic will help because I don't think he feels he is unhappy". She was unable to follow through with the worker's suggestions and finally explained to Billy that he was going to the Clinic "to meet a new friend".

Mrs. Bennett "wondered how Larry would feel when he grew older and knew more about his contact at the Clinic. She was adamant in her refusal to tell him the purpose of the visits".

Mrs. Cook was apprehensive about bringing Jimmy lest the school or neighbors find out. He was inadequately prepared for the Clinic and was very fearful when he was brought for examination, "refusing to let the psychiatrist approach him".

The worker recorded in the Davis file: "Mrs. Davis verbalized concern about telling Judy of the Clinic and felt there was nothing that Judy was concerned about at the moment".

It is evident that in the four cases the parents were reluctant to explain the Clinic to the child in terms of help with their mutual problems at home. This would seem to suggest a non-acceptance of and lack of confidence in the Clinic as felt by the parents themselves. Perhaps they saw it as an
admission to the child of their inability to discipline him. Regardless of reasons, they felt unable to attach any real meaning to the Clinic in their interpretation of it to the child.

Guise, in her study of parents who discontinued treatment, states: "Their essentially negative attitude toward the Clinic was apparent from their negligence in preparing the child for Clinic visits."

It would seem quite reasonable to postulate, therefore, that parents may tend to withdraw from treatment who have difficulty interpreting the Clinic to the child on a realistic basis. (8)

Parents' Flow of Talk

The writer was unable to detect any common pattern in the five cases around either the parents' affect in response to the Clinic situation, or in their tendency to keep or break appointments. In fact, little was mentioned in the recordings about these areas; this would seem to be a regrettable omission.

A consideration of the parents' flow of talk proved to be more enlightening for the purposes of this study. In all the cases the mothers talked freely during the interviews without personal anxiety around their own roles in the child's problems. Mmes. Anderson, Bennett and Cook spoke in a fluid, intellectually-negative, vocally-rejecting manner. Mmes. Davis and Smith also intellectualized, but were more poised and sociable, with a charming, defensive exterior.

It may be that parents who talk volubly and defensively, consciously aim to discuss non-threatening and superficial things, -- tend to reveal more of themselves than they can tol-

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erate, then feel pressed to withdraw. This, however, would have to be compared with parents who continue in treatment in order to ascertain if they, by contrast, have difficulties talking -- difficulties which signify a greater investment of themselves in a gradually formed, sustaining relationship.

The reader is referred to Appendix D of this study which is a tabulation of results obtained when the withdrawal indicators illustrated in this chapter were applied to six additional cases. These were selected at random from the original forty cases perused at the outset as potential material for this study. The results demonstrate that at least six (two-thirds) of the nine indicators were present in each of the six cases.

An interesting trend which appears in this tabulation is the grouping of certain indicators into what might be a syndrome or a collection of symptoms. For example, in cases "E", "F", "H", and "J", indicators 1, 3, 4, and 5 are present. Also, indicators 4 and 5 appear in all six cases. This grouping of indicators would seem to suggest certain dynamic forces at work — an expression, perhaps, of multi-causation in the problem of discontinuation.

While it is acknowledged that these results are by no means conclusive they do, however, help to strengthen the prognostic value of the indicators. Further application of them to a large number of discontinued cases will help to determine their reliability as predictive tools. In this connection a subsequent research design might include an examination of the thirty withdrawal cases which were not used in this study.
It would be important to determine whether or not the nine indicators appear in the same proportion in these thirty cases as in the five examined in this study. In addition, a control group should be analysed in order to determine the presence and extent of withdrawal indicators among those cases which continue through to termination. The indicators would be validated if their incidence in the withdrawal cases was significantly greater than in the continued cases.

The Interviews

This portion of the chapter will constitute an examination of the material in the five follow-up interviews which seemed to emphasize the clients' dissatisfaction with their Clinic experience. This will be done in the belief that it is valuable for the social work staff at the Clinic to be aware of methods or procedures which might tend to aggravate feelings of anxiety or disinterest in the clients, thus encouraging their withdrawal from treatment.

The question arises as to what value can be placed on the verbal responses of the client. It might be argued that these responses may conceal the real reasons for withdrawal; that the real reasons are composed of a complex blending of conscious and unconscious factors of which the client herself is not fully aware. Therefore, she cannot be expected either to understand or communicate her motivation for withdrawal.

This study, while in no way negating the importance of unconscious motivations in behaviour, would also suggest that an understanding of the client's perceptual patterns (i.e. charact-
eristic ways of perceiving) is basic to treatment and to an understanding of the underlying psychodynamics. In a sense these perceptions "are distortions which grow out of each individual's particular way of preserving his attitudes and feeling, and his right to feel hurt and distrustful. It is these distortions which he reveals to the counselor (worker) and which provide the base for their work together." The social worker should be able to recognize these perceptual patterns and to adapt his skills in working with them to enable the client to move forward toward a more satisfying life experience. Thus, the client's verbal responses of dissatisfaction with his Clinic contact are representative of his perceptual patterns and must be considered as valid reasons for withdrawal.

Reasons for Withdrawal

(1) The Waiting Period:

The most outstanding criticism of the Clinic which appears in four of the five interviews is the waiting period between the end of the diagnostic period and the beginning of continued services. Mrs. Anderson spoke of it as if the Clinic had let her down: "They told me I'd hear from them in December but no one called until July". Thirteen months was "far too long and made me lose interest" - (she may have thought that the Clinic lost interest in her).

The Bennetts described the 'wait' as a "terrible thing" - an insult to those who "had to get up a lot of nerve to ask for help in the first place". They blamed the waiting period for their final decision not to continue. "If you'd get rid
of that, you probably wouldn't lose so many people".

Mrs. Cook said the Clinic didn't help Jimmy. "They told me there was a problem behind his behaviour. Instead of doing something they let us wait nearly a year. They should have spent less time going into my background and concentrated on Jimmy - especially when we're going to have to wait so long."

Mrs. Davis described the waiting period as "highly undesirable" - a negation of the problem for which Clinic help was sought. She implied that, because of the thirteen month wait, the Clinic people couldn't have thought their problem to be a serious one. She saw the wait as an interruption of the whole process. Had there been no waiting period Judy would have accustomed herself to the continuing Clinic visits as "something routine". After the wait however, "it just wasn't worth starting all over again."

Throughout, there seems to be a patterned feeling-tone of rejection. In effect, the Clinic (worker) offered help, expressed interest, then devalued the problem and cast it aside, saying, "we are too busy to help you now - you can expect a call from us when we have more time". These are rather harsh words but nonetheless realistic in terms of the dynamics of some emotionally disturbed families who seek outside help.

Clients whose dynamic patterns show strong unmet dependency needs will probably have great difficulty tolerating a waiting period. For example these patterns exist in cases where the parents, particularly the mother, show themselves to have unresolved dependent ties to one of their parents; (e.g. Mrs. Cook); or in cases in which the parents are experiencing difficulty in
the resolution of their dependency on each other; (e.g. Mrs. Smith). Also, there are clients who present a facade of competence and self-sufficiency. This, in reality, may be a compensatory mechanism by which early frustrated dependency needs are disguised; (e.g. Mrs. Bennett). The hostile component of dependency should not be overlooked; this is frequently used as a retaliatory weapon by the client.

Social workers at the Clinic would be well advised to alert themselves for those deprived, dependent clients to whom the waiting period will mean rejection and who are likely to retaliate by discontinuation. The ill effects of the waiting period should seemingly vary in inverse proportion to the ego strengths of the client.

The waiting period will be discussed further in Chapter Four in terms of suggestions and recommendations for alleviating some of its destructive elements for the client.

(2) Lack of Concrete Services:

It has been demonstrated in the case studies that clients who withdraw from treatment tend to have an intellectual approach to the problem as a defense against personal involvement. In other words, they may tend to place the responsibility for cure solely onto the Clinic. This would cause them to expect concrete services (e.g. advice and direction) which, if applied, would magically cause the problem to disappear. With this in mind, the writer examined his interviews with the clients to determine whether or not such a pattern was evident.

Mrs. Anderson stated that the Clinic failed to give her the factual help she needed in coping with Billy's problems.
She related this to her interview with the psychiatrist - "I never did find out what he thought or what he said to Billy". Referring to the Clinic findings, she said, "I really didn't find out anything."

Similarly, Mrs. Bennett criticized the Clinic which had in no way given them the kind of help they wanted, "or needed". The proposed "treatment" for Larry was ridiculous; in effect, it threatened her own need to enforce rigid disciplinary measures. Mrs. Cook expressed a like attitude, contending that she could not understand why the Clinic didn't give her help with Jimmy instead of concentrating on her background. To a milder degree, Mrs. Davis and Mrs. Smith reacted similarly. The former was disappointed with the Clinic at first and thought she was getting nowhere. She finally decided it was a situation which permitted a "catharsis for the mother", this made her "feel" she was being helped. Mrs. Smith felt "cheated" because of her short contact with the psychiatrist. This meant that he did not have time to give her direct help or counsel.

It would seem reasonable, therefore, to suggest that concrete services are wanted or are expected by clients who withdraw. This expectation, as already indicated, tends to be a mechanism by which parents avoid self-involvement.

(3) Reassignment:

Reassignment as a reason for discontinuation was not established as a common pattern in the five interviews although it did seem operative to some extent in the Davis case. Mrs. Davis
came to the Clinic for one interview after the waiting period had elapsed. (This information was not recorded on the file but was voluntarily given to the writer by Mrs. Davis.) She implied that her decision to withdraw became definite at this point. To continue with a new worker would have seemed "just like starting all over again".

Both Mrs. Anderson and Mrs. Smith questioned the re-assignment procedure but without sufficient feeling to indicate that it was a factor in their withdrawal.

It is possible that reassignment would be more damaging to clients when it comes about during a period of continual contact rather than after a waiting period of considerable length such as occurred in the case material of this study. The writer suggests that a future study might explore this area of reassignment.

(4) Sufficient Help Received

The Smith case was singular among those interviewed for this study. According to Mrs. Smith, she discontinued treatment because of the effectiveness of the help received at the Clinic up to the point of the waiting-period. She was helped by her caseworker both to look at her problem and in mobilizing her strengths to do something about it. She happily described the improved relationships between herself, Betty, and her husband. She attributed these positive changes to her Clinic contact: "Mother needed help so that child could be helped."

It would seem that there are cases in which sufficient

\[1\] Miss Flesch's comments as discussed on page 2 would seem to apply more specifically to clients in this category.
help is realized to enable discontinuation with positive results in the form of more harmonious relationships and a corresponding decrease in problem symptomatology. Although "sufficient help received" is a valid reason for withdrawal from treatment, it is, in all probability, a minority one. A study of a larger group of cases would perhaps have determined this more effectively.

(5) **Location of the Clinic**

There has been expressed concern among the Clinic social work staff that the location of the new Clinic building in North Burnaby might be a deterrent to client-continuation. In terms of public transportation facilities, the Clinic is not conveniently accessible, particularly to those in the more heavily populated Vancouver City area.

However, it is noteworthy that only Mrs. Anderson, of the five follow-up contacts, stated dissatisfaction with the North Burnaby location. She stated that Billy would have to miss a day of school in order to keep an appointment at the Clinic. The case summary and the interview would suggest that this was a minor reason for her withdrawal, subordinate to those of the waiting period and the lack of concrete services available to her.

Mrs. Smith, on the contrary, offered a different point of view. She did not refer to the greater distance to the new Clinic as compared to the old. Rather, she thought of the advantages of a new building, suggesting that it would help clients to go to a Clinic "that looks like a Clinic".

It does not seem possible, from this study, to postulate that the location of the present Clinic is a significant reason for discontinuation, although it was possibly a contri-
buting factor in the Anderson case. A larger group of discontinued cases might yield a more definite answer.

In summary, the reasons for discontinuation based on the five follow-up interviews are five in number, the most insistent being the waiting-period and the lack of concrete services; to a lesser degree reassignment, sufficient help received, and the location of the new Clinic, were also noted. Again, it is suggested that these reasons for withdrawal be applied in a further study where, in the light of additional interviews, their reliability might be strengthened.
CHAPTER IV

Toward Continuation

The problem of discontinuation has been discussed both in a general sense as it relates to professional Social Work as a whole and specifically as demonstrated in five selected case studies and interviews. A total of nine withdrawal-indicators emerged from the study of the cases which were suggested as having some prognostic value in determining which future cases might be likely to withdraw. The clients' reasons for withdrawal, based on the interviews, were also discussed. Further study was suggested to determine the reliability of both the indicators of and reasons for withdrawal.

The focus in this chapter will be on ways in which the Clinic social work staff might work through those situations which have been shown as deterrems to continuation or completion of treatment.

The Withdrawal Indicators

One of the main purposes of the study has been to demonstrate these indicators and to point out their value as a base in predicting which cases might discontinue treatment. Another goal, however, is that social workers at the Clinic be able to recognize these indicators in early interviews, and evaluate their influence on the treatability of the client. The worker would then use his skills to help the client neutralize the effects of these indicators which, if ignored, might cripple the treatment process and eventually lead to withdrawal.

These patterns or indicators may well be recognized
as forms of resistance which the client unconsciously uses to defend herself against growth and change. A discussion of the casework methods and skills appropriate to successful handling of these indicators is not within the scope of this study. It might be said, however, that it is important for the workers not only to recognize the indicators as resistance, but also to deal with them in the casework situation. Helen Flores, in her study, states: "The fact that the worker handles the resistance... appears to be significantly related to the mother's continuing in treatment."

It can be expected that these resistance or withdrawal-indicators will be more pronounced in some cases than others, and that the incidence of discontinuation will be in direct proportion to the strength of the indicators. It cannot, therefore, be stressed too strongly that Clinic workers should be on the alert to detect these indicators and to be aware of their prognostic implications. Flores continues:

"Early recognition of resistance and other signs of insufficient motivation is essential in helping parents to make the most beneficial use of the child guidance treatment. The client may be helped to recognize that he is not yet ready for the kind of treatment the child guidance clinic has to offer, and may then be referred to another resource more geared to the kind of help he is able to accept at the time. ---Further, early recognition of insufficient motivation for treatment may allow for working through the blocks that prevent the parent from fully mobilizing himself to continue treatment. Consequently, there will be more effective utilization of the services of the agency which are in such great demand and such short supply."

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3 Flores, Helen, Ibid, p. 37
The workers can perhaps be helped to an early recognition of these indicators by striving constantly to improve their skills in related areas. A greater emphasis on family patterns or family diagnosis is pertinent. Here, the interaction between significant members of a family is a vital force affecting the prognosis of any member (s) who is seeking a more healthy degree of personal or family adjustment through the medium of casework treatment at the Clinic.

In a related sense, a discriminating and accurate system or recording will assist both in bringing these family patterns into a clearer focus, and illuminating such withdrawal indicators as may be present in the case. Finally, but by no means conclusively, perhaps the formulation of the psychosocial diagnosis should include an evaluation of the client's ability to continue treatment. This would bring the problem of withdrawal to the fore in the early stages of the case and so help to impress upon the worker the importance of being alert to its various manifestations.

Reasons for Discontinuation

It was demonstrated in Chapter Three that one reason for discontinuation which appeared in the follow-up interviews was "sufficient help received." The cases that come within this category would, therefore, seem to be treatable under a brief service form of contact. It is suggested that these cases might be recognized as those in which there is possibly not much depth to the child's symptomatic behaviour "in that it seems to be superficially reactive to the parents or to the total family situation; the emotional health and strength both in the parents and
in the child are basically sound; and the parents show considerable potential for gaining an understanding of themselves and of the child, and thereby improving their relationships with each other and with the child."

Greater skill by the Clinic social work staff in the recognition of cases which are amenable to a brief service contact will have beneficial results in both therapeutic and administrative areas. In a therapeutic sense the clients who can respond to a brief contact will not be involved in an extended, time-consuming process which might tend to distort the original problems, superficially increase their intensity, and encourage the clients to withdraw from treatment. Also, these clients will not be required to experience the waiting-period between intake and continued services which has been demonstrated, in many cases, to be a reason for discontinuation.

Administratively, brief contact cases, when applicable, represent an economy of staff time in terms of those cases which go on to continued services. There is also the point that brief service cases relieve their workers from the concern and discouragement often associated with cases which are obliged to go through the waiting-period before effective treatment services can be offered.

A concurrent study in the area of brief services will possibly assist the Clinic social workers in their recognition of cases which can best respond to this type of contact. This

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recognition may also be instrumental in eliminating the category of "sufficient help received" as a reason for client-discontinuation.

Although the procedure of reassignment did not emerge in the interviews as a strong reason for discontinuation, the clients generally stated their dissatisfaction with it. Mrs. Davis was particularly opposed, saying that her final decision to withdraw was prompted by her interview with a new worker after the waiting-period had elapsed.

It is recognized that the administrative organization of the Clinic social workers into the intake and continued service sections necessitates reassignment for those clients who are to receive continued casework services. A discussion of the undesirability of reassignment would, therefore, be unrealistic in this study. On the other hand it would seem important to emphasize a way of handling reassignment so that it will, as far as possible, not be instrumental in encouraging the client to withdraw from treatment.

A valuable approach to the problem of reassignment might be for the worker to discuss it with the client - fully and carefully - through several interviews prior to the waiting-period. There seems to be some tendency among clients to say that they understand a certain Clinic procedure the first time it is mentioned by the worker. Similarly, there is the danger that the worker will accept at face value this statement of the client. However, it is generally recognized in the behavioural sciences that intellectual understanding frequently precedes both emotional understanding and acceptance. Hence, a client may state
her intellectualized acceptance of reassignment, whereas, emotionally, she may be unable to tolerate it. With this recognition, the worker might perhaps take a longer period of time in which to interpret, and explain the reasons for reassignment.

The client will possibly need to have her feelings verbalized and accepted by the worker, thereby decreasing the possibility of her equating reassignment with rejection. It might also be advisable for the client to be assigned to the continued service worker prior to the waiting period and to be interviewed - once or several times - by her new worker at that point. This would make the contact after the wait more meaningful and less threatening to her.

Perhaps the greatest danger in reassignment is that the worker may appear, through the client's eyes, to have lost interest in her. Skillful handling of the procedure - with observable interest and concern for the client shown by both the old worker and the new - will assure the client of the Clinic's continuing support. It will also encourage and stimulate her to remain in treatment.

The follow-up interviews revealed that clients who discontinue may expect concrete services from the Clinic. This expectation has been discussed in terms of it being a defense against self-involvement; a tendency to project responsibility for "curing" the problem onto the Clinic. To offset this danger the Clinic social workers must, from the beginning, attempt to involve the clients in assuming responsibility for their own problems.
Perhaps this expectation of concrete services might be approached both by recognition and verbalization of it by the worker to the client in beginning interviews. This would include the worker's acceptance of this expectation. It might also include encouraging the client to discuss why she thinks her problem can be solved by the Clinic through concrete, prescriptive measures.

At the same time the worker might, with this type of client, see the need for an intensive, detailed, and repetitive explanation of the Clinic's function and services. It is, after all, the client's right to know what she can or cannot expect in the way of help.

The worker should be always alert to manifestations of the client's dissatisfaction with a particular procedure. For example, the client may resent the worker's focus on her background history, (e.g. Mr. and Mrs. Bennett). The worker may need to explain many times why this is necessary. In the same area some clients, (e.g. Mrs. Davis), may be apprehensive of what seems to be aimless talking on her part during the interviews, seemingly without any direction from the worker. The worker should spot this discomfort, support the client in her feelings, and emphasize the purpose of the interview - relating it, if necessary - to the agency's function and to the client's problem.

The worker's choice of words with the client undoubtedly affects her feelings, either positively or negatively, toward her Clinic experience. Both Mrs. Anderson and Mrs. Bennett, of the cases examined in this study, were alarmed by the word 'treatment'. Social workers who frequently resort to jargon among themselves,
may perhaps be inclined to use these mysterious words in inter-
views, particularly in regard to methods or procedures which are
somewhat difficult to explain in ordinary terms, (e.g. services
of the Clinic). The use of jargon may well alarm the client and
create a communication-barrier between herself and the worker.
Social workers at the Clinic would do well to examine their use
of words and, by persistent practise, endeavour to communicate in
simple terms which clients can both understand and accept.

The follow-up interviews also suggested that clients are
often disappointed after their contacts with other disciplines in
the Clinic. The worker can also assume responsibility in this
area, preparing the client for these experiences. This might be
done near the beginning of contact when the Clinical procedures are
reviewed with the client. Then, prior to the Clinical examination,
the worker may involve the client in a discussion of what help she
expects for herself, and her child, from the other disciplines.
This should enable the worker to assess and discuss with the client
any unrealistic expectations. It is always valuable that the
client know in advance what to expect. Later, she may look back
and recognize that her worker understood, anticipated, and ac-
cepted her feelings.

The above suggestions are made in the hope that they may
help to strengthen the client's feeling that the Clinic can and
wants to assist her in coping more healthfully with her problems.
With this confidence the client will be able to invest herself in
the casework relationship, seeking a solution to her problems
through her own growth, rather than through concrete, corrective
prescriptions from the Clinic.
It has been shown that the clients in this study regarded the waiting-period as the most outstanding cause of their discontinuation. Again, as with the problem of reassignment, the wait is an administrative problem, the result of too many clients seeking the services of the Clinic in terms of staff numbers. Until such time as there is a sufficiently large staff at the Clinic to meet the needs of an increasing number of clients, the waiting-period would seem inevitable. Therefore the emphasis here will not be on the values in the dissolution of the wait, but rather on how it might be used by the workers as a therapeutic tool.

It was stated in Chapter Three that clients with good ego-strengths will not experience as much difficulty accepting the waiting-period as those whose egos are weak. It is possible with these 'stronger' clients that the wait might be interpreted as a period in which they could test for themselves their gains achieved during the diagnostic evaluation period. This plan would best be discussed with the client by the new worker who would acknowledge and support the client's new strengths, and highlight the wait as a period of both testing and consolidating these strengths. At the same time the new worker could arrange that, during the wait, he would keep in regular contact with the client by telephone. The client should also be encouraged to call the worker in the event that she feels the need of his help. During these contacts any difficulties or problem areas could be discussed, and, if necessary, a single interview might be arranged to help the client with a particular obstacle.

The regularity of these telephone contacts with the client could be facilitated if a 'brought-forward' filing system were adopted at the Clinic. Under this system the files of those
clients to whom telephone contacts were due could be distributed to their respective workers each morning. After completing the calls, the workers could then "EF" the files to a later date.

This approach could be therapeutic for the client in two ways: it would increase her feelings of ability and confidence to assume an active, participating role in dealing with her own problems; also, the regular telephone contacts would assure her of the Clinic's continuing interest in and concern for her problems during the waiting-period and until continuing casework services could be offered.

There will also be the client with weak ego-strengths who, during the diagnostic evaluation period, might have difficulty relating to the worker in a one-to-one relationship. This difficulty might be a manifestation of various personality disturbances, such as the fear of dependency, lack of self-worth, resistance to personal involvement in the problem, etc. To this particular type of client the waiting-period presents an opportunity to break his threatening contact with the Clinic. Another type of client whose ego is weak may cling to the worker during the diagnostic period, then interpret the wait as a rejection of her by the worker.

These 'ego-weak' clients might respond well to regular group sessions at the Clinic during the waiting-period. In contact with others who share similar or different problems these clients might develop an acceptance of themselves with the accompanying desire to change, thus providing a better foundation for continuing casework services following the wait. These group sessions could be handled by one worker who would encourage the clients to develop, through group process, a better understanding of themselves through interest in and understanding of others.
Discussions would likely tend to consist of a sharing of children's problems, ways of handling these problems, and would hopefully later focus on the clients' role in the problems - this being pursued by the group members themselves.

The worker would enable each client, through the more dilute group relationship, to gradually build ego-strengths - testing their gains on and looking for support to the group-as-a-whole. From the support of the group-as-a-whole the individual client would perhaps be able to move forward, after the waiting-period, to a more meaningful one-to-one relationship with the caseworker, with new strengths to involve herself in working through her problems to a more mature level of adjustment.

These suggestions for a therapeutic use of the waiting-period are by no means exhaustive. They should be supplemented by the Clinic social workers at their sectional, staff and, if possible, interdisciplinary meetings where methods of dealing with the individual problems of clients - including the problem of discontinuation - can best be studied and planned.

**Conclusion**

An attempt has been made, in this study, to explore the problem of discontinuation both from the perspectives of the Clinic and the clients. The suggestion was made that the Clinic social workers, if alert to the manifestations of withdrawal as described in Chapter Three, can early recognize those cases that may tend to discontinue. This recognition should be followed by the implementation of a casework plan designed to help the clients to work through their resistances, thereby enabling them to continue treatment.
The clients' conscious reasons for withdrawal have also been discussed together with suggestions as to how the Clinic workers might overcome those reasons which are based on practices effecting negative attitudes in the clients toward the Clinic.

It is important that the Clinic social work staff make a concerted effort to understand the problem and decrease the rate of discontinuation. Discontinuation must, in nearly all instances, reflect the clients' dissatisfactions with the Clinic services. Social workers will not adequately meet their goals for the clients, themselves, or the Clinic under such circumstances.

Clients who come for help are entitled to the workers' maximum use of self and skills in his endeavour to involve them in casework treatment of sufficient length to ensure for them a happier adjustment and a decrease of anxiety. Social workers themselves need the support and confidence of client-continuation to reinforce their valid areas of professional competence and for stimulation to increase these areas. The Clinic, which is a public community agency, will serve the community best when its services are used to completion by those who come for help. These goals will be more readily attainable as the rate of discontinuation decreases through greater understanding, refinement of skills, and continued research.
Dear Mrs.,

We at the Child Guidance Clinic are always concerned about increasing our ability to help those in the community who need our services. It has occurred to us that a good way in which to approach this would be to talk to someone who has had contact with the Clinic in the past. We are asking for your help in this project.

One of our social workers, Mr. Warde Laidman, will be calling you by telephone next week to see if he might arrange an interview with you at your convenience. This would be of a confidential nature. We hope you will think this activity worthwhile in the belief that, by giving us your thoughtful criticisms of the Clinic, you will be helping us to help others in a more satisfying way.

Yours truly,

Director.
APPENDIX B

Schedule for Case Summaries

1. **Identifying data:**
   a. child's age
   b. sex
   c. symptoms
   d. referral source
   e. who brought the child
   f. length of waiting period between diagnostic period and continued casework services.

2. **Parents responses to and conception of the child's problem.**

3. **Parents' relationship with the Clinic:**
   a. parents' expressed feelings about and responses to:
      - diagnostic evaluation period
      - the worker
   b. services expected
   c. parents' preparation of the child for Clinic visits.
   d. parents' affect, flow of talk, and behaviour regarding appointment keeping as observed and recorded by the worker.
Schedule to be Used as a Guide for Interviewing Clients who Have Discontinued Treatment.

1. Were you satisfied with the Clinic services to your point of withdrawal?

2. Was the waiting period a factor in your decision to withdraw?

3. Was the change in social workers a factor in your decision to withdraw?

4. Has the problem which brought you to the Clinic changed? Is it better? Same? Worse? To what do you attribute this? Has help been received elsewhere?

5. Was your contact with the Clinic helpful? If so, how? If not, how not?

6. Were you given what you think to be a satisfactory explanation of Clinic procedures and of the need for parent participation as well as child?

7. How do you think the Clinic might improve its services?
APPENDIX D

Frequency of "Withdrawal Indicators" in Six Randomly Selected Cases Not Used In This Study.

<table>
<thead>
<tr>
<th>INDICATORS</th>
<th>CASES</th>
<th>TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Kind of referral</td>
<td>E 1</td>
<td>4</td>
</tr>
<tr>
<td>2. Who brought the child. (Lack of father participation)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Sex of the child as related to mother's hostility to her parent of the same sex</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Parents' &quot;responses&quot; to the problem. (Mother's concern for self, not child)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Intellectual approach of parents.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Underestimation of problem</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Negative reaction of parents to Clinic findings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Parents' lack of preparation of child for Clinic.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Parents' flow of talk, free but defensive</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1. As defined and described in Chapter Three.

2. Question marks indicate a suggestion that the "indicator" was present, although there was insufficient evidence to warrant a conclusive rating.
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