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A study of treatment dropouts from the out-patient service of the Wayne County Children's Center.

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A STUDY OF TREATMENT DROPOUTS FROM THE OUT-PATIENT SERVICE OF THE WAYNE COUNTY CHILDREN'S CENTER

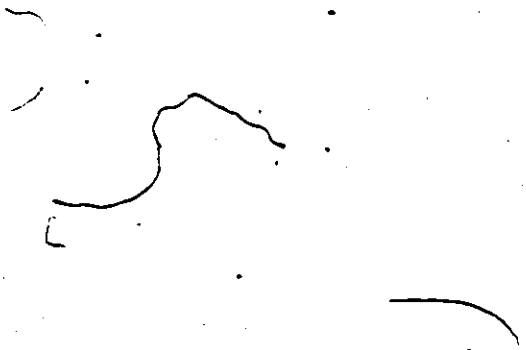
by

Yee Lai-Meng

A Thesis

submitted to the Faculty of Graduate Studies
through the School of Social Work in
Partial Fulfilment of the requirements for
the Degree of Master of Social Work at
The University of Windsor

Windsor, Ontario, Canada
1980



Research Committee

Dr. J. P. Clarke

Professor H. Morrow

Dr. D. Woodyard

DEDICATION

To my Mother, my Wife, and my Daughters.

ABSTRACT

The purpose of this study was to find out whether treatment dropouts and non-dropouts in the Wayne County Children's Center, a non-profit community mental health agency for children and adolescents operating in Detroit, Michigan since 1930, were associated with 1) attributes of the clients and their family background; 2) attributes of the intake therapists; 3) practices of the Children's Center in offering and providing psychosocial services. The dropout problem has been a serious concern of the Wayne County Children's Center for several years.

Research reports on dropouts conducted in mental health clinics, family service agencies, and child guidance agencies were reviewed.

Three research questions and three hypotheses were developed from the literature in order to guide the collection of data. The research questions are enumerated above. The three hypotheses, all related to the first research question, were: 1) parental perceptions of the child's problem; 2) parental discomfort with the child's problem; and 3) parental resistance to exploring problems and the quality of family relationships.

Information for the study was gathered through two instruments. A case review schedule was used to abstract

information from case records. A mailed questionnaire was used to gather feedback on the Center's services from parents and guardians of clients.

A sample of 100 cases was selected from a research population of 319 new cases opened between May and September, 1979. A systematic random sampling procedure was used for sample selection resulting in a research sample of 58 continuing cases and 42 dropout cases. Of the 42 dropout cases, 26 cases (61.9 percent) discontinued after one intake interview, and 16 cases (38.1 percent) discontinued after attending between two to four treatment interviews.

The age of the mothers and types of presenting problems were found related significantly to dropout. The mothers' feelings of discomfort and their attitudes toward exploration of problems were also found statistically related to dropout.

Eighty-three percent of the respondents from the non-dropout group felt that their problems were understood by the therapists as compared to 58.3 percent for the dropout respondents. Eighty-one percent of the non-dropout respondents felt that their problems could be solved by the Center while only 33.3 percent of the dropout respondents shared the same feeling.

Further studies on different samples were recommended to test the variables associated with dropout found significant in this study.

On the basis of the study findings, it was recommended that parents and clients should be informed more fully of the services the Center could offer in relation to their problems; that the professional staff assessment of the client's problems should be conveyed to and discussed with parents; and that parents should be involved in their children's treatment programs.

It was also recommended that go-group should be based on clients with similar problems; that parents who have seen improvement in their children's problems after going through treatment programs should be invited to share their experience with newcomers; that home visits, questionnaires, or phone calls should be used in order to find out why clients miss appointments; and that parents be involved in their children's treatment programs, especially those showing resistance in discussing personal and family problems.

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Appreciation is also extended to the staff of the Center who have directly or indirectly contributed to the study. The study would not have been possible without their cooperation.

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The researcher also wishes to thank other members of the School of Social Work for their interest, encouragement, and support, in particular Dr. L. B. Buckley and Professor M. Harman.

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CHAPTER I

INTRODUCTION

The Study Problem

The problem of clients withdrawing from treatment programs against the advice of therapists, including social workers (or caseworkers), has long been recognized by social agencies and mental health clinics. It is commonly referred to as "dropout" in professional literature. Other terms, like unplanned termination, short-contact case, defection, discontinuance, and premature withdrawal are also used.

A dropout is operationally defined as a client who ceases to make an effort to get care, though he/she still needs it in the professional opinion of the therapist (or caseworker). In other words, a dropout is a client who fails to utilize treatment resources made available to and recommended for him/her to the extent deemed necessary.

According to Levinger (1960, p. 40), "numerous studies have reported the clients' discontinuance of contact with the agency represents a large proportion of persons seen at intake." Family agencies have consistently reported a one-third dropout of intake referrals. The

situation appears to be more serious in the field of psychiatric rehabilitation (Loen and Pascoles, 1968).

A series of studies carried out by members of the Family Service Association of America in 1948 reported that 50 to 60 percent of the cases in family agencies each month were short-contact cases (Shyne, 1948). Another study on the dropout problem conducted in mental health clinics in 1952 reported that between 30 to 65 percent of the patients withdrew before completing treatment (Garfield and Kurx, 1959). A study conducted in a psychiatric clinic for children also reported a dropout rate of 59 percent in 1959 (Tuckman et al., 1959).

Eugiene E. Levitt (1956, p. 429) regarded the family which "voluntarily breaks off contact with the clinic after its staff has invested time and effort in the case" as the most persistent and troublesome problem. The most wasteful type of premature termination, according to him "occurs at a point following a complete diagnostic, a conference staffing, and the assignment of a therapist." Helen Harris Perlman (1960, p. 171) shared the same point of view when she stated that dropout was an economic waste because, "the intake process, even if it is one interview, absorbs time, money, and the energies of the caseworker, supervisory, and clerical staff members." In the field of social services where resources are always in short supply, the wastage incurred by dropout is indeed a serious problem. In an

agency which relies on fees, it could be a catastrophe.

Social administrators are concerned with the problem because it is their responsibility to make sure that agency resources are utilized in the most efficient way to meet community needs. For the therapists or caseworkers, it is a frustrating experience to spend hours waiting for a client who does not turn up for the appointment. The loss of opportunities to attend to the needs of clients may even affect their morale adversely. In most cases, "no-show" will eventually lead to dropout. Another undesirable effect is that the defector may take away the resources from another client who could make better use of them in instances where there is a waiting list. From a professional point of view, this is more important than economic waste.

The crux of the problem lies in the fact that, on the one hand, social service agencies have to accept any eligible request for services, while, on the other, they are in no position to impose their services to those who refuse them. There is nothing to prevent those people who have made the initial requests for services or those who are being served from breaking away whenever they want to. The only way out of this dilemma is to try to reduce dropout rates by motivating potential early terminators to follow through the planned treatment course. To achieve this, early identification of potential dropouts is essential. The intake worker or therapist has to develop the ability to predict whether a screened applicant is likely to drop out.

The value of prediction, according to Merton S. Krause (1962):

> Lies in the fact that the ability to predict quickly and accurately which clients will discontinue would enable casework agencies to apply discontinuance prevention procedures selectively and thereby conserve appointment time that would otherwise be lost because of clients' discontinuance. (p. 308)

Martha Lake and George Levinger (1960) expressed the same view when they stated that:

> If the determinants of client discontinuance were better understood, agencies could probably improve their intake procedures and better fulfill their purpose of meeting the needs of a maximum number of people. (p. 303)

The Purpose of the Study

The purpose of the study was to ascertain why clients drop out from the agency's programs. However, prediction cannot be made in vacuum. It must be based on some observable characteristics. The prediction of dropouts and non-dropouts is only possible if they display distinctive and recognizable characteristics in some areas. The purpose of this study is to identify these distinguishing characteristics in clients. It is an attempt to systematically delineate factors associated with dropouts and non-dropouts. Possible relationships between dropout and the characteristics of intake therapists and between dropout and intake modalities will also be explored.

It is not the intention of this study to analyse causal relationships between variables. It's main objective is to determine the significance of associative relationships between

variables, i.e., association without reference to causality.

Variables selected for testing of association in this study are based on: 1) literature and past studies on the same problem; 2) information recorded at the intake interview; and 3) variables related to the intake procedures used in the Wayne County Children's Center. Through the identification of variables with predictive value in both client and service (agency) sectors, it was hoped that this study would contribute to the development of an instrument for early prediction of potential dropouts.

The Setting of the Study

The study was carried out in the Wayne County Children's Center at which the writer had his Master's field practicum from the School of Social Work, University of Windsor, Windsor, Ontario. The management of the Center has been concerned with the high dropout rate among its clients over the past few years. The study was assigned to the writer as a research project of great interest to agency administration.

The Wayne County Children's Center is a private, non-profit community mental health agency for children and adolescents, which receives payment for its services from Medicaid, Blue Cross and other third party payments. It started as a child guidance clinic in 1930. It's main function then was to provide treatment services for emotionally disturbed children, adolescents and their parents. It has continued these services to the present.

Additionally, in the 1960's, the Center began to diversify it's operation. New programs and services were planned. A Day Treatment Program for Children was introduced. The latest additions to the Center's services were a Group Home and the Teen-Age Parent Program, which serves pregnant youngsters.

The Center provides services for children and adolescents up to the age of 19. Problems for which services are available include: emotional disturbance, hard core delinquency, child abuse, learning disabilities, and school exclusion. At present, services are offered through the following facilities:

Out-Patient Services for Children and Adolescents

Children's Day Treatment Center

Adolescent's Day Treatment Center

Group Home

Teen-Age Parent Program.

Approximately 75 percent of the Center's clients are black. White clients make up 24 percent of the total with 1 percent coming from other ethnic groups. The ethnic composition of the Center's clientele reflects the demographic characteristic of the areas covered by its operation, viz., Wayne County, Michigan.

The majority of the clients belong to the lower income group. About 47 percent of the families earn less than $6,000 per year. Twenty-six percent are in the $6,000 to $10,000 bracket. Only 18 percent of the families have an annual income exceeding $10,000.

This dropout study is limited to the out-patient services of the Center. As noted earlier, out-patient services are available for children and adolescents. Under the decentralization program, services are provided in three units located at different parts of the city. Unit I is located at 17000 Plymouth Road; Unit II, previously housed in the main office, has moved to 7310 West 7 Mile Road in the beginning of 1980; Unit III is operating in the main office at 121 East Alexandrine Road. A fourth satellite unit is being planned for the East side of the city.

Services offered at the out-patient units are: Diagnostic evaluation, individual therapy and counseling, group therapy, family therapy, chemotherapy, psychological assessments, psychiatric evaluation, learning assessment, 24-hour emergency services, tutoring, periodic physical examination, and aftercare.

The objectives of the out-patient services include the following:

- to improve emotional and social adjustments of children and families
- to reduce the number of State hospital institution admissions of clients from the Center's (out-patient) service areas
- to provide aftercare services for children and adolescents returning from institutions
- to reduce the incidence of delinquent and pre-delinquent behavior in the Center's service areas
- to provide an emergency response to family crisis
- to reduce the incidence of child abuse and child neglect. (Orientation Manual, 1979-1980).

The intake operation of the Center is centralized. All applications for services are directed to the intake co-ordinator. Applicants are assigned to either group-intake or individual-intake, the two intake procedures used by the Center. The duty of the intake-coordinator is to assign applicants for services to the appropriate intake modalities on the basis of the nature and severity of presenting problems. Cases designated as emergency or priority are normally assigned to individual intake. All regular cases are assigned to the weekly group intake session.

Individual intake follows the traditional casework procedure in which the therapist interviews the potential client on a one-to-one basis.

Group-intake, as the name implies, is a group operation. Three professional staff and one clerk are involved. In the group-intake procedure, the parents and children are interviewed separately in groups by different therapists. The parents are put into one group to be seen by one therapist. The children are divided into two groups, one consisting of children between 6 and 12 years of age, the other consisting of teenagers between 13 and 17. Each group is seen by one therapist and follows the same general format.

In the parents' group intake session, a lecture on the Center is given, followed by an open-ended discussion of the presenting problems of the children. At the end of the intake session, the parents are given a card informing them of their next appointment date and their therapists.

In the children's group intake session, the same lecture is given, followed by tests in reading, spelling, maths, and figure drawing. The therapist then encourages the children to discuss their problems.

After the interview, the three therapists in charge of the three groups hold a conference to develop a tentative diagnosis for each case.

The objectives of the group-intake interview are as follows:

1. To provide a standard orientation to the mental health services
2. To gather diagnostic information on peer interactions
3. To provide immediate response to requests for services.

Go-group, or orientation-group, deserves to be mentioned here as a treatment method practiced by the Center in response to the needs of the community in which it operates.

The objectives of go-group are as follows:

1. To identify good attenders
2. To introduce clients and their parents to the group process/therapeutic process
3. To resolve reality problems, other issues that can be resolved by simple information exchange, advise and support
4. Extended diagnosis
5. Provide immediate treatment.

At present, approximately 95 percent of the clients processed by group intake are assigned to go-group.

The go-group is an open-ended group with members changing from week to week. As in group-intake, parents and children are seen separately and simultaneously by different therapists. The group session lasts for one hour. Structured exercises related to a common problem such as school, family, peers, and others are conducted at the weekly session.

Each client in the go-group is encouraged to attend six weekly sessions. At the end of the sixth session, a client is interviewed individually to review the progress and to decide upon the need for further treatment. Cases with less than three attendance sessions during the six-week period were normally closed if the letter asking for their attendance was not answered.

Summary

Client dropout has been a problem faced by social service agencies and mental health clinics, especially those dependent in whole or part on client fees (direct or indirect). Social administrators are concerned with the problem because of their responsibility in ensuring efficient use of public funds and limited manpower to meet the needs of the community.

The purpose of this study was to identify variables associated with dropouts and non-dropouts in both the client and service sectors.

This study was carried out at the Wayne County Children's Center which is a community health center pro-

viding mental health services to children and adolescents. A major source of the Center's operating income is third party (Medicaid, Blue Cross) fees for treatment time. Dropout is a special concern because ultimately it could affect the agency's ability to function.

Chapter II will review the studies carried out in family agencies, mental health clinics, and child guidance agencies concerning the problem of the dropout.

CHAPTER II

REVIEW OF THE LITERATURE

Introduction

Client dropout is a problem common to family service agencies and mental health clinics for both adults and children. Though the focus of this study is on children using the out-patient services of a community mental health agency, the literature reviewed also covered studies on dropouts conducted in family service agencies and mental health clinics for adults. Very often, these different settings are dealing with the same kind of people and problems. In a family agency, the social worker is more likely to deal with the problem in terms of family relationships. In a psychiatric clinic, the psychiatrist is more inclined to look at the problem in relation to the system of personality functioning of the individual (Coleman et al., 1957). Similar factors may be operating in all these settings with regard to dropouts. In a child guidance agency, psychiatry, psychology, social work and other professions are involved in a multi-disciplinary approach to the problem of children and adolescents.

Most of the information available on the topic came from studies carried out in family agencies and psychiatric

clinics in the late 1940's and the 1950's. Little attention seems to have been given to the problem in the 1960's and 1970's. An extensive search through social work and other professional publications proved fruitless. The most recent information on the topic was found to form a small section of a book (Gilbert et al., 1976) discussing the dynamics of services on the basis of system theory.

The review may be approached in the following manners:

1. Examining the research studies in chronological order irrespective of settings
2. Examining the research reports according to settings in chronological order
3. Examining the research reports according to variables being analysed regardless of settings.

As this study is looking for variables related to dropouts, the review was organized according to the third approach.

It was noted in Chapter I that different terms have been used to describe the situation in which a client drops out of treatment. As different researchers have their own preferences, different terms were used in different studies.

In this review, terminator, non-stayer, discontinuer were used interchangably with dropout, while remainer, stayer, and continuer were used interchangably with non-dropout. In fact, the terminology is unimportant as long as the concept of client unilateral termination of service is understood.

Social Class

In their study on the relationship between social class and psychiatric disorder, Hollingshead and Redlich (1953) found that the prevalence of psychiatric disorder is related to social class. Their data also showed that a particular type of disorder is associated with a specific social class. Hollingshead and Redlich's study was inspired by the work of a number of sociologists (Rosanoff, 1916; Sutherland, 1901; White, 1903) who found that there is a functional relationship between social environment and mental illness.

The findings of Hollingshead et al., in turn, provided the theoretical base for further research into other aspects of the relationship between environment and mental illness. If there is a connection between social class and mental illness, is there an association between an individual's social background and his length of stay in psychotherapeutic treatment? Some studies have been carried out by social service agencies and psychiatric clinics in response to this question.

An attempt was made by Frank Auld, Jr., and Jerome K. Myers (1954) to develop a theory to explain the relationship of social class and length of stay in treatment.

According to them, the social position of a patient influences what he knows and what he expects from therapy. To some extent, what rewards he will get is also determined

by his social position. If the patient is a suitable candidate for psychotherapy, the rewards he can get from it are many.

> In an ideal case, they (patients) are rewarded when they learn and try out new, more adaptive habits; they are also rewarded by the therapist's attention, by his understanding, and by his emphatic interest in them. (Auld, Jr., et al., p. 58)

But to get the reward of these more adaptive habits, life conditions must offer rewards for adaptive behaviour. The problem with patients of lower social class is that their life has little to offer as reinforcement for a change in behaviour. Moreover, even if there are incentives for such a change, the middle class therapist, unfamiliar with the conditions of lower class life, may not be able to offer guidance relevant to his situation. The gap between social class makes it difficult for a patient from a lower social position to share his experience with the therapist. The middle-class therapist, on his part, is frustrated by his inability to provide help acceptable to his client.

These barriers hamper the establishment of a meaningful client-therapist relationship which is the very basis of this kind of therapeutic process. The encounter is so unrewarding to both sides that the result may be the eventual dropping out of the patient.

Imber et al. (1955) carried out a study on the relationship between social class and length of an individual's stay in psychotherapy. In this study, the experience and

training level was held constant. The selection of patients by therapists was also eliminated. In addition, patients were under administrative pressure to stay in treatment until the completion of the treatment plan.

Subjects of the study were drawn from the out-patient department of the Henry Phipps Psychiatric Clinic, John Hopkins Hospital. Sixty patients were randomly assigned to either individual or group therapy.

The social class rating of the patients was based on the system developed by Warner et al. (1949). The subjects were divided into five classes:

1. upper class
2. upper middle class
3. lower middle class
4. upper lower class
5. lower lower class.

Since there were no upper class subjects and only a few upper middle class subjects in the sample, upper class was deleted and upper middle and lower middle class were combined. The subjects were grouped into middle and lower class.

The findings of the study showed a marked association between social class and duration of stay in treatment. Forty-three percent of the subjects in the lower class were found to have less than 4 interviews and 56 percent stayed beyond this point. In contrast, only 11 percent of the

patients in the middle class dropped out after 4 interviews or less, while 89 percent remained in treatment.

Winder et al. (1955) conducted a study on 100 patients selected from among 1,250 veterans from the Veteran Administration Mental Hygiene Out-patient units in Miami, Florida. The subjects were divided into five social classes using Hollingshead's Index of Social Position (1953). Class I consists of families of wealth, education, and top social prestige; Class II consists of families in which fathers have professional or high-level managerial occupations; Class III includes proprietors, white collar workers, and skilled workers; Class IV consists largely of semi-skilled workers and labourers; Class V includes unskilled and semi-skilled workers with a grade-school education or less.

The length of stay in treatment was grouped into three categories: one to nine interviews, ten to nineteen interviews, and more than twenty interviews. As was done in the study by Imber et al. (1955), Class II and III subjects were grouped together as middle class and Class VI and V were combined and treated as lower class. The subjects included in the study did not have any individual with Class I standing.

The findings of this study supported the hypothesis that social class is related to the duration of an individual's stay in treatment. Middle class patients were found

to be more likely to stay longer in treatment than patients from the lower class.

The study of Sullivan et al. (1957) on the same topic also came up with similar conclusions. In this study, the subjects were divided according to their educational level and occupations.

This study was based on data gathered from records of 268 patients in the Veteran Administration Mental Hygiene Clinic, Oakland, California. The length of stay in treatment was based on the number of interviews using the median number as the cut-off point. The subjects were divided into three sub-groups for cross-validation purposes.

The findings showed a consistent pattern between the "stayers" and "non-stayers" in relation to educational level and occupations. It was found that patients with more years of education and higher occupational level tended to stay longer in treatment.

Coleman et al. (1957) conducted a study comparing a psychiatric clinic and a family agency. The objective of the study was to find out to what extent the services of a psychiatric clinic differed from or overlapped with the services of a family agency.

The study was carried out in the Psychiatric Clinic of the Grace-New Haven Community Hospital and the Family Service of New Haven. Samples for the study were selected from applicants interviewed during the period from October 18, 1954 to January 18, 1955 in the two agencies.

One hundred and fifty-eight clients were selected from the clinic and 112 from the family agency. Comparison was based on information substracted from case records.

The social class of the clients of the two agencies was compared. The classification of social class was based on Hollingshead's Index of Social Position. The findings showed that a high percentage of cases in the Class V group closed after intake in both agencies.

The attitude of the therapist toward the client was suggested by the researchers as one of the most important factors contributing to the problem. The researchers theorized that when a patient from a lower social class does not respond to the characteristic procedures used by the therapist to introduce him/her to the therapeutic situation, the therapist tends to react to the patient with indifference or veiled hostility and rejection. The patient was thus discouraged from continuing in therapy.

Studies carried out in family agencies and psychiatric clinics for adults seemed to support the hypothesis that social class is related to an individual's length of stay in treatment. But the situation in psychiatric clinics for children appeared to be quite different. Studies in child guidance clinics did not show a consistent association between social class and attendance. Conflicting findings were reported.

In a study of 291 cases in a child guidance clinic, Apte et al. (1953), as reported by Maas (1955), found that

lower class families had more dropout cases than the middle class families.

Tuckman and Lavel (1959 did a study in a children's clinic. The children's social status in this study was based on the occupations of the fathers. The criterion for "stayers" and "non-stayers" was based on whether the children completed the treatment course, not on the number of interviews attended. A case was considered terminated if the client did not return to the clinic after missing appointments or if the parents informed the clinic of their child's intention of withdrawing from treatment.

The subjects were selected from patients of eleven psychiatric out-patient clinics in Philadelphia over a one-year period. The study was limited to white children because information on fathers' occupations was not available in a large number of the non-white cases. Seven hundred and eighty cases were selected for the study.

Occupations were classified broadly into four levels: 1) professional, semi-professional, and managerial; 2) clerical and sales; 3) skilled labour; 4) semi-skilled and unskilled labour, personal service, and agriculture.

Findings of the study showed that children from families with higher occupational status and children from families with lower occupational status did not differ in their length of contact with clinics.

The study of Lake (1959), on the other hand, supported the findings of Apte et al. She found that the social class of "continuers" tended to be higher than that of "discontinuers."

Lake's study was conducted in the Child Guidance Center of Mercer County, Trenton, New Jersey. The sample consisted of 100 families which had applied for psychiatric help for their children. Fifty of the families dropped out after the first interview. The other half remained in treatment. The subjects were divided into five classes according to Hollingshead's Index of Social Position. The study found that children from the first three social classes constituted 65 percent of the "continuers." Children from the last two social classes accounted for 35 percent of the "continuers."

Personality Traits

A number of studies carried out in psychiatric clinics for adults had focused on the relationship between personality traits and dropouts.

In 1953, such a study was carried out by Gibby et al. in the Veteran Administration Mental Hygiene Clinic in Detroit. The objective of the study was to analyse personality traits characterizing dropouts and non-dropouts. Records of Rorschach test results were used as a basis for analysis.

The subjects, all males, were divided into three categories. Patients who had attended more than twenty-seven interviews were classified as continuers. Patients who withdrew against the advice of the therapist after attending less than seven interviews were classified as terminators. Those who refused offer of treatment at the initial interview sessions formed the third category.

The analysis of the Rorschach Test records of the subjects in the three groups showed a significant difference in responses to the test between the continuers and terminators. The terminators were characterized by lack of productivity. The average number of Rorschach responses of the terminators was only 20, while the average for the continuers was 31. This lack of responses on the part of the terminators was interpreted as resistance to becoming involved in testing and therapeutic procedures. The findings also showed that continuers had greater awareness of anxiety and were more willing to express their anxiety. The terminators, on the other hand, tended to suppress their anxiety.

Rubinstein et al. (1956) conducted a research to investigate the specific personality and socio-economic variables that differentiate remainers and terminators of psychotherapy. The sample of 129 male veteran patients were selected from nine Veteran Administration Mental Health Clinics throughout the United States. All were new cases with no hospitalization records.

In this study, terminators were those patients who broke off contact after five or less interviews against the advice of therapists. Sixty patients were in this category. Remainers were those patients who had attended more than twenty-six interviews. Sixty-eight patients were in this category.

The findings showed that there were general differences between the terminators and remainers in terms of personality traits. The remainers were found to be more intelligent, better educated, and have a higher level of jobs than the terminators. About 56 percent of the remainers were graduates of either elementary school, high school, or college. Only 34 percent of the terminators had one of these three levels of schooling. Remainers also reported fewer job changes than terminators.

The remainers were found to feel more dissatisfied with themselves, to see themselves as having poorer interpersonal and overall adjustment than the terminators. The terminators were found to be more aggressive. They tended to have more trouble with the law. They were also hostile to authority.

Kogan's study (1957) in a family agency also reported that clients who remained in treatment longer generally exhibited higher intellectual status and better understanding of their problem situation than those who withdrew prematurely.

In a study designed to explore the relationship between personality traits and the individual's length of stay in treatment, the following hypotheses were tested: —

1. Terminators are more likely to have a history of frequent trouble with the law, lack of impulse control, hostility to authority, lack of goal persistence, and lack of personal ties or loyalty.
2. Terminators are less self-dissatisfied.
3. Terminators are less likely to report anxiety.
4. Terminators have more limited vocabulary.
5. Terminators are more authoritarian. (Maurice et al., 1957, p. 321)

The study was conducted by Maurice et al. (1957) on a sample of patients selected from thirteen Veteran Administration Mental Hygiene Clinics all over the United States. Number of weeks in treatment rather than number of contacts was used to classify terminators and remainers as the number of treatment sessions vary from patient to patient. Subjects who had attended six weeks of treatment or less were designated terminators. Subjects who had attended more than twenty-six weeks of treatment sessions were designated as remainers. Patients with more than seven and less than twenty-six weeks of treatment sessions were not included in the study. For cross-validation purposes, subjects were divided into two subgroups with fifty-eight terminators and equal number of remainers in each subgroup.

The findings of the study supported hypotheses 1, 3, and 5. The personality differences of the remainers and terminators were stated as follows:

> The remainer is thus seen as an anxious, self-dissatisfied individual with some psychological insight who is willing to explore his personal problems with others. He has some sense of loyalty to others and tends to persist in activities he undertakes. He is not likely to have been involved in anti-social acts. On the other hand, the terminator either is not anxious or does not admit to being anxious and self-dissatisfied. He is likely to have had a history of anti-social acts. He admits to being undependable and impulsive, and may be authoritarian or rigid in his social attitude. (Maurice Lorr et al., 1951, p. 326)

Earl S. Taulbee was another researcher who believed that "certain identifiable personality variables are associated with the premature termination of, or continuation in, individual psychotherapy" (1957, p. 83).

He drew his subjects from the Veteran Administration Mental Hygiene Clinic in Omaha, Nebraska. Eighty-five patients who had gone through the Rorschach and MMPI Tests were divided into terminators and remainers. Criterion for terminators were those patients who had attended less than thirteen interviews. Patients with more than thirteen interviews were classified as remainers. There were forty patients in the former and forty-five patients in the latter groups. Another fifty 'normal' subjects from the same geographical area from which the patients originated were used as the contrast group.

The findings of the study supported the researcher's hypothesis. Remainers were more likely to show greater improvement. They were found more responsive emotionally to their perceived world and more sensitive to a wider range

of pleasurable and painful stimuli. In addition to being dependent and self-doubting, they also showed increased awareness of feelings of inadequacy, inferiority, and depression. They exhibited better potential for self-appraisal and had greater need to be accepted and to receive affection. They also displayed an immature attitude toward life and had difficulty in controlling their emotion.

The terminators, on the other hand, were more inclined to handle situations in an impersonal and matter-of-fact way. They emphasized intellectual control. They were found able to respond to only a limited range of emotional stimulation. They were found more withdrawn and less open in expressing their anxieties.

These findings supported those produced in studies by Gibby et al. (1953), Rubinstein et al. (1956, and Maurice et al. (1957). The findings of E. Wesley Hiller (1958), carried out in the Veteran Administration Mental Hygiene Clinic at Detroit, also showed that the feeling of anxiety was one of the personality traits of remainers.

Nature of Problem

Nature of problem is another variable frequently studied in relation to the problem of the dropout.

In a study involving 338 cases selected from new cases opened in March, 1947, in the district office of the New York Community Service Society, Blenkner (1954) found

that clients with problems which were psychological and interpersonal in nature were more likely to continue than clients with problems in other areas.

The materials for this study were information recorded in the face sheet and the initial interview. The sample was divided into sub-samples for cross-validation purposes. The characteristics of cases with only one interview were compared with the characteristics of cases with two or more interviews.

But the findings of the study carried out by Ripple et al. (1956) did not support the results of Blenkner's study. The cases of this study were drawn from two Chicago family agencies: The Family Service Bureau of the United Charities and the Jewish Family and Community Service. Three hundred and thirty-four cases were selected from those accepted for services during the period between January 18th to March 17th, 1954.

In this study, problem situations were divided into two broad categories:

1. External problem situation: This is a situation in which the client is the victim of the circumstances or the client has substantially contributed to the creation of the circumstances.
2. Psychological problem: This is a situation in which the problem is one of interpersonal relationship or personal disturbances. (1956, p. 40)

Economic dislocation, social dislocation, economic maladjustment, social maladjustment were designated as external problem situations. Interpersonal conflict (overt

conflict between two people), intrafamilial conflict (overt conflict involving three or more family members), maladaptive interpersonal relationship (covert conflict involving two or more family members), personal disturbances or behaviour disorder not otherwise classified were designated psychological problem situations (1956, p. 41).

The findings of this study showed that a significant relationship existed between the nature of the problem and a client's length of contact with the agency. More than 50 percent of the subjects with external problem situations continued to at least the fifth interview, while only one-third of those with psychological problems did so.

The study of Kogan (1957) seemed to confirm Ripple's findings. Kogan found that, in general, the continuers showed a significantly greater number and variety of problem areas. But discontinuers were found more likely to have problems of family relationships or personality adjustment (1957, p. 374).

Kogan's findings were based on the records of 250 new cases accepted for services at Division of Family Services of the Community Service Society, New York, between November 16th and December 15th, 1953. One hundred and ninety-five of the 250 cases with less than five interviews were designated as short-term cases. Approximately 30 percent of the short-term cases were closed on unplanned basis.

Werble (1958) also carried out a study of adolescent clients of three Chicago family agencies: the Jewish Family

and Community Service, the Family Service Bureau of the United Charities, and the Scholarship and Guidance Association. The sample consisted of 50 continuers and 50 discontinuers. All subjects were in the age group of 14 to 19 years of age and without previous service records.

In this study, discontinuers were defined as clients who had attended four or fewer interviews. Continuers were defined as clients who had gone beyond the fifth interview (Werble, 1958, p. 124).

Werble's findings showed that the predominant problems presented by the continuers were in one of the following areas: malfunctioning in school; in community relations; in peer relations. The discontinuers, on the other hand, tended to report their problems as the malfunctioning in family relations.

The most common complaints of patients served by the out-patient mental health clinic were either psychological or somatic. In the study by Gibby et al. (1953) referred to earlier in this Chapter, the findings showed that the majority of the complaints presented by discontinuers were somatic in nature, like gastric pain, diarrhea, constipation, hysterical blindness, headaches, excessive perspiration, anorexia, breathlessness, and hives. The continuers, on the other hand, presented a combination of somatic and psychological complaints like phobia obsession, compulsion, anxiety, amnesia, worry, irritability, nightmares and depression.

Frank et al. (1957) in their investigation found a positive relationship between an individual's length of stay in treatment and the duration of his illness. Patients who complained that they had been ill for a long time tended to stay in treatment longer than those who stated that they had been ill for only a short period. The study also found that patients with fluctuating illness were more likely to remain in treatment than those with stationary illness.

The study was based on the records of 91 patients served by the Out-Patient Department of the Henry Phipps Psychiatric Clinic.

In the case of child guidance clinics, the findings of Smigelsky's study (1949) showed that parents who referred their children for passive behaviour disorder were more likely to drop out than parents who referred their children for more aggressive behaviour patterns. The explanation, according to Smigelsky, seemed to lie in the fact that parents whose children's behaviour problems were less disrupting to family life were less likely to feel the urgency for treatment. This study was conducted in the Guidance Institute of Berk's County. Where the Child Guidance Clinic is part of a public Board of Education, as in New York City, for example, continuance or discontinuance would be affected by other factors, viz., school behaviour and teacher reactions.

Resistance to Exploration

Another variable believed to be associated with unplanned termination is an individual's attitude toward exploration of his/her problems.

The study conducted in the New York Community Service Society found that relationship exists between attitude toward exploration and early termination. As reported by Blenkner, Hunt, and Kogan (1951), the majority of those who failed to return for more interviews after intake were found to be characterized by "projection of their problems onto others or their environment and a rigid, resistant response to exploration" (Blenkner et al., 1957, p. 28).

Kogan's study (1957) carried out in a family agency also confirmed that resistance to exploration was a significant factor distinguishing short-term cases from long-service cases.

In Kogan's study, short-term case was defined as "a case that receives from a minimum of one interview to a maximum of four interviews before closing" (1957, p. 233). The subjects of the study were selected from new cases between November/December, 1953, in the Division of Family Service of the Community Service Society of New York.

By comparing the cases closed on unplanned basis within four interviews and cases that went beyond the fifth interview, the data showed that continuers were less resistant to exploration of personal problems than discontinuers.

The study of Frank et al. (1957) reported similar results. Continuers were found characterized by their willingness to discuss their problems. In Hiler's study (1958), it was also found that continuers were more inclined to reveal confidential material and inner feelings, to express more inferiority feelings, and were less evasive than discontinuers. The study of Lorr et al. (1958) also produced findings in agreement with the above studies.

Perception of Problem

Some studies conducted in family agencies and mental health clinics found that a client's perception of his own problems were related to whether he/she would stay or drop out.

Blenkner et al. (1951), in summarizing the study conducted in New York's Community Service Society, reported that discontinuers tended to project undue responsibility for their problems on other people or on the environment. Such projection characterized about two-thirds of the subjects who only had one interview.

The study of Rubinstein et al. (1956) also showed similar findings. The remainers tended to think of themselves as having poor interpersonal and overall adjustment. The discontinuers, on the other hand, did not see the problem in themselves. The study of Lorr et al. (1957) found that discontinuers were less dissatisfied with themselves than remainers.

Kogan's study (1957) showed that clients who continued beyond the fifth interview were more likely to feel the need for change in themselves. They were more inclined to attribute the responsibility for the problem situation to themselves rather than to others or the general circumstances.

Similar evidence was produced by Werble's study (1958). Continuers were found more likely to see themselves as the source of their problems. Dropouts were more likely to perceive their problem as coming from the malfunctioning of family relations or sources outside of themselves.

Capacity to Communicate

The study of Smigelsky (1949) referred to earlier found that parents who showed better skills in expressing their anxiety in relation to their children's problems were more likely to continue their contact with the agencies. Parents who dropped out early were poor in communication skills.

The findings of the study of Gibby et al. (1953), also referred to earlier, showed that similar results among patients of a mental health clinic, e.g., the Veteran Administration Mental Hygiene Clinic of Detroit were obtained. Patients who could communicate better stayed longer in treatment.

Hiler's investigation (1958) also reported that lack of skills in verbal communication on the part of the patients contributed to their premature termination. Hiler's study

was also conducted in the Veteran Administration Mental Hygiene Clinic of Detroit. In this study, dropouts were patients with five or fewer interviews. Non-dropouts were those who had attended twenty interviews or more. The findings were based on the performance of these two groups in the Wechler-Bellevue test.

Results of the comparison showed that remainers were more intelligent than terminators in addition to their superior skills in verbal expression.

According to David Fanshel's study (1958) which was carried out in the Family and Children Service of Pittsburgh, poor communication skills were not a significant factor in differentiating dropout and non-dropout cases in general. It was found significant only when the problem presented by the client involved an area which required a good verbal command on the part of the client for its solution. Clients with marital problems were found more likely to discontinue if they had difficulty in expressing themselves.

Sex, Age

In Smigelsky's study (1949), children's age was found to be a significant factor related to dropouts. Parents of pre-school children were more likely to discontinue than parents of older children in a child guidance agency, perhaps because child guidance clinics served school children historically.

But the findings of Simon's investigation (1953), conducted in the same agency, did not support Smigelsky's findings. Simon's sample was selected from "withdrawn cases" in which the parents terminated their contact after being accepted for treatment. Instead of the pre-school children, those in the age group of eleven to sixteen were found more likely to drop out. The sex of the children was found not related to the dropout.

The study of Frank et al. (1957) found that sex and age did not discriminate among patients using the out-patient services of the Henry Phipps Psychiatric Clinic. These findings were supported by David Fanshel (1958) who also found that the attributes of sex and age were not related to the dropout.

With regard to the relationship between ethnic group and the length of contact with the agency, Lorr et al. (1957) found that negroes were more likely to have short contact with mental health agencies than white patients.

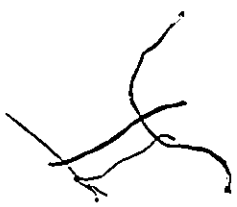
Summary

Studies carried out in family service agencies, mental health clinics, and child guidance agencies were reviewed.

These studies covered investigations on the association between dropout and social class, personality traits, nature of problem, resistance to exploration, perception of problem, capacity to communicate, sex, and age. With the exception of age, differences between dropouts and non-

dropouts in all these variables were found in most of the studies reviewed.

The next chapter will discuss the research methodology of the study and the specific areas to be explored.



CHAPTER III

RESEARCH DESIGN AND METHODOLOGY

According to Selltiz et al. (1959, p. 90) a research design is "the arrangement of conditions for collection and analysis of data in a manner that aims to combine relevance to the research purpose with economy in procedure." The choice of a research design, therefore, depends upon the purpose of the study. In Chapter I, the purpose of this study has been stated as an attempt to identify variables associated with dropouts in the Wayne County Children's Center.

Classification of Design

Tripodi (1977, p. 24) classifies studies seeking to identify relationships between variables as a sub-type of Quantitative-Descriptive Research. Quantitative-descriptive research can be used for the purpose of hypothesis testing or for describing the quantitative relations among variables. With regard to the second purpose, it can be divided into two sub-objectives. The first sub-objective is to measure a series of specific variables in order to answer specific questions posed by research study. The second sub-objective is to look for significant relationships among designated variables in order to formulate more precise hypotheses for further investigation. The

variable relationship study is described as follows:

> Studies searching for variable relationships are those quantitative-descriptive studies which are concerned with the finding of variables pertinent to an issue or situation and/or the finding of the relevant relations among variables. Usually neither a priori hypothesis nor specifications are formulated to guide the research. Survey procedure may be used, and a large number of potentially relevant variables are included in such studies. Often there is an interest in seeking variables with predictive value. (Tripodi, 1977, p. 44)

In this type of study, according to Selltiz et al., "the research questions presuppose much prior knowledge of the program to be investigated," and the investigators must be able to specify clearly "who is to be included in the definition of a 'given community' or a given population" (1976, p. 102). Samuel Finestone and Alfred J. Kahn (1975, p. 62) also stated that descriptive study "requires carefully defined population and representative samples."

This study meets the requirements of a quantitative-descriptive study as described above: the main purpose of this study is to search for variables with predictive value, much prior knowledge of the dropout problem is available, and the population to be included in the study is clearly defined.

Research Questions

The majority of the studies on the topic of the dropout as reviewed in Chapter II focused on the characteristics of the clients. In view of the social environment and the demographic characteristics of the population served by the

Children's Center, it was considered worthwhile to also explore the characteristics of the therapists and the service methods used. This approach was based on the observation of Lake and Levinger (1960, p. 303) which stated that, "discontinuance lies in a combination of factors: the characteristics of the client, of the worker, and of the client-worker relationships."

As noted in Chapter I, the Center has initiated new intake procedures and treatment methods in response to the realities of the community. It is of practical value to explore the effects of these new approaches on dropouts as compared to the more traditional ones.

This study was carried out to answer the following questions:

1. What characteristics of the clients and their background are associated with dropout?
2. What characteristics of the therapists are associated with dropout?
3. Are there any relationships between the intake procedures and dropouts?

Based on the three research questions, variables selected for testing of significance of relationship were divided into three groups: 1) characteristics of the clients and their family background; 2) characteristics of the therapists; and 3) characteristics of intake modalities.

The first group of variables include identifying information for both children (clients) and parents, economic status of families, marital status of parents, and family relationships. The variables of the second group include

the sex, ethnic group, marital status, and employment status of the therapists. The third group of variables include locality of out-patient units and intake modalities.

Hypotheses

In general, children using the out-patient services of child guidance and mental health agencies are under the care of their parents. It follows that the parents' attitude is a crucial factor in studying the dropout problem of these agencies. The following hypotheses, which are connected with the first research question, had been developed for testing:

Hypothesis I: Parents who attribute the responsibility for the existence of their children's problems to the children themselves are less likely to drop out.

Hypothesis II: Parents who feel more discomfort with their children's problems are less likely to drop out.

Hypothesis III: Parents who are resistant in exploring personal problems and family relationships in relation to their children's problems are more likely to drop out.

These three hypotheses were formulated with reference to the findings of some of the studies reviewed in Chapter II. With regard to the perception of problems, the studies of Blenkner et al. (1951), Rubinstein et al. (1956), Lorr et al. (1957), Kogan (1957), and Werble (1958) found that dropouts were more inclined to blame other people or their environment for the existence of their problems. Ripple (1956) reported that the degree of discomfort with their problems

was an important motivating force among clients who remained in treatment. The studies of Blenkner et al. (1951), Kogan (1957), Frank et al. (1957), Hiler (1958), and Lorr et al. (1958) found that the clients' resistance to exploration of their problems was associated with length of stay in treatment.

It should be pointed out here that in this study, these hypotheses were only applicable to only 48 cases of the sample. The reason was that the 100 cases in the sample were processed by different intake procedures. Fifty-two cases went through the group intake process and 48 went through the individual intake process. As the group intake format does not provide sufficient information for in-depth analysis of the parents' attitude and feelings, the hypotheses could only be tested on the 48 individual-intake cases. The intake-interview records for these 48 cases contained sufficient materials for this purpose.

Operational Definitions

Selltiz et al. (1976, p. 55) stated that concepts in research questions and hypotheses must be specific, precise, and explicit. This is to avoid ambiguity and to facilitate a clear understanding of the nature of the study. In other words, concepts must be operationally defined.

As noted in Chapter II, there are different ways to define dropout. Depending on the settings and the preference of the researchers, number of interviews and length

of contact have been used as a basis to differentiate dropouts and non-dropouts. But all definitions must refer to the situation in which a client stops going to the agency or clinic for interview or treatment, although resources have been provided for his/her services.

For the purpose of this study, a dropout is defined as follows:

> After the initial intake interview at which arrangement for further interviews has been made between the client and the therapist, the client has subsequently attended four or fewer interviews.

This definition was adapted from the research plan developed by Ripple (1956) for studying the dropout problem in family agencies.

Clients who had attended five or more interviews were treated as non-dropouts. Cases for which services were completed successfully within four interviews and cases seen for less than four sessions but were still active at the time the sampling procedure was carried out were also treated as non-dropouts.

Clients, for the purpose of this study, means the children, although in some cases the parents may be seen together with the children. The basis for this approach is that initially, it was the problems of the children that brought the parents into contact with the agency. Moreover, the children's problems were the focal point of treatment plans.

Type-case refers to whether a particular case belongs to the emergency, priority, or regular category. The classification of cases into different types is based on the nature and severity of the problem. Behaviour likely to bring immediate danger to the children themselves will be treated on an emergency basis. Behaviour which will deteriorate if not immediately attended to will be treated on a priority basis. The regular category includes all cases not covered by the emergency or priority category.

Family-status refers to the family situation in which the client lived. The child may live with one parent, two parents, or with other relatives.

The employment status of the therapists refers to whether the therapist is a student assigned to the Center for field practice or a full-time staff.

Discomfort is defined as the difficulty experienced by the parents in dealing with their children's problems. The presence or absence and the degree of discomfort felt by the parents were assessed by considering the following factors:

1. Expressing concerns over the client's problems (Low).
2. Admitting having difficulty in coping with the situation (Moderate).
3. Expressing frustrations over the situation (High).
4. Expressing a sense of helplessness over the situation (Very High).

Resistance is defined as the parents' attitudes toward ex-

ploring personal and family relationships in relations to the children's problems. The degree of resistance is assessed by considering the following factors:

1. Showing hesitation in providing information regarding the children's problems (High).
2. Responding to requests for information only when asked (Moderate).
3. Volunteering readily information regarding the children's problems (Low).
4. Discussing freely all aspects of the children's problems as well as family relationships (Very Low).

Population

The subjects of this study were clients using the out-patient services provided by the three Out-Patient Units of the Wayne County Children's Center. Included in the population were 319 cases opened in the months of May, June, July, August, and September of 1979. Most of the non-dropout cases were still active at the time of case selection.

There are advantages and disadvantages in using current cases rather than closed cases in the study of this nature. One of the advantages is that the findings are relevant to the recent changes and developments of the agency. The disadvantage is that sometimes it is difficult to place a case in the dropout or non-dropout category.

For example, a case opened in September may have only two interviews at the time it was read. The case may or may

not go beyond the fourth interview which is the cut-off point in deciding case-status. The judgment of the therapist handling the case has to be relied upon in placing the case. A total of nine cases were decided in this way.

Sampling Procedure

The proportionate systematic sampling procedure was used in the selection of cases. According to Selltiz et al. (1976, p. 523), the systematic sampling procedure is different from the random sampling procedure. The random sampling procedure is a probability sampling process which not only gives each element in the population the equal chance of being included in the sample, but also makes the selection of every possible combination of the desired number of cases equally likely.

Systematic sampling, on the other hand, may either be probability or non-probability. It depends on how the first case is selected. If the first case is randomly picked, then the sample will be a random sample. In order to make the sample of this study a random sample, the first case of each month was randomly picked.

The cases were selected from the intake log book. In order to produce a sample of 100 cases out of a population of 319 cases, it was decided to select every third case after the first case had been randomly picked. The process was repeated for each month. The number of cases selected from each month was proportionate to the total intake of the month.

In the event of a case not falling into the dropout and non-dropout categories for the purpose of this study, the same process was used to select the replacement. For example, if three cases selected from May did not meet the requirements, the first replacement would be randomly picked, the second and third replacements would be picked from the following every third cases. The number of dropout and non-dropout cases was not decided in advance, although the total cases to be included in the sample was 100. It was expected that between 30 to 40 percent of the sample would be dropout cases. The research sample ultimately consisted of 52 continuing cases and 42 dropout cases.

The following categories of clients were excluded from the sample:

1. Clients coming to the out-patient units for evaluation purpose.
2. Clients who were transferred to other agencies after intake interview at the recommendation of the therapists.
3. Clients who were initially seen at the out-patient units but were subsequently (before the fourth interview) transferred to other programs of the Center.
4. Clients who had used the Center's out-patient service before (reopening cases).

Data Collection Instrument

The data collection instruments of this study were a case review schedule and a mailed questionnaire (Appendices I and II).

The case review schedule was developed after "experience survey" discussions with staff of the Center and a review of

relevant research studies. A sample of case records were also read. It was designed to collect information on the characteristics of the subjects, the therapists, and the service methods of the Center.

The main sources of information for this study were the face sheet and the materials recorded by the therapists at the intake interviews. Information in other sections of the case records was not used as it was not available for clients who dropped out after the intake interview. This is to ensure that information for all selected cases is comparable.

The other data collection instrument was a mailed questionnaire to be filled out by the parents or guardians of the clients. The purpose of the questionnaire was to obtain feedback from the parents with regard to their perception of the services provided by the Center.

As noted by Selltiz et al. (1976, p. 297), one of the disadvantages of mailed questionnaires is the poor rate of return. This was expected to be compounded by the social conditions of the subjects of this study. As a result, in constructing the questionnaire, special attention had been paid to the length of the questionnaire, the ease of filling out the questionnaire and mailing it back, and the interest of the questions to the respondents.

Two sets of questionnaires were prepared, one for the dropouts (20 questions) and one for the non-dropouts (18 questions). The two sets of questionnaires were similar

in all aspects except for the two extra questions asking the respondents in the dropout group to state the reasons for their dropping out. Most of the questions were closed-ended with a simple choice of "yes" or "no". The questionnaire was not confidential in the sense that each of them was numbered so that the answers could be checked with information substracted from case records of a particular client on the case review schedule.

The questionnaire was "tested" at the main office of the Center. Parents waiting at the lounge were randomly given copies of the questionnaire to read. The purpose of the pre-testing was to find out 1) whether the questions asked were of interest to them; and 2) whether the questions were easily understood by them. Instead of asking them to fill out the questionnaire, they were asked to comment and make suggestions, although this is not the same as completing a questionnaire.

In the actual data gathering mailed questionnaire survey, to add a personal touch to the "impersonal" questionnaire (Selltiz et al., p. 295), each questionnaire was accompanied by a personalized cover letter addressed to the parents or guardians of the clients. On the questionnaire for the dropouts, the number of interviews the client had attended before dropping out was also stated.

A memo was sent to all staff members of the Center informing them of the study and the questionnaire. They

were requested to encourage the clients to fill out and return the questionnaire in case they received enquiries on the matter.

Data Analysis

The data analysis of this study was performed by computer using the Statistical Package for the Social Sciences program. The SPSS subprograms for frequencies, cross-tabulation, and statistics were used to generate information for the following purposes:

- description of sample
- testing of association between variables
- testing of hypotheses.

Tables, bar charts, and line charts were used to illustrate the findings. For testing the significance of association, chi-square was used.

The analysis was divided into three sections. The frequency distribution of the sample on selected variables was described in the first section. The second section of the analysis covered the research questions. The acceptance or rejection of the three hypotheses were analysed in the third section.

Limitations of the Study

There are several limitations to this study:

1. The main source of information for this study was the materials recorded during the intake interviews. Because the interviews were conducted

by therapists of different disciplines and status, two factors were likely to affect the contents of the records: professional bias and level of training. For example, one therapist might pay more attention to the environmental aspect of the problem while the other emphasized the aspect of personality functioning. This difference might be reflected in the contents of the records. The comparability of the records may thus be affected.

2. The size of the sample (100 cases) and the fact that it was selected from cases opened within a specific period limited it's claim to representativeness. As a result, at best, the findings can only be generalized to the population from which it was selected.
3. There is potential bias in the findings coming from the researcher. Because the case-status of the subjects included in the sample were known to the researcher, such knowledge might affect his judgment in reading the records. For example, in reading a dropout case the researcher might unconsciously pay more attention to information confirming the status of the case. Similar situations, though in a direction, might happen when a non-dropout case was read.
4. The particular social environment and the demographic characteristics of the subjects also

limited the generalization of the findings to other social settings. That is, the findings are based on a sample population of 100 families, 83 percent of which were black.

Summary

This study is classified as a sub-type of quantitative-descriptive study seeking to identify variable relationships.

This study was designed to examine three research questions and to test three hypotheses. The data for this study was based on information obtained from case records and responses to a mailed questionnaire. A sample of 100 cases was selected from a population of 319 new cases of the out-patient units of the Wayne County Children's Center. The systematic random sampling method was used for sample selection.

SPSS was used for data analysis and testing of significance of association between variables.

This study was limited by possible professional bias, sample size, and the social and demographic characteristics of the sample.

The findings of this study will be presented in the next Chapter.

CHAPTER IV

DATA PRESENTATION AND ANALYSIS

Introduction

The findings of this study were presented in the following order:

- Findings related to sample
- Findings related to research questions
- Findings related to the testing of hypotheses.

In presenting the findings related to the research questions, responses to the mailed questionnaire were also discussed. The questionnaire was treated as part of Research Question One.

Whenever appropriate, findings of studies reviewed in Chapter II were referred to for comparison purposes.

Significance of association between variables was based on the level of 0.05. This level of significance was also used as a basis for acceptance or rejection of the null hypothesis.

Description of Sample

Age: The majority (61 percent) of the subjects in sample were in the age group of ten to seventeen. Those in the six to nine age group constituted one-third of the sample. Only 10 percent of the sample were children in the age group of five and below.

Sex: There were more boys (63 percent) than girls (37 percent) in the sample. The average age of the boys (10.3 years) was slightly younger than that of the girls (10.9 years). This was due to the higher percentage of girls (64 percent) in the ten to seventeen age group than the boys (58 percent). Moreover, only one girl (2.7 percent) was in the five and below age group, while nine boys (14 percent) were in this age group. The distribution of the sample by age and sex is shown in Chart 1.

Ethnic group: There were 83 black (83 percent) in the sample. This high percentage of blacks was a reflection of the demographic characteristics of the community served by the Children's Center. This rendered the sample of this study very different from those discussed in Chapter II. Whites were the majority in the sample of those studies.

Family income: Twenty-eight percent of the children in the sample came from families with an annual income below $5,000. The family income of another 28 percent was in the $5,100 and $10,000 bracket. Families earning between $11,000 and $15,00 constituted 8 percent of the sample. Fourteen percent of the families earned more than $16,000 per year. In addition to the ethnic factor, low income was another characteristic of the population.

Employment status: The sample was also characterized by the employment status of the parents. In only 8 percent of the sample were both parents of the children employed. In 15 percent of the sample, only the fathers were working.

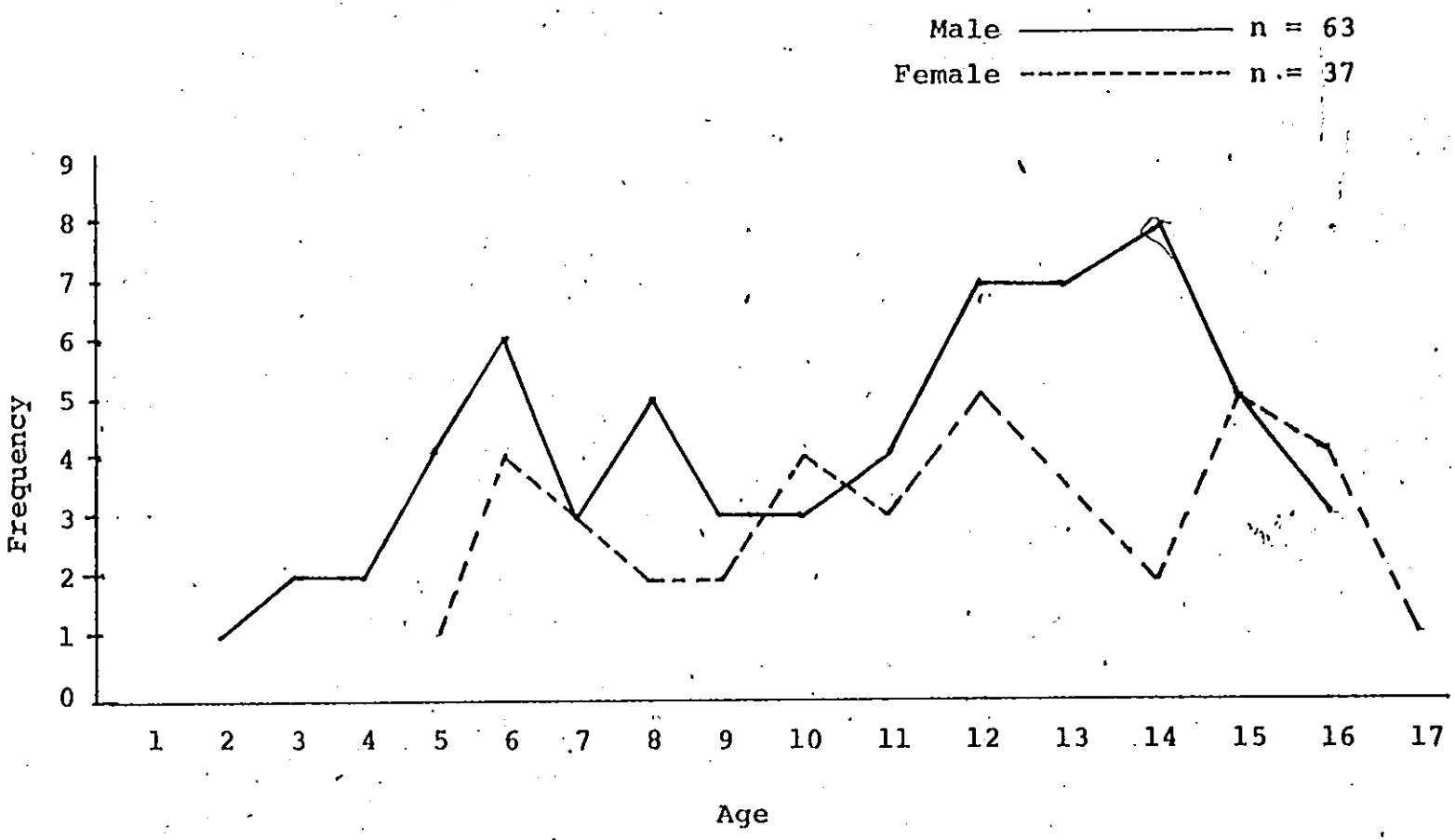


Chart 1 - Frequency Distribution of Sample by Sex and Age

Mothers worked in 17 percent of the sample. Slightly more than half (53 percent) of the families in the sample were on public assistance.

Family status: The majority (58 percent) of the children came from one-parent families. Only 34 percent of the children lived in families with two parents. If one-parent families are equivalent to broken families, then, the sample was dominated by children from broken homes.

Marital status: With regard to the marital status of the parents, 23 percent were separated, 24 percent divorced, and 12 percent never-married.

Siblings: There were sixteen children (16 percent) in the sample who were the only child in the family. Fifty-two percent of the children had either one or two siblings. Children with three siblings or more made up 28 percent of the sample.

Family problems: Parent-child conflict was reported in 20 percent of the sample. Marital conflict was found in 11 percent of the families and sibling-conflict in 7 percent. Forty-two percent of the families in the sample reported no family problems.

Parents' age: In 70 percent of the sample the age of the fathers was not available. As to the age of the mothers, 28 percent were under 30, 34 percent between 31 and 40, and 30 percent were 41 years and above.

Ordinal position: Thirty-two percent of the children in the sample were the oldest in the family. Twenty-three

percent were the youngest. Children in the middle constituted 25 percent of the sample.

Findings Related to Research Questions

The first research question called for the exploring of significant relationships between the characteristics of the clients and case-status.

Case-status by Age-Group

No significant association was found between case-status and the age of the clients. As shown in Table 1 the percentage of dropouts and non-dropouts in the three age groups did not deviate from the overtrend of the sample.

Table 1

Case-Status by Age-Group

Age-group	Non-dropout	Dropout	Total
5 and below	8.6% (5)	11.9% (5)	10.0%
6 to 9	31.0% (18)	26.2% (11)	28.0%
10 and above	60.0% (35)	61.9% (26)	61.0%
Total	100.0% (58)	42.0% (42)	100.0%

Chi-square = 1.08126 df = 3

Significance = ns

The findings did not support Smigelsky's study which reported that children in the younger age group (pre-school) were more likely to drop out. (Chart 2)

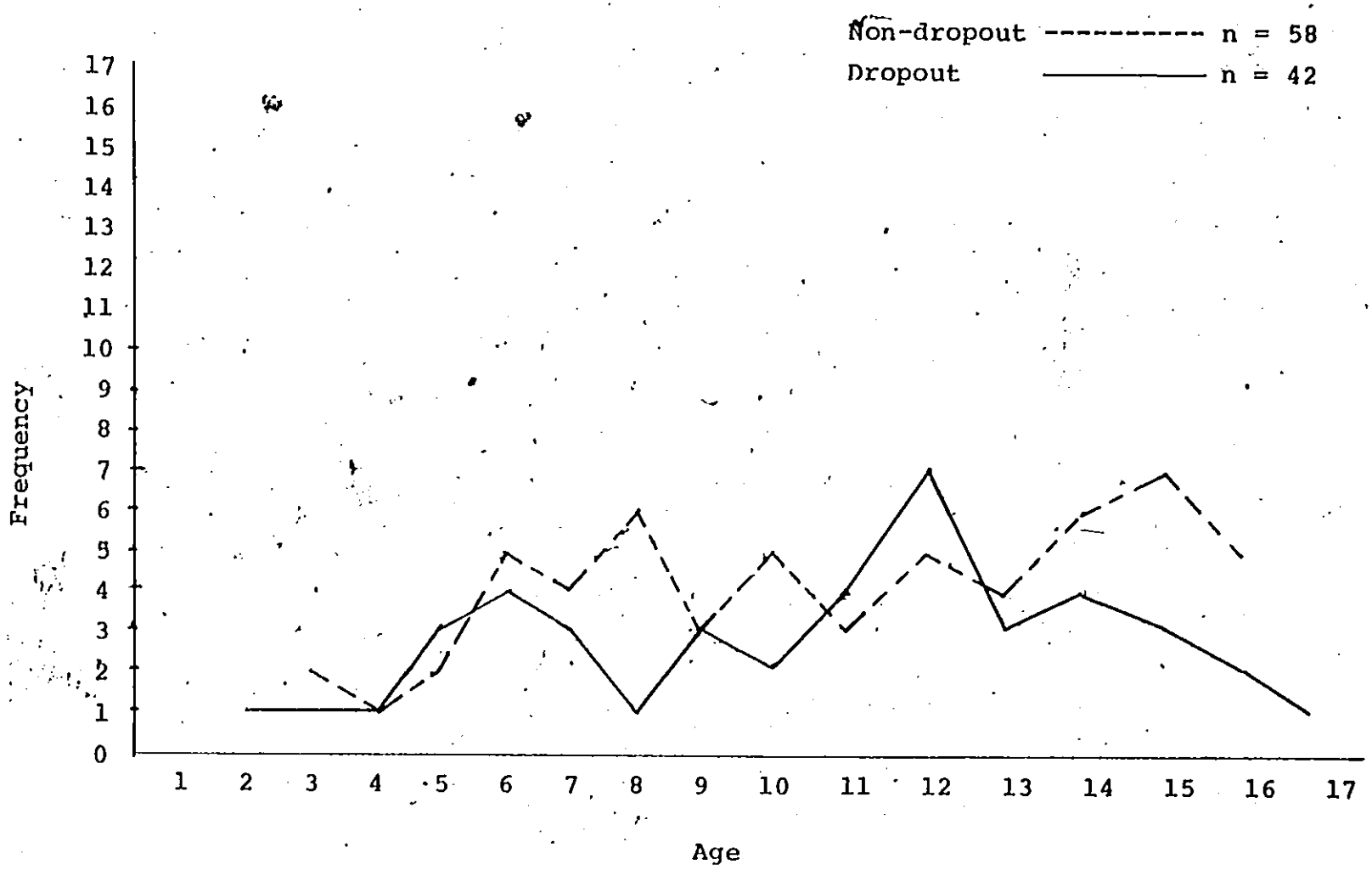


Chart 2 - Frequency Distribution of Dropout and Non-dropout by Age

Ethnic Group

Ethnic background of the clients was not a significant factor differentiating dropouts and non-dropouts. The dropout rate for the blacks was 59 percent as against 52.9 percent for the whites. The finding has to be treated with some reservations because of the small proportion of white children (17 percent) in the sample. The 52.9 percent for the white only group accounted for nine children in a total of seventeen. The 59 percent for the black represented forty-nine in actual number.

Sex

As shown in Table 2, girls appeared to be more likely to drop out than boys. Out of a total of 63 boys, 41 (65.1 percent) went beyond the fourth interview. As for the girls, only 45.9 percent did so. Though the significance of association did not reach the 0.05 level, the 0.06 level did indicate a very strong tendency.

Table 2

Case-Status by Sex

Sex	Non-dropout	Dropout	Total
Male	70.7% (41)	52.4% (22)	63.0%
Female	29.3% (17)	47.6% (20)	37.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 2.76166 df = 1

Significance = ns

The findings seemed to go against the general expectation. Boys, in general, are expected to be more likely to discontinue their treatment because of their tendency to free themselves from parental control, especially those in the ten to seventeen age group. The finding may have something to do with the socio-cultural characteristics of the community from which the sample was drawn. Further research is required in order to answer this question.

Siblings

As a whole, the cross-tabulation did not show any relationships between case-status and the number of siblings a client had (Table 3). But as a group by itself, clients with only one sibling did appear to be more likely to continue as compared to those in other categories. Twenty out of a total of 28 children in this group, or 71.4 percent, attended more than four interviews. The difference was made clearer by looking at Chart 3.

The finding was as unexpected as the one relating to sex. The only child who has the full attention of the parents should be the one who is more likely to remain in treatment. But the 16 children in this group were divided equally between dropouts and non-dropouts. The finding with regard to clients with one sibling deserves further attention.

Table 3

Case-Status by Number of Siblings

Number of Siblings	Non-dropout	Dropout	Total
One	34.5% (20)	19.0% (8)	28.0%
Two	20.7% (12)	28.6% (12)	24.0%
Three	8.6% (5)	11.9% (5)	10.0%
Four	10.3% (6)	4.8% (2)	8.0%
Five and above	6.9% (4)	14.3% (6)	10.0%
Only child	13.8% (8)	19.0% (8)	16.0%
Insufficient information	5.2% (3)	2.4% (1)	4.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 6.14004 df = 6

Significance = ns

Ordinal Position

As in the case of number of siblings, case-status was found not related to the ordinal position of the clients as a whole. But, viewed as a group by itself, the majority of the youngest children in the sample were found to be non-dropouts. As shown in Table 4, 73.9 percent of them, or 6 out of 23, carried on beyond the fourth interview. While clients in other ordinal positions were more or less proportionately distributed between dropouts and non-dropouts, the ratio for the youngest children was almost three to one. This finding seemed to support the popular belief that the

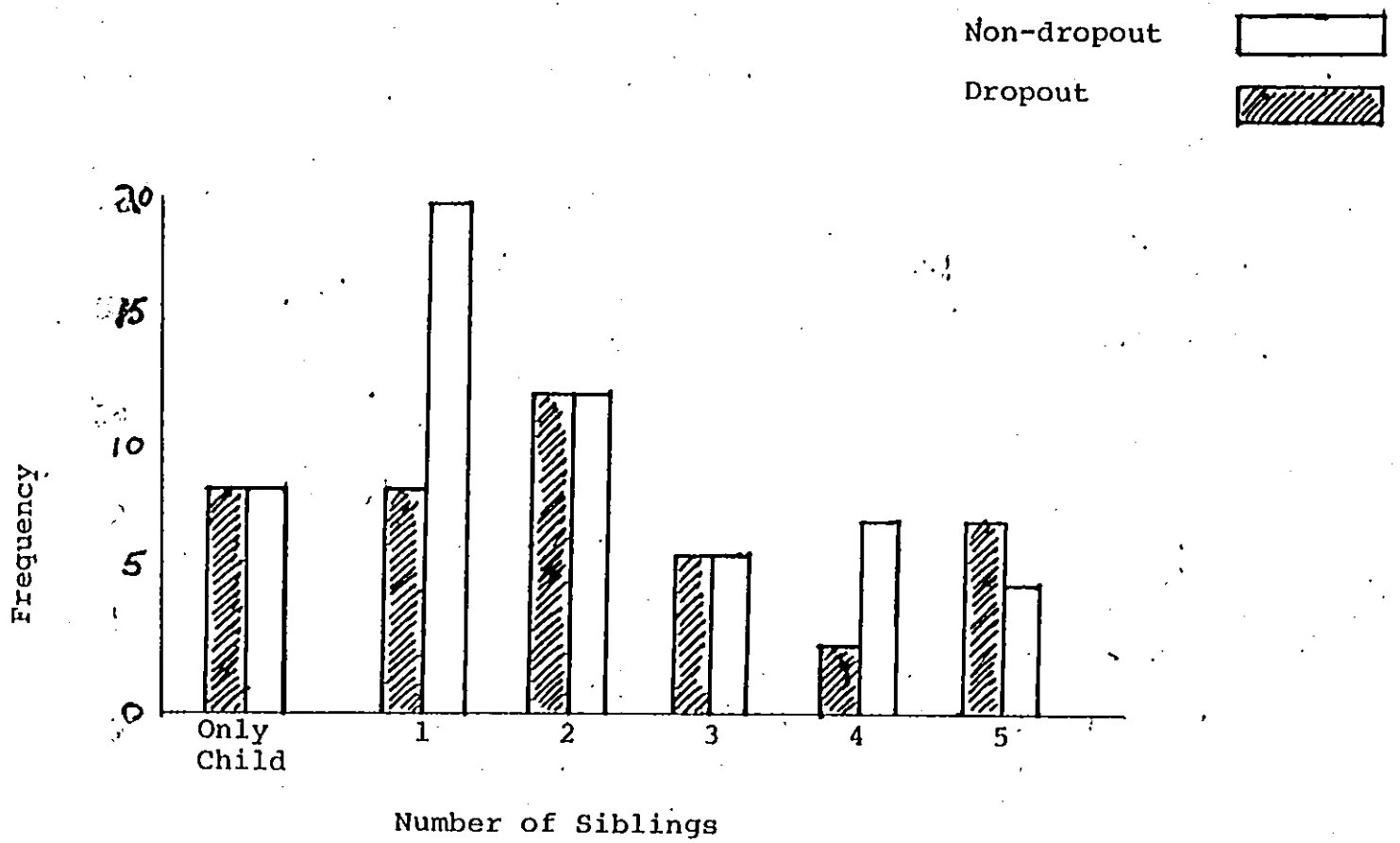


Chart 3 - Case-Status by Number of Siblings (sample)

youngest child of the family usually receives more attention from other members of the family, especially the parents. Further study should be done to confirm the predictive value of this variable. (Chart 4)

Table 4

Case-Status by Ordinal Position

Ordinal Position	Non-dropout	Dropout	Total
Only child	13.8% (8)	19.0% (8)	16.0%
Oldest	29.3% (17)	35.7% (15)	32.0%
Middle	22.4% (13)	28.6% (12)	25.0%
Youngest	29.3% (17)	14.3% (6)	23.0%
Insufficient information	5.2% (3)	2.4% (1)	4.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 3.96743 df = 4

Significance = ns

Age of Mothers

The age of mothers or guardians was found related to the case-status at the 0.01 level. The finding seemed to indicate that the older the mother's or the guardian's age, the more likely is the client to remain in treatment. This can be seen in Table 5. When the mothers' age was 30 and below, 16 out of 28 cases (57.1 percent) dropped out. When the mothers' age was between 31 and 40, 15 out of 34 cases (44.1 percent) dropped out. When the mothers' age rose to 41 and above, only 5 out of 30 cases (20 percent) dropped out.

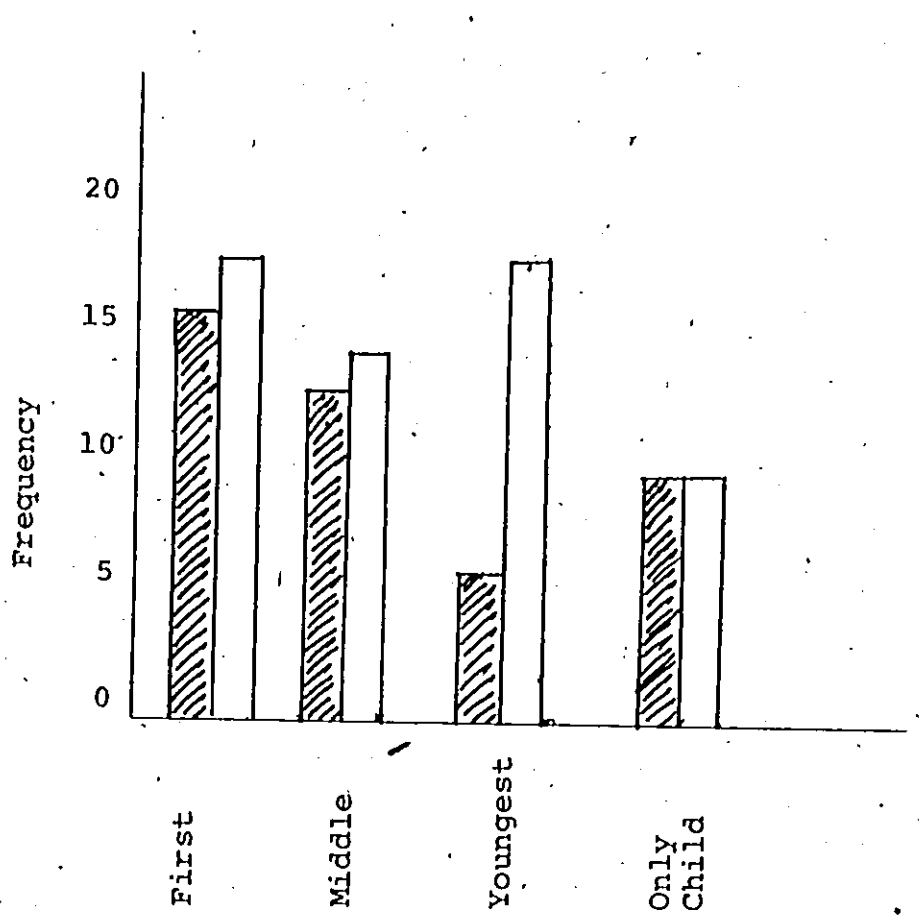


Chart 4 - Case-Status by Ordinal Position

Table 5

Case-Status by Age of Mothers

Mothers' Age	Non-dropout	Dropout	Total
30 and below	20.7% (12)	38.1% (16)	28.0%
31 to 40	32.8% (19)	35.7% (15)	34.0%
41 and above	41.4% (24)	14.3% (5)	30.0%
Insufficient information	5.2% (3)	11.9% (5)	8.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 10.3901 df = 3

$p < 0.05$

On further analysis of the data, grandmothers were found to be an important factor in the finding. Out of seven cases in which the grandmothers were the legal guardians of the clients, six attended more than four interviews.

The high dropout rate among clients with younger mothers may be due to the fact that a young mother has more personal problems or interests than a mother in the older age group. Pre-occupation with those problems or interests is likely to interfere with the mother's attention for her child. Further study is required to confirm the predictive value of this variable.

Employment Status

The employment status of the parents was found not related to case-status. As shown in Table 6, whether the parents

were employed, unemployed, or dependent on public assistance, it made no difference to the dropout and non-dropout rate. But the five cases in which the parents were reported on social security deserves some attention. None of the cases dropped out. Although the number of cases in this group is small, it does show the predictive potential of parents on social security as compared to other employment status.

Table 6

Case-Status by Employment Status of Parents

Employment Status	Non-dropout	Dropout	Total
Both parents employed	10.3% (6)	4.8% (2)	8.0%
Father employed	15.5% (9)	14.3% (6)	15.0%
Mother employed	13.8% (8)	21.4% (9)	17.0%
On Social Security	8.6% (5)	-	5.0%
On Public Assistance	51.7% (30)	54.8% (23)	53.0%
Insufficient information	-	4.8% (2)	2.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 8.23414 df = 5

Significance = ns

Family Income

Contrary to expectations, no association was found between case-status and family income. Clients from families with an annual income below $5,000 were as likely

to drop out as those from families with an annual income over $16,000 (Table 7).

Table 7

Case-Status by Family Income

Family Income	Non-dropout	Dropout	Total
$5,000 and below	27.6% (16)	28.6% (12)	28.0%
$5,100 to $10,000	25.9% (15)	31.0% (13)	28.0%
$11,000 to $15,000	8.6% (5)	7.1% (3)	8.0%
$15,000 and above	15.5% (9)	11.9% (5)	14.0%
Insufficient information	22.4% (13)	21.4% (9)	22.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 0.53819 df = 4

Significance = ns

Social class has been found consistently related to dropout in psychiatric clinics for adults. But the findings of studies conducted in child guidance agencies were mixed. The findings of this study cannot be interpreted as contradicting the findings of those studies (Chapter II) because the definition of social class in those studies includes factors other than family income. If the criteria of social class in those studies were to apply to this study, no class distinction would be found among the sample, as an overwhelming majority of the clients would be classified as lower class.

Family Status

Family status was found not to be related to case-status. Forty-six point six percent of the clients in the sample who lived in single-parent families dropped out. The dropout rate for those who lived in two-parent families was 40 percent. But, it was found that among the subjects who lived with other relatives, a very high percentage (85.7 percent) remained in treatment. As was noted in the section dealing with mothers' age, the other relatives turned out to be the grandmothers.

Marital Status of Parents

When single parents, mostly mothers, were further broken down into four sub-groups, e.g., separated, divorced, widowed, and never-married, a high percentage of non-dropouts were found among clients living with mothers who never married. The dropout rate for this group of clients was as low as 16.7 percent. Out of a total of 12 clients in this group, only two failed to go beyond the fourth interview. The predictive value of this sub-group of single mothers should be further studied.

Overall, the marital status of mothers was not related to case-status (Table 8).

Family Problems

Association at the significant level of 0.03 was found between family-relationships and case-status. While

Table 8

Case-Status by Marital Status of Mothers

Marital Status	Non-dropout	Dropout	Total
Married	20.7% (12)	38.1% (16)	28.0%
Separated	20.7% (12)	26.2% (11)	23.0%
Divorced	17.2% (10)	33.3% (14)	24.0%
Widowed	8.6% (5)	4.8% (2)	7.0%
Never-married	10.2% (10)	4.8% (2)	12.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 6.82630 df = 4

Significance = ns

families reporting marital conflict, parent-child conflict, and sibling conflict had more or less equal share of drop-outs and non-dropouts, families reporting no major conflict showed a significantly lower percentage of dropouts. As shown in Table 9, only 10 out of 42 clients discontinued. Family relationship seemed to be another factor with potential predictive value.

Source of Referral

As shown in Table 10, no significant association was found between the different sources of referral and case-status. But there was a tendency for self-referred cases and cases referred by other agencies to continue in treatment.

Table 9

Case-Status by Family Problems

Family Problem	Non-dropout	Dropout	Total
Marital conflict	8.6% (5)	14.3% (6)	11.0%
Parent-child conflict	19.0% (11)	21.4% (9)	20.0%
Sibling conflict	5.2% (3)	9.5% (4)	7.0%
Alcoholism	-	2.4% (1)	1.0%
None reported	55.2% (32)	23.8% (10)	42.0%
Insufficient information	12.1% (7)	28.6% (12)	19.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 12.02111 df = 5

$p < 0.05$

Out of 13 cases in the self-referred group, 10 (76.9 percent) had more than four interviews. As for cases referred by other agencies, none of the six clients dropped out. Although the number of cases in these two groups were rather small, the percentage was high enough to warrant further study.

Table 10

Case-Status by Source of Referral

Source of Referral	Non-dropout	Dropout	Total
School	19.0% (11)	28.6% (12)	23.0%
Court	3.4% (2)	-	2.0%
Other agency	10.3% (6)	-	6.0%
Friends/ relatives	5.2% (3)	9.5% (4)	7.0%
Self	17.2% (10)	7.1% (3)	13.0%
Police	1.7% (1)	4.8% (2)	3.0%
Hospital	13.8% (8)	11.9% (5)	13.0%
Department of Social Service	3.4% (2)	11.9% (5)	7.0%
Other	25.9% (15)	26.2% (11)	26.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 12.64603 df = 8

Significance = ns

Responses to Questionnaire

The responses of both the dropouts and non-dropouts to some of the questions on the questionnaire are presented here. Forty-two (70 percent) out of the 58 non-dropouts responded to the questionnaire. For the dropout, as expected, the rate of return was only 28 percent, e.g., 12 out of 42. The poor return of the dropout group somewhat

limited the representativeness of the information. Nevertheless, to compare the responses of the two groups to some of the key questions was still a useful exercise. At the very least, it would provide some clues as to how they differed in their perception of the services they received from the Center.

Question: Did any of your friends or relatives object to your going to the Children's Center?

There was no difference in responses to this question. Eighty-six percent of the non-dropout respondents and 83 percent of the dropout respondents replied "no". The reason for asking this question was to find out whether dropout was associated with objection to using the services of the Center by friends or relatives. The findings showed that there was no significant difference between the respondents in this respect.

Question: Did any of your friends or relatives encourage you to go to the Center?

Twenty-five percent of the dropout respondents and 32 percent of the non-dropout respondents replied that there was such encouragement. It was speculated that the non-dropout might get better environmental support in using the Center's resources than the dropout. Although the non-dropout respondents showed a slightly higher percentage rate than the dropout respondents, the difference was insignificant.

Question: Did you have any difficulty getting to the Center?

Eighty-one percent of the non-dropout respondents and 83.3 percent of the dropout respondents reported no difficulty in getting to the Center. It was speculated that dropouts might be related to the problem of accessability. But the responses provided no such support for the speculation.

Question: Did you feel that the therapist understood your problem?

In reply to this question, 83.7 percent of the non-dropout respondents gave an affirmative answer. For the dropout respondents, only 58.3 percent stated "yes". This finding seemed to indicate that the parents' perception of the therapist's understanding was a factor related to case-status.

Question: Did you feel the therapist could help you with your problems?

There was a big difference in responses to this question. While 81.1 percent of the non-dropout respondents stated that they felt the therapists could help them, only 33.3 percent of the dropout respondents felt this way. The relationship between this feeling on the part of the parents and their decision to remain in or to discontinue treatment was quite obvious according to the findings.

Question: Did the therapist tell you what kind of help the Center can offer you?

There was also a big difference in responses to this question. Ninety-five point three percent of the non-dropout

respondents reported that they were told. Only 58.3 percent of the dropout respondents reported so. This was another factor with potential predictive value.

Limitation of the Questionnaire

As noted earlier, one of the limitations of the questionnaire was the poor return of the dropout group of which only 12 cases or 28 percent responded. Another limitation was that in the questionnaire returned by this group, some of the questions were not responded to. As a result, only questions with responses from both groups are discussed here. Given the fact that only 12 out of the 42 (28 percent) dropout families responded, this may be essentially a study of the perceptions and characteristics of clients who continue in service, except for the questions answered by both dropouts and continuing clients and/or families.

Research Question Two

This question calls for the exploring of association between the characteristics of intake-therapists and case-status. Of the 42 dropout cases, 61.9 percent dropped out after the intake interview, 26.2 percent during individual therapy, and 11.9 percent during group therapy and go-group.

Sex, Ethnic Group

Neither sex nor ethnic group of the intake therapists was found to be related to case-status. With regard to sex, 50 percent of the clients seen by male therapists and 40.7

percent of those seen by female intake therapists discontinued. In the case of ethnic group, 42.1 percent of the clients seen by white intake therapists dropped out, the percentage for those interviewed by black therapists was 40 percent (Table 11 and Table 12).

Table 11

Case-Status by Sex of Intake Therapist

Case-Status	Male	Female	Total
Non-dropout	50.0% (7)	59.3% (51)	58%
Dropout	50.0% (7)	40.7% (35)	42%
Total	100.0% (14)	100.0% (86)	100%

Chi-square = 0.13106 df = 1

Significance = ns

Table 12

Case-Status by Ethnic Group of Intake Therapist

Case-Status	Black	White	Total
Non-dropout	60.0% (3)	57.9% (55)	58.0%
Dropout	40.0% (2)	42.1% (40)	42.0%
Total	100.0% (5)	100.0% (95)	100.0%

Chi-square = 0.0 df = 1

Significance = ns

Employment Status

Most students placed with the Center by various universities for field practice are assigned duties in the out-patient units. They perform intake as well as treatment duties. Of the 100 cases in the sample, students were involved in 56 percent of the intake interviews. The findings showed that 37 out of the 56 cases (66.1 percent) interviewed by students at intake continued beyond the fourth session. On the staff side, out of 44 cases interviewed by them, only 21 cases (47.7 percent) continued beyond the fourth interview.

It appeared that cases interviewed by students at intake had a slightly lower percentage of dropouts (Table 13).

Table 13

Case-Status by Employment Status of Intake Therapist

Case-Status	Staff	Student	Total
Non-dropout	47.7% (21)	66.1% (37)	58%
Dropout	52.3% (23)	33.9% (19)	42%
Total	100.0% (44)	100.0% (58)	100%

Chi-square = 2.69236 df = 1

Significance = ns

This finding had to be considered together with those relating to intake modalities. The dropout rate was higher among individual-intake cases than among group intake cases (Table 14). On further analysis, it was found that students were more likely to involve themselves in group intake rather

than individual intake in this sample. Table 14 shows that students handled 78.6 percent of the group intakes while staff only handled 18.2 percent. With regard to the individual intakes, the figure was 81.8 percent for the staff and 21.4 percent for the students.

Table 14

Intake Modalities by Employment Status of Intake Therapists

Intake Modalities	Staff	Student	Total
Individual	81.8% (36)	21.4% (12)	48.0%
Group	18.2% (8)	78.6% (44)	52.0%
Total	100.0% (44)	100.0% (56)	100.0%

Chi-square = 33.62265 df = 1

$p < 0.05$

Marital Status of Intake Therapists

Thirty percent of the cases in the sample were interviewed by married therapists at intake and 70 percent by therapists who were single. The findings showed that 53 percent of the clients interviewed by married therapists at intake dropped out as compared to 37 percent for those interviewed by unmarried therapists. Although a higher percentage of dropouts were found among clients interviewed by married therapists, the difference was not significant.

Research Question Three

This question calls for the testing of association between case-status and the various service methods practiced by the Center.

Treatment Units

As noted in Chapters I and II, out-patient services of the Center are provided through three units located at different places. The sample of this study was drawn from all three units, with 31 percent from Unit I, 28 percent from Unit II, and 41 percent from Unit III. The question being asked here is: Does one unit have a significantly higher drop-out rate than the others?

As shown in Table 15, there was not a difference in the dropout rate among the three Units. The percentage of dropouts was the highers in Unit I (51.6 percent). Unit III had the lowest dropout rate with 36.6 percent. Case-status was found not related to the location of the units.

Table 15

Case-Status by Out-patient Units

Units	Non-dropout	Dropout	Total
Unit I	25.9% (15)	38.1% (16)	31.0%
Unit II	29.3% (17)	26.2% (11)	28.0%
Unit III	44.8% (26)	35.7% (15)	41.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 1.75409 df = 2

Significance = ns

Intake Modalities

As noted in Chapter I, two types of intake procedure are used by the Center to process applicants for services. Of the 100 cases in the sample, 48 percent went through the individual-intake procedure and 52 percent went through the group-intake procedure. Does one intake modality tend to produce significantly more dropouts than the other?

As shown in Table 16, no significant relationship was found between intake modality and dropouts. But the group-intake modality did show a slight tendency of having lower dropout rates. Thirty-four out of 52 group-intake cases (65.4 percent) continued in treatment while only 18 cases (34.6 percent) dropped out. As for the individual-intake cases, 24 out of 48 cases (50 percent) dropped out and a similar number continued. The difference may be due to the nature of problems rather than methods of intake.

Table 16

Case-Status by Intake Modalities

Intake Modality	Non-dropout	Dropout	Total
Individual	41.4% (24)	57.1% (24)	48.0%
Group	58.6% (34)	42.9% (18)	52.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 1.83472 df = 1

Significance = ns

Treatment Modality

It is rather difficult to analyse the relationship

between treatment methods (individual therapy, group therapy, go-group) and case-status as 61 percent of the dropout cases broke contact after the intake interview. Of the remaining 38.1 percent, 11.9 percent dropped out during group therapy or go-group, and 26.2 percent during individual therapy. The actual number of cases that dropped out between the intake interview and fourth interview was too small to have any significance.

Type-Case

As noted in Chapter II, cases were classified into three types according to the nature and severity of the problem. It was found that cases of an emergency nature were more likely to drop out, and cases of a regular nature were more likely to continue. While 4 (57.1 percent) out of 7 emergency cases dropped out, only 15 (27.8 percent) out of the 54 regular cases did so. Thus, type-case was found related to case-status at the $p < 0.05$ level (Table 17). However, this finding should be treated with caution as 24 of the sample were not classified because of insufficient information. The relationship between nature of problem and dropout rate deserves to be studied further. The study of Ripple et al. (1956), Kogan (1957), Werble (1958), Frank et al. (1957), and Smigelsky (1949) have all produced evidence showing significant relationship between the nature of problems and dropout rate.

Table 17

Case-Status by Type-Case

Type-Case	Non-dropout	Dropout	Total
Emergency	5.2% (3)	9.5% (4)	9.0%
Priority	12.1% (7)	19.0% (8)	15.0%
Regular	67.2% (39)	35.7% (15)	54.0%
Insufficient information	15.5% (9)	25.8% (15)	24.0%
Total	100.0% (58)	100.0% (42)	100.0%

Chi-square = 10.07408 df = 3

$p < 0.05$

Findings Related to Hypotheses

As noted in Chapter III, different recording formats were used in individual-intake and group-intake interviews. Materials relating to the parents' discomfort, resistance, and perception of the client's problem were only available in the records of cases processed by the individual-intake procedure. Three hypotheses were formulated to test the relationships between the parents' attitudes and case-status. Of the 100 cases in the sample, 48 percent were processed by individual-intake procedure. The ratio between dropouts and non-dropouts in this group was 50 percent each.

HYPOTHESIS I

> Parents who attribute the responsibility for the existence of their children's problem to the children themselves are less likely to drop out.

The findings, as shown in Table 18, did not indicate

any significant relationship between the parents' perception of their children's problems and case-status. But a difference in dropout rate did show up. In cases in which the clients were thought to be responsible for their own problems, a lower rate of dropouts (35 percent) occurred. Cases in which responsibility for the problems were attributed to other members of the family had a higher percentage of dropouts (59.1 percent). As the significance of association did not reach the $p < 0.05$ level, the null hypothesis was accepted.

Perception of problem has been found to be related to the length of contact with the agency by Blenkner et al. (1951), Rubinstein et al. (1956), Lorr et al. (1957), and Kogan (1957). But the findings of this study were not comparable to those of the studies mentioned above. While the perception of the above studies referred to that of the client's own, the perception of this study referred to the parents', not the client's. (Table 18)

HYPOTHESIS II

> Parents who feel more discomfort with their children's problem are less likely to drop out.

The findings showed that 74.1 percent of the cases in which the parents who expressed frustration and a sense of helplessness over their children's problems returned to the Center for more treatment sessions. In cases in which the parent's discomfort was less intense, 73.3 percent of the

parents did not bring their children back for more than four treatment sessions. For parents whose discomfort was low, the dropout rate was 100 percent. (Table 19)

Table 18

Case-Status by Parents' Perception of Children's Problems

Responsibility for Problem	Non-dropout	Dropout	Total
To client	54.2% (13)	29.2% (7)	41.0%
To family members	37.5% (9)	54.2% (13)	45.0%
To outsiders	4.2% (1)	4.2% (1)	2.0%
Insufficient information	4.2% (1)	12.5% (3)	8.3%
Total	100.0% (24)	100.0% (24)	100.0%

Chi-square = 3.52727 df = 3

Significance = ns

Table 19

Case-Status by Parents' Discomfort

Discomfort	Non-dropout	Dropout	Total
High	83.3% (20)	29.2% (7)	56.0%
Moderate	16.7% (4)	45.8% (11)	31.0%
Low	-	25.0% (6)	12.0%
Total	100.0% (24)	100.0% (24)	100.0%

Chi-square = 15.52592 df = 2

$p < 0.05$

The null hypothesis was thus rejected as the relationship was found significant at better than the 0.05 level.

HYPOTHESIS III

> Parents who are resistant in exploring personal problems and family relationships in relation to their children's problems are more likely to drop out.

The findings, as shown in Table 20, indicate a significant association between resistance and case-status. The higher the resistance, the higher the dropout rate.

Table 20

Case-Status by Parents' Resistance

Resistance	Non-dropout	Dropout	Total
High	-	20.8% (5)	10.4%
Moderate	12.5% (3)	20.8% (5)	16.7%
Low	87.5% (21)	58.3% (14)	72.9%
Total	100.0% (24)	100.0% (24)	100.0%

Chi-square = 6.90000 df = 2

$p < 0.05$

All the five cases in which parents were found unwilling to discuss personal and family problems with the therapists dropped out. Among parents with moderate resistance, 62 percent dropped out. The rate of dropout for patients with low resistance was 40 percent. It is worth pointing out that only 10.4 percent of the parents in the sample were found resistant. Seventy-two percent of the parents were

found willing to share their problems with the therapists either moderately or freely. This seemed to show that resistant parents were a minority among those applying for the Center's services.

The null hypotheses was rejected as the relationship was significant at the $p < 0.05$ level.

Summary

The demographic characteristics of the sample were described in this Chapter.

Findings on cross-tabulation between case-status and selected variables in the client and service sectors were presented. Responses to questionnaires were analysed. Type-case and age of mothers were found to be related to dropouts at the $p < 0.05$ level of significance. The findings also showed a strong tendency for female clients to discontinue therapy.

Hypothesis I was not supported while Hypotheses II and III were supported by the findings of this study.

Based on the findings, the next Chapter will present recommendations for improving the dropout situation and for further study of the problem.

CHAPTER V

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

The purpose of this study was to identify the characteristics of dropout and non-dropout cases in the Wayne County Children's Center. The study was carried out to determine some possible relationships between selected characteristics of dropout and non-dropout as discussed in the literature and variables related to the clients, therapists, and agency practice.

Two data collection instruments were developed for this study. The case review schedule was used to obtain information from the case records. This information involved client and/or parent/guardian data. The mailed questionnaire was used to collect information on the parents' perception and feelings in respect of the services provided by the Center for their children.

The selection of variables for this study was guided by three research questions. In addition, three hypotheses related to the parents' attitudes toward their children's problems were tested.

The study sample of 100 cases (58 continuing and 42 dropout) was selected by a systematic random sampling method

from a population of 319 new cases opened between May and September, 1979.

Blacks constituted 83 percent of the sample. Based on cases in which records were available, 56 percent of the sample came from families with an annual income less than $5,000. Fifty-three percent of the families were on public assistance. Fifty-nine percent of the clients lived in single-parent families. Only 34 percent of the clients enjoyed a two-parent home environment.

Conclusions Related to Research Questions

Two variables, the age of mothers and nature of problem, were found to have potential predictive value. Clients with mothers over 41 years of age had significantly lower dropout rates than clients with mothers below 40 years of age. Clients with more severe problems were more likely to drop out than clients with problems of a less severe nature. Clients found in either group should be considered targets for preventive measures.

The sex of the clients also showed a strong association with the case-status at the .06 level of significance. Girls were found more likely to drop out than boys.

No characteristics of the intake therapists were found significantly related to dropout or non-dropout. The findings indicated that personal characteristics of intake therapists had no bearing on case-status.

The locality of out-patient units was found not related to the rate of dropout. However, a higher percentage of dropouts among clients processed by individual-intake modality than clients processed by group-intake modality was found. Given the findings that emergency and priority cases were more likely to drop out, and these cases were processed by individual-intake modality, the potential of group-intake in reducing dropouts should be explored.

Conclusions Related to to Questionnaire

The data collected through the questionnaire showed some differences between the parents of dropout and non-dropout clients with regard to their perception of and feelings toward the service provided by the Center.

While 83.7 percent of the non-dropout respondents felt that the therapists understood their problems, only 58.8 percent of the dropout respondents felt the same way. Ninety-five percent of the non-dropout respondents reported that they were told by the therapists the services they would receive from the Center, but only 58.3 percent of the dropout respondents were so informed. A very high percentage of the non-dropout respondents (81.1 percent) felt that the Center staff could solve their problems, but only 33.3 percent of the dropout respondents shared the same feeling.

On the basis of these findings, it is concluded that there is a need for the parents to be ensured that their

problems are understood by the professional staff; to be informed of the specific services offered to them; and to be convinced of the effectiveness of the treatment programs.

Conclusions Related to Hypotheses

The findings of this study did not support the first hypothesis which stated that the parents' perception of the children's problems was related to case-status.

The second hypothesis which stated that the degree of discomfort of the parents is related to case-status, was supported by the findings at better than the 0.05 level of significance. Based on these findings, it can be said that parents who feel less discomfort with their children's problem are more likely to drop out.

The third hypothesis was also supported by findings of this study. Parental resistance to exploration of personal and family problems was found associated with high dropout rates at better than the 0.05 level of significance.

Thus, parental discomfort and resistance are variables with value for predicting potential dropout from non-dropout. Measures should be taken to motivate parents displaying these attitudes to continue with their children's treatment.

Recommendations

The following recommendations are based on the findings of this study:

1. In processing applications for service, special attention should be paid to female applicants; to applicants whose mothers are under 40 years of age; and to applicants whose problems are of an emergency nature, because high dropout cases were found in these three groups in this study.
2. Based on feedback derived from responses to the questionnaire, therapists should make a special effort in the following areas at the intake interview:
   (a) To find out what the parents see as their children's problems and discuss with them their own assessment of the problems. This is important because the parents are naturally anxious to know how the therapists perceive their children's problems. The parents may not agree with the assessment and ask questions, but the discussion itself may serve to arouse the parents' interest in the causes of their children's problems and enable them to gain a better understanding of the problems. In addition to being an educational process in terms of providing more information to the parents on their children's problems, the discussion may also serve as a first step in involving the parents in their children's treatment. The discussion may also have the effect of preventing the parents from taking the attitude that once their children have been accepted for treatment, their problems are entirely the responsibility of the Center's professional staff.

(b) To find out what help the parents expect from the Center. Parents applying for services for their children may not know what kind of help they can get from the Center. They may come with unrealistic expectations or even wrong conceptions of the Center's services. To deal with the question of service expectations at the earliest stage of contact will prevent future disappointment. The knowledge of service expectations may enable the therapists to evaluate the dropout potential of the parents.

(c) To explain to parents what specific help the Center can offer them in relation to their children's problem. To give a general account of the services offered by the Center may prevent the parents from harboring unrealistic expectations, but it is not enough. To discuss with parents the specific services or treatment programs to be provided to their children will have the effect of focusing their attention on their children's problems.

3. In view of the findings that parents who feel less discomfort with their children's problems and parents who show high resistance in discussing personal and family problems are less motivated to continue, effort should be made to involve them in their children's treatment programs as early as possible. Involvement could come

in the form of specific tasks to be performed within or outside the treatment sessions in relation to their children's problems. It is hoped that their commitment would arouse their interest to continue.

4. As far as possible, go-group should be formed around parents with children having similar problems. Experience sharing could be more beneficial and meaningful if members of the group share the same kind of problem. This could be done by scheduling treatment sessions for cases of similar nature on the same date and time.

5. At present, go-group is organized around new cases. This means that parents in a go-group are not familiar with the treatment methods of the Center. They may not have any idea as to their effectiveness. It is essential to develop their confidence in this respect. One way of doing this is to arrange discussion sessions between parents in the go-group and parents who have seen improvement in their children's problems after going through treatment programs. By sharing their experience with the newcomers, they may help them develop a positive attitude. Moreover, their children's improvement is evidence of the effectiveness of the treatment programs. This may serve as a motivator for the newcomers to stay.

6. With regard to clients who have missed appointments, the practice of the Center is to remind them with letters.

No effort is made to find out the reasons for the clients dropping out. It would be better if the letter is accompanied by a simple questionnaire designed to gather information on the reasons for not keeping appointments. Given the characteristics of the population, response to the questionnaire may be poor, but valuable information may be gained from the few who do respond. Home visits or phone calls may also be used for this purpose if the resources (staff) are available. This information may shed more light on the dropout problem and form the basis for further research.

7. In view of the findings that cases processed by group-intake showed a lower dropout rate as compared to cases processed by individual-intake, the use of this intake modality should be expanded. Cases normally going to individual-intake should also be considered for group-intake.

Further Research

Further study should be carried out on different samples in order to provide more information on the dropout problem of mental hygiene clinics and child guidance agencies. In future study, special attention should be paid to variables found significantly related to dropout or showing a strong tendency of such relationship in this study. These variables are: nature of problem, age of mother, parents' discomfort in relation to the child's problem, parents' resistance to

exploration of family problems and relationships, and the sex of the children.

The predictive value of variables identified by this study, if confirmed by further research as related to dropout and non-dropout, should be tested by constructing a prediction table. That is, on the basis of the variables listed in such a prediction table or "index," an intake therapist might be able to predict whether the client would continue or drop out, thus enabling a realistic identification of treatment priority cases as well as an early warning of potential dropout.

APPENDIX 1

CASE REVIEW SCHEDULE

PART 1. A.

I.D.: _____ Name: _____

Address: _____

Age: _____ Sex: _____ Ethnic Group: _____

Family Status:	1. Single parent	____
	2. Two parents	____
	3. Living with other relatives	____
	4. Living with foster parents	____
	5. Living in group home	____
	6. Others	____
Source of Referral:	1. Referred by school	____
	2. Referred by court	____
	3. Referred by other agency	____
	4. Referred by friends/ relatives	____
	5. Self-referred	____
	6. Police	____
	7. Hospital	____
	8. Department of Social Services	____
	9. Other	____
Previous Mental Health Services:	1. None	____
	2. DMH inpatient	____
	3. Inpatient (all others)	____
	4. Others	____
	5. Unknown	____

Type Case:	1. Emergency	____
	2. Priority	____
	3. Regular	____
Out-patient Unit:	1. Unit I	____
	2. Unit II	____
	3. Unit III	____
Intake Modality:	1. Individual	____
	2. Group	____
Treatment Modality:	1. Individual therapy	____
	2. Family therapy	____
	3. Go-group	____
	4. Group therapy and others	____
Therapists Seen:	1. One	____
	2. Intake therapist and go-group	____
	3. Intake therapist and treatment therapist	____
	4. More than two therapists	____
Case Status:	1. Planned termination/active	____
	2. Unplanned termination (dropout)	____
Point of Dropout:	1. After intake	____
	2. After ____ session(s) with therapist	____
	3. During go-group	____
	4. On waiting list	____

Child's Presenting Problems as Reported by Parents/Guardians:

1. School problems

   a. Grades dropping or working below potential ____

   b. Learning problems, slow learner or failing ____

   c. Skipping classes or truant ____

   d. Excluded, expelled or suspended ____

2. Home problems

   e. Sleeping or eating problems ____

   f. Running away ____

   g. Physical or sexual abuse or neglect ____

3. Problems in home, school, or neighborhood

   h. Restless, nervous, anxious or poor attention span ____

   i. Isolated or withdrawn ____

   j. Depressed-cries easily; seems sad, threatens suicide ____

   k. Psychosomatic complaints ____

   l. Wetting, soiling ____

   m. Suicide attempt ____

   n. Was raped or sexually molested ____

   o. Was physically attacked (mugged, etc.) ____

   p. Destructive of property ____

   q. Verbal or physical conflicts with siblings or peers ____

r. Verbal or physical conflicts with parents or teachers ____

s. Molested or raped someone ____

t. Physical assault causing injury to someone ____

u. Arson or fire-setting ____

v. Stealing, shoplifting, curfew violations, other misdemeanors ____

w. Mute ____

x. Apparent psychotic symptoms--hallucinations, delusions, bizarre behaviour ____

y. Unusual or extensive sexual behaviour ____

z. Others ____

PART 1. B.

The degree to which client admits the existence of presenting problem(s):

1. Denial ____

2. Some ____

3. Many ____

4. Insufficient evidence ____

To whom does the client attribute responsibiliyt for the existence of problem(s):

a. To his own behaviour and attitudes ____

b. To behaviour or attitudes of person(s) of the family or household or relatives ____

c. To behaviour or attitudes of person(s) outside family household, or close relatives, but with whom client or members of his/her family has had direct personal contact ___

d. Adverse social or economic conditions ___

e. Others (including physical limitations) ___

The degree of the client's discomfort regarding the problem(s) which he/she brings to the agency:

1. Very high ___ 2. High ___ 3. Moderate ___ 4. Low ___

5. Very low ___ 6. Insufficient evidence ___

The degree to which the client appears willing to work on his/her problem(s):

1. Very high ___ 2. High ___ 3. Moderate ___ 4. Low ___

5. Very low ___ 6. Insufficient evidence ___

The degree to which the client resists exploration of his/her problem(s) with the therapist:

1. Very high ___ 2. High ___ 3. Moderate ___ 4. Low ___

5. Very low ___ 6. Insufficient evidence ___

The client's response to the therapist:

1. Positive ___ 2. Indifferent ___ 3. Negative ___

4. Insufficient evidence ___

PART II. A.

Age: Father ___ Mother ___

Marital Status of Parents:

1. Married ____
2. Separated ____
3. Divorced ____
4. Widowed ____
5. Remarried ____
6. Never-married ____

Employment Status of Parents:	Father	Mother
1. Currently employed		
a. full-time	____	____
b. part-time	____	____
c. sheltered	____	____
2. Unemployed		
a. on layoff	____	____
b. looking for work	____	____
c. not looking for work	____	____
d. retired	____	____
e. disabled	____	____
f. on public assistance	____	____

Family Income: _____ p.a./p.m.

Number of Siblings: Male ___ Female ___ Ordinal Position: ___

Educational Attainment of Parents:

1. Father _____
2. Mother _____
3. Insufficient evidence _____

Family Problems:

1. Marital conflict ____
2. Family breakdown ____
3. Parent-child conflict ____
4. Sibling conflict ____
5. Alcoholism ____
6. Financial problem ____
7. Others ____

Involvement with other Social Agency:

1. Yes ____
2. No ____

PART II. B.

To whom the parents attribute responsibility for the existence of the client's problem(s):

a. To the client's own behaviour and attitudes ____

b. To behaviour or attitudes of themselves or member(s) of the family of household or close relatives ____

c. To behaviour or attitudes of person(s) outside family or household, or relatives, but with whom client or members of the family have had direct contact ____

d. Adverse social or economic conditions ____

e. Others (including physical limitations) ____

The degree of the parents' discomfort regarding the problem(s) the client brings to the agency:

1. Very high ___ 2. High ___ 3. Moderate ___ 4. Low ___

5. Very low ___ 6. Insufficient evidence ___

The degree to which the parents appear willing to be willing to be involved in treatment program:

1. Very high ___ 2. High ___ 3. Moderate ___ 4. Low ___

5. Very low ___ 6. Insufficient evidence ___

The degree to which the parents resist exploration of client's problem(s) and family relationships:

1. Very high ___ 2. High ___ 3. Moderate ___ 4. Low ___

5. Very low ___ 6. Insufficient evidence ___

PART III

Demographic information on intake therapist

Name: _____

Sex: ____ Age:____ Ethnic Group: _____

Student: ____ Staff: ____

Marital Status:

1. Married ____
2. Single ____
3. Separated ____
4. Divorced ____
5. Widowed ____
6. Remarried ____

Demographic information of treatment therapist

Name: _____

Sex: ____ Age:____ Ethnic Group: _____

Student: ____ Staff: ____

Marital Status:

1. Married ____
2. Single ____
3. Separated ____
4. Divorced ____
5. Widowed ____
6. Remarried ____

Name: _____

Sex: ____ Age: ___ Ethnic Group: _____

Student: ____ Staff: ____

Marital Status:

1. Married ____
2. Single ____
3. Separated ____
4. Divorced ____
5. Widowed ____
6. Remarried ____

APPENDIX II

QUESTIONNAIRE FOR PARENTS/GUARDIANS

Please answer the questions by placing an X on the dotted lines.

A. Were you referred to the Children's Center

1. by school ....
2. by court ....
3. by friends/relatives ....
4. self ....
5. others ....

B. Did any of your friends or relatives object to your going to the Center?

1. Yes ....
2. No ....

C. Did any of your friends or relatives encourage you to go to the Center?

1. Yes ....
2. No ....

D. Did you have any difficulty getting to the Center?

1. Yes ....
2. No ....

If Yes, please indicate the problem(s):

a. transport ....
b. busy with housework ....
c. work commitment ....
d. others (illness, etc.) ....

E. Were you put on the waiting list?

1. Yes ....
2. No ....

F. What were the problems that brought you to the Center?

_____

_____

_____

G. Did you feel the therapist understood your problem(s)?

1. Yes ....

2. No ....

H. Did you feel the therapist was friendly?

1. Yes ....

2. No ....

I. Did you feel the therapist could help you with your problem(s)?

1. Yes ....

If possible, please give reasons _____

_____

_____

2. No ....

If possible, please give reasons _____

_____

_____

J. Did the therapist tell you what kind of help the Center can offer you?

1. Yes ....

2. No ....

K. Did you like the therapist?

1. Yes ....

If possible, please give reasons _____

_____

_____

2. No ....

If possible, please give reasons _____

_____

_____

L. What help did you expect from the Center?

_____

_____

M. Did you get the kind of help you expected from the Center?

1. Yes ....

2. No ....

N. Did you see your son(s)/daughter(s) getting better after he/she had gone through the treatment program?

1. Yes ....

2. No ....

O. Do you have any friends/relatives who have used the Center?

1. Yes ....

2. No ....

P. Had you been to other agencies before you came to the Center?

1. Yes ....

2. No ....

If Yes, please indicate what kind of agency

_____

Q. Did you talk about your child's/children's problems with them?

1. Yes ....

2. No ....

R. Did you talk about your problem(s) with other parents visiting the Center?

1. Yes ....

2. No ....

S. After _____ session(s), you did not come back to the Center. Could you please tell us what made you come to that decision?

_____

_____

_____

T. In what way do you think the Center can help you with your problem(s)?

_____

_____

_____

THANK YOU VERY MUCH FOR YOUR KIND COOPERATION. PLEASE USE THE ENCLOSED STAMPED ENVELOPE IN RETURNING THE QUESTIONNAIRE TO US.

APPENDIX III

THE CHILDREN'S CENTER
Community and family mental health services
with a special emphasis on children

101 Alexandrine East
Detroit, Michigan 48201
Phone: 313-831-5535

4th January 1980

During the last year, your child was seen at Children's Center. At Children's Center we are interested in looking at what we do and trying to find ways to do it better. To do this we need your co-operation as only you can tell us whether we have helped you with your child's problems and whether you are satisfied with what we have done for your family.

We have enclosed a set of questions for you to fill out and return to us as soon as you can. Your answers to these questions will help us to improve our services.

The information you give will be kept confidential. Please be honest. Thank you very much for your help.

Sincerely,

(Signed) Dr. Todd
Deputy Director

TT/ndk

APPENDIX IV

THE CHILDREN'S CENTER

DATE: November 12, 1979

TO: Out-Patient Staff and Students

RE: Letter to Staff

Dr. Todd and I are conducting a study on the problem of client dropout. The purpose of the study is to look for possible causes leading to the breaking off of contact with the Center by the client families. It is hoped that the findings of the study will throw some light on this problem.

In order to collect relevant information from the clients regarding their perception of and feeling about the services provided by the Center, a questionnaire (attached) will be sent to one hundred client families intaked during the months of May, June, July, August, and September of 1979.

If you receive any inquiry regarding the questionnaire, please encourage the client to fill out the questionnaire and assure them that the information will be kept confidential. Please provide any assistance required by the client for its completion. Please call Dr. Todd or me if you have any questions about the study.

Lai-Meng Yee
Social Work Intern

LMY/ndk

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VITA

Yee Lai-Meng was born on May 7, 1939 in Malaysia. In 1962 he graduated from the Nanyang University of Singapore with a B.A. degree in Modern Languages. After working for a few years in a commercial firm, Mr. Yee joined the National Youth Leadership Training Institute of Singapore as an Instructor. His main duty at the Institute was to plan and conduct training courses for youth workers attached to community centers.

Mr. Yee was awarded a scholarship by the Canada Commonwealth Scholarship and Fellowship Committee to pursue a social work program in Canada in September, 1977. In the same year, he enrolled in the School of Social Work, The University of Windsor as a B.S.W. make-up student. His undergraduate field placement was at the United Way of Windsor and Essex County. He obtained his B.S.W. degree in 1979.

With the recommendation of the Director of the School of Social Work, Mr. Yee's scholarship was extended to cover the M.S.W. program. He started the graduate program in the Fall of 1979. As a graduate student, his field placement was at the Wayne County Children's Center. Mr. Yee is expected to complete his M.S.W. program in the Summer of 1980.