

1968

Study of children with affective complaints involved in attrition from a child psychiatric clinic during the pre-therapy stage

George Ellis Dasher
University of Nebraska Medical Center

This manuscript is historical in nature and may not reflect current medical research and practice. Search [PubMed](#) for current research.

Follow this and additional works at: <https://digitalcommons.unmc.edu/mdtheses>

Recommended Citation

Dasher, George Ellis, "Study of children with affective complaints involved in attrition from a child psychiatric clinic during the pre-therapy stage" (1968). *MD Theses*. 2976.
<https://digitalcommons.unmc.edu/mdtheses/2976>

This Thesis is brought to you for free and open access by the Special Collections at DigitalCommons@UNMC. It has been accepted for inclusion in MD Theses by an authorized administrator of DigitalCommons@UNMC. For more information, please contact digitalcommons@unmc.edu.

A STUDY OF CHILDREN WITH AFFECTIVE COMPLAINTS
INVOLVED IN ATTRITION FROM A CHILD PSYCHIATRIC CLINIC
DURING THE PRE-THERAPY STAGE

George Ellis Dasher

Submitted in Partial Fulfillment for the Degree of
Doctor of Medicine

College of Medicine, University of Nebraska

January 29, 1968

Omaha, Nebraska

TABLE OF CONTENTS

I.	Introduction	1
II.	Original Project	3
III.	Affective Project	5
IV.	Significant Factors	6
	a. Age	6
	b. Sex	6
	c. Grade	7
	d. Income	7
	e. Birth Order	7
	f. Total Number of Visits	7
	g. Presenting Complaints	8
	1. Regressive Behavior	8
	2. Delayed Development	8
	3. Affective Symptoms	8
	4. Social Isolation	8
	5. Other	8
	h. Referral Source	9
	1. Error in Diagnosis with Inappropriate Referral	9
	2. (5) Gross Ignorance or Lack of Sophistication Concerning Indications for Service	9
	1. Family and Child	10
	1. Grossly Inappropriate Parental Motivation	10
	2. (3) Flight From Other Professional Advice in Which Child Was Diagnosed as Needing a Type of Treatment Unacceptable to Both Parents	10
	3. (6) Flight Into Health	10
	j. Clinic Activity	11
	1. (4) Failure to Resolve Collaborative Problems Between Clinical Team Members	11
	2. (6) Failure to Assess True Nature of Motivation of Parents and Child in Seeking Care	11
	3. (9) Excessive Wait for Service	11
V.	Conclusion	11
VI.	Recommendations	13
VII.	Summary	13
VIII.	Table I	14-15
IX.	Table 2	16
X.	Tables 3-18	17-22
XI.	Appendix A	23-28
XII.	Appendix B	29
XIII.	Bibliography	30

A STUDY OF CHILDREN WITH AFFECTIVE COMPLAINTS
INVOLVED IN ATTRITION FROM A CHILD PSYCHIATRIC CLINIC
DURING THE PRE-THERAPY STAGE

The problem of case attrition is a continual one in all outpatient clinics, but, although exact statistics are not available at this time, it appears to be especially true for psychiatric clinics in general, and child psychiatry clinics specifically.

Many theories have been proposed to explain these "drop outs." A few studies have been done to test these theories. Unfortunately many of these were done with data from adult clinics and it is difficult to apply statistics from adults to children due to the number of variables, such as the influence of parents and families on children.

Some notable studies, done especially on child psychiatry clinics, are those by Drucker and Greenson,² Gordon,³ Inman,⁵ and Tuckman and Lavell.⁸

Inman⁵ conducted telephone follow-ups on families who failed to return to the Chicago Institute of Juvenile Research. She was mainly interested in determining why the families didn't return, if they went elsewhere, and if the original problem appeared better to the families. The main reasons for not returning were: 1. Problem gone. (Over one-half the cases the child was said to be "improved," although the mother often could not explain how.); 2. They thought they

were not supposed to return; 3. Too long of wait. Less than one third of the families sought help elsewhere. Mothers of girls and of the more severely disturbed children were most likely to seek other help.

Tuckman and Lavell's⁸ studies of case attrition were from the aspect of stage of clinic process, classifying stages as intake, diagnostic, evaluation, and treatment. Each stage was evaluated for significant variables, such as: Referral source, living arrangements of child, religion, number of problems presented.

Some of their general findings included that children living in institutions and foster homes were less likely to terminate than children living with parents or relatives. In reference to the number of the number of presenting problems, they found in the intake stage, children with three or more problems were more likely to terminate. In the diagnostic stage the opposite was true, and in the treatment stage the one with more problems were more likely to drop out.

Their findings did not, however, seem to support one of the popular theories of case attrition, that of the families with the longest distance to travel are more likely to drop out.

Drucker and Greenson² and Gordon³ have conducted somewhat lesser studies with children's clinics. Drucker and Greenson² found essentially the mother wanted a direct course of action

rather than the more indirect, noncommittal approach shown by most clinics. When this was not offered they felt unhelped. Gordon³ found that group therapy may be the answer in reducing attrition.

Other studies, not concerned with children's services, out of interest because they illustrate some of the other popular theories and findings on attrition, are by Heine and Trosman,⁴ Mayer and Rosenblatt,⁶ Morris and Soroker,⁷ and Woodward, Patton and Pense.⁹

Morris and Soroker⁷ conducted a telephone survey similar to Inman's.⁵ They called persons who were placed on a waiting list and then did not return. One half of the persons contacted said their problems had cleared, although almost half of these admitted to seeking outside help. About half of those who still had problems said the problems were better.

Heine and Trosman's⁴ findings were similar to Drucker and Greenson's.² That is, if a person's expectations of treatment differ too far from that offered, the person leaves the treatment.

The greater number of treatment alterations yields the greater number of case drop outs is the finding of Mayer and Rosenblatt.⁶ Woodward, Patton and Pense⁹ reports that an increase in volunteer or student staff (rapid staff turnover) contributes to attrition.

Original Project

The original project was conducted at the Childrens' Service

Outpatient Clinic of the Nebraska Psychiatric Institute. It was directed by Richard L. Cohen, M.D.,¹ associate professor at the University of Nebraska College of Medicine and chief of Children's Service at the Nebraska Psychiatric Institute. It was designed to attempt to take into consideration the various theories and thoughts involved with attrition in child psychiatry and collect data from as large a series as possible in a controlled series. Because the basic data for the present study was taken directly from this project a brief description of the project follows.

The experimental groups consisted of the last 250 cases coded as "drop out" with the Institute's data process retrieving system. This number was reduced to 167 because 83 cases did not meet the strict definition of attrition used in the project.

One hundred control cases were selected at random. The only qualification necessary to be a control case was that attrition had not occurred. The ultimate outcome of the case, good or bad, had no bearing.

Each case was read independently by three raters who filled out a special protocol (See Appendix A). The protocol consisted of 40 items, 22 objective and 18 which involved subjective judgment. The judgments involved the three vital areas in the case: 1. The referral source; 2. The family and child; 3. The Clinic activity.

The data was entered on punch cards for quick referral and ease in handling.

The cases were divided into two groups, therapy and pre-therapy (intake and evaluation) to avoid ambiguity arising from what proved to be two different populations. This resulted in 41 experimental cases and 26 control cases in the therapy groups and 126 experimental and 74 control cases in the pre-therapy group. It was in this latter group that the significant division of cases occurred which prompted this study.

Table One contains the original statistical data for the pre-therapy group. Examination of this table shows that the presence of affective disorders as one of the presenting complaints produced a difference between the experimental group and the control group that was significant at the .05 level, using the Chi square method. By actual figures this represents 13 experimental cases (10%) and 1 control case (1%).

No explanation of this difference was readily available. One possible theory proposed by Cohen¹ is they may be more prone to "spontaneous" remission and may resort to flight into health.

Affective Project

The data processing cards and original protocol sheets for the 13 attrition cases and one control case with affective complaints were then reexamined.

In general these complaints were found to run the gamut from "catatonic with conversion reaction" through "depressed and withdrawn," to "unhappy" and "acts weird."

It was felt that the extremely small numbers involved, especially only one control case, would produce abnormal populations and make any formal attempt at statistical analyses between control and experimental groups meaningless.

However, it is possible to study what trends tend to make these 13 attrition cases with affective complaints similar to, or different from the other 113 attrition cases in the pre-therapy group. The data for the one control case are presented in Appendix B.

In the following comparison, the word "significant" will be used to describe trends and is in no way to be confused with "significance" in formal statistical sense. Table 2 is a list of the factors thought to show some significant trend.

Age The average age of the group with affective complaint (A-group) was 10.6 years. The average age of the "control" group with no affective complaint (C-group) was 10.2 years.

Sex* A-group had nearly a 50-50 spread of male-female with slightly more males (54%). C-group had almost 3/4 males. This trend could possibly be explained if we assume that males are more likely to present with non-affective type.

*See Tables 3 through 18 for actual percentages for A- and C-groups.

Grade The average grade in school for the 10 children in A-group whose grade could be determined, or were not in special schools, was 4.9. The average grade for the 98 C-group children, whose grade could be determined, was 4.1. These averages are felt to be commensurate with the average ages previously determined.

Income The income class was based on whether the family was receiving public assistance of some kind. It is interesting to note that the A-group had nearly twice the percentage (15% opposed to 8%) of families receiving public assistance. An explanation for this is not easily forthcoming unless you make a rather broad assumption that an environment involving the necessity of public assistance would stimulate the appearance of affective symptoms in the children.

Birth Order The significant trend in this category is an inordinately small percentage of children in the A-group born second, and a correspondingly small number in the C-group of children born third. No reason for this difference can be readily ascertained.

Total Number of Visits The number of visits is significant in the agreement between the two groups. All 13 of the A-group and 93% of the C-group dropped out after four visits or less. This is a reflection of the fact that therapy was never begun.

Presenting Complaints

Regressive Behavior There is a slight difference here with no cases in the A-group and 5.4% in the C-group. The interesting fact here is the total lack of cases in the A-group with this complaint in conjunction with affective complaints. The general thought was that perhaps children with affective complaints would also have regressive complaints attached.

Delayed Development With this complaint, the C-group has over twice the percentage of positive responses than the A-group. This would suggest that the type of children prone to present with affective symptoms are the types which develop intellectually and physically along the normal lines.

Affective Symptoms The 100% A-group and 0% C-group is a reflection of the selection process.

Social Isolation The relatively high percentage shown in the A-group as compared to the other group could be a product of the affective symptoms. These would tend to isolate the child and often this will be the primary complaint with the affective symptoms mentioned secondarily.

Other These symptoms represent a varied group that fit no one category and are so varied as to make it impossible to make a comparison.

Referral Source

1. Error in Diagnosis with Inappropriate Referral

The significant trend in this class is the fact that the A-group had nearly four times the percentage of the C-group. This would go along with the previously mentioned list of complaints for the affective group. When cases are admitted where the complaint is as vague as "is unhappy," or "acts weird," there are bound to be a number of wrong diagnoses.

5. Gross Ignorance or Lack of Sophistication Concerning Indications for Service

Here again, the A-group's percentage is four times the C-group. Coincidentally, the percentages are exactly the same. In a way this seems fitting, although one does not necessarily require the other. A referral source may understand the service offered very well, but make an erroneous diagnosis. On the other hand a very astute diagnosis can be offset by a person who is ignorant of the service offered.

This trend is probably the result of the same vague complaints as mentioned before. If a child presents to a person ignorant of the clinic activities with complaints of "is strange," or "acts weird" the first place they may think of is a psychiatrist.

Family and Child This area proved to be the area with the most reliable data and therefore the most interesting results of Cohen's¹ study.

In the area of the group with affective symptoms versus nonaffective symptoms there were only three areas with any trends, and they were negative ones.

1. Grossly Inappropriate Parental Motivation This was a very significant area in the original study. Here, however, there is a slight trend for the C-group to have a larger percentage. This would seem to indicate that perhaps the group of parents with children with affective symptoms are a little more motivated concerning their child, but for some other reason, they still dropped out.

3. Flight From Other Professional Advice in Which the Child Was Diagnosed as Needing a Type of Treatment Unacceptable to Both Parents (or as Irreversibly Damaged; "Shopping")

Here, none of the cases in the A-group were in this class. Again, this may be an indication that the parents in the A-group were more motivated toward their children and were actually looking for help for their children.

6. Flight into Health This was a very significant area in the original study, but not one case with affective complaints fell into this group. This is in direct contrast to the theory presented by Cohen.¹

Clinic Activity This area was one of the most difficult to obtain data on in the original study. The data was obtained from the clinic's own charts, so, in effect, the clinicians were rating their own performance. Most humans will not voluntarily write their failures in a chart, so many of these facts must be inferred. Therefore, the data supplied to this study is also in doubt. These were three areas with some trends, one of which appears to be very interesting.

4. Failure to Resolve Collaborative Problems Between Clinical

Team Members Not one A-group fell into this class.

6. Failure to Assess True Nature of Motivation of Parents

and Child in Seeking Aids Again, no A-group fell into this group.

7. Excessive Wait for Service This factor appears to be very interesting. Although exact data were hard to ascertain in the original study, a general idea as to the spread of activity of the Clinic could be determined.

This was a highly significant factor in the original study and in this study. The A-group had a percentage nearly 10 times the C-group. This would indicate the largest part of the original significance was due to the affective group.

Conclusion

As expected, the same problem with data collection affected this study as originally. Again, no hard or fast rules can be

drawn concerning the higher attrition rate of the affective group. However, a few general ideas concerning some of the underlying factors can be drawn.

When compared with the rest of the pre-therapy group, the parents of the children with affective complaints appear to be more highly motivated in seeking aid for their children, perhaps even over-motivated and concerned with the child (notably some of the complaints such as "unhappy," "acts strange," and "has no friends"). They do not appear to be running from other professional advice or "shopping." This may indicate a somewhat better understanding of what the clinic may offer. The fact that none of the families resorted to "flight into health" would also indicate the recognition on the part of the family of the problem, and a refusal on their part to accept minor change as a cure.

As near as possible with the data available, the referral source and clinic appear to come under some suspicion. The referral source appears to have a problem diagnosing these complaints correctly. Also there appears to be some confusion as to the nature of the service offered or necessary for children with these complaints.

The only area in which the available data can attack the clinic is the excessive wait for service. If the parents of these children are over-concerned with them, it is conceivable

that any delay would cause them to become impatient. In this case it would seem that they could seek help elsewhere. We have no data on this.

Recommendations

I can only echo Dr. Cohen¹ on the need for further study into the field of attrition. The studies should be prospective, conducted by someone outside the clinic activity, and should include personal follow-up of the families to determine their actual feelings in the matter.

Summary

Cases (13 attrition, 1 control) presenting to a child psychiatric clinic with affective complaints and terminated in the pre-therapy stage were taken from a larger more general study where they produced a high degree of significance. The 13 attrition cases were compared to the other 113 attrition cases in the pre-therapy group as to factors which made them different from the cases with other complaints.

The differences and ~~some~~ similarities were discussed as to possible reasons of the high significance of this one complaint.

Some recommendations for future studies were made.

Acknowledgement

Thanks are extended to Mr. Steve Kneer, Mr. Mark Ware, and especially to Dr. Richard Cohen for aid received in preparing this study.

Table 1

Values of Chi-square comparing the distributions of subjects in the Pre-therapy Attrition and Pre-therapy Control Groups for each factor.

<u>Factor</u>	<u>df</u>	<u>x²</u>
Age	10	8.89
Sex	1	.37
Race	1	.01
Religion	1	1.82
School	3	26.32***
Grade	3	2.97
City	3	5.53
Parents	5	21.19***
Income	1	.05
Number of Siblings	6	4.24
Birth Order	4	4.76
Source of Referral	2	4.24
Initial Contact to Last Contact	8	13.75*
†Last Contact to Closing	8	20.90***
Follow-up	1	10.30***
Staff	5	8.81
Trainees	5	7.54
Total Number of Visits	1	.14
Did Patient Ever Return to Clinic	1	.00
Presenting Complaint:		
Antisocial Behavior	1	.00
Regressive Behavior	1	1.77
Delayed Development	1	2.65
Psychosomatic	1	.61
Motility Disturbance	1	.34
Affective Symptoms	1	4.46**
Learning Disorder	1	.00
Social Isolation	1	.03
Other	1	1.30

***p > .01

**p > .05

*p > .10

†Chi-square was calculated excluding such rare cases as "unknown," "none," and/or "other."

Table 1 (continued)

<u>Factor</u>	<u>df</u>	<u>χ^2</u>
Referral Source:		
1. Error in diagnosis with inappropriate referral.	1	16.10*
2. Failure to explain nature of service and properly prepare family (including coercive referrals).	1	3.38*
3. Ambivalent referral - mixed signals given to family concerning value and competency of service.	1	.07
4. "Dumping" referral - desperate move following one or more unsuccessful attempts at treatment (i.e., a negative referral rather than a positive one).	1	.12
5. Gross ignorance or lack of sophistication concerning indications for service.	1	.06
Family and Child:		
1. Grossly inappropriate parental motivation.	1	9.12***
2. Family overstressed by multiple demands and unable to persist in treatment efforts for child.	1	.41
3. Flight from other professional advice in which child was diagnosed as needing a type of treatment unacceptable to both parents (or as irreversibly damaged; "shopping:").	1	1.67
4. Gross ignorance or lack of sophistication concerning nature of service offered.	1	2.90*
5. Insufficient interest in or investment in the rearing of this child.	1	9.04***
6. Flight into health.	1	11.06***
Clinic Activity:		
1. Failure to make proper "diagnosis" early enough.	1	.11
2. Failure to apply previously established intake criteria.	1	.11
3. Breakdown in supportive relationship with family because of lack of continuity of care.	1	.00
4. Failure to resolve collaborative problems between clinical team members.	1	.12
5. Mis-assignment (e.g., one or more professional people on case too inexperienced for complexity of problem).	1	-----+
6. Failure to assess true nature of motivation of parents and child in seeking care.	1	.07
7. Excessive wait for service.	1	6.97***

***p .01

**p .05

*p .10

+Chi-square was calculated excluding such rare cases as "unknown," "none," and/or "other."

Table 2

Factors Deemed Significant in Difference Between
A-group and C-group

- Age
- Sex
- Grade
- Income
- Birth Order
- Total Number of Visits
- Presenting Complaint:
 - Regressing Behavior
 - Delayed Development
 - Affective Symptoms
 - Social Isolation
 - Other
- Referral Source:
 - 1. Error in diagnosis with inappropriate referral.
 - 5. Gross ignorance or lack of sophistication concerning indications for service.
- Family and Child:
 - 1. Grossly inappropriate parental motivation.
 - 3. Flight from other professional advice in which child was diagnosed as needing a type of treatment unacceptable to both parents (or irreversible damaged; "shopping").
 - 6. Flight into health.
- Clinic Activity:
 - 4. Failure to resolve collaborative problems clinic team members.
 - 6. Failure to assess true nature of motivation of parents and child in seeking care.
 - 7. Excessive wait for service.

Table 3

Distribution of A-group and C-group subjects according to sex.

Group	<u>Sex</u>	
	Male	Female
A	46	54
C	73.5	26.5

Table 4

Distribution of A-group and C-group subjects according to presence of public assistance.

Group	<u>Public Assistance</u>	
	Yes	No
A	15	85
C	8	92

Table 5

Distribution of A-group and C-group subjects according to birth order.

Group	<u>Birth Order</u>				
	*	1	2	3	4±
A	0	46.1	7.7	23.1	23.1
C	2.7	39.8	33.6	8.9	15.0

*Unknown

Tables 3-18 are in percentages.

Table 6

Distribution of A-group and C-group subjects according to total number of visits.

Group	<u>Number of Visits</u>	
	1-4	5+
A	100	0
C	93	7

Table 7

Distribution of A-group and C-group subjects according to presenting complaints.

Group	<u>Regressive Behavior</u>	
	Yes	No
A	0	100
C	5.4	94.6

Table 8

Distribution of A-group and C-group subjects according to presenting complaints.

Group	<u>Delayed Development</u>	
	Yes	No
A	7.7	92.3
C	18.6	81.4

Tables 3-18 are in percentages.

Table 9

Distribution of A-group and C-group subjects according to presenting complaints.

Group	<u>Social Isolation</u>	
	Yes	No
A	23.1	76.9
C	5.4	94.6

Table 10

Distribution of A-group and C-group subjects according to presenting complaints

Group	<u>Other</u>	
	Yes	No
A	7.7	92.3
C	15	85

Table 11

Distribution of A-group and C-group subjects according to referral source variables.

Error in Diagnosis with Inappropriate Referral

Group	Yes	No
A	7.7	92.3
C	1.8	98.2

Tables 3-18 are in percentages.

Table 12

Distribution of A-group and C-group subjects according to referral source variables

Gross Ignorance or Lack of Sophistication
Concerning Nature of Service Offered

Group	Yes	No
A	7.7	92.3
C	1.8	98.2

Table 13

Distribution of A-group and C-group subjects according to family and child variables

Grossly Inappropriate Parental Motivation

Group	Yes	No
A	38.5	61.5
C	49.5	50.5

Table 14

Distribution of A-group and C-group subjects according to family and child variables.

Flight from other Professional Advice ("Shopping")

Group	Yes	No
A	0	100
C	7.1	92.9

Tables 3-18 are in percentages.

Table 15

Distribution of A-group and C-group subjects according to family and child variables.

Group	<u>Other</u>	
	Yes	No
A	0	100
C	2.7	97.3

Table 16

Distribution of A-group and C-group subjects according to clinic variables.

Failure to Resolve Collaborative Problems Between
Clinical Team Members

Group	Yes	No
A	0	100
C	8.8	91.2

Table 17

Distribution of A-group and C-group subjects according to clinic variables.

Failure to Assess True Nature of Motivation of
Parents and Child in Seeking Care

Group	Yes	No
A	0	100
C	8.8	91.2

Tables 3-18 are in percentages

Table 18

Distribution of A-group and C-group subjects according to clinic variables.

<u>Excessive Wait for Service</u>		
Group	Yes	No
A	15.4	84.6
C	1.8	98.2

Tables 3-18 are in percentages.

NEBRASKA PSYCHIATRIC INSTITUTE

Children's Service

Protocol for Attrition Project

A. Identifying Data

1. Name _____ 2. Case No. _____
3. Birthdate _____ 4. Sex _____ 5. Race _____ 6. Religion _____
7. School and Grade _____
8. Parent (s)

Mother _____	Age _____
Father _____	Age _____
Occupation _____	Income _____
9. Siblings (with ages)

_____	_____
_____	_____
_____	_____
_____	_____
10. Referral Source, Organization and Address.
11. Date "referred" _____
12. Date of "initial contact" _____
13. Date of "ongoing service" _____
14. Date of "last contact" _____
15. Date "closed" _____
16. Follow-up _____
17. Stage of Termination _____
18. Total number of interviews _____
19. Return or not _____
20. Number of treatment sessions _____
21. Presenting complaint _____

B. Professional Personnel Assigned to Case

1. Staff

2. Trainees (other than medical students)

Note: If medical students were assigned to case, indicate numbers (not Names) and with whom they had professional contact. If during the time the case was active in the clinic it was transferred between one or more persons in Category 1 or 2, indicate the change and the date it occurred, if possible.

C. Referral Source

1. Error in Diagnosis with Inappropriate Referral

2. Failure to Explain Nature of Service and Properly Prepare Family
(including coercive referrals)
3. Ambivalent Referral--mixed signals given to family concerning value
and competency of service
4. "Dumping" referral--desperate move following one or more unsuccessful
attempts at treatment (i.e., a negative referral rather than a positive one)
5. Gross ignorance or lack of sophistication concerning indications for
service
6. Other (specify)
7. Unknown

D. Family and Child

1. Grossly inappropriate parental motivation.
2. Family overstressed by multiple demands and unable to persist in treatment efforts for child.
3. Flight from other professional advice in which child was diagnosed as needing a type of treatment unacceptable to both parents (or as irreversibly damaged) ("shopping").
4. Gross ignorance or lack of sophistication concerning nature of service offered.
5. Insufficient interest in or investment in the rearing of this child.

6. Other (specify)

7. Flight into health.

E. Clinic Activity

1. Failure to make proper "diagnosis" early enough.
2. Failure to apply previously established intake criteria.
3. Breakdown in supportive relationship with family because of lack of continuity of care.
4. Failure to resolve collaborative problems between clinical team members.

5. Mis-assignment (e.g. one or more professional people on case too inexperienced for complexity of problem).

Failure to assess true nature of motivation of parents and child in seeking care.

7. Excessive wait for service.

8. Other (specify)

9. Unknown

APPENDIX "B"

Pre-Therapy Control: Affective Complaints

Eight year white male; Catholic

Third grade, public school

Resident of Omaha, no public assistance

Adopted, no siblings

No follow-up

Seven visits to clinic, did return again at later date

Presenting Complaints

Anti-social behavior, delayed development, affective complaints

Referral Source:

No positive factor

Family and Child:

No positive factor

Clinic:

3. Breakdown in supportive relationship with family because of lack of continuity of care

BIBLIOGRAPHY

1. Cohen, R.L. and Richardson, C.H., A Retrospective Study of Case Attrition in a Child Psychiatry Clinic, Presented at American Orthopsychiatry Association, March, 1967.
2. Drucker, M., The Meaning of Waiting for Help, The Reiss-Davis Clinic Bulletin, 2:97-103, 1965.
3. Gordon, S., Are We Seeing the Right Child? Child Guidance Intake: The Sacred Cow,,American Journal of Orthopsychiatry, 35:131-137, 1965.
4. Heine, R. and Trosman, H., Initial Expectations of the Doctor-Patient Interaction as a Factor in Continuance in Psychotherapy, Psychiatry, 23:275-278, 1960.
5. Inman, A., Attrition in Child Guidance: A Telephone Follow-up Study, Smith College Studies of Social Work, 27:34-73, 1956.
6. Mayer, J. and Rosenblatt, A., Client Disengagement and Alternative Treatment Resources, Social Casework, 47:3-12, 1966.
7. Morris, D. and Soroker, E., A Follow-up Study of a Guidance Clinic Waiting List, Mental Hygiene, 37:84-88, 1953.
8. Tuckman, Jacob and Lavell, M., Attrition in Psychiatric Clinics for Children, U.S. Public Health Reports, 74:309-315, 1959.
9. Woodward, L., Patton, R. and Pense, C., 1961, The Value of Statistical Reporting in Planning and Revision of Community Mental Health Programs, American Journal of Orthopsychiatry, 31:292-319, 1961.