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A Study of Factors Affecting Discontinuance among Patients Attending the Chattanooga Psychiatric Clinic

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To the Graduate Council:

I am submitting herewith a thesis written by Nancy Louella Alverson entitled "A Study of Factors Affecting Discontinuance among Patients Attending the Chattanooga Psychiatric Clinic." I have examined the final electronic copy of this thesis for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Master of Science, with a major in Social Work.

Dana L. Tugle, Major Professor

We have read this thesis and recommend its acceptance:

Don E. Savage, Elizabeth Stewart

Accepted for the Council:
Dixie L. Thompson

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

May 26, 1965

To the Graduate Council:

I am submitting herewith a thesis written by Nancy Louella Alverson entitled "A Study of Factors Affecting Discontinuance among Patients Attending the Chattanooga Psychiatric Clinic." I recommend that it be accepted for nine quarter hours of credit in partial fulfillment of the requirements for the degree of Master of Science in Social Work.

Major Professor

We have read this thesis and recommend its acceptance:

Accepted for the Council:

Dean of the Graduate School

A STUDY OF FACTORS AFFECTING DISCONTINUANCE AMONG PATIENTS ATTENDING THE CHATTANOOGA PSYCHIATRIC CLINIC

A Thesis

Presented to

the Graduate Council of

The University of Tennessee

In Partial Fulfillment

of the Requirements for the Degree

Master of Science in Social Work

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by

Nancy Louella Alverson

June 1965

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INTRODUCTION

To call a psychiatric clinic for assistance with one's own problem or for help with one's family difficulties is indicative of some degree of motivation on the part of the applicant. It is necessary, however, for the degree of motivation to be stimulated, resistance to exploration to be reduced, and the potential service of the clinic to be emphasized, if the person is to be helped in progressing from the application point to the position in which he will be able to become a participant in a treatment relationship. Most assuredly, with the exception of a minute number of short-term completed treatment cases, continuance is fundamental to the utilization of psychotherapy or casework treatment.

I. PROBLEM

The Chattanooga Psychiatric Clinic of Chattanooga, Tennessee, as well as other psychiatric clinics and all of the helping professions, is concerned about the numerous individuals and families who demonstrate some degree of interest in seeking assistance, but who break contact after some stated plan to continue with the clinic has been made.

Studies of other social agencies and clinics have indicated that of every three persons who present themselves and their problems to these community organizations asking for and presumably needing the help that is offered there and who receive some promise of help or at least further attention, one does not return for the second interview.[1] At the Chattanooga Psychiatric Clinic during the fiscal year beginning July 1, 1962, and ending June 30, 1963, there was a very high rate of discontinuance. Of the 473 cases which were terminated that year 279 were closed when the patient withdrew, services being incomplete.[2] Thus 59 per cent of the patients dropped out before receiving what the Clinic staff felt was adequate service. Out of the 446 new cases opened that year only 15 per cent dropped out after the first interview despite the fact that a plan had been formulated for them, but the drop-out rate increased throughout the early contacts.

The high rate of discontinuance is disturbing from several points of view. Most prominent, probably, is the economic waste. The intake process, even if it is completed

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[1]Helen Harris Perlman, "Intake and Some Role Considerations," Social Casework, XLII (April, 1961), 171.

[2]Department of Mental Health, Annual Report of the Department of Mental Health State of Tennessee for the Fiscal Year Ending June 30, 1963 (Nashville: Department of Mental Health, 1963), p. 34, Table 15.

in one interview, absorbs time, money, and the energies of the therapists, chiefs of the departments, and clerical staff. But even more disturbing is the loss of the chance to give therapy not only where it is manifestly needed but at the point in time when anxiety, stress, and motivation are of such a high degree as to prompt a person to request help. Intake should be considered crucial for the forces creating the problem may have come to the place where a series of breakdowns and maladaptations could take place in the person's life situation should he not receive appropriate and effective intervention.[3] Another loss is brought out by a study made at Family Service Society of Atlanta, Georgia, which showed that the tendency is for applicants not to re-apply after a short contact.[4]

If psychiatric clinics and social agencies could make an accurate prediction from the first interview of the probability of the patient's continuing, perhaps more effective and constructive use could be made of the time of the staff and of the person seeking help. The demands for the services of the psychiatric clinic and of all social agencies are multiplying and the number of available trained

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[3]Perlman, op. cit., p. 171.

[4]Hugh Harlen Vaughn, "A Study of the Characteristics of Sixty-nine Brief Service Cases at Family Service Society, Atlanta, Georgia" (unpublished Master's thesis, The University of Tennessee, Knoxville, 1960), p. 30.

staff is failing to grow proportionately. The problem of the discontinuer is vital because the therapist and all professionals engaged in helping are constantly searching for methods to reach an optimum number of persons with the most beneficial services.

II. PURPOSE OF STUDY

It was hoped some answers would be found by the present study to the question of why patients with the degree of motivation sufficient to contact a clinic drop out before they have received the maximum service offered. The investigation covered a range of factors with the possibility of opening up areas for further research. It was thought the results might clarify some reasons for discontinuance with the expectation that some might be amenable to change so that the patient's (or family's, in the case of a child patient) resistance to exploration might be reduced, his motivation for problem solving stimulated, the potential assistance of the Clinic realized, and the obstructing reality factors eliminated.

The problem to be studied was discontinuance and the specific objectives of the study were four. The study attempted to ascertain whether or not there were objective social characteristics shared by patients who discontinued after the initial intake interview despite a plan to

continue, and whether or not these differed from objective social characteristics shared by the group of patients who continued through the diagnostic work-up. The two groups were then compared as to two other important characteristics: source of referral, and presenting problem. Diagnosis was not available for all patients and particularly not for those who discontinued after one interview. The primary diagnoses given were tabulated and a limited comparison made between the continuers and those discontinuers for whom a diagnosis was made. Also the two groups were compared on certain situational factors that might be related to discontinuance, to find out if they occurred with greater frequency in the group who discontinued than in the group who completed the diagnostic process. Service given the two groups of cases was compared to see what effects the type of service offered by the Clinic might have had regarding the discontinuance.

III. DEFINITION OF TERMS

A "patient" was defined as a person who contacts the Clinic by phone, by "dropping in", or by letter, and is given an appointment.

The term "therapist" has been used to designate a professional person (psychiatrist, psychologist, or psychiatric social worker) employed at the Clinic with whom the patient was given an appointment.

The "initial intake interview" was the first in-person or "face to face" contact the patient had with the therapist on a professional basis.

"Child" as used in this study, referred to an individual under twenty-one years of age, who had not forfeited his status as a minor through marriage or other legal means.

A "diagnostic work-up" consisted, for the purpose of this study, of the patient's (or the patient's family in the case of a child) being seen for one or more intake interviews, and subsequently, the patient's being referred for psychological testing or psychiatric evaluation as the case might indicate. The entire process might total anywhere from two to five or more interviews, depending on the individual case.

"Situational factors" employed in this study were such things as length of time between scheduled appointments, reaction to fees, distance the patient lived or worked from the Clinic, ability of the patient to take time off from work, transition of patients from one professional person to another, being able to get someone to care for young children in the home, and patients's physical condition.

The characteristics to be studied were age, sex, race, marital status, amount of family income, education, occupation, source of referral, and type of primary presenting problem.

The term "Clinic experience" was used in the table titles to designate whether a patient discontinued after one interview or continued through the diagnostic work-up.

"Age status" for this study was used in the table titles to designate whether a patient was an adult or a child.

IV. METHOD AND SCOPE OF THE STUDY

For the purpose of this study the case records were drawn for all the new cases for the fiscal year beginning July 1, 1962, and ending June 30, 1963. It was hoped that the majority of the cases opened during that time would have had the diagnostic work-up completed and perhaps would have been enabled to terminate treatment by the time of this study (October, 1964 - January, 1965).

This study took into consideration only those cases in which patients failed to follow through despite a plan with the Clinic to continue contact after the initial interview, and those in which the patient followed through as

far as completing the diagnostic work-up. Of a total of 446 new cases opened during the stipulated period of time there was a total of 144 cases that fitted the limitations. Sixty-seven people dropped out after one intake interview; seventy-seven people continued through the diagnostic work-up. Of the sixty-seven drop-outs, thirty-three were children and thirty-four adults. The total of seventy-seven continuers consisted of forty-three adults and thirty-four children.

Of the adult study group 44.2 per cent dropped out after one interview, whereas 55.8 per cent continued through the diagnostic work-up. Of the child study group 49.2 per cent discontinued after one interview and 50.8 per cent completed the diagnostic work-up (see Table I).

The study dealt with only those patients for whom this was their first contact with the Clinic. This criterion was stipulated because patients having utilized Clinic services previously might be expected to differ from new patients in regard to many factors considered pertinent for the study. Those cases which were closed by Clinic plan after the first interview or those in which referrals to other agencies were made were not considered since the study was focused on patients dropping out after a plan had been made for them to continue at the Clinic.

TABLE I

DISTRIBUTION OF PATIENTS BY AGE STATUS AND CLINIC EXPERIENCE

Age Status	Total		Dropped After One Interview		Continued Through Diagnostic Work-Up	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total	144	100	67	46.5	77	53.5
Adult (53.5%)	77	100	34	44.2	43	55.8
Child (46.5%)	67	100	33	49.2	34	50.8

The study of reality factors in the patient's situation which tended to hinder his participation in following through with plans was limited to those mentioned in the record. Should inferences be drawn they might prove erroneous in many instances. Also, the tabulation and discussion of diagnoses was necessarily limited to those cases in which the Clinic did decide upon a diagnostic classification.

The case records of the Chattanooga Psychiatric Clinic were employed to obtain the data for the study. It was not necessary that they be closed. Two assumptions were made: the cases of the chosen year were representative of the universe of Clinic intake, and the case record was a valid representation of the transaction between patient and therapist.

Eight cases that fitted the limitations of the study could not be located. Two were of patients in the category that discontinued after one interview; six belonged to the group that continued through diagnostic work-up.

Each case studied was analyzed by the use of a prearranged schedule in order to facilitate obtaining certain objective facts. There were five sections which made up the schedule; they allowed for the study of discontinuance as a function of characteristics of the patient and of the patient's family, situational factors, and the opportunity

offered by the Clinic (see Appendix A).

All data were drawn from case record material which had not been prepared specifically for research purposes. In many instances factors sought were not available from the record. This was particularly true of those cases in which the patient (or patient's family in the case of the child) was seen for only one intake interview. However, these records did contain sufficient information to warrant their use. Similar and related studies, as well as Clinic manuals and professional journals, were employed.

V. AGENCY SETTING

The Chattanooga Psychiatric Clinic is a medical clinic with a multidisciplinary staff. It serves the entire Chattanooga area as the only non-profit, out-patient, community mental health facility. According to the 1960 United States Census the population of this area was as follows: 130,009 for the city; 237,905 for Hamilton County; 283,169 for the entire Metropolitan Area. There are four private psychiatrists in the city, and an in-patient psychiatric wing at Baroness Erlanger Hospital: Moccasin Bend Psychiatric Hospital offers in-patient treatment and also operates a day hospital, but none of these offer the same services in the same

manner as does the Clinic.

In 1945 at the annual meeting of the Chattanooga Family Service Agency the subject of needed psychiatric resources was brought up and action toward securing them began. Next the Council of Community Forces was written and urged to form a committee to study the needs. This was accomplished and about two years following the organization of this Council committee, a psychologist was employed in December, 1947, and the Guidance Clinic was formed. The original Council committee administered the Clinic until December 13, 1948, when the Mental Health Association of Hamilton County, Incorporated, was organized and chartered. The Constitution and By-Laws for this new agency provided that the Mental Hygiene Association and the Guidance Clinic should be administered by a single board of directors. It was incorporated by the Board of Directors under the state laws as a non-profit organization for tax purposes, medical and legal reasons.[5] In January, 1965, the Board voted to change the name of the facility to Chattanooga Psychiatric Clinic. Financial support comes from a variety of resources: The United Fund, City, County, State, and Federal funds, fees, and contributions.

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[5]Board of Directors of Chattanooga Guidance Clinic, "History of Chattanooga Guidance Clinic" (Chattanooga, Tenn.: Chattanooga Guidance Clinic, 1957). (Mimeographed.)

VI. AGENCY PURPOSE

The Psychiatric Clinic provides psychiatric services to those who have psychiatric problems which interfere with their making a comfortable adjustment to their environment. There are no geographical, financial, age, racial, or religious limitations to the services of the Psychiatric Clinic.

Emphasis is on consultation, diagnosis, and treatment for individuals, and readjustments of community situations for the purpose of prevention of emotional problems.[6]

VII. AGENCY FUNCTION

The Clinic provides four basic services:

1. Diagnosis and treatment of emotional and mental illness and of personality disorders.
2. Consultation services to physicians, schools, welfare agencies, ministers and other professional groups.
3. Public education as it relates to Clinic services.
4. Professional education and training.

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[6]Phillipp Sottong and Staff, "Policy Book of the Chattanooga Guidance Clinic" (Chattanooga, Tenn.: Chattanooga Guidance Clinic, undated), p. 1. (Mimeographed)

VIII. AGENCY STAFF

The Chattanooga Psychiatric Clinic utilizes a team approach in the diagnosis and treatment of all patients. Three psychiatrists, three clinical psychologists, and three psychiatric social workers complete the professional staff. The Clinic serves as a field placement for the training of psychiatric social workers from the University of Tennessee School of Social Work. Each discipline, psychiatry, psychology, and social work, makes its own specialized contribution of knowledge to the total clinic process.

IX. AGENCY PROCEDURE

The applicant's initial contact with the Clinic is usually by telephone, and this intake is used as a screening device. It is a Clinic policy that the person must call and make his own application. Exceptions are made for exceedingly few patients. A child's parent or legal guardian must call in order to refer him. The staff believes the patient must want help and assume the initiative in requesting it. Over the telephone basic identifying information is secured, as well as a brief description of the problem. It is determined if the Clinic is the appropriate facility to serve the

person and also how emergent the situation is. The applicant is told something of what he may expect from the Clinic. Besides telephone intake, a few "drop in" patients are seen for the same purpose.

The first intake appointment for the patient (or for the patient's parents in the case of a child) is with a psychiatric social worker. The adult patient is almost always seen alone. It is thought that a more accurate picture of the person's feelings about himself and his situation can be obtained in this manner. Both parents are seen for intake regarding a child patient when at all possible. The psychiatric social worker obtains a developmental history, full background information, as well as a description of the presenting problems, and further orients the patients to Clinic policy. Intake may be completed in one interview or may require several, depending on the patient and his problem. A summary of these findings is presented at a Screening Conference, attended by the chief psychiatrist, chief psychologist, and chief social worker. It is at Screening Conference that decisions are made regarding further diagnostic studies. In most instances further diagnostic work-up is indicated and a psychiatrist or psychologist is assigned to make the evaluation; if a patient is considered an emergency, arrangements are made for early evaluation. Evaluation is made by psychiatric interview or psychological

tests. Psychologists do all testing and also see people for treatment purposes. The psychiatrists treat, evaluate, supervise medication if indicated, and recommend hospitalization when required.

Social workers are responsible for all telephone intake as well as for all intake interviews. The social worker formulates his impressions which contribute to the evaluation but he does not make the formal evaluation. The social worker does see patients for treatment as do the other professionals on the team.

Following the patient's diagnostic work-up, a Staff Conference is held, attended by the entire professional Clinic staff. Further diagnostic impressions are formulated, and recommendations made.[7] If it is the decision that the patient (and/or the patient's family in a child's case) should be treated at the Clinic, he (or they) will be assigned a therapist (psychiatrist, psychologist, or psychiatric social worker) who may or may not be a person whom he (or they) have seen previously. It is important to note here that this procedure has been explained during intake and each professional person has attempted to work through his termination of contacts with the patient (or patient

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[7]Wilton Lee, "Social Work Manual" (Chattanooga, Tenn.: Chattanooga Guidance Clinic, 1962). (Mimeographed.)

group) and to prepare him for his next Clinic contact, whatever it may be.

CHAPTER II

RESULTS OF THE STUDY

The cases selected for study were those in which the patient (or family in the case of a child) had had one interview at the Clinic and then had not returned despite Clinic expectation of giving further service, and those in which the patient (or family) had continued to attend Clinic until completion of the diagnostic work-up. It was thought that this time difference in the two sub-groups would permit the investigator to discover more clearly any differences in the characteristics of the continuers and discontinuers than would be possible if the cut-off points for selection of the study population were closer in time. A study done by Duncan and Mayton at the Atlanta, Georgia, Family Service Society compared continuers and discontinuers at four points in time. The writers stated as one of their conclusions that in their opinion the cases could have better been divided into two groups for study.[1]

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[1]Paul Eugene Duncan and Mary Jo Mayton, "A Study of Characteristics of Cases in Which Clients Discontinued Treatment Despite Plan at the Family Service Society, Atlanta, Georgia" (unpublished Master's thesis, The University of Tennessee, Knoxville, 1962), p. 44.

Other studies have demonstrated that as early as the first interview there are clues discernible as to a patient's continuing or dropping out.[2]

I. IDENTIFYING INFORMATION

Child and adult continuance and discontinuance. During the fiscal year beginning July 1, 1962, and ending June 30, 1963, there were 446 new cases opened. Of these, sixty-seven dropped out after one intake interview whereas a total of seventy-seven continued through the diagnostic work-up. (The remaining 302 cases did not meet the criteria for inclusion in the study.) Of the sixty-seven drop-outs, thirty-four were adults and thirty-three were children. In the children's cases one or both parents or guardians were seen for the interview; the child was never seen at the Clinic since children are not interviewed until they come for psychological testing. It would therefore have to be concluded that it was probably the parent or guardian who wanted to discontinue and not the child.

Seventy-seven patients continued through the diagnostic work-up. Forty-three were adults and thirty-four were children (see Table I). Of the adult cases 44.2 per cent

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[2]Leonard S. Kogan, "The Short Term Case in a Family Agency," Social Casework, XXXVIII (June, 1957), 373.

discontinued after one interview, but 55.8 per cent continued through the diagnostic work-up. From these percentages one could say that adults had a somewhat greater probability than children of continuing with the Clinic. The difference was not significant when tested by chi square.

Of the thirty-three children whose cases terminated after one interview, in ten cases both parents were seen, in twenty only the mother was seen, in one only the father was seen, and in two relatives or legal guardians were seen. Of the thirty-four children who continued, in twenty-two cases both parents were seen, in ten the mother only was seen, and in two other relatives were seen. It was important for continuance for both parents to be seen. When tested by chi square it did not prove significant.

Of the forty-three adult continuers, thirty-nine were seen alone and four with others. Of the thirty-four drop-outs thirty were seen alone and four with others. These findings show no important difference between the adults who continued and the ones who dropped out.

Sex. Sixty-four or 44.4 per cent of the cases in the study groups were males and 55.6 per cent or eighty of the cases were female. Of the drop-outs, twenty-one were male children, ten were male adults, twelve were female children and twenty-four were female adults. Of the continuers, nineteen were male children, fourteen adult males, fifteen female

children, and twenty-nine were adult females. Sex was not a significant factor in continuance (see Table II).

Age. The median age in the group of children who dropped out after one interview was ten, the mean age was 10.8 and the modal category was nine to ten years. The median age for the child continuing through the diagnostic work-up was thirteen, the mean age was 13.7 and the modal category was fifteen to seventeen. It would seem that the somewhat older child was more likely to continue with the Clinic. This may be because often the older child was seen alone for testing whereas the younger child's parents were often seen by a social worker while the child was being tested by a psychologist; this was a joint evaluation. Perhaps the older child could better make his own transportation plans and therefore came to the Clinic alone, not necessitating the involvement of many family members each time he came. This would presumably influence continuance.

The mean age for the adults discontinuing after one interview was 34.2 years, the median was thirty-two, and the mode was thirty-nine years. The mean age for the adult continuer was 32.5, the median was thirty-one, and the modal age was 31.5 years. The difference in the two groups did not appear to have any bearing on whether or not a patient continued. The slightly younger person seems to continue with

TABLE II

DISTRIBUTION OF PATIENTS BY SEX, AGE STATUS, AND CLINIC EXPERIENCE

Sex	Total		Discontinued[a]			Continued[b]		
	Number	Per Cent	Total	Child	Adult	Total	Child	Adult
Total	144	100.0	67	33	34	77	34	43
Male	64	44.4	31	21	10	33	19	14
Female	80	55.6	36	12	24	44	15	29

a. The behavior of the group of patients in this study who dropped out after one interview will be referred to as "discontinued" in all tables hereafter.

b. The behavior of the group of patients in this study who continued through the diagnostic work-up will be referred to as "continued" in all tables hereafter.

the Clinic longer, but the difference between the two groups is too small to provide a good basis for speculation.

Religion. Out of 144 cases, 119 were Protestants, 7 were Catholic, 5 were of no religion, and in 15 cases religion was not given. There were no Jewish patients in the two classifications studied. Religion did not appear to relate to continuance but perhaps to use of Clinic services.

Number of children in family of child cases. For those children continuing through diagnostic work-up, the mean number of children in the family was 2.7, the median was two and the mode two. Of the children dropping out the mean number of children in the family was four, the median was three, and the modal category was three to five children. It would appear that families in which the child patient stayed in contact with the Clinic had fewer children than did those families in which the child patient discontinued. Perhaps they had more time and money to invest in one child since they had fewer children; perhaps they were more conscious of problems because more individual attention could be focused on each. It may also be important that they did not have as many children to plan supervision for while they were going to the Clinic.

Marital status of adult study group. There were seventy-seven in the total adult study group. Of these fifty-three or 68.8 per cent were married, twenty or 26.0 per cent were not currently married or living with spouse and in four or 5.2 per cent martial status was not known. Twenty-two or 64.7 per cent of those adults dropping out after one interview were married whereas eleven or 32.4 per cent were not and marital status of one or 2.9 per cent were not known. Thirty-one or 72.1 per cent of the adults continuing through the diagnostic work-up were married, nine or 20.9 per cent were not currently married or living with a spouse, and for three or 7.0 per cent marital status was not known (see Table III). When tested by chi square being married was not a significant factor in continuance. Perhaps the married adult came out of a sense of responsibility to the rest of the family or because of pressure placed on him by the family. It can be speculated that the person who remains in a marriage possesses traits which enable him to try to work out problems while remaining in a situation rather than escaping from it, and that these presumed traits would operate in favor of his continuing in the Clinic situation.

Race. Eleven and eight-tenths per cent or seventeen of the 144 study cases were Negro and 88.2 per cent or 127 were white. Of the Negro patients 76.4 per cent or thirteen

TABLE III

DISTRIBUTION OF ADULT PATIENTS BY MARITAL STATUS AND CLINIC EXPERIENCE

Marital Status	Total		Discontinued		Continued	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total	77	100.0	34	100.0	43	100.0
Married	53	68.8	22	64.7	31	72.1
Not currently married or living with spouse	20	26.0	11	32.4	9	20.9
Single	(11) *	(14.3)	(6)		(5)	
Divorced	(4)	(5.2)	(2)		(2)	
Separated	(3)	(3.9)	(2)		(1)	
Widowed	(2)	(2.6)	(1)		(1)	
Unknown	4	5.2	1	2.9	3	7.0

*Numbers in parentheses show the breakdown of the major category immediately above.

dropped out after one interview and 23.6 per cent or four continued through the diagnostic work-up. Forty-two and five-tenths per cent or fifty-four of the white patient group dropped out after one interview whereas 57.5 per cent or seventy-three continued through the diagnostic work-up. It was evident that the majority of Negroes did drop out after one interview (see Table IV). In this study race was a significant factor in continuance.[3]

In Green's study of the Negro patient group made at the Guidance Clinic in 1956, she found that only limited use was being made of the Clinic services by the Negro population of the community. Her findings did not indicate a significant difference between races in the length of time each continued with the Clinic; in both races the greatest number of patients made only one or two visits, terminating for the most part immediately following intake. Of the sixty-eight white cases studied, fourteen broke contact after intake.[4] "Intake" as used in Green's study often meant more than one interview. Fanshel, in his study of a family

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[3] $\chi^2 = 6.95$; significant at one per cent level.

[4] Lucille Evans Green, "A Study of Negro Clients Seen at the Chattanooga Hamilton County Guidance Clinic from September 1954 through August 1955" (unpublished Master's thesis, The University of Tennessee, Knoxville, 1956), pp 45, 33, 34.

TABLE IV

DISTRIBUTION OF PATIENTS BY RACE AND CLINIC EXPERIENCE

Race of Patient	Total		Discontinued		Continued	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total	144	100.0	67	46.5	77	53.5
Negro (11.8%)	17	100.0	13	76.4	4	23.6
White (88.2%)	127	100.0	54	42.5	73	57.5

agency, did find a positive association between continuance and socio-economic status but not associated with age, sex or race.[5]

Occupation, education, and source of income. In each case studied occupation, education, and source of income were sought in order to determine the social status of the patient or of the parents in a child's case. The records were markedly lacking in this information. In case records which gave occupation, it was not specific enough to classify accurately. There was no section on the face sheet for information about the amount of education the adult patient had obtained or the amount the parents of a child patient had. No record specifically indicated the source of income of the patient or the parents of a child patient.

Who made initial application and who was seen. Due to the regular procedures of the Clinic, adult patients with very few exceptions made their own applications and were seen alone, and all but a very few children were referred by parents or legal guardians.

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[5]David Fanshel, "A Study of Caseworkers' Perceptions of Their Clients," Social Casework XXXIX (December, 1958), 543-551.

Fees and amount of patient's family's yearly income. The Clinic had a sliding fee scale based on the patient's family's yearly income (see Appendix B). For the patient who discontinued the modal category fee was $.50 to $.99, and the mean fee was $3.13. The patient who continued through the diagnostic work-up had a modal category fee of $3.00 to $3.99, and the mean fee was $4.11. It was apparent that the continuer had a somewhat higher fee and that this was presumably based on a proportionately higher income. When the fee rate was analyzed in order to determine the yearly income of the patients studied, it was found that the average discontinuing patient would presumably have had an annual income of approximately $3,130 and that the continuing patient would have had an annual income of $4,110 (see Table V).

From the ninety-six incomes that were given in the case records some conclusions were drawn. The modal category income of the drop-outs was from $1500 to $2999 and the mean income was $3314.99. The modal category income for continuers was $5000 to $9999 and the mean income was $4071.01 (see Table VI). For the purpose of this study those patients having an income of $2999 or less were considered the low income group. Those patients who had an income of from $3000 to $9999 were considered the middle income group, and all those patients having an annual income of $10,000 or above were considered the upper income class group. Therefore, the

TABLE V

DISTRIBUTION OF PATIENTS BY FEE RATE PER INTERVIEW AND CLINIC EXPERIENCE

Patient's Fee per Interview	Total	Discontinued	Continued
Total	144	67	77
None	16	11	5
$ .50 to $ .99	16	12	4
$ 1.00 to 1.99	17	7	10
$ 2.00 to 2.99	7	3	4
$ 3.00 to 3.99	21	7	14
$ 4.00 to 4.99	11	2	9
$ 5.00 to 5.99	18	7	11
$ 6.00 to 6.99	10	3	7
$ 7.00 to 7.99	5		5
$ 8.00 to 8.99	4	2	2
$ 9.00 to 9.99	1		1
$10.00 to 10.99	6	5	1
$11.00 to 14.99			
$15.00 to 19.99	1	1	
$20.00 to 25.00	1		1
Not Set	10	7	3

*All members of a family are treated for one fee rate based on the family's yearly income.

TABLE VI

DISTRIBUTION OF PATIENTS BY PATIENT'S FAMILY'S YEARLY INCOME AND CLINIC EXPERIENCE

Patient's Family's Income per Year	Total	Discontinued	Continued
Total	144	67	77
None	7	7	
$ 1 to $1,199	6	4	2
$ 1,200 to $1,499	4	3	1
$ 1,500 to $2,999	21	15	6
$ 3,000 to $3,999	15	6	9
$ 4,000 to $4,999	10	2	8
$ 5,000 to $9,999	29	9	20
$10,000 to $14,999	2	2	
$15,000 to $24,999	1	1	
$25,000 and above			
Not given	48	18	30

finding of the study was that those of the medium income group continued with the Clinic longer than did those of the lower income group. It also appeared that people of the upper income group were not making use of the Clinic, as there were only four of these, and all but one discontinued. Perhaps they sought and used private psychiatric help. The conclusion reached concerning amount of patient's family's yearly income could not be considered valid since in forty-eight cases this was not given. In only ten cases was the fee rate not set, so the conclusions based on fee rate were considered valid. Using fee as the probable indication of income did give a lower mean and mode than the actual mean and mode in ninety-six cases in which income was listed. The Clinic would seem to have had patients whose incomes ran somewhat higher than one would have expected by looking at fees only; because of variations in the fee set (which may have been due to factors in the individual case) fee alone was not an absolutely reliable indication of income.

Assuming that social class is correlated with amount of income, the conclusion in the present study was that patients of the middle class were more likely to continue than those of the lower class. Coleman and collaborators in a study at a psychiatric clinic and a family agency reported that members of the two lowest social classes were less

likely to go beyond the intake phases than members of higher classes.[6] Auld and Myers have demonstrated that differences in income are not alone accountable for the use of psychiatric services; middle-class patients are more "psychologically minded", whereas lower-class patients tend to receive less psychological rewards and more punishment from using psychiatric facilities.[7] Sullivan et al. concluded from their findings regarding the lower class and continuance that individuals who are least prepared to confront life challenges are the ones who stand to gain least from psychotherapy.[8]

Diagnosis. Table VII groups the diagnoses into major diagnostic categories and as to whether or not the person was, for the purposes of this study, a "continuer" or "discontinuer" (see Table VII). Only primary diagnoses were considered. Comparison of diagnosis of those patients dropping out with those continuing is of limited value because in thirty-nine cases or 58.2 per cent of the former no diagnosis

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[6]Jules V. Coleman, and others, "A Comparative Study of a Psychiatric Clinic and a Family Agency: Parts 1, II," Social Casework, XXXVIII (February, 1957), 3-8, 74-80.

[7]Frank Auld and Jerome K. Myers, "Contributions to a Theory for Selecting Psychotherapy Patients," Journal of Clinical Psychology, X (January, 1954), 56-60.

[8]Patrick L. Sullivan, Christine Miller, and William Smelser, "Factors in Length of Stay and Progress in Psychotherapy," Journal of Consulting Psychology, XXII (February, 1958), 7.

TABLE VII

DISTRIBUTION OF PATIENTS BY MAJOR DIAGNOSTIC CATEGORY, AGE STATUS, AND CLINIC EXPERIENCE

Patients as to Major Diagnostic Category	Total		Discontinued		Continued	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total Cases	144	100.0	67	100.0	77	100.0
Chronic brain disorders	1	.7			1	1.3
Psychotic disorders	11	7.6	5	7.5	6	7.8
Psychophysiologic autonomic and viseral disorders	2	1.4			2	2.6
Psychoneurotic disorders	33	22.9	11	16.4	22	28.6
Personality disorders	26	18.0	5	7.5	21	27.3
Transient situational personality disorders	19	13.2	6	8.9	13	16.9
Mental deficiencies	2	1.4	1	1.4	1	1.3
No diagnosis made	50	34.7	39	58.2	11	14.3
Adult Cases	77	100.0	34	*	43	*
Chronic brain disorders						
Psychotic disorders	9	11.7	5		4	
Psychophysiologic autonomic and viseral disorders	2	2.6			2	
Psychoneurotic disorders	25	32.5	11		14	
Personality disorders	14	18.2	4		10	

TABLE VII (continued)

Patients as to Major Diagnostic Category	Total		Discontinued		Continued	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Transient situational personality disorders	8	10.4	3		5	
Mental deficiencies	1	1.3			1	
No diagnosis made	18	23.4	11		7	
Children's Cases	67	100.0	33	*	34	*
Chronic brain disorders	1	1.5			1	
Psychotic disorders	2	3.0			2	
Psychophysiologic autonomic and viseral disorders						
Psychoneurotic disorders	8	11.9			8	
Personality disorders	12	17.9	1		11	
Transient situational personality disorders	11	16.4	3		8	
Mental deficiencies	1	1.5	1			
No diagnosis made	32	47.8	28		4	

*Percentages not shown where base is smaller than fifty.

was made. Of the twenty-eight diagnosed drop-outs the largest diagnostic category was psychoneurotic disorders, which was made up of 16.4 per cent or eleven of the patients. Of the patients continuing through the diagnostic work-up 28.6 per cent or twenty-two patients were diagnosed as having psychoneurotic disorders; 27.3 per cent or twenty-one patients of the continuers were diagnosed as having personality disorders, and 16.9 per cent or thirteen patients of this group were given the diagnosis "transient situational personality disorder". In view of the traditional use of clinics for treatment of psychoneuroses, it was of interest that there was such a relatively large number of the continuers in this study who had personality disorders.

II. THE PATIENT'S PROBLEM

Primary reason for referral. A comparison was made of the patients who discontinued treatment after one interview and of those who continued, as to primary reason for referral (see Table VIII). Out of the total of 144 cases, sixty-five patients came to the Clinic because of problems of social adjustment; fifty-seven patients came for help with problems of emotional conflict; nineteen came because of physical complaints; two came because of symptoms of brain damage or

TABLE VIII

DISTRIBUTION OF PATIENTS BY PRIMARY REASON FOR REFERRAL, AGE STATUS, AND CLINIC EXPERIENCE

Patients by Reason For Referral	Total	Child			Adult		
		Total	Discontinued	Continued	Total	Discontinued	Continued
Total	144	67	33	34	77	34	43
I. Problems of Social Adjustment	65	42	23	19	23	11	12
A. Problems with family relationships, marital complaints	(11)*				(11)	7	4
B. Problems with environmental adjustments	(9)	(2)	1	1	(7)	4	3
C. School adjustment problems	(20)	(20)	13	7			
D. Childhood behavior problems, acting out	(15)	(15)	7	8			
E. Problems of social withdrawal and difficulty with interpersonal relationships	(10)	(5)	2	3	(5)		5
II. Problems of Emotional Conflict	57	20	7	13	37	16	21
A. Symptoms of depression, sucidal	(24)	(7)	1	6	(17)	8	9
B. Impairment of thought processes	(3)	(2)	1	1	(1)		1

TABLE VIII (continued)

Patients by Reason For Referral		Total	Child			Adult		
			Total	Discontinued	Continued	Total	Discontinued	Continued
C.	Extreme fears, anxiety, nervousness	(24)	(10)	4	6	(14)	6	8
D.	Symptons of psychotic behavior	(6)	(1)	1		(5)	2	3
III.	Physical Complaints	19	3	3		16	6	10
IV.	Symptoms of Brain Damage or Mental Retardation	2	2		2			
V.	Reason for Referral Not Given	1	1			1	1	

*Numbers in parentheses show the breakdown of the major category immediately above.

mental retardation; reason for referral was not given in one case. Thirty-four persons having problems of social adjustment dropped out after one interview and thirty-one having this type problem continued through diagnostic work-up. Of fifty-seven patients having problems of emotional conflict twenty-three discontinued after one interview and thirty-four continued through the diagnostic work-up. Nine of the nineteen cases coming because of physical complaints dropped out after one interview and ten continued. There would seem to be relatively little difference between the discontinuer and the continuer as to major reason for referral. Those having problems of emotional conflict did show a slightly greater tendency to continue perhaps because they were more motivated since the problems were theirs and were presumably causing them discomfort. Since the problem was ego-dystonic it might be so painful and anxiety provoking that they felt increased necessity to get help with it and then to work on it and so would continue with the Clinic.

Those with problems of social adjustment might have come to appease others or through pressure placed on them by the referring person. After coming once, they may have felt they had fulfilled their obligation. Also patients coming with this type of problem may have approached the Clinic in order to make someone feel guilty for the problem. For instance they may have implicated their children or spouses

as the source of difficulty. After one interview they may have felt they had achieved their purpose or may have seen that the Clinic would not accept their assessment. Karpe found in her study at Worcester Child Guidance Clinic that often mothers came to the clinic as if it were a court, in order to punish or accuse their children.[9]

Patients with physical complaints were relatively evenly distributed between continuers and discontinuers. In cases of psychosomatic illness, anxiety and tension are usually handled by the illness itself and there may be less motivation to work on the problem toward a different solution. While the patient has the psychophysiological disorder his anxiety is somewhat bound and there is less tension and psychic pain. The body acts out the discomfort.

It should be remembered that the classification of reasons for referral is partially an interpretation of the problem by therapists and therefore there may be some bias.

Degree of urgency of the problem. The patients were considered as to the degree of urgency of the presenting problem (see Table IX). Clinic policy was to give an emergency appointment when in the judgment of the person doing telephone intake, the problem was considered acute. For the

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[9]Marietta Karpe, "Resistance and Anxiety as Factors in the Discontinuance of Child Guidance Treatment" Smith College Studies in Social Work, XII (1942), 384.

TABLE IX

DISTRIBUTION OF PATIENTS BY DEGREE OF URGENCY OF THE PROBLEM, AGE STATUS, AND CLINIC EXPERIENCE

Patients by Degree of Urgency	Total		Child			Adult		
	Number	Per Cent	Total	Discontinued	Continued	Total	Discontinued	Continued
Total	144	100.0	67	33	34	77	34	43
Acute	21	14.6	14	10	4	7	6	1
Long standing	122	84.7	53	23	30	69	27	42
Not given	1	.7				1	1	

purpose of this study therefore, in any case in which an emergency appointment had been given the problem was classified as acute. From the 144 cases studied 122 cases involved problems that would be considered as of long standing and only twenty-one cases were those in which the problems or situation would be classified as acute. In one case the degree of urgency could not be determined.

During the time period covered by this study there were many patients having acute problems but the majority did not fall within the limitations of the study group because they were referred elsewhere or were hospitalized following the first intake appointment.

The continuers had seventy-two cases of problems of long standing and five cases in which the situation was acute. The drop-outs had fifty cases of problems of long standing and sixteen cases in which the problems were acute. Whether or not a problem was acute or of long standing was a significant factor in continuance.[10] The high proportion of of acute problems among the discontinuers raises questions unanswered by this study, and points to need for further investigation.

Patients having problems of long standing usually had experienced an increase of anxiety or tension when they

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[10] $X^2 = 7.575$; significant at one per cent level.

finally decided to request help. The problem was growing worse and they were resigned to the fact that they were going to have to have assistance. When they finally did come to this point, they were ready then to continue contact in the majority of instances. In the other cases it seemed probable that the person had not yet reached this point.

Referral source. As Table X shows 63 patients or 43.8 per cent of the total were referred to the Clinic by physicians. This may be an indication of the high standing of the agency within the medical community. There are three psychiatrists on the Clinic staff, and it is considered a medical facility. The medical referrals do comprise the greatest proportion of referrals. Twenty-four patients or 35.8 per cent of those dropping out after one interview were referred by physicians whereas thirty-nine or 50.6 per cent of the continuers were physician referrals.

Social agencies referred 19.3 per cent or thirteen patients who were discontinuers and only eight cases or 10.4 per cent of the continuers. Eleven patients or 16.4 per cent who dropped out after one interview were referred by other community organizations but only five patients or 6.5 per cent of the continuers were so referred (see Table X).

It would appear that various social agencies and community organizations may have pressured their clients into

TABLE X
DISTRIBUTION OF PATIENTS BY SOURCE OF REFERRAL, AGE STATUS, AND CLINIC EXPERIENCE

Patients by Referral Source	Total		Discontinued		Continued	
	Number	Per Cent	Number	Per Cent	Number	Per Cent
Total Patients	144	100.0	67	100.0	77	100.0
Physicians	63	43.8	24	35.8	39	50.6
Other professional individuals	7	4.9	1	1.4	6	7.8
Social agency	21	14.6	13	19.3	8	10.4
Community organization	16	11.1	11	16.4	5	6.5
Friend or relative	13	9.0	4	6.0	9	11.7
Self referred	23	15.9	13	19.3	10	13.0
Unknown	1	.7	1	1.4		
Children	67	100.0	33	*	34	*
Physicans	26	38.8	12		14	
Other professional individuals	1	1.5			1	
Social agency	14	20.9	8		6	
Community organization	13	19.3	9		4	
Friend or relative	6	8.9	1		5	
Self referred	7	10.4	3		4	
Unknown						
Adults	77	100.0	34	*	43	*
Physicians	37	48.0	12		25	
Other professional individuals	6	7.8	1		5	
Social agency	7	9.1	5		2	
Community organization	3	3.9	2		1	
Friend or relative	7	9.1	3		4	
Self referred	16	20.8	10		6	
Unknown	1	1.3	1			

*Percentage not shown where base is smaller than fifty.

contacting the Clinic; the same may have been true of some doctors. Also, they may have been failing to prepare the person for what he could expect from the Clinic and what the Clinic could expect from him. Due to the source of referral the patient may already have had negative feelings about the Clinic when he came.

Twenty-three patients were self referred and of these thirteen dropped out after one interview, and ten continued. This is contrary to what one would expect. It would seem that a patient would have been more likely to continue if he had come to the Clinic of his own volition. Perhaps some of these people had actually been referred by other people or organizations but failed to report it. They could have possibly been so angry at the source of referral that they would not mention it. Also they might have feared the findings would in some way not be kept confidential and did not want the referring source to know of their contacts and so would not name it.

III. SERVICE TO PATIENT

The groups studied were compared as to number of times seen, number of therapists seen, time covered by contacts, and number of appointments broken. It was thought

these factors might be influential as to whether or not a patient continued with the Clinic.

Number of times seen. The sixty-seven discontinuers were by definition those who were seen once. For the children continuing through diagnostic work-up, the average number of interviews for the closed cases was about thirteen but ten cases of the thirty-four were still being seen in treatment; presumably these cases, when closed, would raise the average. The average number of times the adult patient who continued through the diagnostic work-up and whose case is now closed was seen was slightly over fourteen, but there are fourteen of these forty-three adult cases still being seen in treatment so again it is presumed that the average would be raised by inclusion of these fourteen cases when they are closed.

Number of therapists seen. The sixty-seven patients who dropped out after one interview were seen by only one therapist. As defined for the purposes of this study, a therapist is a professional person (psychiatrist, psychologist, or psychiatric social worker) employed at the Clinic and with whom the patient was given an appointment. Of the thirty-four child continuers, twenty-five saw two

therapists, eight saw three therapists, and one saw four therapists, for an average of 2.3 therapists seen. Of the forty-three adult continuers, thirty saw two therapists, twelve saw three therapists, and one saw four therapists, for an average of 2.3 therapists seen. During the diagnostic work-up the patient did see several therapists for evaluation. When the diagnostic work-up was completed and the patient was assigned a therapist for treatment, it was rare that there was a change of therapist.

Time covered by contacts. A factor sought in the study was the length of time or the number of days in the time span the patient had contact with the Clinic from the time he first contacted the Clinic by telephone or "dropping in" until his case was terminated. This information was not given for the cases of patients who discontinued after one interview. Ten children in the study group are still in treatment and are having Clinic contacts, but for the closed cases of this type the average number of days was approximately 172. Fourteen adult patients of the study group are still in treatment but for the closed adult cases the average was approximately 221 days. It seemed the adult remained in contact with the Clinic somewhat longer than the child.

Number of appointments broken. In ninety-three of the 144 study cases the number of appointments broken was not given. Fourteen of the child and fourteen of the adult discontinuers broke one appointment as would be expected. Seven of the continuers broke one appointment, five broke two, and one broke four. Usually there were few cancellations after the second appointment.

IV. SITUATIONAL FACTORS

The patient's utilization of psychotherapy or casework is determined by his motivation, capacity, and the opportunity afforded him by both the agency and his environment. Provided these components are adequate and appropriate, it is theorized that patients will make use of therapy or casework help if forces outside of the agency or the patient are not too restrictive and unmodifiable.[11] For this study the following environmental or situational factors that might affect motivation, capacity, and opportunity to come to the Clinic were considered: distance from the Clinic or time involved in traveling from home or business, physical disability, inconvenience of times at

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[11] Lillian Ripple, "Factors Associated with Continuance in Casework Service," Social Work, II (January, 1957), 87.

which appointments were offered or made, problems involved in planning for family members while coming to the Clinic, transition of patients from one therapist to another, waiting list, time between appointments, and the fee system. Unless the patient specifically mentioned that one or more of these factors presented a problem and it was included in the recording the factors were not considered to be of importance. As might be expected, in only two cases of those patients who discontinued were situational factors mentioned. Perhaps as a patient had more contact with the Clinic he was able to discuss and work out some of these problems. Often they may have been mentioned to the individual therapist but not recorded.

Distance or time away. Out of the 144 cases studied there were five cases in which distance or time away from home or work was mentioned as a problem; all five were cases of continuers.

Waiting list and time between appointments. Two other factors considered were the length of time between the initial inquiry and the first appointment and also the length of time between the application interview and the next step in the Clinic process. In no case was this recorded as a problem. An accurate comparison can not be made because in

the cases of twenty-one children who discontinued after one interview and twenty-five adult cases of the same category a next appointment was not definitely scheduled; it must be assumed that further contact was left to the patient since service was not considered completed. On the basis of the appointments given there were the following averages: For the child drop-out the average time between the initial inquiry and the intake interview was almost forty-two days and the average time between the intake interview or interviews and the appointment for psychological testing which was not kept was approximately ninety days; for the adult drop-out in the same order the time was nearly thirty-one days involved in the first waiting period and thirty-five days between intake and the scheduled appointment for evaluation. The child continuer had thirty-one days wait between the initial inquiry and the first interview and 105 days following intake until psychological testing or evaluation. The adult continuer had an average of thirty-five days of waiting between the initial inquiry and the first appointment and eighty-four days between intake and the next step. Length of time the patient has to wait did not distinguish between the continuers and discontinuers. It was speculated that if they wanted help they appeared to be able to withstand a waiting period. Perhaps some of those who did not continue felt their situations were hopeless. Others may have felt they

had worked out satisfactory solutions to their own problems. As mentioned in the description of the Clinic process, should a patient be considered an emergency, arrangements were made for early testing or evaluation as the case may have indicated.

Transition of patients from one therapist to another. Every patient who came to the Clinic and who continued past the intake process saw more than one professional person; the average number was two and three-tenths. Besides the psychiatric social worker who did the intake, the patient saw a psychiatrist or psychologist depending upon which was indicated. As mentioned in the section on Clinic procedure, if it was decided that the patient should be treated at the Clinic, he was assigned a therapist who may or may not have been a person whom he had seen previously. In no case was change of therapist mentioned as having caused a patient to discontinue contact with the Clinic.

Physical disability. In one case out of 144, there was mention of the fact that a patient had a physical disability which made it difficult to come to the Clinic. This one patient was a continuer.

Necessity of planning for other family members while patient comes to clinic. In one case of a child discontinuer, it was mentioned that planning for other family members during visits to the Clinic caused some difficulty. In three cases of adults who continued through the diagnostic work-up, it was mentioned that that other family members had to be planned for. Thus out of 144 cases there were only four cases in which it was mentioned. It might have been inferred in many other cases since it was often mentioned how many young children were in the home, and it seemed that some plan necessarily had been made for them.

Resistance to fee system. One mention was made of resistance to the fee system among all of the discontinuers. Among seventy-seven continuers eight cases contained some statement of resistance about the fee system. Presumably this was worked through with the therapists since the patients did continue.

Appointments before holidays or special occasions. In no case that fell within the study was there recorded any mention of a patient not being able to come for his appointment because it came before a holiday or some special occasion. Intake appointments are not scheduled by the Clinic the day before a holiday.

CHAPTER III

SUMMARY AND CONCLUSIONS

This study emerged from concern at the Chattanooga Psychiatric Clinic of Chattanooga, Tennessee, about the numerous cases at the Clinic of patients who discontinued treatment despite Clinic plans to continue. Answers to four questions were sought:

1. Are there common characteristics among patients and families who discontinue after the initial interview?
2. Are there common characteristics among patients and families who continue through the diagnostic work-up?
3. What are the differences and similarities between the group who discontinue after the initial interview and the group who continue through the diagnostic work-up?
4. Are there situational factors in the discontinuing patient's situation which tend to hinder his participation in following through with plans?

The data were collected entirely from cases new to the Chattanooga Psychiatric Clinic between July 1, 1962, and June 30, 1963. The study population consisted of 144 cases and included all cases which had been closed despite plan after the first intake interview and all cases which had continued through the diagnostic work-up. The material was divided into four major areas:

1. Characteristics of the patients.
2. Factors about the patient's problem.
3. Service offered by the Clinic.
4. Situational factors.

A structured schedule was employed to secure data from the case records.

The study group of 144 cases broke down into sixty-seven discontinuers, thirty-four of whom were adults and thirty-three of whom were children. These groups of discontinuers were nearly equal in number, differing by one, Of the 144 patients studied seventy-seven were continuers with forty-three being adults and thirty-four children; there was a difference of only nine patients in these two groups of continuers. The entire group of continuers was larger by ten patients than was the entire group of discontinuers.

It was surprising that the numbers of discontinuers and continuers were so nearly equal and this raised some questions. It would be helpful to know whether these

proportions of continuers and discontinuers would remain stable if a greatly enlarged sample of the Clinic intake were studied. There is a need for research concerning what community agencies and the public know about the Clinic. What are the attitudes of the community toward the Clinic? Are there elements in the Clinic procedure that have not been considered in this study which play an important role in continuance? It is possible that there are unknown attitudes on the part of the patient toward the existing Clinic procedure that may influence whether or not a person continues. There may be psychological attitudes and factors which are not known at the present. Certainly, a need exists to look both inside the Clinic and into the community for unknown factors that influence discontinuance. The possibility does remain that the number of continuers and discontinuers would remain nearly equal no matter what kind of study was done.

Of the adult patients 44.2 per cent discontinued after one interview, but 55.8 per cent continued through the diagnostic work-up. Of the child patients 49.2 per cent terminated after one interview, but 50.8 per cent continued through the diagnostic work-up. From these percentages one could say that adults had a somewhat greater probability than children of continuing with the Clinic. The difference was not significant when tested by chi square. The fact that there was no remarkable difference between the child and

adult continuers and discontinuers was consistent with the overall finding that continuers and discontinuers were almost equal; therefore, whatever factors were responsible apparently affected all, not one segment. Separate studies of children and adult patients are needed to sort out the differences that are lost when looking at the total. An interesting question for study is that of the elements which may enter into a parent's decision not to continue contact with a clinic when the original request has been for help with a child's problem, and the elements in an adult's decision not to continue with a clinic for help with a problem he perceives as his own.

In the majority of continuing child cases both parents were seen for intake purposes; this was not true for the majority of drop-outs. This factor did not distinguish significantly between drop-outs and continuers. It seemed important for continuance for both parents to be seen if at all feasible; this is a current policy of the Clinic. Perhaps greater adherence to it is possible, but it does raise some questions as to how best to help the child who has a parent who refused to come in or the child who has only one parent. More research on this would be helpful.

Of the cases in the study groups 44.4 per cent of the patients were males, and 55.6 per cent were females. Sex of

of the patient did not appear as a statistically significant factor in continuance. Once again, there seems to be need for a separate study of children and adults. It is believed that more boys are referred than are girls to clinics over the country. In the present study however, the numbers of boys and girls in the sample were nearly equal.

It is of some interest that of all males in the sample who discontinued, two-thirds were children, while of all females discontinuing, only one-third were children. No explanation for this is readily apparent.

The median age for the child dropping out after one interview, was ten years, whereas for the child who continued, the median age was thirteen years. It appeared that the somewhat older child was more likely to continue. Perhaps the older child could better make his own transportation plans and therefore came to the Clinic alone not necessitating the involvement of many family members each time he came. It could be speculated that the parents of an older child became more concerned about his need for help. Earlier they may have felt the child would outgrow his problem, but finally they may have come to the realization he would not. A need is indicated for some further studies focused on the relationship of situational factors to age of continuers. A study of individual cases by interviewing them might bring to

light more factors, or greater frequency of factors sought in this study than were given in the record.

The mean age for the adult discontinuer was 34.2 years and for the adult continuer it was 32.5 years. There was not a great deal of age difference between the two groups when one considers the mean age, but it should be remembered that there were many people of far greater or lesser years that composed these means. The slightly younger adult continued with the Clinic longer than an older one; possibly he had more energy to invest in the treatment process and had more hope for the future. Since there was so little difference, this finding again indicates that studies in depth, of discontinuers and continuers, would have meaning for the Clinic.

Out of the 144 cases, 119 were Protestants, 7 were Catholic, and none were Jewish. Religion did not appear to relate to whether or not a patient continued with the Clinic but rather to the utilization of Clinic services. It seemed that the Clinic needs to reach out to these religious groups that are not using the community mental health facility and to acquaint them with the available program. Certainly, the area population was very highly Protestant but one would have expected these other groups to have been making greater use of the Clinic than was found. They had no other facilities for their own specific group which offered the same services.

Race did prove a significant factor in discontinuance. There were only seventeen cases of Negro patients in the study population and the majority (thirteen) dropped out after one interview. Race was significant at the 1 per cent level. The Negro community should have the Clinic services made known and interpreted to it; real assurance of the availability of service is needed. One means of reaching the group would be through Negro organizations, churches, and professional groups. Use might be made of the Negro newspaper and radio stations. Perhaps if there were increased use by Negroes, there would be a greater proportion of this group continuing with the Clinic, after their first contact.

It is interesting that Fanshel could relate continuance to socioeconomic status and not to race. A future study might investigate in depth the cases of Negroes who come to the Clinic, for study of class factors (education, income, occupation) and upward mobility or lack of it, middle class values, or other relevant factors.

The married adult continued with the Clinic longer than the adult not currently married or living with his spouse. This factor did not distinquish significantly between drop-outs and continuers. It could be that the married patient came out of a sense of responsibility to his family or because of the pressure they might have placed upon him. The study did indicate that 26.0 per cent of the adults

studied were not currently married or living with a spouse. This is greater than one would expect to find in the population as a whole.

Families of child patients which have fewer children continue for a greater period than those with a large number of children. It might be that they had a greater amount of time and money to invest in one child since they had fewer children. Also parents who have fewer children may become more upset about their child's behavior. They may be more "child centered" and over-protective and what other parents might consider normal, they might become distraught over and seek professional help.

Occupation, education, and source of income were sought for every patient or for the parents in a child's case. It had been hoped that the social status of the patient could be determined in this way but the information was markedly lacking from the records. Education was not given and the specific type of occupation was listed in few cases. It was indicated that more specific information on all three factors on which social class is based would be desirable. Out of 144 cases, the income was given in ninety-six cases. There was supposed to be a correlation between the family's yearly income and the fee rate according to the Clinic's sliding fee scale; the fee was set in all but ten

cases so some of the implications about amount of yearly income were based upon the fee rates. It was found that the continuer had a mean fee rate of $4.11 whereas the discontinuer had a mean fee rate of $3.13. The discontinuer had a higher fee and, it would be assumed, a proportionately higher income. Those of the medium income group appeared to continue longer than those of lower income. If income is a criterion of social class, the conclusion would be that the patients of the middle class were more likely to continue than those of the lower class. This is consistent with findings of similar studies. People of the upper class did not make much use of the Clinic services. It would be supposed that they had funds to seek private professional help.

Diagnoses were compared, with no significant difference being found between the discontinuer and continuer. In the majority of cases in which patients dropped out after one interview, no diagnosis was made. The diagnosis most frequently given to both continuer and discontinuer was psychoneurotic disorder; this was as one would have expected in an out-patient, community, psychiatric facility. The next largest category of continuers was given the diagnosis of personality disorder. This was somewhat contrary to what one would have expected. Upon examination of the records, it was found that most of these patients were coming for symptom

relief. Temporarily overcome by anxiety or depression they came for "short term" help with this and not for their basic characterlogical problems. As soon as they were given "symptom relief" they frequently terminated treatment.

The largest number of patients came to the Clinic primarily because of problems of social adjustment. Problems of emotional conflict were the primary reason for referral of the next largest number. Those patients having problems of emotional conflict demonstrated a slightly greater tendency to continue. Perhaps they were more motivated since the problems were theirs and internalized and were causing them discomfort.

Most cases were those of patients whose problems would be classified as being of long standing and not acute. Out of 144 cases, 122 cases were of patients having problems of long standing and not of an emergency nature. Of the twenty-one acute cases sixteen patients dropped out after the first interview. This was a statistically significant factor in discontinuance. Possibly some people called the Clinic in a moment of great stress, then given someone to talk to who helped them to get some perspective on their problems, were able to go on (at least in their own opinion) without further outside help; the large number of drop-outs among patients who were classified as having acute problems suggests this, that even the very skilled professional person

cannot always judge adequately on the basis of a telephone contact what is emergent, and it may be that some situations thought to be acute were not. Offer of immediate help in such a case is a justifiable service, and though the patient may need longer term help, he may use the strengths he has been using to get along with, after the acute stage passes.

During the time period studied, there were many patients having acute problems but the majority did not fall within the limitations of the study group due to the fact that they were referred elsewhere or hospitalized following the first appointment.

Medical referrals comprised the largest proportion of referrals. Of the discontinuers 35.8 per cent were referred by a physician, and 50.6 per cent of the continuers were referred by a physician. Social agencies and community organizations referred more persons who dropped out after one interview than they referred continuers. It might be that they pressured these people into coming or failed to prepare them as to what they might expect. Also the patient might have felt he was "getting the run around" by the various agencies and organizations. He might also have felt that since the referring agency or organization could not help him his situation was hopeless. In some cases the patient could have better been handled by the referring social agency if this agency had had Clinic consultation. The Clinic does

offer consultation, but it is necessarily limited because of the number of staff members and the amount of Clinic time.

As part of this study, the type of service offered to the patient by the Clinic was explored. The factors looked at were the following: the number of times the patient was seen, the time covered by contacts with the Clinic, the number of professional people the patient had contact with at the Clinic, and the number of appointments the patient broke. None of these constituents proved relevant to whether a patient continued or discontinued.

Situational factors which might have played a part in the patient's continuing or failing to continue were sought. For this study the following environmental or situational factors were considered: distance from the Clinic or time involved in traveling from home or business, physical disability, inconveniences of times at which appointments were offered or made, problems involved in planning for other family members while the patient was coming to the Clinic, transition of patients from one therapist to another, the effect of the waiting list and the time between scheduled appointments, and reaction to the fee system. There was very scant information in the record regarding any of these factors. One of the major recommendations as a result of this study is for more comprehensive case recording; more specific information about reality factors that should cause the

patient some difficulty would be helpful and should be planned for in connection with any future research. It would be helpful to future studies if the recording were more complete, but also it would be a valuable asset in diagnosis and treatment of the patient.

Often failure to continue could be due to emotional conflicts and resistance which might be difficult to detect in the one interview. A fertile field for future study would be examination of particular points in the Clinic process at which resistance comes up. Another possible area for study is the relationship between patient's attitudes in first interviews and whether the patients continue or discontinue.

In comparing those patients who discontinued after one interview with those who continued through the diagnostic work-up, more similarities than differences were found. It can be theorized that the factors examined were not the ones relevant to continuance and other indicators should have been sought. Many factors that were to be examined could not be, due to the fact they were not recorded. Only the following factors were significant in differentiating the two groups: race and degree of urgency of the problem - the latter factor in an unexpected direction inasmuch as more persons, proportionately, with urgent problems dropped out after one interview.

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APPENDIX

APPENDIX A

SCHEDULE

Dropped out after initial interview _____

Continued through diagnostic work-up _____

I. Identifying Information

A. Case No. _____

B. Type Case
1. Child _____
a. Both parents seen _____
or M _____
Which parent seen F _____
b. Sex of child M ___ F ___
c. Age of child _____
d. Number of children in family _____
e. Ordinal position of child _____

C. Fee _____

D. Religion: P _____
C _____
J _____

E. Occupation _____

F. Race: C _____
W _____
other _____

2. Adult _____
a. Seen With
alone ____ mate _____
b. Age _____
c. Sex: M _____ F _____
d. Marital Status _____

G. Income
1) Amount _____
2) Source _____

H. Amount of education _____
of patient or parents of child

I. Who made the initial application? Patient _____
Relative _____
Other _____

J. Who was seen? M ____ W ____ Both ____ Child _____

K. Diagnosis if given: _____

II. The Problem and Patient's Reaction to It..

A. Was the problem one which was concerned primarily with:

1. Problems of Social Adjustment _____

a. Problems with family relationships, marital complaints _____

b. Problems with environmental adjustment _____
c. School adjustment problems _____
d. Childhood behavior problems, acting out _____
e. Problems of social withdrawal and difficulty with interpersonal relationships _____

2. Problems of Emotional Conflict _____
a. Symptoms of depression, suicidal _____
b. Impairment of thought processes _____
c. Extreme fears, anxiety, nervousness _____
d. Symptoms of psychotic behavior _____

3. Physical Complaints _____

4. Symptoms of Brain Damage or Mental Retardation _____

5. Reason for Referral Not Given _____

B. Did patient consider the problem acute or long standing _____

III. Source of Referral

Did he come to the Clinic:

1) on referral from a physician _____
2) on referral of other professional individuals _____
3) on referral of a social agency _____
4) on referral of a community organization _____
5) on suggestion of a friend or relative _____
6) Self referred _____
7) Unknown _____

IV. Service on Case

1) Number of times seen _____
2) Number of therapists seen _____
3) Period of time covered by contacts _____
4) Number of appointments broken _____

V. Situational Factors which May Have Had Some Effect on Patient's Breaking Contact

A. Was distance from the agency or time involved in travel from home or business a problem?

yes _____ no _____

B. Length of time between

1) Initial inquiry and first appointment _____
2) Application interview and next step in the Clinic process _____

C. Was case referred to another therapist after intake?

yes _____ no _____

D. Did patient have any physical disability which made coming to the office a chore?

yes _____ no _____

E. Did patient's coming for interviews necessitate planning for other family members, e.g. young children, after school plan, care of ill family members, etc? yes _____ no _____

F. Did patient question, express resistance to, or appear concerned by the Clinic fee system?

yes _____ no _____

G. Did the appointment offered come just before a holiday or some special occasion when patient might normally be expected to be more usually involved with affairs at home?

yes _____ no _____

APPENDIX B

CLINIC FEE SCHEDULE

A. Diagnostic and Consultative fees: These are determined by the first digits of the yearly incomes:

	Interviewing		Testing	
	Family Members	Single (18+)	Family Member	Single
$ 1,200 or less	$ .50	$ 1.00	$ 1.00	$ 1.50
1,200 - 1,500	1.00	2.00	2.00	2.50
2,000	2.00	4.00	4.00	5.00
3,000	3.00	6.00	6.00	8.00
4,000	4.00	8.00	8.00	10.00
5,000	5.00	10.00	10.00	15.00
10,000	10.00	20.00	20.00	25.00
15,000	15.00	25.00	25.00	25.00
20,000	20.00	25.00	25.00	25.00
25,000	25.00	25.00	25.00	25.00

B. A minimum of fifty cents will be charged.

C. Because of the Guidance Clinic's policy of giving regular appointment times to the patient in order to save the patient's time, it is not possible to fill in that time with another patient if an appointment is not kept. Therefore, if the patient has not cancelled his appointment at least by the day before he is to come in, he will be billed for that time.

D. At each visit the patient should stop at the office either just before or just after his interview to verify his next appointment and take care of payments.

E. A double telephone buzz indicates that the interview has ended. In most instances the interview is fifty minutes for each patient.

F. As is shown in the above table the fees for testing are double those of the interviewing, because for every hour that the psychologist spends in testing he spends another hour scoring, interpreting, etc.