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Profile of care provided in a school service

Perfil de atendimentos realizados em um serviço escola

Perfil de atención brindada en un servicio escolar

Ana Cláudia Longo
Atitus Educação, Passo Fundo – RS/Brasil
ORCID: 0000-0002-5321-3603
E-mail: anaclaudialongo9@gmail.com

Maíra Fontana
Atitus Educação, Passo Fundo – RS/Brasil
ORCID: 0000-0002-5445-0862
E-mail: maira.fontana@hotmail.com

Michele Minozzo Sathes
Faculdade Anhanguera, Passo Fundo – RS/Brasil
ORCID: 0000-0001-6973-5919
E-mail: psicologamichele2016@gmail.com

Cristina Pilla Della Méa
Atitus Educação, Passo Fundo – RS/Brasil
ORCID: 0000-0002-8733-1560
E-mail: cristina.mea@atitus.edu.br

Vinícius Renato Thomé Ferreira
Atitus Educação, Passo Fundo – RS/Brasil
ORCID: 0000-0001-9786-7775
E-mail: vinicius.ferreira@atitus.edu.br

Cláudia Mara Bosetto Cenci
Atitus Educação, Passo Fundo – RS/Brasil
ORCID: 0000-0001-9998-2339
E-mail: claudia.cenci@atitus.edu.br

Abstract
Clinical practice during psychology training is often performed in school clinics, with the identification of the characteristics of the clientele served being fundamental for improving the care. The aim of this study was to identify the profile of patients attended, in the modalities of children, adolescents, adults, couples and families, in a school clinic of psychology located in Rio Grande do Sul. An investigation of the profile of 667 medical records of children, adolescents, adults and couple and family patients treated between 2011 and 2017, was carried out, investigating sociodemographic data, type of initial assessment conducted, number of sessions, theory used, source of the referral, reason for seeking care, diagnostic hypothesis and reason for termination of the care. Specific characteristics of these variables were identified according to age and type of care. There was a significant number of medical records with incomplete data, making the data analysis difficult. Better control of medical record information would provide more detailed knowledge of the profile attended in school clinics.

Keywords: School clinic; Psychotherapy; Training.

Resumo
A prática clínica durante a formação em psicologia é realizada muitas vezes em clínicas-escola, e conhecer características da clientela atendida é fundamental para o aprimoramento do atendimento. Objetivou-se levantar o perfil de pacientes atendidos numa clínica-escola, nas modalidades infantil, adolescente, adulto, casal e família de uma clínica-escola de psicologia localizada no Rio

Grande do Sul. Realizou-se um levantamento de perfil de 667 prontuários de pacientes infantis, adolescentes, adultos e de casal e família atendidos, entre os anos de 2011 a 2017, investigando dados sociodemográficos, tipo de avaliação inicial conduzida, número de sessões, teoria utilizada, quem encaminhou, motivo da busca, hipótese diagnóstica e razão do término do atendimento. Identificou-se características específicas destas variáveis conforme a faixa de idade e tipo de atendimento. Houve um expressivo número de prontuários com dados incompletos, dificultando a análise dos dados. Um melhor controle das informações dos prontuários permite um conhecimento mais detalhado do perfil atendido em clínicas-escola.

Palavras-chaves: Clínica-escola; Psicoterapia; Formação.

Resumen

La práctica clínica durante la capacitación en psicología a menudo se realiza en clínicas escolares, y conocer las características de la clientela atendida es fundamental para mejorar la atención. El objetivo de este estudio fue elevar el perfil de los pacientes tratados e una clínica escolar, en las modalidades de niños, adolescentes, adultos, parejas y familiares de una clínica escolar de psicología ubicada en Rio Grande do Sul. Se realizó una encuesta de perfil de 667 registros médicos niños, adolescentes, adultos y parejas y pacientes familiares, de 2011 a 2017, investigando datos sociodemográficos, tipos de evaluación inicial realizada, número de sesiones, teoría utilizada, derivación, motivo de búsqueda, hipótesis diagnóstica y motivo de fin de la atención. Las características específicas de estas variables se identificaron según la edad y el tipo de atención. Hubo un número significativo de registros médicos con datos incompletos, lo que dificulta el análisis de datos. Un mejor control de la información de los registros médicos permite un conocimiento más detallado del perfil atendido en las clínicas escolares.

Palabras clave: Clínica-escola; Psicoterapia; Formação.

Introduccion

School clinics, also called school services, are present in health courses such as dentistry, physiotherapy and psychology, and are mandatory services under the legislation that regulates the profession of the psychologist (Campezatto & Nunes, 2007, Lei n. 4.119, 1962). Data from 2017 indicate the existence of 696 psychology undergraduate courses in Brazil, with a total of approximately 249,000 spaces (Instituto Nacional de Estudos e Pesquisas Educacionais Anísio Teixeira [INEP], 2018). Even though no statistics were found on how many school clinics exist in Brazil, this number is substantial when considering the number of Higher Education Institutions (HEIs) offering the course and the number of students performing internships.

Psychology services are spaces integrated into the higher education courses where students have contact with the professional practice and the clinic, with supervision by professors from the educational institution (Araújo & Boaz, 2013; Gauy, Fernandes, Silvares, Marinho-Casanova, & Löhr, 2015; Souza, Santos, & Vivian, 2014). The presence of a clinical service open to the public and directed by professors is mandatory in the psychology course (Lei n. 4.119, 1962), being required by the national curricular guidelines of the psychology courses (Resolução n. 5, 2011). In addition to the academic function, the services fulfill a social function, as many clinics set a maximum income limit for patients and charge symbolic values for the care. Therefore, school clinics face the challenge of simultaneously meeting the learning and professional improvement requirements of the students and fulfilling the demands of those who depend on this service (Amaral, Luca, Rodrigues, Leite, & Lopes, 2012; Boeckel et al., 2010; Lustosa, Cótica, & Eygo, 2015). For this, the school clinic must ensure the physical, material and pedagogical conditions necessary for the proper progress of the activities (Conselho Federal de Psicologia, 2013; Oliveira-Monteiro, Herzberg, Oliveira, & Silvares, 2013). Patients seek care for different complaints and requirements and undergo an initial assessment, being then referred to psychotherapy (Souza et al., 2014; Lustosa et al., 2015). The medical records contain information such as the evaluation and screening results, referral, care progress, case evolution, sociodemographic data and

information about the treatment itself (Cunha & Benetti, 2009).

Studies have been conducted to identify the profile of cases seen in school clinics, with different methodologies and focused on descriptive statistics (Bortolini, Pureza, Andretta, & Oliveira, 2011; Campezatto & Nunes, 2007; Cunha & Benetti, 2009; Macedo, et al., 2011; Maravieski & Serralta, 2011; Melo & Perfeito, 2006; Merg, 2008; Neumann & Wagner, 2015; Romaro & Capitão, 2003; Simões, Sampaio, Oliveira, & Favoretto, 2013; Souza & Correa, 2013; Souza et al., 2014; Vivian, Timm, & Souza, 2013). Identifying the characteristics of the patient of school clinics is relevant, as it allows strategies for the reduction of treatment abandonment to be improved, helps in the organization of the institution and refines the clinical guidelines given to the interns (Amaral et al., 2012; Honda & Yoshida, 2012; Macedo et al., 2011; Souza et al., 2014). This study aimed to identify the profile of patients treated at a psychology school clinic located in the north of Rio Grande do Sul state, including children, adolescents, adults, couples and families. Information was collected regarding sociodemographic data (gender, age, education, religion, marital status and family income), what motivated the search for care (reason for seeking help and referred by whom) and about the treatment itself (diagnostic hypothesis, theoretical approach, number of sessions, number of absences and how the treatment was terminated).

Method

Outline

This is a documentary, quantitative-descriptive and retrospective research.

Participants

The study participants were 667 patients attended at a psychology school clinic located in a city in the north of Rio Grande do Sul state, through the analysis of their medical records. The medical records of adult patients treated from April 2011 to December 2016, children from April 2011 to December 2016, adolescents from April 2012 to December 2017 and couples and families from March 2012 to December 2017 were included. Medical records of patients in group care were excluded because these were sporadic in the clinic.

Instruments

A form was elaborated to tabulate the main data from the medical records of children, adolescents, adults, couples and families that were attended at the psychology school clinic in the periods stipulated, including data such as gender, age, education, marital status, type of care, referral source, complaint, diagnostic hypothesis and how the treatment was terminated.

Procedure

The collection took place during office hours, because the records are locked for confidentiality reasons. After checking that the medical records referred to patients that were no longer receiving care, the data were entered into a spreadsheet, with gender, age, education, religion, reason for seeking care, source of the referral, what was the diagnostic hypothesis, whether a psychological evaluation was performed, which theoretical approach was used, the number of sessions performed, the number of absences and how the treatment was terminated. In the case of child and adolescent patients, information on kinship, age, civil status and family income was also sought.

The classification of patients as either children or adolescents was based on the Child and Adolescent Statute, which considers a person aged up to 11 years and 11 months as a child and one between 12 and 18 years of age as an adolescent (Lei n. 8.069, 1990). The reason for seeking care was performed by grouping the complaints (Romaro & Capitão, 2003) into the following categories: affective and behavioral problems (complaints of insecurity, disobedience, depressive symptoms, aggression, isolation, anxiety symptoms); school difficulties (learning

disabilities, poor school performance, school failure, and resistance to school); cognitive deficit (immaturity and developmental delays); mourning (loss of family members due to death); somatic symptoms (headaches, stomach aches and urine leakage); eating symptoms (refusal to eat or overeating); symptoms of violence (victims of physical, psychological or sexual assault and victims of bullying); family difficulties (parental difficulties in setting limits, parental difficulties in showing affection, parental separation, parental conflict, sibling conflict, absence of one or both parents due to abandonment).

This study was approved by the Ethics Committee of Faculdade Meridional (IMED), with CAAE numbers 66364217.0.0000.5319, 58121816.4.0000.5319 and 98403018.3.0000.5319. All patients treated at the site sign a consent form at the beginning of the care, which states that the data can be used for research and ensures complete confidentiality regarding their identity.

Data Analysis

In the statistical analysis, quantitative variables were described through mean and standard deviation. To assess the association between categorical variables, the chi-square test and ANOVA were used. The level of significance considered was 5% ($p \leq .05$).

Results

The study data refer to 667 medical records, covering the years 2011-2017, 254 of children (38.08%, age range 0 to 12 years); 96 of adolescents (14.39%, 12 to 18 years); 303 of adults (45.43%, 18 years and over) and 14 of couples and families (2.10%), 3 being of couples (0.45%) and 11 of families (1.65%). The couple and family care, in this analysis, were considered together, except when mentioned. In the comparison of the distribution by sex, a total of 387 women (59.30%) and 265 men (40.60%) were attended, with 1 (0.20%) that declared "other" sex, with a statistically significant difference ($X^2 = 357.7$, $p < .001$). There were more males ($X^2 = 23.9$, $p < .001$) in the child consultations, more consultations of adolescent females ($X^2 = 5.04$, $p = .025$), and more adult females ($X^2 = 305.7$, $p < .001$). The differences between men and women treated in family and couple modalities were not analyzed, as this sample was not described in detail. The mean family income was R$ 1,074.57 (SD = 686.99), with a minimum of R$ 0.00 and a maximum of R$ 5,915.00. The highest mean value was found in couple and family care (R$1,297.09), followed by adults (R$ 1,118.68), adolescent (R$ 1,061.59) and child (R$ 1,018.70) care, without presenting a statistically significant difference ($F = 1.28$, $p = .28$). The predominant religion was Christian (n = 437, 67%), followed by spiritualist religions (n = 23, 3.5%), although this data was not included in 164 of the medical records (n = 25, 1%).

An evaluation was considered when interviews occurred and the application of any psychological evaluation instrument, and screening when only interviews occurred in the initial reception process of the case. Evaluation predominated as the initial data collection strategy (n = 241, 36.2%) followed by screening (n = 221, 33.2%), with there being a high number of omissions of this information (n = 205, 30.6%). Regarding the type of care, the evaluation was predominant among the children (n = 126, $X^2 = 89.32$, $p < .001$), screening in adolescents (n = 50, $X^2 = 27.44$, $p < .001$), with an absence of this information in adults (n = 178, $X^2 = 90.38$, $p < .001$), although, where it appeared, the evaluation predominated (n = 70, 23.1%), and evaluation in the couple and family care (with no statistically significant difference in this; n = 8, $X^2 = 3.57$, $p = .17$).

The mean number of sessions, considering all modalities, was 12.18 (SD = 15.08), with a minimum of 0 (did not attend the first session) and a maximum of 107. The highest mean number of sessions was in the child mode (M = 13.76, SD = 17.81), followed by adult (M = 11.65, SD = 14.06), adolescent (M = 9.99, SD = 9.58), and couple and family

(*M* = 9.29, *SD* = 7.60), with no statistically significant difference (*F* = 1.77, *p* = .15). Regarding the number of absences, the total mean was 2.83 (*SD* = 3.48), the highest being in adults (*M* = 3.89, *SD* = 4.23), followed by couples and families (*M* = 2.69, *SD* = 2.59), children (*M* = 2.14, *SD* = 2.82) and adolescents (mean=1.77, *SD*=1.69), with a statistically significant difference (adults missing more) (*F* = 14.07, *p* < .001).

The predominance of reasons for the termination of treatment, considering all modalities, was dismissal (*n* = 274, 41.1%), followed by abandonment by the patient (*n* = 221, 33.1%). Dismissal was considered when patients missed 3 consecutive sessions without warning, and abandonment when they no longer wanted the care (*n* = 495, 74.2%). There were 77 (11.5%) cases of discharge, 33 referred to another type of care (4.9%), 32 continued receiving psychotherapy at the end of the year analyzed (4.8%) and this information was missing in 30 medical records (4.5%). Treatment abandonment predominated as the reason for termination in the child (*n* = 98, 38.6%), adolescent (*n* = 48.5%) and couple and family (*n* = 12, 85.7%) care; dismissals predominated in the adult care (*n* = 193, 63.7%).

By type of care, the mean age of the child consultation patients at the time of completion of the initial form was 7.76 years (*SD* = 2.18). The main person responsible registered in the medical records was the mother (*n* = 206, 81%), followed by the father (*n* = 20, 7.9%) and grandparents (*n* = 17, 6.7%). The cases were referred by family or friends (*n* = 85, 33.4%), the school (*n* = 65, 25.6%) and health professionals (*n* = 53, 20.9%). In 35 medical records (13.8%) the person that forwarded the patient was not indicated, therefore it was not possible to identify the percentage of patients that spontaneously sought the consultation. The main reason for seeking the consultation was the presence of compulsive behavior (*n* = 113, 44.5%), followed by difficulties associated with family relationships (*n* = 57, 22.4%) and abuse, violence and/or neglect (*n* = 42, 16.5%). In 207 medical records (81.4%) the reasons for seeking care were not recorded. Regarding the diagnostic hypothesis (DH), ICD F90 - Attention-deficit hyperactivity disorder (*n* = 15, 5.9%) was the most frequent followed by F70 Intellectual disabilities (*n* = 10, 3.9%). The predominant theory used for the treatment was psychoanalytic guidance (*n* = 83, 32.68%), followed by cognitive behavioral therapy (CBT) (*n* = 32, 12.6) and referral for assessment (psychological or neuropsychological) (*n* = 24, 9.45%). In 97 records (38.19%) the theory used was not reported.

In the adolescent care, the mean age was 13.95 years (*SD* = 1.5). As in the child care, the mother was reported as the main person responsible (*n* = 74, 77.1%), and in 47 medical records (49%) this data was not found. The majority of the cases were referred by family or friends (*n* = 40, 41.6%), followed by health professionals (*n* = 16, 16.7%) and the school (*n* = 14, 14.6%), and in 21 medical records (21.9%) the information was not reported. The reason reported for seeking the care was the presence of compulsive behavior (*n* = 44, 45.8%), difficulties related to family relationships (*n* = 21, 21.9%), and abuse, violence and/or neglect (*n* = 13, 13.5%), while in 9 medical records (9.4%) this information was not recorded. The main DH were ICD F70 Intellectual disabilities (*n* = 7, 7.3%), although 78 records (81.3%) did not contain this data. There was a predominance of referral for CBT-based care (*n* = 28, 29.2%) followed by psychoanalytic guidance psychotherapy (*n* = 15, 15.6%) and systemic care (*n* = 10, 10.4%), with 40 medical records (41.7%) not containing this data.

In the adult care, the mean age was 37.9 years (*SD* = 14.4). Health professionals (*n* = 86, 28.4%) were those that made the most referrals, followed by family or friends (*n* = 59, 28.4%), while in 138 medical records (45.4%) this information was not recorded. The main reasons reported for seeking the consultation were difficulties in family and/or marital

relationships (*n* = 71, 23.4%), followed by anxiety, stress and associated symptoms (*n* = 60, 19.8%) and mood and depressive symptoms (*n* = 38, 12.5%). In 31 records (10.23%) this information was not clearly recorded. The main DH proposed were ICD Z71 Persons encountering health services for other counseling (psychotherapy) and medical advice (*n* = 46, 15.2%) and F41 Anxiety disorders (*n* = 9, 2.97%). This information was not included in 232 (76.57%) medical records. Referrals were made for CBT (*n* = 93, 30.7%), followed by psychoanalysis (*n* = 38, 12.5%) and systemic theory (*n* = 31, 10.2%), with this information not found in 140 records (46.2%).

Regarding the couple and family care, 7 referrals were made by health professionals (50.0%) and this data was not recorded in 6 medical records (42.9%). One referral (7.1%) had been made by the judiciary. The main reason for seeking care was difficulties in marital and family relationships (*n* = 8, 57.3%). No DH were identified in the couple and family care, due to theoretical issues. The consultations were all performed (100%) using the systemic approach. Table 1 summarizes the main findings by type of care.

Table 1
Summary of main results

	Children	**Adolescents**	**Adults**	**Couples and Family**
Sex	Majority male	Majority female	Majority female	Not calculated
Main person responsible	Mother	Mother	Not calculated	Not calculated
Primary Referral Source	Family/ friends School Health professionals	Family/ friends Health professionals School	Health professionals Family/friends	Health professionals
Initial assessment strategy most used	Evaluation	Screening	Evaluation	Evaluation
Most frequent reasons for seeking care	Behavior problems Family relationship difficulties Abuse, violence and/or neglect	Behavior problems Family relationship difficulties Abuse, violence and/or neglect	Family relationship difficulties Symptoms of anxiety, stress, and associated Mood and depressive symptoms	Difficulties in family relationships
Most frequent diagnostic hypotheses	F90, Attention-deficit hyperactivity disorders F70 Intellectual disabilities	F70 Intellectual disabilities Many medical records without this data	Z71 Persons encountering health services for other counseling F41 Anxiety disorders Many medical records without this data	Not calculated
Most frequent theoretical approach	Psychoanalytic guidance CBT	CBT Psychoanalytic guidance Systemic	CBT Psychoanalytic guidance Systemic	Systemic
Most frequent form of termination	Dismissal	Dismissal	Abandonment	Dismissal

Discussion

The study of the medical records presented a higher number of adult consultations, followed by children and adolescents, and a smaller number of consultations with couples and families. The findings are in agreement with other studies that indicated a higher demand for psychological service by adults, followed by children and adolescents (Bortolini et al., 2011; Maravieski & Serralta, 2011; Porto, Valente, & Rosa, 2014). Although it was not the focus of this study, it is possible that this data reflects the orientation profiles of the mentor professors, who supervise cases more focused on their training and professional practice. In the school clinic, child consultations predominate on the waiting lists, however, this does not mean that most of the consultations are necessarily for children, because the consultation capacity will depend on the advisor and the number of interns working with this age group.

The majority of the records showed the Christian religion, however, many (over 25%) did not include this information, suggesting that this data was not recorded. Although this data is in line with the demographic profile of religion in Brazil, with a prevalence of religions of Christian denomination (77.5%), among these Catholicism (86.5%) (Maravieski & Serralta, 2011), incomplete medical records make it difficult to analyze this information.

Women sought more consultations than men, however, there was a difference according to the type of care: in children there were more males, while in adolescents and adults there were more females. This is in agreement with the literature, which says that women seek psychological care more (Simões et al., 2013). Male predominance has already been identified in the child clientele (Sei, Skitnevsky, Trevisan, & Tsujiguchi, 2019), with a tendency to be equal among adolescents and to become mostly female in adult consultations (Campezatto & Nunes, 2007; Cunha & Benetti, 2009; Figueiredo-Campos, , Marques, & Bacelar, 2022; Macedo et al., 2011; Maravieski & Serralta, 2011; Souza et al., 2014; Vivian et al., 2013; Mantovani, Maturano, & Silvares, 2010; Melo & Perfeito, 2006; Merg, 2008; Peron, Cândido, & Neufeld, 2020; Santos, 2006). In childhood, boys present more symptoms of aggression, impulsivity and agitation, while girls have more symptoms of depression, anxiety and withdrawal (Cunha & Benetti, 2009; Marturano, Toller, & Elias, 2005; Melo & Perfeito, 2006; Merg, 2008; Santos, 2006; Vivian et al., 2013), therefore the symptoms of boys are what draw more attention in seeking care. The majority of the adolescents were female, which is in line with other studies (Maravieski & Serralta, 2011; Vivian et al., 2013), although prevalence rates closer to 50% have already been found (Macedo et al., 2011; Schoen-Ferreira, Silva, Farias, & Silvares, 2002). The females presented a predominance of affective symptoms, while the males' affective problems were as frequent as school and conduct problems (Macedo et al., 2011, Sei et al., 2019). For the adults, cultural issues have possibly influenced this difference in seeking care because, while psychotherapy seems to be better accepted among women, adult men may have difficulty facing behavioral issues (Costa, Herek, Marutti, Piffer, & Camargo, 2007).

It was identified that in the couple and family consultations, the mean family income was higher, and lower in the child consultations, although without a statistically significant difference. Data on income from family consultations varies, being around 3 minimum wages (Bonafé Sei & Gomes, 2017; Neuman & Wagner, 2015, Sei et al., 2019). Brazilian regional socioeconomic variations may influence this data.

The evaluation predominated as the initial method of assessment of the patients, however there was a difference according to the type of care: in children, adults and couples and family consultations, the evaluation predominated, while for adolescents it was screening. Screening aims to gather relevant information about the life history and treatment requirements, with some sessions with the

patient and their family members (Scaglia, Mishima, & Barbieri, 2011), while techniques and psychological tests are used in the psychological evaluation to understand the requirements, as well as to identify and evaluate specific aspects (Cunha, 2003). There were a significant number of medical records without information on how the case was initially assessed, whether through screening or a more systematic evaluation, especially in the adult consultations, making it difficult to analyze this variable.

The greatest number of sessions occurred in the child consultations, followed by adults, adolescents and couples and family, although without a statistically significant difference. There was a higher mean number of absences for adult consultations, showing a statistically significant difference compared to the other groups, followed by couples and families, children and the lowest, adolescents. Seeking child psychotherapy goes through the assessment of this need by the parents, that is, they decide whether or not to bring their child for the consultation. Seeking psychological help for children may also be a form of help seeking by the parents to ensure the child's well-being (Andrade, Mishima-Gomes, & Barbieri, 2012). When parents are included in the child's care, adherence is more likely (Oliveira, Gastaud, & Ramires, 2016), as well as when referrals are made by other professionals (e.g., pediatricians, neurologists, speech therapists) (Gastaud & Nunes, 2009). The adherence to the child consultations was higher than in the other modalities possibly due to pressure from school and family, because while symptoms persist psychotherapy continues, while adults and couples/families have greater autonomy to miss the treatment.

Regarding the termination of care, there was a predominance of dismissal of patients in the clinic with 3 consecutive unexcused or unarranged absences, which predominated in the child, adolescent and couple and family consultations. In the adult consultations, abandonment was predominant. Psychotherapy abandonment rates are high, ranging from 38.21% to 64.0%, being characterized as the main form of termination of therapy in school clinics (Campezatto & Nunes, 2007; Cunha & Benetti, 2009; Maravieski & Serralta, 2011; Souza et al., 2014; Vivian et al., 2013; Sei et al., 2019; Figueiredo-Campos, et al., 2022). Usually patients do not justify why they drop out, they just stop attending (Maravieski & Serralta, 2011; Souza & Corrêa, 2013; Souza et al., 2014), which characterizes abandonment (Bortolini et al., 2011). The reasons for the abandonment of the treatment by patients may be varied, such as financial conditions, waiting time for care, the location of the school clinic and being attended by interns, among others (Milagre & Dias, 2012). The main reasons for the termination of the care in this study were not in the medical records, however the termination rate was higher in the female patients compared to the men. Treatment abandonment predominated in child and adolescent consultations, in agreement with other studies (Cunha & Benetti, 2009; Vivian et al., 2013). Abandonment in child care may be associated with early symptom improvement, given that the main requirement is linked to behavioral problems, and identifying these factors and intervening early may reduce the risk of abandonment (Mantovani et al., 2010). Therapist switching may favor abandonment, which is common when it comes to school clinics, and a period of joint care (with the old and new therapist) facilitates adaptation and may reduce abandonment (Lhullier, Nunes, Antochevis, Porto, & Figueiredo, 2000).

Mothers were mentioned as the main person responsible for monitoring the care of children and adolescents, indicating that this figure has a relevant role in the monitoring of the psychotherapy. The mother seems to be responsible for monitoring the child and adolescent in therapy, with this finding being in agreement with other studies (Cunha & Benetti, 2009; Melo & Perfeito, 2006; Schoen-Ferreira et al., 2002). Regarding the mean age found, this converges with other studies that identified the age range of 7 and 9 years (Merg, 2008; Cunha & Benetti, 2009), which can be

explained due to school entry (Cunha & Benetti, 2009; Santos, 2006), requiring a process of adaptation to a new environment and the need for different behavior than that performed at home.

In the child and adult care, family and friends were those who were referred to first when indicating psychological care, and health professionals indicated adults, couples and families more for psychotherapy. This suggests a shift in influence, which initially appears to be from family and close people at the beginning of the development process, to practitioners, suggesting that adults, couples, and families may have other problems as the trigger for seeking care (Maravieski & Serralta, 2011; Simões et al., 2013; Souza et al., 2014). The majority of the children and adolescents sought care through referrals from friends and relatives, followed by referrals from the school and health professionals, which have been (not always in this order) the main referral sources in other school clinics surveyed (Cunha & Benetti, 2009; Melo & Perfeito, 2006; Merg, 2008; Vivian et al., 2013).

The child and adolescent consultations indicated behavior problems, difficulties associated with family relationships and abuse, violence and/or neglect as the main reason for the consultations, while the adults reported complaints associated with interpersonal and family relationships (also couples and families), followed by anxiety and stress symptoms and mood symptoms. There seems to be a shift from the initial complaint throughout the development of the family life cycle, from behavioral issues affecting family and school to family and interpersonal conflicts, to anxiety and mood symptoms. Boys entering school are referred with more frequent complaints of aggressive behavior, affective symptoms, attention problems, learning and relationship difficulties (Cunha & Benetti, 2009; Melo & Perfeito, 2006; Merg, 2008, Sei et al., 2019), with this being influenced by cultural changes (Boaz, Nunes, & Hirakata, 2012). The predominant reasons for adult patients seeking treatment were interpersonal relationships (Peron et al., 2020), anxiety symptoms, and mood symptoms, and for couples and families difficulties in interpersonal and family relationships (Porto et al., 2014), although symptoms of depression and anxiety have also been found with higher prevalence (Maravieski & Serralta, 2011).

In childhood, attention problems and intellectual deficits were identified as the main DH, also predominating in adolescence, while for adults, multiple interpersonal situations and anxiety and affective conditions were the most frequent. The large number of medical records (n = 535, 80.2%) without this information should be highlighted, which suggests that during the psychotherapeutic process seeking the identification of a formal DH does not seem to be a priority in the care. However, the complaint may be related to difficulties in the family environment, not fulfilling the diagnostic criteria for a disorder (Melo & Perfeito, 2006), although the ICD has codes that allow the identification of clinical care (e.g., Z70). In the consultations of couples and families, as epistemologically it is not usual to work with a DH based on the ICD or DSM, this data does not appear, possibly because there is no specific coding system.

The most reported DH among the children was F90, Attention deficit hyperactivity disorder (5.93%), while for the adolescents it was F70 Intellectual disabilities and for the adults Z71 Persons encountering health services for other counseling (psychotherapy). There was a significant absence of this information in the adolescent and adult records. Attention deficit hyperactivity disorder (ADHD) is characterized by a combination of hyperactive behavior and inattention, indicating the presence of behavioral problems (World Health Organization, [WHO], 1993). Other studies have presented similar results (Vivian et al., 2013), and the most frequent complaint in children and adolescents is school difficulties (Porto et al., 2014), usually associated with ADHD clinical characteristics, although this may be underdiagnosed (Cunha & Benetti,

2009; Santos, 2006; Schoen-Ferreira et al., 2002; Vivian et al., 2013). For adults, there was a predominance of seeking psychotherapy, without having a DH recorded in the medical record. It is possible that this information is missing or that a formal assessment that presents a DH was not conducted or that the data was not recorded.

The cases of children were treated predominantly by students supervised by professors using the psychoanalysis framework, in adolescents and adults, the CBT framework predominated, and in family and couple consultations the systemic framework was mainly used. Psychoanalysis has been widely used in child consultations, followed by CBT (Cunha & Benetti, 2009; Vivian et al., 2013), possibly due to the great influence that this theory still has as development theory. As adolescence and adulthood progress, frameworks based on CBT predominate, and in the case of couples and families, the theoretical framework is systemic, when considering the specific type of care provided.

In this study, the high volume of missing information is highlighted. Most studies conducted in school clinics derives data from documentary research by consulting patient records (Honda & Yoshida, 2012). However, many medical records do not present important information for sample characterization and/or understanding of the case (Figueiredo-Campos et al., 2022) Incomplete records make it difficult or even impossible to conduct research or even monitor the progress of the care, which are necessary to give a report of activities performed in the clinic to supervisors, academics, patients and the institution (Campezatto & Nunes, 2007; Herzberg, 2007). The detailed monitoring of activities during supervision contributes to the exercise of good practices to be performed in the labor market in the future (Maravieski & Serralta, 2011).

Final considerations

Most of the school clinic consultations were for adult patients, with the majority of them women (in the child consultations boys predominated), with the predominance of the evaluation as the initial assessment of the requirement. The highest mean number of sessions occurred in the child consultations, with there being a higher mean number of adult absences, and predominance of dismissal from the clinic as the end of the therapeutic process (abandonment predominated for the adults). In child and adolescent care, the mother was reported as the main person responsible for monitoring the care, with family and health professionals being the main sources of referral. For the children and adolescents the main complaint was behavioral problems, interpersonal and family difficulties, and abuse, violence and neglect, while for the adults anxiety symptoms were predominant, and family difficulties for couples and families. The predominant DH were attention difficulties and intellectual disabilities for the children and adolescents, with the lack of this information predominating for the adults. The child consultations were predominantly performed using psychoanalytic guidance, those of the adolescents and adults using CBT and the systemic approach for couples and families. The results found in this study are in agreement with the literature from other studies performed in school clinics, therefore, even considering the Brazilian diversity, it should be emphasized that there is some uniformity in the care provided in different regions.

The high number of medical records without complete information of the consultations performed was evidenced. Considering that the care is supervised, it should be taken into account that different theoretical frameworks may direct the investigation or emphasize some data and not others, and this may explain, at least in part, the absence of this information. However, other important information, regardless of the theoretical approach, was absent, which justifies the advisors' attention to what is present in the medical records. In this regard, the role of the supervisors in identifying absences and controlling the intern's registration performance is essential.

The limitations of the study highlighted are that when tabulating the data to categorize the reasons for seeking care, it was necessary to evaluate them so that a grouping was possible. Possible misinterpretations in the medical record may have occurred, although every effort was made to group the data into the proposed classes as accurately as possible. Similarly, in the care of couples and families, the participants' gender and age were not coded, as it was a very varied number for each consultation, especially in the family care. Future research may take these limitations into account to make the data more complete and accurate, and to allow further analysis.

The importance of studies that deal with the space of teaching clinics is also highlighted. Even with many Psychology courses in the country, there was a lack of studies on this topic. New studies could investigate, for example, the training profile and performance of the supervisors of school clinics, as well as their practice, as this factor may be associated with the clientele attended in the clinic, and consequently affect the amount of care provided in the different modalities. There is a high demand for child consultations, however, in the case of this study, the largest volume of consultations occurred with adults, and this factor may partly explain this difference. It could also be interesting to compare the profile of the care provided in school clinics with other modalities offered, such as private care and the public service, in order to identify whether the clientele of school clinics have specific characteristics or are part of a wider set of services. Similarly, these comparisons will allow the identification of similarities or differences related to the question of treatment abandonment and other characteristics associated with the care.

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Dados sobre os autores:

- *Ana Cláudia Longo:* Graduada em Psicologia (Atitus Educação). Psicóloga clínica.

- *Maíra Fontana*: Especialista em Terapia Cognitivo Comportamental (Atitus Educação). Psicóloga clínica.

- *Michele Minozzo Sathes*: Mestre em Psicologia (Atitus Educação), Docente do Curso de Psicologia da Faculdade Anhanguera (Passo Fundo, RS, Brasil).

- *Cristina Pilla Della Méa:* Mestre em Envelhecimento Humano. Docente do Curso de Psicologia da Atitus Educação.

- *Vinícius Renato Thomé Ferreira:* Doutor em Psicologia (PUC-RS). Docente da Graduação e Mestrado em Psicologia da Atitus Educação.

- *Cláudia Mara Bosetto Cenci*: Doutora em Psicologia (PUC-RS). Docente da Graduação e Mestrado em Psicologia da Atitus Educação.