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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

PLACEMENT RECOMMENDATIONS FOR CLIENTS OF A CHILDREN'S PSYCHIATRIC CLINIC: A STUDY OF TWENTY CASES AT THE CHILDREN'S PSYCHIATRIC CLINIC OF THE MASSACHUSETTS MEMORIAL HOSPITALS

(January 1, 1949-December 31, 1953)

A thesis

Submitted by

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(B.A., Dalhousie University, 1943)

In Partial Fulfillment of Requirements for

the Degree of Master of Science in Social Service

1955

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CHAPTER I

INTRODUCTION

This study was made in the Massachusetts Memorial Hospitals, Boston, of twenty children who were treated in the Children's Psychiatric Clinic at some time between January first 1949 and December thirty-first 1953. This group of twenty were children for whom treatment could no longer be considered useful or possible, while the children continued to live in their own homes. Since additional treatment was considered essential for all of the children, recommendations were made by the clinic that they be placed away from their homes for an extended period of time.

This group is of interest since the recommendations for the children seemed to be at variance with the primary aim of the Children's Psychiatric clinic, namely, through work with environmental and psychic problems of children and parents, to attain healthier, happier, adjustments for family members within the family unit. From a child placement agency's point of view it is of interest to compare this group of children with those considered capable of using placement profitably.

Purpose of the Study

The writer undertook to answer the following questions:

1. What were the factors which made placement preferable to continuing treatment in the home?

2. What types of placement outside their own homes were recommended for these children?

3. What was the reasoning behind the choice of the particular type of placement recommended?

The writer was also interested in determining whether the desired resources needed for these children were available or lacking in the community.

Selection of the Sample

This study includes all children seen either in treatment or for evaluative study, for a five year period from January 1, 1949 to December 31, 1953, whose treatment could not be continued while the children remained at home. This five year period was chosen for several reasons. First, the children's Psychiatric Clinic was not established until September 1948, and the writer considered that the first four months would be a period of organization of policies and procedures. Secondly, this clinic was dissolved in September 1954 as a part of the Massachusetts Memorial Hospitals and was reorganized under the auspices of the Boston City Hospital. Thirdly, a minimum period of five years seemed indicated in order to give as broad a scope as possible since this group of twenty children was small compared to the total number of children seen in the clinic. Only cases

closed by the end of the five year period were considered. This was necessary in order to include the treatment recommendations and the help given by the clinic with future planning for the children and families. Of the twenty children, fourteen were recommended for institutional placements and six for foster home placements. This study does not include children who were recommended, for therapeutic reasons, for temporary placement away from their homes, such as summer camps or day schools.

Source of Data

The data have been taken in the main, from the social service and the psychiatric records of the children. A large proportion of the social service records used were recorded in summary form. Those few children who were seen by students of psychiatric social work had records written in process style recording. Where recorded information was lacking, it was possible to gain additional data from the children's psychiatric social worker, who knew each child in the study. She also gave aid in selecting the sample which was obtained from a study of the intake book of the Children's Psychiatric Clinic during the period from January 1, 1949 to December 31, 1953.

Method of Procedure

Once the sample was selected a schedule (see copy in appendix) was drawn up and filled out, in order to obtain,

and have in ordered form, descriptive information about the children in the study. This information was obtained from the children's social service records and the doctor's charts of the Children's Psychiatric Clinic. The twenty cases were abstracted in detail in order to obtain a diagnostic picture of the children and their families, the treatment planning, the reasons for the failure of the treatment and the recommendations for the future.

After the introduction, Chapter II gives a description of the Children's Psychiatric Clinic, including a general picture of the treatment aims of the clinic. Chapter III includes a discussion of the present day philosophy of child placement, with a description of the types of placement which are in general use. Chapter IV gives a description of the general characteristics of the children and parents in the study. Chapter V includes a detailed analysis of the cases referred for placement to foster homes and to institutions. Five cases are used for illustrative purposes. Chapter VI presents the summary and conclusions.

Limitations of the Study

Since this is a study of only twenty cases the conclusions which can be drawn are limited. Although the sample is an exhaustive one including all cases referred for placement in the five year period it is small compared to the total number of children treated in the clinic.

As already stated most of the information was obtained from the social service and psychiatric records on the families. The psychiatric records, although useful for treatment purposes, did not lend themselves to a study of this type since the recording consisted of detailed descriptions of interviews with no clarification of treatment progress or planning. The social service records were often in brief summary form with few details on actual case work methods used. They did include treatment planning, however. It was not possible to gain follow-up information on how effective the treatment recommendations were when carried out.

This study is descriptive in nature as there was no opportunity for control groups or experimental design. The study of a group of children who were not referred for placement, but whose problems compared to those exhibited by this group, might have been an interesting addition to the study.

CHAPTER II

DESCRIPTION OF THE CLINIC

The Children's Psychiatric Clinic of the Massachusetts Memorial Hospitals was one of the three subdivisions of the Psychosomatic Clinic, the psychiatric clinic of the hospital.

This psychosomatic clinic, situated in the out patient department of the hospital, was established in 1946 to evaluate and treat adults with personality problems of psychoneurotic and psychosomatic types. Its scope was gradually broadened and in 1947 a Seizure Clinic was added to treat patients suffering from epilepsy. The third division, the Children's Psychiatric Clinic, was established in 1948. It was founded primarily for the purpose of evaluating and treating emotional problems in children, and somatic symptoms that might develop on a basis of emotional disturbances. For administrative reasons the Children's Psychiatric Clinic was dissolved in September 1954. It was reorganized immediately as a part of the Boston City Hospital. Patients and staff transferred to that hospital. The cases in this study, however, were active while the clinic was part of the Massachusetts Memorial Hospitals, Psychosomatic Clinic.

Each of these three subdivisions of the Psychosomatic Clinic was directed by a staff physician. Students of medi-

cine, psychology, and social work drew caseloads from all three sources.

Functioning in the Children's Psychiatric Clinic, henceforth known as the clinic, was characterized by the usual child guidance teamwork approach. The basic professional staff comprised a psychiatrist, psychologist and psychiatric social worker. At the time of this study there was a director and an assistant director, both psychiatrists, a part-time psychologist, psychiatric social worker, and a full-time resident doctor in training. At least two other residents gave half of their time to work in the clinic, and a number of other resident psychiatrists and physicians, plus some of the older psychiatrists and physicians especially interested in child psychiatry, also carried cases. In cases accepted for treatment, it was regular practice for the children to be seen by the psychiatrist, and the parents to be seen by the psychiatric social worker. In certain instances children were treated by the psychiatric social worker under supervision from the psychiatrist. Psychiatrists occasionally treated parents if it was considered necessary as part of the whole treatment plan, or useful for training purposes for the psychiatric residents. Routine psychological examinations were not carried out as part of intake procedure, as is done in many clinics, but a large proportion of children were seen by the psychologist on psychiatric recommendation.

The intake policy of the clinic included children up to eighteen years of age. Only those children were accepted for treatment who showed neurotic and psychosomatic symptoms of recent origin, having developed them within a year prior to application to the clinic. Generally children showing symptoms of psychosis were not accepted for treatment in this clinic. However, a certain number were taken on for treatment, for training purposes for the psychiatric residents. Children referred by the staff of the hospital were always accepted for evaluation, and some of these continued in treatment. Additional referrals came from other hospital clinics, private physicians and psychiatrists, community agencies or through private individuals. As part of the intake policy the clinic did not limit itself to any particular geographic area in accepting referrals. The purpose of the intake policy was twofold:

1. To insure rapid psychiatric care for those children whose symptoms, if they were obliged to wait the usual six to nine months period might become much more fixed and difficult to modify;

2. To procure good teaching cases for the residents and medical students.[1]

The treatment aims in this clinic resembled, in the main, the treatment aims of most child guidance clinics in this

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1. Dr. Eleanor Pavenstedt, Letter to Dr. A. Z. Barhash, American Association of Psychiatric Clinics for Children, 1950, unpubl.

country. The problems of the children were the central focus of the clinic's work, which, as previously stated, was generally the area of the psychiatrist. It was believed, however, that effective treatment of children could not be carried out unless accompanied by effective work with parents. This belief stemmed from the knowledge that the usual setting for the behavior problems and anxieties of children was the precariously balanced, rejecting or neurotically functioning family. Thus parental cooperation was essential.

> One might say that the minimum for therapy would be parent's readiness to let the child take help; in still more favorable situations parents should have a readiness to take and use help for themselves, and for therapeutic result, they should become able to see the interconnection between the child's problems and their own behavior and needs and how, in turn, their needs are related to their own early life frustrations, hostilities and anxieties.[2]

In addition to this work with the child and his parental figures, in order to study the whole child in his family unit, it was necessary to include a study of his sibling relationships, as well as his school and community relationships. Often environmental modifications and manipulations were carried out such as referrals to other community agencies or school changes, always with the aim of cementing familial ties and maintaining healthy, workable balances in the families.

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2. Gordon Hamilton, Psychotherapy and Child Guidance, p. 289.

The techniques used in attempting to carry out these treatment aims will not be discussed in detail. Methods vary with each child and family because of differences in personalities of treating personnel, as well as differences in those being helped. For all families accepted by the clinic intensive efforts were given to study, diagnosis and treatment plans according to accepted child guidance standards. Treatment generally was carried out on a weekly interview basis, young children were seen in the playroom while adults and adolescents were seen in the interviewing rooms. Home and community visits were also made when considered therapeutically necessary.

Generally the clinic served about 100 children a year either in treatment or for evaluation. The average length of treatment was approximately 18 months.

As is true of all Child Guidance Clinics, there was a proportion of cases in this clinic for whom treatment was not a constructive experience, for a variety of reasons. Some families terminated treatment of their own accord. For others termination was suggested by the clinic. For a certain group the treatment goal was to help parents relinquish their children to placement away from them. It is this group of twenty cases which is the focus of this study.

CHAPTER III

PRESENT DAY PHILOSOPHY OF PLACEMENT

A tremendous amount has been learned in the past twenty years about the importance of a happy home life and good family relationships in the normal development of children. Much has also been learned about the devastating effects upon children of separation from their parents, or other persons to whom they have become attached.

> For the infant, the possible physical consequences of the resulting emotional disturbance engendered by separation may in extreme instances even threaten his existence. For the older child, separation from affectional ties nearly always holds an element of blame for himself, of badness and punishment therefor, as well as an element of desertion and failure on the part of the persons from whom he is being separated.[1]

Since the beginning of World War II many studies have been made in order to learn the effects on children of separation from their parents. One such study, Infants without Families, was carried out by Anna Freud and Dorothy Burlingham. They observed children who had been removed from their families for safety purposes, and placed in the country districts, because their families lived in the cities of England which were targets of enemy bombing. The study found that

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1. Emily Mitchel Wires, "Placement for Adoption A Total Separation," Journal of Social Casework, 30:283, July 1949.

even under traumatic external circumstances a child was generally better adjusted, happier, and healthier, if kept with his parents. Those sent away to places of safety were often seriously damaged emotionally.

The prevalent idea of two decades ago, traces of which have lasted to the present day, was to save a child from a poor environment and to give him a new set of values. This plan many times ended in failure because it is a child's own parents who, "for good or ill he values and with whom he is identified."[2] A child cannot face the fact that his parents do not love him because of the pain it causes him and because even the least adequate parent at some time will show love for his child.

It is difficult to realize that for so many years social case workers thought to be well fed, properly clothed, adequately housed and to have an opportunity for education, recreation and religion were all the requirements necessary for an adequate life. Consequently children were often moved from parental homes because the social workers deemed them unfit by their own personal standards or by existing community standards. As one of these children described this period, "The social workers are the bats and I am just the ball they sock from one place to another."[3]

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2. John Bowlby, Maternal Care and Mental Health, p. 69.

3. Leontine Young, "Placement from a Child's Viewpoint," Journal of Social Casework, 31:250, June 1950.

The theory evolved from practice in the child welfare field makes very clear that depriving a child of the right to his own home creates in him a deep insecurity as to his chances of survival and engenders in him anxiety, hostility and resentment. Because of these traumatic effects, good case work aims toward prevention of this separation. This aim is also common to other helping professions such as psychiatry, medicine and law. In any work with children and their families placement is never the first choice as an objective. "The parents whether a hindrance or an asset, continue to keep the primary responsibility for the bringing up of the children and a social agency has no choice but to treat the parents in some fashion."[4]

When, either because of absence of parents or when every effort to foster workable relationships between children and parents have failed, it is sometimes necessary to plan placement of children away from their families. Elaborate methods of preparation for the event from the children's and parents' viewpoints have been evolved, so as to minimize as much as is humanly possible the traumatic effects on the children's personalities. Intensive studies are made of children and families to determine the best type of placements to meet individual needs.

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4. Gordon Hamilton, Psychotherapy and Child Guidance, p. 281.

Many variations of placement are in use to attempt to meet these needs. Looking back in history to the last part of the nineteenth century and early twentieth century the first attempts were the large almshouses or orphanages giving custodial care. Later around the third decade of the twentieth century came an extreme swing of the pendulum to the use of the foster home as a substitute for a child's own home. During this period advocates of foster home care had strong criticisms of institutions for children, many of them valid. These institutional children often resembled coins from a mint and had little strength or understanding to live in the outside world. However, it was learned with much difficulty that all children could not use foster homes as substitutes when their own homes were not available to them. Especially those children who were strongly tied to their own parents could not tolerate substitutes, no matter how good. Nor could children live happily in foster homes who were so disturbed or handicapped that they could not fit into normal community living.

Today agencies have at their disposal many modifications of these two earlier types of care. There are still foster homes in use ranging in types where children are kept free of charge to those where either the parents or agency pays board or the child himself works and pays his own board. In the institutional field there are many variations of the old orphanages. There are still large congregate institu-

tions where more or less mass care is administered, but the trend is towards smaller group settings where more intensive study and treatment can be carried out. Group foster homes are often used for adolescents. Mentally retarded children, those with severe physical handicaps or severe emotional disturbances use the small treatment institutions effectively. Boarding school placements are frequently used as a more temporary measure, when strengths still exist in families.

For any type of placement the child is given an active part in planning the separation from his family and his parents are given help in accepting the idea of placement, and in dealing with their own guilt and anxieties. Because child placement social workers know that no home is better than a child's own home unless he is prepared to use it, intensive and exhaustive efforts are invested in helping parents understand what placement means to them and to their children. They often come to an agency hoping placement will be a solution to their problems. They must know what they will give up through placement, i.e., that they cannot see their children's day-to-day care, have no control over activities, friendships or affectional ties formed by their children. They must be helped to face how they will feel having their children cared for by other people, and that they will advertise their failure to the world as parents because they have given up their children. They must know that on one hand their children will feel angry toward them

and on the other feel that they themselves are unworthy of love. They also must be aware of how their children will react to separation, and the difficulties a change of home environment will bring for them. Usually their children will deny the reality of placement or the necessity of it, but it is their task to help them accept it.

Once separation has been effected, in good practice, it is remembered always that the parents, though absent, are an integral part of the child's life, and as such, must be considered. Constantly the family situations are reevaluated, and efforts made to reestablish the family as a unit.

The appropriate placement for each child must be decided on a skilled casework basis according to the needs of the individual child. Some of the factors which must be taken into consideration are the nature of the child's relationship to his own family, the strength and permanence of emotional ties which bind him to them, as well as age, physical and mental condition, temperament and habits.

It is generally believed that children in preschool years should not be placed in an institution. Foster home placement is a constructive alternative to the child's own home for most children capable of forming new relationships. There is an obvious need of a foster home placement where there is illness of the mother, death of the parents or alcoholism or feeblemindness of parents. Certain children can never adjust to foster home care, however. The most

outstanding examples include:

1. The child, who, because of illness or accident involving the parents, must be temporarily out of his home, but who has such an emotional tie with his parents, that it is difficult for him to accept foster parents. This child responds better in the impersonal atmosphere of an institution.
2. The adolescent who is going through a period of breaking away from his own home and finds a foster home so repressive he cannot take root in it; or because he is disappointed in adults whom he loves, dares not relate to other adults. Because of this he sets out to prove that the foster home is bad and the foster parents intolerable.
3. The child with behavior problems that are not understood and with which the average foster parent cannot cope. For this child the institution may be used as a study home. An institution thus used must be equipped to give skilled services and relate these to the day by day life of the child.
4. The children in need of convalescent care in cases where they can profit from group life. For these children institutional care must combine the advantages of group life with individualization. Many parents feel their own status less threatened by institutions, because they believe that the change of environment is the important factor, and thus the need for placement is not their fault.[5]

Neither a foster home nor an institution should be regarded as the only type of care for a particular child. Changes in a child's needs or situation may necessitate interchangeable use of both forms, or as stated previously, reestablishment in his own family.

The reasons children need placement away from their own homes are many and varied. In general, there are two main categories:

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5. Hazel Frederickson, The Child and his Welfare, p. 153.

1. Those children whose family groups have dissolved because of the disasters that attend human life, i.e., death, separation, divorce, serious parental illness, either physical or mental.
2. Children who are placed for therapeutic measures. These include the child whose behavior has reached a point, "where it serves as such a constant irritant to the parents that they cannot change their attitudes to him; therapy may not be available, or may not be able to improve the parent's attitudes toward the child within a reasonable period of time. The community and the school may be bitterly antagnostic to the child, or contribute in other ways to his difficulties in development."[6]

In the light of this present day child placement philosophy, we look at the twenty children who were referred by the Children's Psychiatric Clinic for placement away from their own homes. The areas for study will be the homes from which the children came, the problems they presented, their treatment in the clinic, and the therapeutic reasons for the clinic recommendations.

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6. Gerald H. J. Pearson, M.D., Emotional Disorders of Children, p. 313.

CHAPTER IV

DESCRIPTION OF THE CHILDREN IN THE STUDY

From the two previous chapters we have seen that the guiding philosophy in both child guidance clinics and child placement agencies is toward maintaining and strengthening the family as a unit. This is accomplished, in general, by environmental modifications and by some form of psychological manipulation. It has been stated that

> the most basic treatment of the child lies in the gratification of his real needs - subsistance, family life, health, work, education, play and group associations. Subsistance needs must be met by the production of income; other needs by appropriate fulfillment. Affectional needs are met through real relationships. There is no substitute for income, housing, food and shelter, and there is no therapeutic substitute for family relationships.[1]

In the Children's Psychiatric Clinic there were a number of children and families who could not be helped toward even minimum standards or goals established with and for them. An alternative plan had to be recommended by the clinic. In a few instances this alternative was not accepted and carried through, as any growth or change was too painful to attempt.

Of the children and families treated in this clinic from January 1, 1949 to December 31, 1953, there were twenty for

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1. Gordon Hamilton, Psychotherapy and Child Guidance, p. 4.

whom treatment was blocked and for whom the alternative plan recommended was placement of the children away from their own homes. Some general descriptive statistics are given to show these children in their family settings and the specific recommendations made by the clinic for their future planning. These recommendations included placement of the children either in foster homes or in institutional settings. The institutional placements recommended were of four types, namely boarding schools, training schools, specialized treatment institutions and schools for retarded children. Henceforth we refer to the two groups who made up the twenty children of the study as the institutional group and the foster home group.

Age and Sex of the Children

Six of the twenty children were suggested by the clinic for placement in foster homes, four were boys and two were girls. Of the fourteen recommended for institutional placement ten were girls and four were boys. Table I shows the age and sex of the children in these two groups.

The median age for the foster home group was seven while that of the institutional group was twelve. Chapter III of this study reveals the professional thinking that the adolescent group can use an institutional placement more profitably than they can use foster homes, while younger children capable of forming new relationships can often thrive better in

foster homes. Some of the planning in this clinic may have been influenced by this knowledge.

TABLE I.

AGE AND SEX OF THE CHILDREN RECOMMENDED FOR PLACEMENT

	FOSTER HOME GROUP			INSTITUTIONAL GROUP		
Age	Boys	Girls	Total	Boys	Girls	Total
Under 5 years	1	1	2	0	0	0
5 years, under 10	3	0	3	0	3	3
10 years, under 15	0	1	1	4	5	9
15 years, under 20	0	0	0	0	2	2
Total	4	2	6	4	10	14

Religion and Color

Ten of the group were of Protestant religious affiliation, four were Jewish and six were Roman Catholic. There was only one Negro child in the group. Table II shows the religious break-down of the foster home and institutional groups. The lack of Roman Catholic children in the foster home group was interesting. An explanation of this could be the larger number of Roman Catholic institutional facilities which are available in this city.

TABLE II.

RELIGIOUS AFFILIATION OF THE CHILDREN

Religion	Foster Home Group	Institutional Group	Total
Protestant	4	6	10
Jewish	2	2	4
Roman Catholic	0	6	6
Total	6	14	20

Ordinal Position of the Children in the Study

In the foster home group two of the six children were brothers and were placed together. They had a younger brother, not seen in the clinic, who was also placed. Two of this group were only children. One child was the third child of a family of four. He and his younger brother were placed. Their older siblings were employed and away from the home. The last child of this group was the only boy in a family of five children. His own mother was dead, and he was the object of his stepmother's projection of her hatred of males. In general it might be said that the families of the children recommended for foster home placement fairly consistently ceased to be close family units with the placement of these children. The institutional group shows less

of a family collapse with placement.

Four of the institutional group were the oldest children in their families. Five were the youngest and three were middle children. The sizes of these families ranged from two to eight children, the majority being made up of three or more children. In each of these cases the siblings were either older and had left home for work or marriage, or they remained with the parents. Two of this group were only children.

Sources of Referral to the Children's Psychiatric Clinic

Sources of referral of the children to the clinic in relation to the final placement recommendations is seen in Table III.

TABLE III.

SOURCES OF REFERRAL TO THE CHILDREN'S PSYCHIATRIC CLINIC

	Numbers of Children		
By Whom Referred	Foster Home Group	Institutional Group	Total
Medical settings	4	11	15
Psychiatric clinics	1	1	2
Social agencies	1	1	2
Schools	—	1	1
Total	6	14	20

Fifteen of the children in this study were referred to the Children's Psychiatric Clinic from medical settings, such as other clinics, in the Massachusetts Memorial Hospitals, outside hospitals or medical clinics, or by private doctors. Of the two referred by other psychiatric clinics, one was over age for the referring clinic, and the other needed immediate care which the referring clinic could not give because of a long waiting list. Two children came from community agencies, one from a children's agency and one from a family agency.

Problems of Children as Stated at Referral to the Clinic

Most of the children had difficulties in more than one area when first referred to the clinic. School difficulties and inability to form good relationships usually accompanied many of the other complaints especially in the institutional group. As the children were studied more intensively during treatment the multiplicity of the problems of each one was even more evident. Table IV gives an indication of the problem areas seen on referral only, in relation to the type of placement planning later recommended by the clinic.

TABLE IV.

PROBLEMS OF CHILDREN AS STATED AT REFERRAL

Problems at Referral	Institutional Group	Foster Home Group	Total
Physical illness with no organic base	2	0	2
Physical illness	1	0	1
School and learning problem	10	1	11
Speech difficulties	1	2	3
Eating problems	2	2	4
Enuresis and soiling	2	4	6
Fire setting	2	1	3
Stealing	3	1	4
Masterbation	2	1	3
Overactivity	3	3	6
Excessive fears	3	1	4
Sex delinquency	3	0	3
Inability to form relationships	12	0	12
Incorrigibility	5	0	5
Atypical children	2	0	2
Total	53	16	69

Marital Status of the Parents

In studying the marital status of the homes of the twenty children five groupings have been used:

1. The children's natural parents living together in the home with the child.
2. Parents separated, i.e., parents living apart but no legal separation. The child lived with one parent.
3. Parents divorced and the child living with one or other parent.
4. Parents divorced and one parent remarried so that the children lived with a step-parent.
5. Children living in the home when one parent was dead.

TABLE V.

MARITAL STATUS OF PARENTS

Marital Status	Foster Home Group	Institutional Group	Total
Natural parents living together	2	6	8
Parents separated	0	2	2
Parents divorced	2	2	4
Parents divorced and remarried	1	4	5
One parent deceased	1	0	1
Total	6	14	20

In the eight cases where the natural parents of the children were living together, all except one showed constant marital friction and strife and often open aggression which the children witnessed. The marriages seemed based on very neurotic needs of the parents. In the cases where there were divorces and remarriages many marital problems also existed.

Economic Status of the Parents

In the twenty families studied two were completely dependent financially on assistance from outside sources. Fifteen were self supporting but very frequently were not able to meet minimum needs and had to seek temporary outside assistance. Two families were able to meet minimum standards of living and one was in the professional group and had better than average economic standards.

Physical and Mental Health of the Parents

Physical illness in this instance refers to those parents whose physical condition prevented or incapacitated them from carrying out normal responsibilities. Included in the group are tuberculosis, heart disease, war wounds, asthma and arthritis. In the four cases of physical illness of one parent, it was the fathers who were ill and unable to work to support their families. Many emotional problems accompanied the physical illnesses. Two of the fathers were considered hypochrondriacal. In the family where the mother

and father were physically ill the father was unable to be employed but looked after the children's school and clinic attendance. The mother had severe diabetes and deafness. She was able to care for most family needs in the home but seldom went into the community.

Mental illness refers to those parents who at some time during the clinic contact were diagnosed as psychotic, psychopathic or psychoneurotic.

TABLE VI.

INCIDENCE OF MENTAL AND PHYSICAL ILLNESS

Illness	One Parent	Two Parents
Physical illness	4	1
Psychosis	5	1
Psychoneurosis	9	2
Psychopathic personality	1	—
Total	19	4

In the five families where one parent suffered from psychosis in each instance it was the mother. Three were hospitalized during the clinic contact and two although they were considered seriously ill were able to function in the community. In the family where both parents were psychotic, the father had been in the hospital for a period of time and

the mother was hospitalized just before placement of the child was recommended.

Diagnoses on several parents were unknown either because of death, divorce or refusal to cooperate in treatment. As can be seen, the incidence of emotional disturbances in the parents of these children was extremely high. A large percentage of parents in the psychoneurotic group were alcoholic.

Length of Clinic Contact

The average length of treatment in the clinic was about eighteen months. As can be seen in Table VII, several children in this group were seen for a much longer period. The three children who were seen for less than six months were among the group seen for evaluation purposes only.

TABLE VII.

LENGTH OF CLINIC CONTACT

Period	Foster Home Group	Institutional Group	Total
Under 6 months	0	3	3
6 months, under 1 year	2	4	6
1 year, under 2 years	3	4	7
2 years, under 3 years	1	3	4
Total	6	14	20

One was a child referred to the school for retarded children. It was felt she could not benefit from psychotherapy. One was anatypical child for whom placement in a treatment institution was considered an immediate necessity because her mother was psychotic and the third was a boy who needed custodial care in a training school. In several cases either parental contact or treatment of the children continued after placement.

CHAPTER V

BASIS OF RECOMMENDATION FOR FOSTER HOME AND INSTITUTIONAL PLACEMENT

The study of twenty children for whom the Children's Psychiatric Clinic recommended placement away from their own homes reveals that there were two general types of placement suggested, namely foster home care and institutional care. For six children, four boys and two girls, foster homes seemed the best plan to meet their needs. For the remaining fourteen, the decision was to recommend institutional care. Four types of institutions were suggested, boarding schools, training schools, small treatment institutions and in one case a school for retarded children. Table VIII shows the number and sex of the children referred to the four types of institutions.

TABLE VIII.

CHILDREN REFERRED TO INSTITUTIONS

Type of Institution	Boys	Girls	Total
Boarding School	2	2	4
Training School	1	3	4
Treatment Institution	1	4	5
School for Retarded Children		1	1
Total	4	10	14

The group referred for foster home placement was a younger age group and all of the children had the capacity to form close relationships. The boarding school group appeared to have the best prognosis of the institutional groups as the children were less emotionally disturbed, were highly intelligent and capable of using psychiatric help. The children referred to treatment institutions, training schools and the school for retarded children needed protected settings for an extended period of time as they were unable to live in the community with safety for themselves or others.

The case histories of one child from the foster home group and one from each of the four institutional groups are given in detail for illustrative purposes. At the end of each history a summary is given of the general characteristics of the group the child represents.

Foster Home Group

Mary was ten years old when she first came to the Children's Psychiatric Clinic. She had been referred by another psychiatric clinic in the community whose waiting list was very long. They felt her problems needed immediate attention. She had choked on a piece of meat one month prior to referral, and since then had refused to eat solid foods. She was on a diet of liquids and semi-solids which she could melt in her mouth before swallowing.

Mary was an only child. Her mother was 42 years old and her father aged 44. Until shortly after Mary's illness the paternal grandmother had lived in the home. Her relationship to Mary was a close one, but as she became more of an invalid she needed nursing home care. Mary's father was a draftsman by trade. Both he and Mary's mother spent a great deal of time in church work. They taught Sunday School, sang in the choir and lead group activities.

Mary's early developmental history was fairly normal. She was breast and bottle fed and presented no early feeding problems, except that she was a slow eater. Toilet training was slow and exasperating to the mother, but was completed at the age of three and a half. Mary walked at thirteen months, and was always a bright, interested, child with no strong aggressive or destructive trends. Sleeping habits were poor between the ages of two and five when Mary had many nightmares and fears of the dark. Her parents handled this by one or the other lying down with her until she fell asleep. They continued to do this until referral time.

Mary was always a physically delicate child. She had many colds and contracted most of the childhood diseases. She was subject to nasal congestion, and at such times was very afraid of choking and often refused to eat. At the age of six she was knocked down by a motorcycle and the same year her grandmother had a hospitalization. Mary was always a timid child, afraid of being hurt. She would not call adults by name. She cried easily and frequently.

A study of her environment showed that up until the referral year Mary had enjoyed school and had progressed well. She belonged to the Y.W.C.A., a girl scout group and a club in her school. She had a number of casual friends but only two close friends. She loved to entertain her peer group but was shy with adults. About the time of her choking episodes she had begun to do poorly in school, often refused to attend, saying that she had no friends and her teacher disliked her. Mary's mother was horrified at the thought of having school problems along with everything else.

A study of Mary's mother revealed her to be a very infantile, inadequate person. She had lost her own mother when she was two years of age and was brought up by a strict elderly aunt. She was separated from her five siblings. She did office work prior to her marriage but hated it, and suffered a nervous breakdown during that time. She pictured herself as fearful, frail and shy, and seemed unable to see herself as an independent person able to function on her own. She echoed others' attitudes and ideas, and was very much dominated in marriage by her husband's mother. Mary's father appeared to be a more adequate person, but he was also very shy and retiring. He left the care of Mary entirely to his wife. He was, however, much more optimistic about the outcome of his daughter's treatment.

Mary was seen twice weekly in the clinic by a psychiatrist for a nine month period. Her mother was seen at the same time by a psychiatric social worker. Work with the mother showed her to be consumed with guilt and anxiety about

her own involvement in Mary's problems. She identified herself so closely that she could not seem to see herself and her daughter as two distinct people. One of the treatment aims was to help her separate herself as a person from Mary. She was able to give few details on her life prior to marriage. She said she could not remember. Her attitude towards Mary was one of annoyance, exasperation, and concern lest Mary grow up to be a fearful woman, unable to face life. She needed constant reassurance that Mary could be cured. She was encouraged to express her own fears, anxieties and guilt feelings in order to alleviate them so that she could function more constructively and positively. She was also encouraged to take part in activities outside her home.

Mary's symptoms improved remarkably under treatment. It was found that she had the capacity to form close relationships although she needed a great deal of individual attention and affection. Her eating problems cleared up, in that she could eat all foods. She continued to be a very slow eater, however. As she became more aggressive and less fearful in her behavior, began to eat normally and showed an interest in outside activities even in a summer camp plan, her mother began to show additional symptoms of illness. She became extremely nervous, suffered sleeplessness and was terribly concerned over her own and Mary's recovery. Finally she became so ill that hospitalization was necessary. She was treated with electric shock therapy and psychotherapy with very poor results. During this period Mary lived with various friends in the neighborhood. The clinic helped her with her confusion and anxiety caused by the loss of her parent. Eventually a more permanent foster home plan was made with the family when it became evident that the mother would not be able to care for Mary for a long period of time. Mary made an excellent adjustment to the foster home.

The group referred for foster home placement was small. There were four boys and two girls. The median age of the group of seven years was younger than the group referred for institutional care, for whom the median age was twelve years. Two of the children were under five years of age, three were between five and ten years and one child, Mary, was ten. All were in the age group where love and care on a very individualized basis were necessary.

The problems this group exhibited included feeding problems, enuresis and soiling, sleeping difficulties, overactivity, excessive fears and emotional immaturity for chronological age. The clinic felt that these problems could be handled by warm, sympathetic, understanding foster parents. One child in the group had symptoms of a slightly more severe nature, namely, stealing, fire setting and school refusal along with masturbation, nose boring, enuresis and soiling. However, he had been placed previously in a foster home with success, and his symptoms only developed when he was removed from the foster home by his father and step mother. His request was for a foster home. Generally then, the children in this group had the ability to form close relationships on an individual basis.

A study of the parents of this group revealed a poor prognosis for the reestablishing of family units. Two boys who were placed together in a foster home had parents who were divorced. Their mother was psychotic and hospitalized and nothing was known of their father. One boy was an illegitimate child whose step father was alcoholic and disinterested in his stepson. When his mother died of tuberculosis the maternal grandmother attempted his care, but was old and ill herself. The boy who showed the most severe behavior problems wished for foster home placement. Much work was done to help his parents accept this plan for him, since it was not possible to modify their attitudes toward him.

Mary's family has already been discussed. The other girl in the group was the daughter of a paranoid mother and a feebleminded, hypochondriacal father. The mother was hospitalized through the clinic and the father was helped to seek foster home placement for his two daughters.

We can sum up the reasons for the clinic's recommendations for foster home placement as follows:

1. The ability of the children in the group to form, and a need on their part for, close meaningful relationships.
2. Symptoms and problems displayed by the children of a nature which could be handled without too much threat or discomfort for foster parents.
3. Severe illness or death of one parent, but the other parent having the ability to accept and cooperate with foster home placement.

In general help and guidance would be needed for each of these family groups for an extended period of time. In each case the children's agencies accepting the referrals took over the care of the family planning. With the exception of Mary, treatment for the children and families in this clinic was discontinued, since it was felt the children's problems would clear up with the change in their environment.

Boarding School Group

John was fourteen years old at the time of referral to the Children's Psychiatric Clinic. He had been referred from a child guidance clinic, where his brother was a patient. John had been truanting from school. Diagnostic interviews showed him to be a very personable, essentially well organized and highly intelligent boy. His school problem seemed to center around an undeveloped capacity for self expression and competition. He was preoccupied with control of aggression and the constant pressure of his difficult family situation.

John's mother came from a solid, stable family from the midwest. When her mother died she was in her adolescence and she followed an older married sister to Boston. She became involved in some delinquent behavior and lived in a series of boarding and training schools. At eighteen she married a man in his middle age, John's father. When he died of pneumonia, John's aunt, who was childless, wished to take John into her home. His mother married again quickly to keep a home for the child, but there was much discord and unhappiness in this marriage which finally ended in divorce. There was one child of this marriage, John's half brother, an atypical child. The mother became alcoholic at this time and John was placed in a boarding school for a period of two years. Two years prior to referral the mother married for the third time, and attempted to reestablish herself and her home. This third husband had been brought up by a controlling grandmother. He had a rigidly organized personality with many limitations. He accepted the younger boy, but found it difficult to establish a relationship with John. John's mother was hospitalized for several short periods for alcoholism without too much success.

The treatment goals in the clinic for John were to help him with his concern and confusion about his mother and his succession of unaccepting fathers, and to help him organize himself in terms of his own future. At first the psychiatrist tried to foster good relationships between John and his step father, but the step father was unable to accept a father role with the boy. The psychiatrist became the ideal father figure and treatment continued on this level. John's school performance improved but social adjustment with his peers was still poor. As he tended to project all his adolescent conflicts on his parents, the psychiatrist felt he needed a neutral environment where he could solve his problems of growth, and find constructive encouragement to develop his excellent personal and intellectual potentialities. A boarding school plan was acceptable to John and arrangements were made for therapy with the psychiatrist to continue.

John's mother was seen in treatment by a psychiatrist in the clinic and also by a psychiatric social worker. The psychiatrist's goal with her was to attempt to stem the tide of her masochistic acting out, through an accepting understanding male relationship, so that she could better organize herself for her family.

The social work contacts with this family consisted mostly of assessing John's community and school environment and in making practical arrangements in connection with placement.

John was one of the group of four children recommended for institutional care who were referred to boarding schools. There were two boys and two girls in the group. The girls were thirteen and fourteen years of age and both boys were fourteen at the time of their referral to the clinic. All of the children were treated in the clinic for periods of from one to two years before placement was planned. They all responded well to treatment. They were children with high intelligence quotients, but all were having school difficulties, such as school failures, truanting episodes and poor relationships with their peer groups. Three of the children had severe psychosomatic symptoms such as prolonged virus infections, temporary loss of speech, fainting spells, headaches and nervous tics. Symptoms in all cases appeared to stem from unstable home situations, which were hampering normal emotional growth and adding greatly to the usual conflicts of the adolescent period.

None of the four children lived in the same home with two natural parents. In one case the mother and father were separated but not divorced. In another the step father had

just deserted, and in the other two families the step fathers were living in the homes with the mother and children.

One of the group was an only child, but in this home were younger siblings of his mother, who were a source of rivalry and jealousy. One boy, John, had an atypical brother who was under psychiatric care. The third child of the group had an older sister who was married and out of the home and the fourth had three younger female siblings.

None of the parents of the children in this group had been diagnosed as psychotic, but several were considered psychoneurotic, and in each family there was one alcoholic parent or step parent. However, in all cases the mothers, at least, were cooperative in having their children treated, and were considered able to take and use help for themselves. Two of the mothers were seen in psychiatric treatment in the clinic, in addition to receiving social casework help. All were helped to see the effect their own difficulties had on their children. They were able to accept the idea of boarding school placement as a positive part of the treatment plan. In each case the clinic either continued to give help to the parents after the children were placed or referrals were made to family service agencies in the community.

Prior to placement in the boarding schools, every effort was made to work out solutions to the children's difficulties while the children remained in their own homes. Community resources were utilized and there was close cooperation with

the schools the children attended. However, even with very comprehensive work in many areas it was finally felt that these children could not work through their adolescent conflicts while attempting to cope with the exaggerated strains and pressures in their homes. The common elements seen in this group were:

1. The children were of good intelligence and capable of using psychiatric help profitably.
2. Because of the conflicts and complications in the homes, neutral settings seemed more conducive toward healthy solutions to the children's problems. Remaining in the home would probably have led to delinquent behavior patterns.
3. Many positive elements existed in the parent child relationships, and parents cooperated well in the treatment plans. The children continued to have a home base for holidays and future planning.
4. Treatment continued for parents and children during placement.

Treatment Institution Group

Dora, aged eight, was referred to the clinic by another Children's Psychiatric Clinic who had been treating her for three years. She was diagnosed as an atypical child. She was too old for the referring clinic setting and they felt she needed therapy with a male therapist, as she had had little association with a father person. She was seen in this clinic for a two year period.

Dora's mother and father were divorced. She lived with her mother and her maternal grandmother. She was an only child. Her mother was also an only child who had been very attached to her father before his death when she was thirteen. She married a very unstable Air Force pilot and was divorced from him when Dora was six. Dor'a mother was a very lonely person unable to form close relationships and very ambivalent about Dora. She often resorted to violent punishment of the child and had many hostile phantasies about her, but felt the need to keep her close because of her own loneliness. She was in great conflict over her relationship to the maternal grandmother. She resented her dependence on her, but became enraged when the maternal grandmother stayed out of the home for any length of time. Both maternal grandparents had been alcoholic. Dora's mother was often depressed and resorted frequently to alcohol herself, to help forget her difficulties. She had trouble differentiating herself from her environment, and could not single out who were important figures to her. She seemed to have suffered very early deprivation, and the losses she experienced in life appeared to be narcissistic losses rather than losses of true object relationships. She considered herself quite worthless and expressed a good deal of guilt over her neglect of Dora.

Dora was a sickly baby during her early months. She gained weight slowly and suffered from colic and diarrhea. Weaning and toilet training were accomplished early and carried out rigidly. Her parents moved several times during her infancy and shen she was nearly two her mother had a psychotic breakdown. She was not hospitalized but grossly neglected Dora. At the age of five Dora was brought to a child guidance clinic because she was having severe temper tantrums, was soiling and smearing, was inverting her pronouns in speech and was showing other evidences of atypical development. Dora's father was active in making this referral but soon lost interest. There were periods during early contact when the mother was often depressed and unable to come to clinic or give Dora adequate care. Throughout clinic contact, which was on a twice weekly basis for two years, Dora presented problems to her mother because of her hyperactive and aggressive behavior which involved her in numerous difficulties in the community, and prevented her from learning at school. She made many emotional demands on her mother which the mother could not meet.

During Dora's treatment with the psychiatrist, her mother was seen by the psychiatric social worker. She was given help with the losses she had experienced and with her relationship to the maternal grandmother and to her friends

in the community. She used her interviews also to unburden herself about the tremendous responsibility and drain she felt in raising Dora alone. It was clear in the contact with Dora that any setback suffered by the mother, or any inability on her part to give to the child, reflected itself immediately in Dora, so that strong support had to be given to the mother.

In the last year of contact Dora became bigger and stronger and could no longer be handled by the mother who had to resort to physical force for the most part in disciplining the child. Because of community complaints to police and city officials, requests from the mother and because of unmet emotional needs in the child's life, it was decided to place her in a treatment institution. Much effort was expended in finding the right type of placement and funds to help meet the costs. Once Dora was settled in placement the clinic contact with the family ended. For future help and planning transfer was made back to the clinic who had referred the child to this clinic.

The group of children recommended for placement in treatment institutions was made up of four girls and one boy. The girl's ages were five, seven, eight and fifteen at referral. The boy was thirteen. All were seriously disturbed children. Two were diagnosed as atypical children, two were primary behavior disorders and one, the oldest, exhibited a wide range of emotional disorders, including bizarre thoughts and stories, enuresis, excessive fears, eating and sleeping difficulties and poor school adjustment. Two of the children, the adolescent girl and one atypical girl were seen for evaluation and placement planning only. The others were each seen for over two years. Three were referred from medical settings, one from a child guidance clinic, and one from a public school principal.

The home situations in all of this group were very disturbed. Two sets of parents were divorced and two were separated. In one case there was a step parent in the home. The one boy lived with his natural parents but the marriage was a very neurotic one with much open aggression which the boy witnessed. One mother was an alcoholic, two had been diagnosed psychotic, one of these was later hospitalized, and one mother was out of the picture completely.

Parental help and cooperation in treatment was consequently difficult to obtain or to use constructively. Intensive casework help was given to two mothers with poor results. After placement two were referred to other sources for psychiatric help and one to a family service agency. The one father seen, refused to cooperate in any way with the clinic. He was physically very ill, having suffered a severe head injury, and in personality was rigid and cold. The parents of the one boy in this group terminated treatment and did not carry through placement as far as was known.

The points of similarity in this group were:

1. Children with severe emotional disorders, requiring very intensive psychotherapy and a protected environment.
2. Little or no strength in the home to cope with the children's problems or cooperate in treatment.
3. Community resources unable to be of help and in some instances completely intolerant of the children's

behavior.

4. Parental figures of the children in need of intensive psychiatric treatment or protected environment for themselves.

The Training School Group

Jean, aged fifteen, was referred to the Children's Psychiatric Clinic by a mental hospital, out patient department where she had been studied because of a record of fire setting. Her family had been known to a family agency which had previously arranged for Jean's placement in a children's institution from which she had run away.

Jean came from a Jewish family of old world culture. Her father was fifty-nine years of age, mother forty-four, and there were two siblings younger than Jean. Her father was unable to work as he suffered from asthma, arthritis and deafness. The family was maintained by public assistance funds. Several maternal and paternal relatives lived nearby and there seemed to be a cohesiveness in the family group, although there was little warmth and much friction between Jean's parents. Her mother was a very shy, retiring woman who had poor vision, was hard of hearing and had diabetes. She found it difficult to assume a real mother role and attempted to keep her children on a very dependent level. She left all community contacts, such as the children's schools and clinics to the father. The father was a very dependent, demanding person who seemed quite hypochondriacal. He had never assumed the role of provider for the family. As long as his children were willing to accept his authority he could handle them, but once they began to rebel he felt no longer responsible for them. He had no close relationships with any of the children and resented any good opportunities that were given them.

There was little developmental history on Jean. The family told that she developed normally, without problems until she was eleven years old, when she began to menstruate. At that time she began to be moody and uncooperative.

Jean's relationship to her mother was an ambivalent one. She would vacillate between creating a violent scene because of some small action of her mother's and being very affectionate to her mother. The mother was very passive and permissive and gave in to Jean's whims and fancies. Jean and her father were often not on speaking terms and he was very apprehensive about losing control of his daughter. He had many

fears and phantasies of what might happen to her, that she might steal, become promiscuous or kill someone. Jean flqunted her unacceptable activities in front of her father and often expressed the wish that both of her parents would die.

Essentially Jean's relationship with her siblings was one of rivalry. At times she ignored them completely, and at other times she would beat them unmercifully without provocation. They were fearful of her and gave in to her wishes. She resented any parental attention paid to them. If she was reprimanded for her attitudes she would rant and rave, strike the children and then leave the house.

Jean's school adjustment was poor. She often truanted, never studied and would not allow her parents to see her report card. She forced them to sign it unseen. The school reported her to be quiet and unfriendly, but capable of better scholastic achievement. She had only one friend, a gentile girl who was considered delinquent and with whom Jean would frequently run away over night.

Clinic contact with Jean and her family continued for a year and a half. Jean's behavior became progressively worse, until she was running away frequently, once to New York City. When she came home from a flight she threatened to kill her parents and siblings. They were terrorized by her behavior. The clinic and the family decided that she must be given custodial care to protect both her and her family, as the parents were completely unable to cope with her acts of hostility and aggression.

Throughout the contact there was no casework carried out with Jean's mother. While Jean was seen by the psychiatrist, her father, who brought her to clinic, saw the social worker. He seemed very threatened by the idea and refused to allow his wife to attend clinic. When the parents were seen together by the social worker, on five different occasions, the father took a passive role but resented his wife's talking and terminated the interviews quickly. The social worker attempted to provide a supportive relationship for the father, and tried to help him see some positives in Jean. This was a difficult task and he remained hostile to Jean and resistive to casework. After placement, however, casework with the family was continued.

Jean was one of the group of four children, three girls and one boy, who were referred by the clinic for placement in training schools. At the time of referral two of the

girls were fifteen years of age, the boy was fourteen, and one girl was thirteen. Jean's contact with the clinic, one and a half years in length, was the longest. The others were seen for five, six and eight months. On the whole the length of treatment for this group was shorter than that of the group referred for other types of placement. With the exception of Jean, the group was really seen on an extended evaluation basis, with concerted attempts at treatment.

The problems in this group included truanting from school, running away from home, inability to form positive relationships, firesetting, uncontrolled aggressive and hostile behavior, incorrigibility, profanity and sex delinquency. Many of these are similar to problems displayed by some of the other groups, but in general in this group they seemed to be much more firmly established patterns of behavior. Also the repercussions of their anti-social acts, such as firesetting and sex delinquency, were more widespread in their effects on the community. The multiplicity of the severe problems in each individual case was also noted. These children were coping with the normal problems of adolescence, but they were attempting to cope when they had none of the intellectual or emotional strengths displayed by the boarding school group. All of them showed very early and almost constant parental deprivation.

Two girls in the group lived with their natural parents and in both cases there was constant marital friction between the parents, severe physical illness of the fathers and emotional immaturity of the mothers. One girl was the daughter of an alcoholic, sexually promiscuous mother and a father who was in a penal institution. The one boy in the group lived with his mother and step father. The step father was twenty-five years older than the mother and was completely rejecting of his step son. Parental cooperation with the clinic in this group was poor.

The common characteristics of the group can be summed up as follows:

1. These children had little ability to form close relationships in the community or to relate constructively to therapists in the clinic. The clinic felt these children might gain strengths in associating with other children in a protected environment which would supply controls, rules and structure for the children to hold to.
2. The group displayed many severe problems. If the children were not in controlled settings their behavior would be destructive to themselves and to the community.
3. The parents of these children had few positive feelings for them. The parental group itself was so deprived emotionally that they had little to give

the children. There was much physical illness, emotional immaturity and often delinquency of parents.

The One Child Referred to a School for Retarded Children

Emily at fourteen was referred to the Children's Psychiatric Clinic by a children's group work agency in the city. There was a question of mental deficiency. Emily was accepted for evaluation.

Evaluation interviews did not disclose much information on Emily's early history. She was the oldest of eight children. At two and a half years of age and again at five she had had convulsions which paralyzed her left side. She was in the hospital both times but the parents did not know the cause of the convulsions. Emily began to talk at three, but continued to have speech difficulty up to the time of referral. She started school at six and repeated the first grade. Then her youngest sister entered school and helped Emily by answering for her and doing her work, so that she reached seventh grade. She was not promoted beyond this.

One of the family complaints was that Emily did not play with children her own age. She enjoyed much younger children and liked childish games in spite of constant criticism for this. In personality Emily was quiet and stubborn and her parents were unable to reason with her. No form of discipline seemed to be effective.

Emily's mother was an adequate, relaxed person who took a real interest in the activities of her eight children. Her housekeeping standards were poor but the children were well fed and clothed. The father, however, was an alcoholic and often unemployed, so that the family lived on a marginal income. He was very strict with all the children. He forced them to be weaned and toilet trained very early. Emily was very much afraid of her father and he was particularly impatient with her. The seven younger siblings appeared to be bright adequate children. The second oldest was very fond of, and protective toward Emily at school and in the community. Neighbors often commented on Emily's difference from the rest of the family. She was able to do baby sitting and some household tasks but her mother could give her little responsibility. Emily was friendly with one maternal aunt. This was her closest relationship, and in general she was a fairly isolated child.

Emily was seen in three evaluation interviews with a psychiatrist. She was unresponsive and gave little information, answering "yes" or "no" to questions asked. A series of psychological tests were done and Emily presented a picture of a very frightened, immature, anxious girl with a very limited endowment. At best the clinic felt she could never function beyond the level of a mentally defective person.

Emily's mother was seen by a psychiatric social worker in three interviews. Her idea of treatment seemed to be that a doctor would be able to make Emily stop playing with younger children and could talk to her about the danger with boys. In general she was very confused and upset by her oldest daughter's lack of response and childish behavior.

The Clinic did not treat children who were retarded to the degree Emily was. She was unable to use or understand therapeutic methods. It was felt that Emily needed to be institutionalized in a school for retarded children. There, she could receive training in skills to help her protect herself from physical danger, and perhaps even to learn how to earn a livelihood and adjust herself to social life, so that she would be happier and a more useful citizen. The clinic felt Emily's family could not be objective enough to give her this training in skills and social adjustment. Her mother would probably, on the one hand, feel too much pity and try to help Emily too much, and on the other, be ashamed of the child and attempt to force her to learn too quickly. Emily's lack of response evoked an irritated rejecting reaction from her father. This feeling of being rejected and unloved would hamper her learning process.

In addition, a school equipped to handle retarded children would provide round the clock training, where, in

Emily's home the daily routines, happiness and interests of nine other people had to be considered. Emily would be, in an institution, with children on her own level. She would not be looked down on, criticized, teased or coddled. She could even feel success. For these advantages the clinic felt an institutional placement would outweigh the traumatic effects of separation from her family. Recommendations to this effect were sent to the referring agency who would handle the placement since their relationship to the family was a close, positive one.

CHAPTER VI

SUMMARY AND CONCLUSIONS

This study of the Children's Psychiatric Clinic of the Massachusetts Memorial Hospitals, Boston, was made of twenty children seen in treatment at some time between January first 1949 and December thirty-first 1953. For these twenty children placement away from their own homes was recommended by the clinic because treatment could no longer be considered useful or practical while the children remained at home.

An examination of the treatment aims in this clinic revealed that they were similar to those of most child guidance clinics throughout the country. The problems of the children were the main focus of the clinic's work. It was considered essential, however, to work with the parents of the children in order to see the family as a unit and to learn how the problems of the child affected the family relationships and how they, in turn, affected the child's behavior. The relationship of the families to their communities was also studied. All efforts were primarily geared toward strengthening the unity of the families. For the twenty cases in this study attempts in this direction failed.

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A study of the present day philosophy of child placement agencies showed a change in their approach over the past twenty years. Formerly children were moved from their homes without too much thought or insight. Records of placement failures and increased knowledge on the part of children's agencies of modern psychiatry have made them realize the vital importance to children of their own parents. The focus of work in modern child placing agencies is now on keeping children in their own homes. Placement is of course still necessary for many children, but every effort is given toward helping parents who have failed as parents to reestablish themselves, and to encourage them to maintain close bonds, even though separated physically from their children. Many types of placement are used today to meet the individual needs of the children who have to separate from their parents.

The twenty children recommended for placement by the Children's Psychiatric Clinic seemed to fit into the two general categories of children who came to agencies for placement, namely, those whose family groups had dissolved, and those who were placed for therapeutic measures. The twenty children in the study were referred to foster homes and institutional placements. In general those in the foster home group were children whose families had dissolved because of the disasters attending human life, such as illness, divorce and death. Both parents of one child in this group were psychotic and three had psychotic mothers. The institu-

tional group's placement referrals seemed based more on therapeutic treatment measures. There was some overlapping, however.

A detailed analysis of the twenty cases showed a wide variety of children's problems and an extraordinarily large number of emotionally disturbed parents. As this was a descriptive study of the group, it was not possible to compare these children and their parents with those for whom placement was not recommended. However, it was evident that every effort was made by the clinic to keep these families as units. For families not in this group either the clinic's treatment methods were more effective, or the families terminated treatment before it reached the stage of placement referral, or the clinic did not feel the families could use placement as an effective part of treatment.

Placement as recommended by the clinic was a very positive part of the treatment planning. Foster home referrals were made generally when the children did not have parental figures to nurture them and because of their young age they needed and could form close ties with parent substitutes.

The institutional referrals included four different kinds of children's institutions, namely, boarding schools, treatment institutions, training schools and one school for retarded children.

Children in the boarding school group were of high intelligence and capable of using psychiatric help to advantage.

There were strengths in their home relationships, but enough sources of conflict that they needed neutral settings for a temporary period to help them solve their adolescent problems so that they would not resort to delinquent behavior. The prognosis for this group was good. The children were less disturbed emotionally than those in the other institutional groups. It was not felt by the clinic that they could use foster homes, however, since they were in the adolescent age group and not capable of relating closely to new parental figures.

The group referred to treatment institutions was a very emotionally disturbed group. Their parents also showed severe symptoms of emotional maladjustment and had little strengths to offer these children. Intensive psychiatric treatment was necessary and in each case a very controlled environment. Parents also needed psychiatric care and this was either provided by the clinic or parents were helped to seek it elsewhere.

The training school group showed many severe symptoms of deep-seated problems. This was the oldest group in age and the group which showed the poorest prognosis. The children needed custodial care to protect themselves and their communities, and in general they were not responsive to clinic treatment. Their relationships were poor and their families had little affection for or interest in them.

Placement was carried out in all but one of the clinic referrals. One family whose son was referred for placement in a treatment institution withdrew from treatment. In most cases the clinic worked closely with the parents in effecting the placements. Psychological support was given both parents and children, as well as help in the actual manipulation of the environment. The treatment institutions were the most difficult to find in the community and it required a great deal of effort on the part of the social service department to facilitate these placements.

Psychiatric treatment was either continued after placement or suitable referrals were made for all children and parents needing it. A follow up study of these children would prove of interest and would help to clarify the wisdom of the planning.

Accepted 5-27-55
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BIBLIOGRAPHY

Bowlby, John, Maternal Care and Mental Health. Geneva: World Health Organization, 1952.

Frederickson, Hazel, The Child and his Welfare. San Francisco: University of California, W. H. Freeman and Company, 1948.

Freud, Anna,and Dorothy Burlingham, Infants Without Families. London: George Allen and Unwin Limited, 1945.

Hamilton, Gordon, Psychotherapy and Child Guidance. New York: Columbia University Press, 1947.

Pearson, Gerald H. J., Emotional Disorders of Children. New York: W. W. Norton and Company, 1949.

Wires, Emily Mitchel, "Placement for Adoption A Total Separation," Journal of Social Casework, 30:283-288, July 1949.

Young, Leontine, "Placement from a Child's Viewpoint," Journal of Social Casework, 30:250-255, June 1950.

Unpublished Material

Pavenstedt, Eleanor, M.D., Unpublished Letter to Dr. A. Z. Barhash, American Association of Psychiatric Clinics for Children, 1950.

APPENDIX

SCHEDULE

CHILD

1. Name
2. Address
3. Age
4. Sex
5. Religion
6. Ordinal position in family
7. Color
8. School placement

FAMILY

1. Ages of parents
2. Marital status of parents
3. Economic status of parents
   a. average
   b. marginal
   c. receiving public assistance
4. Ages of siblings
5. Number of siblings
6. Other relatives living with family

REFERRAL

1. Source of referral
2. Time of referral
3. Presenting problems

TREATMENT

1. Child seen by
2. Parents seen by
3. Diagnosis of child
4. Diagnosis of parent
5. Treatment recommendations