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Psychiatric placement of children: an
exploratory study of twenty cases where
the Worcester Youth Guidance Center
recommended placement

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BOSTON UNIVERSITY
SCHOOL OF SOCIAL WORK

PSYCHIATRIC PLACEMENT OF CHILDREN:
AN EXPLORATORY STUDY OF TWENTY CASES WHERE THE
WORCESTER YOUTH GUIDANCE CENTER RECOMMENDED PLACEMENT

A thesis

Submitted by

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CHAPTER I

INTRODUCTION

Purpose of the Study

An exploratory study was made of twenty cases where the Worcester Youth Guidance Center recommended the placement of a child. The internal and external factors leading to the recommendation were investigated. In some cases brought to a guidance clinic the recommendation is for placement for the child. In contrast to the placing agencies, guidance clinics state no explicit criteria for such a recommendation. The seriousness of removing a child from his home is recognized and the reasons for doing so must be pressing. The study was designed to explore some of the factors in such cases which might yield material for the development of such criteria.

An assumption was made that the guidance clinic was selecting the recommendation of placement as a disposition of the case because it anticipated that other forms of treatment would not be successful or could not be accepted by the family. The primary question asked concerned the role of external factors, as used by a placing agency, and internal factors as used in other clinic cases. A subsequent question concerned the nature of the internal factors.

Scope of the Study

Twenty cases where the Worcester Youth Guidance Center had recommended placement were used. They were selected on the basis of the making of the recommendation, regardless of later events, and the presence in the record of sufficient material on the areas under investigation.

The study was focussed on factors in the family's situation which might make it impossible for the family to maintain the child. External factors were included. The internal factors sought were those relevant to the assessment of the milieu in which the child developed; those which indicated whether this milieu could be changed for the benefit of the child; and those which indicated whether the mother wanted such change and had the capacity and willingness to participate in making it.

Data Collected

Information was collected on the family composition and social and economic factors in the families which might bear upon the necessity for removing the child from the home. Internal factors were assessed by the collection of data on the mother's attitudes in areas pertinent to her ability to maintain the child in the home and her capacity for seeking and using treatment help for the child while he remained in the home.

The source of data in these areas was the mother's expressions of attitudes to the family situation and the child within the clinic and her verbalized or implied feelings about the clinic and her expectations of it.

Limitations of the Study

The data collected was analysed in terms of the frequency of the occurrence of the situations or attitudes studied within the group of cases. No attempt was made to relate these frequencies to either cases where placing agencies place or to cases where a different disposition is made by a guidance clinic. Follow-up information was available

in few cases and events following the recommendation were influenced by too many disparate factors to allow for investigation of whether the recommendation led to a successful form of treatment and why.

CHAPTER II

BACKGROUND

The Meaning of Placement

The placement of children away from their parents has always been an important part of child welfare work. The meaning of such placement has been given a great deal of consideration in terms of the effect which it has on the child. As understanding of the emotional life of children grew, so did the recognition of the tremendous emotional impact which separation from the parents has on the child.

Taking a child out of his home is a peculiarly wrenching ordeal for parent and child alike, more rather than less so if hostilities are involved. It is frightening and dislocating to lose one's parents by death, by distance, and most of all by rejection.¹

Because of the impact which it has upon the child, placement has come to be considered as in and of itself undesirable. "In any work with children and their families placement is never the first choice as an objective."² Agencies do not want to place children; they will do their best to do a good job of it if it is forced upon them. To decide to place a child is to make a decision which has grave meaning for the child and is therefore to be considered with gravity. It is essential to know why this decision is made.

¹Gordon Hamilton, Theory and Practice of Social Case Work, p. 282.

²Elizabeth Kingsley Lavers, "Placement Recommendations for Clients of a Children's Psychiatric Clinic: A Study of Twenty Cases of the Children's Psychiatric Clinic of the Massachusetts Memorial Hospitals (January 1, 1949 - December 31, 1953)", p. 13.

The most familiar criteria for why the decision is made are those of the child-placing agency. These reasons are quite specific. At one time children were placed because the family could not afford to care for them properly. As a criterion for placement, financial disability is being eliminated.

The latest step in the development of methods for child protection is the concept that the child, whenever possible, should be left in his own family. We have already noted that until the end of the nineteenth century many children were taken away from their parents because of their poverty, and because it was thought that a pauper family could not properly bring up a child. The findings of modern psychology and psychoanalysis, as well as the observations of the juvenile courts and social agencies dealing with difficult and maladjusted children, proved, however, that it would be advisable to enable the children to remain at home with their mothers and siblings. Economic aid granted to the mother would allow her to rear her children instead of forcing her to give the children away and work . . . It was the first White House Conference on the Care of Dependent Children, in 1909, which emphasized the need of financial help to mothers in order to preserve the family.³

Children are placed because the parents are ill or absent or because they are abusive to the children or because the children are unmanageable in the community and both child and community must be protected.

Many families cannot, do not want, or are not competent to maintain themselves as units, because of death or other interruption, defect or distortions in the child-caring and home-making capacities . . . separation is [required] because of incompetent parents or parents who do not want their children or because of extreme behavior problems or unusually severe handicaps.⁴

³Walter A. Friedlander, Introduction to Social Welfare, p. 331.

⁴Hamilton, op. cit., p. 282.

In the child-placing agency, these are the predominant criteria. They are standards of assessment of the home situation and are largely dependent upon external factors in the home. The choice is between a placement home and no home.

There are children who cannot live with their families, children who are orphans without relatives, abandoned children whose parents are unknown, children who have been deserted by their parents, children whose parents are unable to keep them because of illness or who have been committed to a prison. Some parents also may be a direct danger for their children.⁵

Legal safeguards have been established so that no unnecessary placement may be made against the wishes of the parents. "One objective of adoption laws is to protect the child from unnecessary separation from his natural parents or mother who might give him love and good care if adequate help were available."⁶ The efforts of the agencies are frequently directed to changing the family situation in such a way that the family no longer meets the negative "standard" of inadequacy which demands placement. Continuing efforts are being made to make standards more specific and to develop more and better means of avoiding the necessity of placement. Effort is also made to improve the quality of placement institutions and foster homes and the preparation of child and family for them. Placing agencies, protective agencies and courts are aware of the importance of this decision and are working to offer better service and to cushion the impact when it cannot be avoided.

⁵Friedlander, op. cit., p. 339.

⁶Ibid., p. 343. [*italics his*].

Placement in a Guidance Clinic

The guidance clinic is also aware of the impact of placement. Emotional factors are the material with which the clinic works and with awareness of them the clinic cannot take lightly the decision to place a child. When external factors make the decision necessary, as in a placing agency, the child must be placed. In the guidance clinic, this is not always the case. Families which come to the clinic are seldom so deteriorated as the extremes of the placing agencies would indicate. Although they may be poor, live in a run-down neighborhood and have lost one parent through desertion or illness, the fact that referral is made to a clinic rather than a placing agency implies that alternatives to placement are envisaged by the family and the referral source. The clinic, and in all probability the client and the referral source, are considering the case upon application in terms of treatment for the child and the parents while the child remains in the home. The referral would not be made if there were an emergency situation or external factors which determined the necessity of placement.

The placing agencies have their criteria, which are largely factors in the external situation of the child. Placement is not a usual recommendation in clinics, where it is the internal factors within the situation, rather than the externals of family deterioration, which are being evaluated. There are undoubtedly cases in which the referral itself is questionable; where the case required placement in accordance with the criteria of the placing agencies and should initially have been

referred to such an agency. There are other situations in which these criteria are not applicable and where the guidance clinic recommends placement. They recognize the impact of separation and they have the family together; they do not break it up without good reason. The reasons must be seriously and carefully thought out; they need to be spelled out more explicitly.

The establishment of such criteria is important. In the type of case seen in a guidance clinic there is opportunity for the consideration of whether or not to place on the basis of a psychiatric evaluation of whether or not treatment would be effective with the child in the home. Although the availability and expense of placement resources is an important factor, placement has more of the elements of a treatment of choice in its use by the clinic than by other agencies. Where placement was formerly the resource of social workers as an approach to social problems, although frequently with psychiatric consultation, in guidance clinics it becomes the resource of the psychiatrists for the treatment of psychiatric problems or the impact of social factors upon psychological adjustment.

The reasons generally stated for recommending placement are pressing ones. They are to be found in such material as the discussion of cases which need and are appropriate to residential treatment programs.

These were the deeply disturbed children whose behavior had made them unacceptable at home, in school, and in the community and who found themselves in such a deep, intensive struggle with their environment that they could not accept or use help

while continuing to live in it.⁷

They are also discussed in relation to justifying the use of placement as a resource by psychiatrists.

There are . . . situations where the problem between the child and the parents . . . has reached such a degree of bitterness that no amelioration can be expected until parents and child are separated for some time . . . We do realize that separation of the child from the parents produces another traumatic situation for the child, but we believe that this trauma can be dealt with during treatment. We do not believe that mere separation of the child from his parents is always a useful treatment measure, but we do believe that just as psychiatrists and social workers have erred in the past in considering it a treatment measure in itself, so they tend to err in the present in not utilizing it sufficiently as an adjuvant form of therapy.⁸

In the exploration and development of this use of placement as a treatment measure by the guidance clinic or psychiatric resource, criteria for the recommendation are needed. This was the reason for the present study.

The Study of Clinic Placement

Interest in the internal factors leading to a recommendation of placement is based on the assumption that when a guidance clinic considers placement it is evaluating the internal rather than the external situation. This assumption cannot be taken for granted. The cases must be investigated to determine whether the guidance clinic bases its recommendation on external factors as do placing agencies. It is probable

⁷Betty Ann Weiner, "A Study of Fifty Children Needing Residential Psychiatric Treatment seen in the New Hampshire Mental Hygiene and Child Guidance Clinics During 1953", p. 9.

⁸O. Spurgeon English and Gerald H. J. Pearson, Emotional Problems of Living, p. 173.

that a combination of external and internal factors form the basis of the decision. The externals should not have the determining influence on the clinic's appraisal of the total situation.

The external factors which might be important are those related to the social and financial position of the family; financial disability, large families, broken marriages, sick, absent or deserting parents, or mothers who through age or illness are unable to care for the children. The religion of the families and the agencies to which they have turned or which have used their authority to get help for the families are also of interest.

The problems of the child who is referred are of significance in determining whether the guidance clinic recommends placement on the basis of the effect of the child's symptoms upon the community. The age of the child will also effect whether the child can be maintained in the home and tolerated in the community or whether he requires protection from an unfavorable environment.

Where the guidance clinic was making a placement as a part of its function rather than sorting out cases inappropriate to its function for referral to the placing agency, the decision to make the recommendation was determined by the psychological milieu of the home situation and had its relationship to the adjustment or pathology of the child. The reason for the placement is that the internal milieu of the family is sufficiently damaging to the child to outweigh its trauma of separation.

The explicit criteria for recommending placement must be the

factors which form this damaging internal milieu. The psychological milieu, the internal family situation, which met the implicit or intuitive criteria and determined that placement was to be desired, was investigated. The nature of the internal situation which required placement was described through the study of maternal attitudes. The dominance of the influence of maternal attitudes upon the development of a child is generally accepted. The growing interest of guidance clinics in the mothers and in the treatment of mothers as requisite to helping the children, bears witness to this. The study asked whether the maternal attitudes were the source of the psychological milieu requiring placement. This question was selected as the hypothesis of the study. The maternal attitudes were the primary area of exploration.

"What was the mother's attitude?" must be followed by the question "attitude to what?" Areas were selected within which the mother's attitude influenced the milieu of the child. Where a child needed placement it can be hypothesized that the maternal attitudes in those areas influenced the development of the unfavorable internal situation which determined the need for placement. Her attitude must be evaluated to test the hypothesis.

The mother herself is the child's initial environment. Later the father and the parents as a couple take on increasing significance. Conflict between marital partners, whether together or separated, is influential in the development of difficulty in the child. Although the father is only infrequently seen in a guidance clinic, an estimation of the marital situation can be made through the examination of material the

mother brings. The mother's attitude toward the father was evaluated.

The area of the relationship between the mother and the child, which is important both in the development of the child's personality and in the decision as to whether the child can change his patterns in the home environment, can also be approached through the determining maternal attitudes. The mother's feeling about the child himself is important. Does she want him, or does she reject him? The mother's rejection, where present, is a frequent cause of serious disturbance in the child. It is a prime portion of the milieu and may be a determinant in whether the child may make a satisfactory adjustment while in the home.

In making a recommendation that a child be placed, a clinic is saying that it feels that treatment with the child in the home will not be successful. The internal situation of the home, as it is seen when the case is considered, is a vital part of the material for the decision. If the home, in its internal factors, is one which cannot nourish the child; a home with intense marital conflict and with a mother who is rejecting of the child, placement must be considered. There is, however, a preliminary decision. This is whether the home situation can be changed.

The factor of the mother's rejection or acceptance of the child is also important in considering whether the home can be changed. Rejection is an indication that it cannot. If the mother does not want the child, it would seem likely that she would be more interested in seeing him placed than in undertaking to change herself and the child so he may

remain. Acceptance of the child indicates a desire to retain him but may indicate that he has become an expression of the mother's own problems; a piece in her emotional economy. It is necessary to determine whether she wants him as he is, complete with symptoms, or can play a part in the disappearance or amelioration of his symptom picture.

The mother's attitude toward the symptoms is related to her attitude to the child and is influential both in the current home situation and in the likelihood of change in it. She may see them as disrupting to herself and to the home. Where the symptoms are highly disrupting, they have already assumed a role in the relationship between the mother and the child and have increased the disturbance in the milieu of the child's development. The aftereffects of the symptoms and the mother's response to them may make the home impossible for the child.

The mother's attitude toward the symptoms is also important in her ability to seek and use treatment help. "A person must feel more uncomfortable than comfortable with his problem in order to want to do something about it, and this malaise will serve to push him."⁹ The mother must feel some disruption from the symptoms in order to seek help for them. She must want to see them changed. Too much discomfort, however, may also create a push to doing something about the symptoms by removing them, with the child, from the home.

The mother's feeling about the causation of the child's symptoms

⁹Helen Harris Perlman, Social Casework: A Problem-Solving Process, P. 186.

forms another factor in the home situation and in the capacity for changing it. If the mother feels that she is responsible for the development of the difficulty, this will add to the malaise which pushes her but also to the conflict in the home. If she feels she has had nothing to do with the child's condition and blames it on events or conditions outside her control, she may feel that she cannot or need not alter the situation by her own efforts. The mother's projection or introjection of responsibility must bear upon the decision to place the child.

Presuming that the mother desires some change in the situation and is thereby somewhat amenable to treatment, she must feel that such change can come about.

Two conditions must hold for the sustainment of responsible willingness to work at problem-solving: discomfort and hope . . . Accompanying [discomfort] must be some promise of greater ease or satisfaction, and this¹⁰ promise pulls the person to bend his effort toward some goal.

If the mother feels that the clinic will be unable to help her, she has already done half the work of withdrawing. Children may be placed because the mother can anticipate no help from treatment.

The home environment, as measured by the marital situation, the feeling for the child and the disruption created by the symptoms helps determine whether the child can develop in the home atmosphere and is therefore an area in the search for criteria for recommending placement. If the environment is unfavorable the second consideration is whether it can be changed. The possibility of change is reflected in

¹⁰Ibid.

the mother's discomfort with the symptoms or ability to give up gratification from them, in her discomfort in blaming herself for them and in her possession of some hope that the clinic can help. These areas indicate whether the mother wants the situation changed.

When change is possible and an alternative to placement thereby open, the mother must be willing to participate in treatment as well as desirous of change.

"Willing" involves taking several steps beyond "wanting," one at a time or all in one leap. They consist of seeing one's self as a potential force in shaping one's ends; of charging one's self with taking some active part in making whatever changes must come about; and of mobilizing one's self to act.¹¹

The mother's assignment of responsibility for the development of the symptoms to herself is the first step in her seeing herself as a force in the child's life. This step is reinforced by any hope of help she may have of the clinic.

The remaining question is whether the mother can charge herself with taking part in treatment and mobilize herself to do so. The mother must be helped in order that the home situation may change and reinforce the child's gains in treatment or help him to gain. In order to be helped, the mother must become involved in the helping process.

Without this, no armamentarium of understanding and skills is of any avail. No matter what the nature of the client's problem is, he must want some help or change and must reach out with some part of himself to use it.¹²

¹¹Ibid.

¹²Ibid., p. 185.

The inability of the mother to involve herself in treatment should form a criterion leading to a recommendation of placement.

CHAPTER III

METHOD

Selection of the Sample

The sample for the study consisted of twenty cases in which the Worcester Youth Guidance Center had recommended that the child be placed. The cases were selected by informal questioning of present agency workers as to cases where they recalled that a recommendation of placement of any kind had been made by the Center. This method was necessary because no record is kept of such placement recommendations in statistical listings or combined files, reflecting the individual nature of the making of such recommendations. In some cases the recommendation was not recorded clearly in the case-record itself. Cases were undoubtedly missed which were not recalled or where the worker had left the agency.

From the forty-two cases located in this fashion, exclusions were made for several reasons. Cases where recording did not include the work with the mother were omitted, as were those where such recording, combined with diagnostic summaries, did not give sufficient information. Two cases where the child was diagnosed to be organically retarded were also eliminated. It was felt that these cases in actual fact fell outside the purview of the Center for purposes other than diagnosis. The placement was not recommended as a resource for psychiatric help and in each case it seemed clear that the case had been brought to the clinic largely for confirmation of suspected retardation and the decision for placement rested on this single factor in the entire situation. Some

cases where the complaints included retardation were retained as diagnostic study indicated the retardation to be emotional rather than organic.

Twenty-five cases then remained, of which twenty were boys and five girls. The inclusion of the five girls promised more confusion than additional information and represented a proportion of girls which was well below the usual distribution among the Center's cases. In order to simplify the presentation and analysis of data, the girls were omitted.

Following these omissions, twenty cases remained in which material was available in the case record for the determination of most of the data desired. All data was taken from the case folders, as it was felt that adding to the data by conferences with the workers would be possible only in a few of the cases and the cases which would be thus expanded would be determined by the chance factor of whether the worker was still in the agency. In addition, in some cases the material would necessarily be influenced by changes in the attitudes of the mother or the pathology or the behavior of the child which had taken place subsequent to the recommendation where treatment was continued.

Data Collection

Data collected covered a number of areas of factual face-sheet information: the age of the child and his grade in school, the religion of the family, the complaints, the dates of intake interviews and conference, the referral source. Information on the family included the

parents' ages and marital status, the age and sex of the siblings, the family income, education and occupation and the length of the marriage.

In addition, the client's attitude to the referral source was recorded where available as well as any follow-up information and the diagnostic and prognostic formulations made by clinic staff members.

The data also covered the maternal attitudes to the marriage, the clinic, involvement, the symptoms, responsibility for the symptoms and attitude to the child. Judgments of the attitudes of the mothers were estimated from the mother's verbalizations as recorded by the worker and the worker's expressions of the tonal quality of the mother's verbalizations or the affect shown. In some instances these estimates were clarified or confirmed by the worker's estimate as given in diagnostic summaries prepared for conferences. Where the mother's verbalizations were contradictory or different attitudes were expressed at different times with relatively equal frequency, the estimate was placed in the middle category of uncertain, ambivalent or vacillating. Where it was not possible to determine the nature of the mother's attitude or where no verbalizations were recorded around a particular subject, no estimate was made. Where uncertainty is indicated it is that of the mother rather than the investigator.

The mother's attitude to the marriage was rated from hostile, through ambivalence to positive feeling, with five possible positions. It was also noted whether the father came to the clinic. Her attitude toward the clinic was rated in accordance with the degree of hopefulness or hopelessness indicated. Five positions were given, from a conviction

that the clinic would cure the child, through uncertainty to a conviction that the clinic would not help. The mother's involvement in help was rated with five possible positions from maximal active participation, through vacillation to minimal, passive participation.

The mother's feeling about the symptoms was rated in five positions according to the degree of disruption felt by the mother to be created in the home. The positions ranged from "very disrupting" to "not disrupting". The mother's assignment of responsibility for the development of the symptoms was rated from an entire projection through a conflicted assignment to an entire introjection, again with five possible positions. Her attitude toward the child was rated from acceptance, through ambivalence to rejection in five positions. (For the complete scales, see copy of the schedule, Appendix 1.)

The scaling of attitudes was determined by the relative weight or frequency of expressions of attitude within each case rather than by comparison of one case with another. Divisions on the scales of attitudes were not intended to be equal within any one scale or from one scale to another. Where changes in attitudes during treatment were apparent, earlier attitudes were used for the assessment.

Limitations

It was initially hoped that some assessment of the success or failure of the recommendation and of the impact which it had on the mother and her reaction to it might be made. Inspection of the case records, however, revealed that there was not sufficient information avail-

lable in them to determine this. In most cases, recording was done with relative thoroughness for the early interviews, but the recommendation could only be discussed in somewhat later contacts and these were often recorded in summary or not at all. In some cases a referral was made for actual placement or placement was made by a court agency on the Center's recommendation so that no information is available beyond the summaries sent to the agencies to which referral was made. In other cases there is considerable correspondence in the record relative to applications and admission procedures in institutions. Where information as to the disposition of the case was available it was noted on the schedule but no attempt to discover details of follow-up was made.

It would be very valuable to have some means of gauging whether or not the placement itself was a constructive experience for the child and whether or not the recommendation was in retrospect a wise one. Unfortunately, any attempt to make such a judgment is complicated by a number of factors. In recommending placement for therapeutic ends, the type of institution or group or foster home to which the child is sent is of paramount importance. Here the reality of what is available impinges sharply on the theory of what would be most beneficial to the child. Treatment facilities are limited in number and either sharply limited in space or grossly overcrowded. In addition to the limitation in available space and available services within the institutions, adequately staffed institutions are very expensive and frequently funds to maintain a child in a suitable placement are simply not forthcoming. For

these reasons it is only infrequently that the specific recommendations of the Center can actually be carried out and that an objective judgment can thereby be made of the wisdom of the recommendation.

These reality limitations, of course, also have implications fo_r the making of the recommendation. While the Center might feel that a child would be best served, from a therapeutic point of view, by a certain type of placement, this may not be the recommendation since it is known to be impracticable. This limits the agency's ability to use pl_acement as a method of treatment and also the possibility of evaluating the success of the agency's actual recommendations.

CHAPTER IV

THE SETTING

The Worcester Youth Guidance Center was first established as an out-patient clinic of the Worcester State Hospital in 1922. In 1923 it was moved to Memorial Hospital, a general hospital, and in 1929 it moved to a building of its own. The present name was substituted for the former name of Worcester Child Guidance Clinic in 1948.

The Center offers treatment on a team basis by psychiatrists, social workers and psychologists for children with emotional problems and their parents. The type of treatment undertaken is determined diagnostically. In some cases treatment is on a supportive casework basis with the parents while the child is seen in more intensive therapy, or the parent receives more intensive help while the child is seen supportively. More frequently, intensive casework treatment or psychotherapy is offered the parents and play therapy or psychotherapy offered for the child.

Some children not living in the home are accepted for treatment and some older adolescents are accepted for treatment independent of the parents. In most instances, however, a case is not accepted unless the parents, or at least the mother, agree to come regularly for treatment designed to help them with their own difficulties, usually those effecting the condition of the child, as well as with the handling of the child and the child's problems. An effort is made to involve the parents in help for themselves during intake and this involvement is one determinant of the acceptance of the case.

In the majority of cases children and parents are seen on a

once-a-week basis. Most parents are seen by social workers, although some parents are seen by members of other disciplines under social work supervision. Children are seen by members of all three disciplines, although usually by psychiatrists and psychologists, under psychiatric supervision. Fees are charged on a sliding scale based on income. Consultation fees range from one to twenty dollars for each interview. Treatment fees range from ten cents to twenty dollars on a weekly basis which includes all members of the family being seen.

The Center also offers diagnostic services for children and their parents and for other agencies. Consultation on a short-term basis is offered to parents where treatment is not desirable or not feasible. The Center has a program of consultation services to schools in the area and other agencies as well as offering public education speakers and group discussion leaders to the community. Research projects are carried on under the auspices of the Center and training is given in the three disciplines. The Center is a member clinic of the American Association of Psychiatric Clinics for Children and is approved as a training center.

The intake procedure of the Center has developed to offer service to as many clients as possible. This has resulted in a policy of limiting the number of long-term cases of dubious prognosis which can be carried in the clinic at any one time. Intake interviews are offered within a very short time to all applicants. Cases are not accepted for treatment until sufficient diagnostic understanding has been gained to judge the prognosis of the case. If treatment time is not available in the near and foreseeable future, treatment is not offered. There is no

waiting list for treatment and whenever possible where treatment cannot be offered, the client is given as much help as is possible on a short-term consultation basis.

Intake conferences, led by the director and attended by the chief psychologist and chief social worker as well as all team members who have had contact with the case during intake, consider cases where there is question around disposition. The disposition of the case is in accordance with a number of alternatives. It may be decided to offer the client treatment described above for the mother or for both parents and for the child. If it appears the more promising alternative treatment may be offered to the parents, without continuing the child in treatment. The parents may be offered continued consultation around the problems that the child presents.

If treatment for parents and child is advisable, but no treatment time is available, the parents may be offered a time-limited period of consultation. In some cases such consultation seems diagnostically indicated, regardless of the availability of treatment time, and is offered to the client. In such cases the child may or may not be seen.

In cases where treatment or consultation in the Center do not seem to be indicated, referral may be made to other resources. The family might be referred to family service or other social agencies. Private individual therapy or analysis might be recommended for one or both parents or for the child. A recommendation that the child be placed might be made.

CHAPTER V

CHARACTERISTICS OF THE SAMPLE

Numbers in each Group

The sample consisted of twenty boys. The ages of the boys ranged from four and a half to thirteen years. The average age was slightly over ten years, which is two years older than the average boy at the clinic in 1956 to 1957.¹ For purposes of comparison the boys were divided into two age groups; one of eight boys from four and a half to nine and a half and one of twelve boys from ten to thirteen.

The ages of the mothers of these children ranged from twenty-five to fifty years. There were ten mothers from twenty-five to thirty-nine years and nine mothers from forty to fifty years. In one case the age of the mother was not recorded.

In fifteen of the twenty cases both parents were living together in the home with the child. In one additional case the parents had lived together until the relatively recent death of the father. There was one case of divorce and three of separation. Six of the children were only children. Nine had one sibling. One had two siblings and four had three or more siblings. Eight of the children were Roman Catholic; six Protestant; two Jewish; one of mixed Catholic and Protestant parentage. Religion was not recorded in three cases.

Income is not a large factor in the normal work of the WYGC

¹"Annual Report, Nineteen Fifty Seven," Youth Guidance Center, Two State Street, Worcester, Massachusetts.

and is thereby often vague in recording. Fees charged were recorded in eighteen cases and although these vary with the size of the family and the type of service being offered, they were used to make an approximate division of the sample into three economic groups. In the first group, representing incomes up to about \$2600, there were seven cases. In the second group, with an income from about \$2600 to about \$3900, there were six cases. In the third group, with incomes above \$3900, there were five cases.

Referral sources were listed in all cases. In some cases several sources were indicated. According to the policy of the clinic, initial telephone calls and appointments are made by the parents and formal referrals by other sources are not solicited. Referrals are therefore determined by asking the parent how he heard of the clinic. Although replies may be indefinite or several sources may be given, they are clear as to agency or type of resource which has been consulted. Referrals were classified, where more than one was given, according to the source adjudged to bear the most authority in the parent's eye. Where a court source was given, this was listed rather than a school or medical source and where a school source was given this was listed rather than a medical source. Referrals were listed as "self" only when no other source was given.

The sample was divided into four groups by referral: 1. Self-referrals, including one by a neighbor and one by the child, three cases. 2. Medical referrals, including family physicians, private psychiatrists and a speech clinic, seven cases. 3. School referrals, including atten-

dance officers, teachers and school-affiliated child-study and medical facilities, and also including one referral through the placement agency which had arranged the adoption of the child and one Department of Public Welfare referral where the mother was on ADC, six cases. 4. Court referrals, including the Probation Department and the Juvenile Police, four cases.

In examining the total list of complaints, it was discovered that all cases showed either A. Achievement problems or B. Acting-out behavior. Achievement problems included those where the mother cited poor school grades or work or failure to pass in school, or in cases of pre-school children, where she questioned the child's capacities. Behavior problems included cases where the mother complained of asocial, anti-social or dissocial behavior on the part of the child. In only one case were both of these classifications noted and in this the acting-out behavior was in the form of temper tantrums. It was decided to categorize all cases as either achievement or behavior problems, with the overlapping case listed as an achievement problem. This gave a total of five cases of achievement problems and fifteen cases of behavior problems.

In most cases a number of complaints were made by the mothers. The complaints made in addition to those of achievement or behavior were categorized from the mother's wording. Additional complaints included the following: C. Relationships with parents, including discipline problems or a feeling of being unable to "reach" the child; reported in eight cases: D. Habit Symptoms, including masturbation, thumb-sucking, bed-wetting, nail-biting, etc; reported in three cases: E. Affect difficulties

where the child showed inappropriate or disproportionate feeling or was cited as being confused or unhappy; reported in three cases. F. Relationships with peers, where the child was cited as relating poorly or hostilely or having no friends; reported in two cases. The number of complaints made in each case and the overlapping of types of complaints are shown in the listing of each child in Appendix 2.

In checking the classification of cases where complaints other than achievement or behavior were listed, it was found that all habit symptoms cited occurred in cases classified as behavior problems (see Table 1). All listings of difficulty in peer relationships occurred in

TABLE 1
ADDITIONAL PROBLEMS CITED BY PARENTS

Additional Problems	Classification	
	Achievement	Behavior
Parent relationship	3	5
Habit symptoms	-	3
Affect disturbance	1	2
Peer relationship	2	-

cases classified as achievement problems. Cases of affect disturbances were proportionately divided between cases classified as achievement difficulties and those classified as behavior problems. Difficulties with parents were somewhat weighted to the achievement group, with three of the five achievement problems showing such difficulty as compared with five of the fifteen behavior problems.

Significance of Characteristics

The fact that these boys were somewhat older than the general clinic population would indicate that placement is a more usual recommendation with older children. Several things might be suggested from this. One is that the clinic is considering that younger children can be more easily maintained in the home and controls more effectively set so that there is less difficulty, even with the same problems, if the child is younger. The clinic may also be more reluctant to consider placing a younger child, feeling that he is more in need of the mother and less able to manage a change in the environment than is the older child. It may also be that the greater age of the child indicates that problems have had a longer time to develop so that the symptoms have become harder to manage and a greater degree of internalization of the problem has taken place which makes treatment more difficult.

The presence of broken marriages in only ~~one~~^{two} of the twenty cases would suggest that, in spite of whatever conflict may exist within the family, the clinic is not recommending placement on the basis of the deterioration of the family which makes it impossible for them to establish a home for the child. These are not predominantly cases where there is no father and the mother may or may not make an attempt to keep the family together, as is often the situation in cases which are brought to placing agencies or come to the attention of protective services. The mothers are not giving up and leaving the children or giving them away. They are maintaining the family unit and seeking help to make the unit easier to maintain and manage.

The majority of the families are small, which would suggest that the need for placement does not arise from the mother's reduced capacity to deal with the problems of one child because of pressures from many other children. Similarly, although income figures seem low, the families were able to manage and were willing to pay a fee for help in keeping the child in the home rather than attempting to shift the financial burden imposed by the child onto public agencies. In general, this picture would indicate that these cases, coming to the guidance clinic, are not the overburdened mothers with large families and low incomes who seek placement of the child and for whom placement is desired because they are physically and financially unable to make other arrangements.

Only four referrals came from the court. This would suggest that by and large these families are well enough integrated as units to be seeking help with the problems that the child presents before these problems become a concern to the controlling agencies of the community. Half of them were seeking help which was not volunteered to them, through self-referral and appeal to medical people. Another fairly large group accepted help volunteered but not compelled through the school and social agencies. The cases in which the guidance clinic recommends placement do not seem to be those in which the community demands such action on the basis of the external behavior of child or parents.

Correlations of Characteristics

A number of interesting isolated relationships and more complex patterns emerged in comparing the characteristics discussed above with

each other. In many instances the evaluation of these correlations is questionable because of the absence of comparative statistics for the clinic population in general or for conditions in the geographic area. Where a possible correlation is not given or commented upon, it may be assumed that it was considered and found not to be significant.

The religion of the families was compared with marital status and income (see Table 2). Of the eight cases with Roman Catholic affiliation, in four the parents were separated, which is all of the cases where

TABLE 2
RELIGION BY MARITAL STATUS AND INCOME

	Religion				
	Cath	Prot	Jew	Mixed	Total
Marital Status					
Together	4	6	2	1	13
Separated	4	-	-	-	4
Income					
Lower	5	1	-	-	6
Middle	1	1	2	1	5
Higher	1	3	-	-	4
Total	7	5	2	1	15

such separation existed. Income was also lower in the Catholic families with five of the six low income families being Catholic out of seven Catholic families whose income was known. Of the five Protestant families

with known income, three were in the highest bracket of four families falling there and one was in the lowest bracket. The two Jewish families and one of mixed affiliation were in the middle bracket. This would seem to suggest that in the case of the Catholic families the clinic's recommendation was more often based on the external factors of income and broken marriage than in the case of the other religious groups. Information was not available to determine if this were indicative that the Catholic group required greater external pressure before bringing a child to the clinic or if some other factor associated with the religion made it less likely that treatment of families with external pressures would be successful if they were Catholic.

The size of the family was compared with the age of the mother and the age of the child (see Table 3). It was found that in nine of

TABLE 3
FAMILY SIZE BY MOTHER'S AGE AND AGE OF CHILD

	Number of Siblings				Total
	none	1	2	3 or more	
Mother's Age					
25-39	2	3	1	4	10
40-50	4	5	-	-	9
Age of Child					
4½ to 9½	1	4	1	2	8
10 to 13	5	5	-	2	12

fourteen cases where there were one or two children the mothers were be-

tween forty and fifty years of age while in all five families where there were three or more children the mothers were between twenty-five and thirty-nine. Placement was apparently more likely to be recommended to a younger mother where there was a large family. This might suggest that the clinic felt that the younger mother would have less tolerance for treatment and less capacity for helping the child in the presence of the demands of a large family. The younger mother's large family also suggests a rapid succession of children which would have decreased her ability to perceive difficulties and seek help before the problem had grown to dimensions requiring placement.

The children in the smallest families were also somewhat older. Five of the six only children were older. Half of the younger boys, however, fell in the group of children with one sibling which includes nine of the twenty cases. In spite of this weighting of younger boys with one sibling, there were only five cases of the eight younger boys with one or two siblings while there were ten of the twelve cases of older boys in this group. This would indicate that where treatment conditions are favorable in terms of a small number of other children demanding the attention of the mother, the clinic is more likely to recommend placement of an older boy than of a younger one.

The income of the families was found to be directly related to the age of the mother (see Table 4). Of the seventeen cases where both factors were known, eight mothers were between twenty-five and thirty-nine and nine between forty and fifty. Seven of the younger mothers were making incomes in the lower two brackets, with five of the older

TABLE 4
FAMILY INCOME AND MOTHER'S AGE

Mother's Age	Income			
	Lower	Middle	Higher	Total
25-39	4	3	1	8
40-50	3	2	4	9

mothers. The remaining four older mothers and one younger mother were making incomes in the highest bracket. This suggests that the tolerance of the younger mothers for keeping the child in the home is greater where the pressure of a low income is not a factor.

The family income was also found to be closely related to the age of the child and the marital status of the parents (see Table 5).

TABLE 5
INCOME BY MARITAL STATUS AND AGE OF CHILD

Marital Status	Income			
	Lower	Middle	Higher	Total
Together				
Child $4\frac{1}{2}$ to $9\frac{1}{2}$	2	2	1	5
Child 10 to 13	1	4	4	9
Separated				
Child $4\frac{1}{2}$ to $9\frac{1}{2}$	2	-	-	2
Child 10 to 13	2	-	-	2
Total	7	6	5	18

All of the families where the parents were separated fell in the lowest economic bracket. Of the four represented in the separated families, two were in the younger group and two in the older, as contrasted to a total of eight younger boys and twelve older ones. This would indicate that separation is more frequent in families of younger boys. The families where the parents are together and the children are older seem to make better incomes, although the factor of the parents remaining together or separating seems the more significant. This suggests that where low income is a factor, the clinic is more likely to recommend placement if the family is broken or that where the family is broken the recommendation is more common where there is an additional external factor of low income.

Referral sources were compared to marital status, religion and income (see Table 6). Two of the mothers separated from their husbands were referred by schools. All of the medical referrals were of cases where the parents were together, including seven of the total of sixteen such cases. Protestant families included more school referrals, proportionate to the comparative numbers of Protestant and Catholic families represented, while Catholic families included more medical referrals. This would suggest that the clinic was more likely to recommend placement in spite of the family's having sought help actively if the family were Catholic. Medical referrals were largely of families in the middle income range while court referrals were largely of families in the lower range. There were no referrals from the court of families in the upper range. This would suggest that the clinic felt that treatment was more feasible in spite of the family's not having sought help until the com-

TABLE 6
REFERRAL BY MARITAL STATUS, RELIGION AND INCOME

	Referral Source				
	Self	Medical	School	Court	Total
<hr/>					
Marital Status					
Together	2	7	4	3	16
Separated	1	-	2	1	4
<hr/>					
Religion					
Catholic	1	3	2	2	8
Protestant	1	1	3	1	6
Jewish	1	1	-	-	2
Mixed	-	1	-	-	1
Total	3	6	5	3	17
<hr/>					
Income					
Lower	1	1	3	2	7
Middle	1	4	-	1	6
Higher	1	2	2	-	5
Total	3	7	5	3	18

munity intervened, if there were not the additional pressure of low income.

The presenting problems in each case were compared with marital status, religion and income (see Table 7). It was found that all complaints of achievement difficulties came from families where the parents were together. This suggests that the united family is more likely to perceive and seek help for achievement difficulties and that the clinic is more likely to recommend placement for a behavior disturbance if the

TABLE 7
COMPLAINTS BY MARITAL STATUS, RELIGION AND INCOME

	Complaints		
	Achievement	Behavior	Total
Marital Status			
Together	5	11	16
Separated	-	4	4
Religion			
Catholic	3	5	8
Protestant	-	6	6
Jewish	1	1	2
Mixed	1	-	1
Total	5	12	17
Income			
Lower	1	6	7
Middle	3	3	6
Higher	1	4	5
Total	5	13	18

family is broken.

The Protestant children all fell in the group of behavior problems while the Catholic children showed a higher number of achievement difficulties relative to the totals of achievement and behavior problem cases. The clinic is more likely to recommend the placement of an achievement problem child if the family is Catholic.

Over half of the achievement problem cases fell in the middle income bracket, as compared to a third of the total number in that brac-

ket. The behavior problem cases appeared in about the same proportion in the lower and higher income brackets. This suggests that a middle income family is less able to use treatment for an achievement problem than is either a higher or lower income family.

The presenting problems, the age of the child and the referral sources were compared (see Table 8). The younger boys showed a higher proportion of achievement problems and a higher proportion of school re-

TABLE 8
COMPLAINT AND AGE BY REFERRAL

	Referral Source				Total
	Self	Medical	School	Court	
Achievement Problems					
Age $4\frac{1}{2}$ to $9\frac{1}{2}$	-	3	-	-	3
Age 10 to 13	1	1	-	-	2
Behavior Problems					
Age $4\frac{1}{2}$ to $9\frac{1}{2}$	-	-	4	1	5
Age 10 to 13	2	3	2	3	10
Total	3	7	6	4	20

ferrals, although in no case was a boy both an achievement problem and a school referral. All court referrals were for behavior difficulties and three of the four such referrals were of older boys. Medical referrals were predominantly of younger boys with achievement problems and older boys with behavior problems. Of the boys with behavior problems the schools referred the younger ones while the courts and medical sources

referred the older ones. The clinic would appear to be more likely to recommend placement for a behavior problem if the boy is older and if the parents are disturbed enough by his behavior to seek help or the community has intervened. With the younger boys the recommendation seems more likely to be based upon the more internal consideration of achievement.

Summary of Characteristics

The sample of twenty cases included twenty boys from the ages of four and a half to thirteen years. Four families were broken by divorce or desertion and one by death of the father. The sample was predominantly Roman Catholic and of low income. Medical and school referrals formed a majority. Although a number of other types of complaints were listed, the group was divided into five cases showing achievement difficulties and fifteen showing acting-out behavior.

The Roman Catholic families showed the highest percentage of marital separation and low income. The larger families showed a lower age of the mother and younger children. Families with younger mothers, older children and broken marriages made lower incomes.

Referrals from medical sources were more frequent in families with unbroken marriages, Catholic families and families in the middle income bracket. School referrals were more frequent in broken marriages and Protestant families. Court referrals were more frequent in the lower income bracket.

Children referred for achievement difficulties were more frequent in unbroken homes, Catholic families and the middle income bracket. Behavior problems were more frequent in Protestant homes of the lower and

higher income brackets. Younger boys showed a higher proportion of achievement problems than did older boys. Court referral was more frequent with older boys with behavior problems while medical referral was frequent for younger boys with achievement problems and older boys with behavior problems. School referrals were frequent with younger boys with behavior problems.

CHAPTER VI

MATERNAL ATTITUDES

Tabulation of Scales

Data was collected and the maternal attitudes recorded according to the six scales in as many cases as possible. Data for every case in the sample was collected only by means of the scales of the mother's involvement in help and the mother's attitude to the child. The number of cases at each point on each scale was then tabulated (see Table 9).

The results of the tabulation were the most striking for the scales of involvement and attitude to the child. In the former, nine cases indicated minimal, passive participation in the helping process while none indicated maximal active participation. The remaining eleven cases were rather evenly spread between fair and little participation. In the scale of attitudes to the child, ten cases indicated rejection of the child as the predominant attitude. No cases showed thorough acceptance of the child. Of the remaining ten cases, three showed ambivalence inclined toward acceptance and seven were balanced in ambivalence.

This would suggest that the factors of the mother's ability to become involved in treatment and her attitude to the child are among the leading determinants in the clinic's decision that a child be placed. These are clearly internal factors; one relevant to the milieu of the child, the other relevant to the capacity for change in that milieu. The importance of these factors indicates that the original hypothesis is correct in the assumption that the clinic places on the basis of the psychological milieu and chooses a recommendation of placement over an

an offer of treatment on the basis of the mother's inability to use treatment.

TABLE 9
TOTAL FINDINGS ON ATTITUDE SCALES

Category	No. of cases	Total
Mother's attitude to marriage		
Hostile to father	4	
Ambivalent-hostile	7	
Ambivalent	4	
Ambivalent-positive	1	
Positive feeling	1	17
Mother's attitude to clinic		
Will cure child	4	
May cure child	0	
Uncertain	5	
Unlikely to cure child	2	
Won't help	6	17
Mother's involvement in help		
Maximal active participation	0	
Fairly active participation	3	
Vacillation in participation	5	
Little, passive participation	3	
Minimal passive participation	9	20
Mother's attitude to symptoms		
Very disrupting	6	
Fairly disrupting	5	
Uncertain	3	
Little disrupting	3	
Not disrupting	2	19
Responsibility for symptoms		
Entirely projected	6	
Largely projected	1	
Conflicted	7	
Largely introjected	2	
Entirely introjected	2	18
Mother's attitude to child		
Accepting	0	
Ambivalent-accepting	3	
Ambivalent	7	
Ambivalent-rejecting	0	
Rejecting	10	20

Maternal attitudes to the father were hostile in all but two cases. Marked ambivalence was shown in four cases and some ambivalence in seven, with the remaining six cases showing hostility without ambivalence. This would suggest a milieu of hostility between the parents, even where this has not become externalized as a separation, is being used as a criterion for placement by the clinic.

Maternal attitudes to the clinic were rather hopeless. Of the seventeen cases scaled, only four showed marked hopefulness about the probable results of clinic help while five were uncertain of the results and six were markedly hopeless. The clinic would appear to be considering the mother's hopelessness as indicative of her inability to use treatment help and thereby as a criterion for recommending placement.

The mother's attitude to the degree of disruption produced in the home by the child's symptoms was recorded in nineteen cases. In six cases the mother found the symptoms very disrupting while only five found them little or not at all and three were uncertain about the degree of disruption. The mother's assignment of responsibility for the genesis of the symptoms was conflicted in seven of the eighteen cases recorded and projected in six while in four cases it was largely or entirely introjected.

Maternal Attitudes and Characteristics

Comparisons were made of the maternal attitudes in the sample cases with the characteristics of the cases discussed in Chapter V. The frequency of the occurrence of certain attitudes in cases with certain characteristics was recorded. The mother's attitude to the father was

not used in these comparisons because of the prominence of negative attitudes, with little significant variation, and the smaller number of cases where any assessment had been made. There was also some question in the investigator's mind about the accuracy of assessments which were made, since references to the father were often very infrequent and the evidence of attitudes rather slim.

There were similarly only seventeen cases in which the mother's attitude to the clinic could be assessed. There appeared, however, to be a clearer validity to these assessments and they were compared to the number of siblings the child had, the religion of the family, family income and the source of referral (see Table 10).

Mothers of only children seemed markedly more hopeful about clinic help than did mothers of more children. Three of the four hopeful mothers in the entire sample were mothers of only children, although three others were among the seven less hopeful mothers. Mothers of two children showed more uncertainty than mothers of one child and more hopelessness than any other group.

Of the Catholic and Protestants, the mothers showed about equal numbers of hopeless attitudes but more of the Catholic mothers were hopeful while more of the Protestant mothers were uncertain. Of the three income groups, the middle group showed the most uncertainty, while the higher income group showed the greatest proportion of hopefulness and the lower group was highest in hopelessness although it also showed a higher proportion of hopefulness than did the middle income group.

TABLE 10
MOTHER'S ATTITUDE TO CLINIC BY CHARACTERISTICS

Characteristics	Attitude to clinic					Total
	Hopeful		Hopeless			
	1	2	3	4	5	
No. of Siblings						
none	3	-	-	1	2	6
one	1	-	3	1	3	8
two	-	-	1	-	-	1
three or more	-	-	1	-	1	2
Total	4	-	5	2	6	17
Religion						
Catholic	2	-	1	1	2	6
Protestant	1	-	2	-	3	6
Income						
Lower	1	-	1	-	4	6
Middle	-	-	3	2	-	5
Higher	2	-	1	-	2	5
Total	3	-	5	2	6	16
Referral Source						
Self	-	-	1	-	-	1
Medical	2	-	3	2	-	7
School	1	-	-	-	5	6
Court	1	-	1	-	1	3
Total	4	-	5	2	6	17

Referral source was known for all of the seventeen where maternal attitudes to the clinic were known. The mothers referred by the school showed the highest proportion of hopeless attitudes, including

five of the six school referrals and five of the six mothers indicating the most hopeless attitudes. This would suggest that where there is some pressure, from the authority of the school, indicating somewhat less desire to seek help on the part of the mother and an attitude of hopelessness is added to this, the clinic is more likely to feel that treatment will not be successful. Those referred by medical resources indicated an equally high percentage of both hopeful and uncertain attitudes.

The attitudes of the mothers to the symptoms, gauged by the degree of disruption the mothers felt the symptoms caused in the home, were compared with the children's ages, the mothers' ages, marital status, religion, income, referral source and the presenting problem (see Table 11).

The number of mothers finding the symptoms very or quite disrupting was about proportional for the two age ranges. There were more mothers of older children who found the symptoms less disrupting, however, and more mothers of younger children were in the middle range. Older mothers seemed to find the symptoms somewhat more disrupting than did the younger mothers. Mothers who were separated from their husbands clearly found the child's symptoms more difficult to tolerate. Catholic families also found the child's symptoms more difficult. The middle income group was less disrupted by them than the higher income group.

The mothers who found the symptoms most disrupting were predominately referred by the schools. Mothers referred by the courts found the symptoms slightly more disrupting than did those who referred themselves while the medical referrals showed the most mothers who found the

TABLE 11
MOTHER'S ATTITUDES TO SYMPTOMS BY CHARACTERISTICS

Characteristics	Disruption from Symptoms					Total
	Most	2	3	4	Least	
Child's Age						
4½ to 9½	3	1	2	1	-	7
10 to 13	3	4	1	2	2	12
Mother's Age						
25 to 39	3	2	2	1	1	9
40 to 50	3	3	1	1	1	9
Marital Status						
Together	4	4	2	3	2	15
Separated	2	1	1	-	-	4
Religion						
Catholic	2	2	2	1	-	7
Protestant	2	1	-	2	1	6
Income						
Lower	3	1	2	1	-	7
Middle	-	2	1	2	1	6
Higher	3	2	-	-	-	5
Referral Source						
Self	-	2	-	-	1	3
Medical	1	2	2	2	-	7
School	4	-	1	-	1	6
Court	1	1	-	1	-	3
Total	6	5	3	3	2	19
Problem						
Achievement	-	2	1	1	1	5
Behavior	6	3	2	2	1	14

symptoms less disrupting. The mothers of children with behavior difficulties found these symptoms a great deal more disrupting than did mothers of children with achievement difficulties. These facts would suggest that the disruption of the home situation by the symptoms becomes a factor which makes treatment less feasible only when it is combined with other inauspicious factors such as greater age in the mother, broken marriages, authoritative referrals and behavior difficulties.

The mother's assignment of responsibility for the symptoms, from projection to introjection, was compared with the number of children in the family, the family income and the referral source (see Table 12). The mothers of only children were equally divided between complete projection of responsibility and a conflicted attitude. Mothers of two children were predominately conflicted and the mother of three children introjected responsibility. The nicety of the progression was spoiled, however, by the mothers of four or more children, who showed almost as high an occurrence of projection of responsibility as did the mothers of only children.

Of the three income groups, the mothers in the highest income group showed a greater tendency to project responsibility than either other group and the least tendency to introject of any group. The lower income group showed the greatest tendency to introjection. This would suggest that where the mother introjects responsibility and may be motivated to treatment because of this, the external factor of low income becomes a determinant in the recommendation of placement.

Of the four referral sources, mothers referred by medical re-

TABLE 12

MOTHERS' ASSIGNMENT OF RESPONSIBILITY BY CHARACTERISTICS

Characteristics	Assignment of Responsibility					Total
	Projected			Introjected		
	1	2	3	4	5	
No. of Siblings						
none	3	-	3	-	-	6
one	2	1	3	1	1	8
two	-	-	-	-	1	1
three or more	1	-	1	1	-	3
Total	6	1	7	2	2	18
Income						
Lower	2	-	2	1	1	6
Middle	2	-	2	1	1	6
Higher	2	1	2	-	-	5
Total	6	1	6	2	2	17
Referral Source						
Self	-	1	2	-	-	3
Medical	2	-	2	1	2	7
School	2	-	2	1	-	5
Court	2	-	1	-	-	3
Total	6	1	7	2	2	18

sources showed the greatest tendency to introjection. Mothers referred by courts showed the highest degree of projection with mothers referred by the schools showing the next highest degree of projection. Mothers who had referred themselves were the most conflicted and were also somewhat high in projection of responsibility.

The mother's involvement in help, from maximal active participation to minimal passive participation, was compared with the mother's age, the religion of the family, the income and the referral source (see Table 13). Although none of the mothers were maximally involved, the

TABLE 13
MOTHERS' INVOLVEMENT BY CHARACTERISTICS

Characteristics	Involvement					Total
	Maximal 1	2	3	4	Minimal 5	
Mother's Age						
25 to 39	-	1	5	1	3	10
40 to 50	-	-	1	2	6	9
Religion						
Catholic	-	2	3	-	3	8
Protestant	-	1	1	1	3	6
Income						
Lower	-	1	3	1	2	7
Middle	-	1	2	1	2	6
Higher	-	-	-	1	4	5
Total	-	2	5	3	8	18
Referral Source						
Self	-	-	1	-	2	3
Medical	-	3	1	2	1	7
School	-	-	2	-	4	6
Court	-	-	1	1	2	4
Total	-	3	5	3	9	20

younger mothers were somewhat more involved than was the older group,

showing more cases where involvement was vacillating. There was a slight increase in involvement of Catholic mothers over Protestant mothers. The degree of the mother's involvement varied inversely with the income of the family, with the higher group all showing low involvement, the middle group distributed fairly evenly and the lower income group showing the most involvement. This suggests that when there is some involvement, though little, the unfavorable external factor of low income becomes a criterion for the decision to recommend placement.

Of the four referral sources, mothers referred by the school and mothers who had referred themselves showed the least involvement in the helping process. Mothers referred by the court showed somewhat more involvement than school or self referrals and mothers referred by medical resources showed the highest degree of involvement.

The mother's acceptance or rejection of the child was compared to the mother's age, the number of siblings, the religion of the family and the referral source (see Table 14). The younger mothers appeared to be somewhat more rejecting of the child while the older mothers were somewhat more ambivalent toward their children. Mothers of only children were more accepting, mothers of two children more ambivalent and mothers of three or more children showed the highest degree of rejection of their children. Protestant mothers were somewhat more rejecting than were Catholic mothers.

Of the referral sources, mothers referred by medical sources showed the greatest acceptance of the children. Mothers referred by the courts and self referrals the next greatest acceptance. Mothers referred

TABLE 14
MOTHERS' ATTITUDES TO CHILD BY CHARACTERISTICS

Characteristics	Attitude to Child					Total
	Accepting 1	2	3	4	Rejecting 5	
Mother's Age						
25 to 39	-	1	3	-	6	10
40 to 50	-	1	4	-	4	9
No. of Siblings						
none	-	2	1	-	3	6
one	-	1	4	-	4	9
two	-	-	-	-	1	1
three or more	-	-	2	-	2	4
Total	-	3	7	-	10	20
Religion						
Catholic	-	1	4	-	3	8
Protestant	-	1	2	-	3	6
Referral Source						
Self	-	-	1	-	1	2
Medical	-	2	4	-	2	8
School	-	1	-	-	5	6
Court	-	-	2	-	2	4
Total	-	3	7	-	10	20

by the schools showed a far the highest degree of rejection of the children.

Summary of Maternal Attitudes and Characteristics

A maternal attitude of hopelessness regarding the probable re-

sult of clinic help was seen in mothers of two children, the lower income group and school referrals. Uncertainty was seen in Protestants, medical referrals and the middle income group. The greatest hopefulness was seen in mothers of one child, Catholic mothers, the higher income group and medical referrals.

A maternal attitude toward the symptoms of the child as most disrupting was seen in older mothers, broken marriages, Catholic families, the higher income group, school referrals and behavior problems. In the middle of the scale were mothers of younger children, the lower income group and self and court referrals. A maternal attitude of less disruption was seen in mothers of older children, younger mothers, the middle income group, medical referrals and achievement difficulties.

An attitude of projecting responsibility for the development of symptoms was seen in mothers of only children or four or more children, the higher income group and court referrals. A conflicted attitude was seen in mothers of two children, the middle income group and school and self referrals. The introjection of responsibility was seen in mothers of three children, the lower income group and medical referrals.

An attitude of the mother indicating more involvement in treatment was seen in younger mothers, Catholic families, the lower income group and medical referrals. The least involvement was seen in older mothers, the higher income group and school and self referrals.

Greater acceptance of the child was seen in mothers of only children, Catholic families and medical referrals. Ambivalence was seen in older mothers, mothers of two children and self and court referrals.

Greater rejection of the child was seen in younger mothers, mothers of three or more children, Protestant families and school referrals.

Correlation of Attitude Scales

Correlations were run of all possible pairs of attitude scales. Correlations with the scale of the mother's attitude to the father indicated that the more hostile mothers projected more of the responsibility for the genesis of the child's symptoms while showing more acceptance of the child. The smaller number of cases where the mother's attitude to the father was known, the relatively slight evidence on which assessments had to be made and the predominance of nearly equivalent degrees of hostility, made correlations on this scale seem less conclusive than those of other scales.

The mother's assignment of responsibility was compared with the degree of her involvement in the helping process (see Table 15). Of the

TABLE 15

INVOLVEMENT AND ASSIGNMENT OF RESPONSIBILITY

Involvement		Responsibility					Total
		Projected		Introjected			
		1	2	3	4	5	
Maximal	1.	-	-	-	-	-	-
	2.	-	-	1	1	1	3
	3.	-	-	3	1	1	5
	4.	2	-	1	-	-	3
Minimal	5.	4	1	2	-	-	7
Total		6	1	7	2	2	18

six cases where the mother projected all responsibility, four showed minimal involvement and two showed little involvement. The one case where responsibility was largely projected also showed minimal involvement. A high comparative frequency was also seen in the three cases which showed conflicted assignment of responsibility and vacillation in involvement and in the four cases showing introjection or largely introjection of responsibility and fair involvement or vacillation.

The comparison of the mother's involvement in the helping process with her attitude toward the effect of the child's symptoms on the home (see Table 16) showed that the mothers who indicated the least tolerance of the child's symptoms also showed the least involvement in help.

TABLE 16
INVOLVEMENT AND ATTITUDE TO SYMPTOMS

Involvement		Attitude to Symptoms					Total
		Most disrupting		3	4	Least 5	
		1	2				
Maximal	1.	-	-	-	-	-	-
	2.	-	-	1	2	-	3
	3.	1	2	1	-	1	5
	4.	1	-	1	1	-	3
Minimal	5.	4	3	-	-	1	8
Total		6	5	3	3	2	19

Out of six cases where the mother felt the symptoms to be very disrupting and eight cases where the mother was minimally involved, four coincided. Three of the remaining four cases of minimal involvement reported symp-

toms fairly disrupting. On the reverse of the scale, of the three mothers fairly actively involved and the three indicating little disruption, two coincided.

The scales of the mother's attitude to the child and that of the mother's attitude to the symptoms were compared (see Table 17). A

TABLE 17
ATTITUDES TO CHILD AND SYMPTOMS

Attitude to Symptoms		Attitude to Child					Total
		Accepting		Rejecting			
		1	2	3	4	5	
Most disrupting	1.	-	1	1	-	4	6
	2.	-	-	2	-	3	5
	3.	-	-	1	-	2	3
	4.	-	1	2	-	-	3
Least disrupting	5.	-	1	1	-	-	2
Total		-	3	7	-	9	19

high proportion of the cases where the mother felt the symptoms to be especially disrupting to the family coincided with those cases in which the mother was rejecting of the child. These cases included four of the six where the symptoms were felt to be very disrupting and four of the nine in which the mothers were rejecting of the children. The remaining five cases where the children were rejected were distributed normally among the cases where the mother found the symptoms fairly disrupting and where she was uncertain about the degree of disruption. The coincidence of cases was also higher than normal where the mother was ambivalent to

the child and indicated an attitude toward the symptoms in the middle three categories of fairly disrupting, uncertain and little disrupting.

The scale of the mother's hopeful to hopeless attitude toward the clinic was compared with that of her attitude toward the child and the two were then separated by the type of presenting problem in the case (see Table 18). In comparing the two scales, it was found that of eight

TABLE 18

ATTITUDE TO CLINIC AND CHILD BY PROBLEMS

Attitude to Clinic	Attitude to Child					Total	
	Accepting		Rejecting				
	1	2	3	4	5		
ACHIEVEMENT PROBLEM CHILDREN							
Most Hopeful	1.	-	-	1	-	-	1
	2.	-	-	-	-	-	-
	3.	-	-	1	-	1	2
	4.	-	1	-	-	-	1
Most Hopeless	5.	-	-	-	-	-	-
	Total	-	1	2	-	1	4
BEHAVIOR PROBLEM CHILDREN							
Most Hopeful	1.	-	2	1	-	-	3
	2.	-	-	-	-	-	-
	3.	-	-	1	-	2	3
	4.	-	-	-	-	1	1
Most Hopeless	5.	-	-	1	-	5	6
	Total	-	2	3	-	8	13

cases in which the mother was rejecting of the child and six cases where the mother was least hopeful of clinic help, five coincided. The remain-

ning four cases of rejection of the child fell in the middle or lower categories of the hopeful scale. All five of the coinciding cases were behavior problem children, as were three cases of the four others showing rejection.

At the other end of these two scales, of three cases falling in the ambivalent-accepting category of attitudes to the child and of four cases rated as most hopeful of clinic help, two coincided. Both of these were also behavior problem children.

The scales of the mothers' attitudes to the children and their assignments of responsibility for the symptoms were compared. These scales were then divided according to the presenting problem(see Table 19). Out of six cases where the responsibility was entirely projected and eight where the mother was rejecting of the child, four coincided. Of these six cases, five were behavior problems. Seven of the eight cases of rejection of the child were behavior problems as were five of the six cases where the responsibility was projected.

A high frequency was represented by three cases falling in the middle category of both scales. These were included in a total of seven cases falling in the middle range of the scale of attitudes to the child and in seven cases falling in the middle category of responsibility. Of these three cases, two were behavior problems and one achievement difficulties. The totals represented were five achievement problems and thirteen behavior problems.

The scales of the mother's attitude to the child and her invo-

TABLE 19
RESPONSIBILITY AND ATTITUDE TO CHILD BY PROBLEMS

Responsibility	Attitude to Child					Total	
	Accepting		Rejecting				
	1	2	3	4	5		
ACHIEVEMENT PROBLEM CHILDREN							
Projected	1.	-	-	1	-	-	1
	2.	-	-	-	-	-	-
	3.	-	1	1	-	-	2
	4.	-	-	-	-	-	-
Introjected	5.	-	-	1	-	1	2
	Total	-	1	3	-	1	5
BEHAVIOR PROBLEM CHILDREN							
Projected	1.	-	-	1	-	4	5
	2.	-	-	-	-	1	1
	3.	-	2	2	-	1	5
	4.	-	-	1	-	1	2
Introjected	5.	-	-	-	-	-	-
	Total	-	2	4	-	7	13

lvement in the helping process were compared. These scales were then divided by the type of problem, the age of the child and the marital status of the parents (see Tables 20 through 22). Of the ten cases in the most rejecting category and the nine cases in the least involved category, seven coincided. The seven cases where the mothers were ambivalent to their children were spread evenly from the fairly involved to the little involved with a smaller relative number of cases in the minimally involved category.

Of the seven cases falling in the categories of rejecting mothers with minimal involvement, all were children with behavior problems (see Table 20). Of the seven cases falling in the ambivalent category of

TABLE 20
INVOLVEMENT AND ATTITUDE TO CHILD BY PROBLEMS

Involvement	Attitude to Child					Total
	Accepting		Rejecting			
	1	2	3	4	5	
ACHIEVEMENT PROBLEM CHILDREN						
Maximal	1.	-	-	-	-	-
	2.	-	1	1	-	-
Minimal	3.	-	-	-	-	1
	4.	-	-	-	-	-
	5.	-	-	2	-	-
Total		-	1	3	-	1
BEHAVIOR PROBLEM CHILDREN						
Maximal	1.	-	-	-	-	-
	2.	-	-	1	-	-
	3.	-	1	2	-	1
	4.	-	1	1	-	1
Minimal	5.	-	-	-	-	7
	Total		-	2	4	-

attitudes to the children, three were achievement problem children as compared with a total of five achievement problems in the twenty cases.

When the scales of involvement and the attitude to the child were divided by the age of the child (see Table 21), it was found that four of the seven cases of minimal involvement and rejection of the child

TABLE 21
INVOLVEMENT AND ATTITUDE TO CHILD BY AGE OF CHILD

Involvement	Attitude to Child					Total
	Accepting		Rejecting			
	1	2	3	4	5	
·YOUNGER BOYS - 4½ to 9½						
Maximal	1.	-	-	-	-	-
	2.	-	1	1	-	-
	3.	-	-	-	-	2
	4.	-	-	-	-	-
Minimal	5.	-	-	-	-	4
	Total	-	1	1	-	6
OLDER BOYS - 10 to 13						
Maximal	1.	-	-	-	-	-
	2.	-	-	1	-	-
	3.	-	1	2	-	-
	4.	-	1	1	-	1
Minimal	5.	-	-	2	-	3
	Total	-	2	6	-	4

were younger boys. This represented a larger proportion than could be assumed from the totals of eight younger boys and twelve older boys.

Conversely, of the seven cases of ambivalence to the child, six were older boys. The two cases of fairly active participation among cases of younger boys was also proportionately higher than the one case among older boys.

This would suggest that the clinic recommends the placement of younger boys only when the family milieu is considerably worse than is the case when it recommends placement of an older boy.

When the marital status was related to the degree of involvement and the attitude to the child (see Table 22), it was found that families

TABLE 22
INVOLVEMENT AND ATTITUDE TO CHILD BY MARITAL STATUS

Involvement		Attitude to Child					Total
		Accepting		Rejecting			
		1	2	3	4	5	
TOGETHER							
Maximal	1.	-	-	-	-	-	-
	2.	-	1	2	-	-	3
	3.	-	1	-	-	1	2
	4.	-	1	1	-	1	3
Minimal	5.	-	-	2	-	6	8
	Total	-	3	5	-	8	16
SEPARATED							
Maximal	1.	-	-	-	-	-	-
	2.	-	-	-	-	-	-
	3.	-	-	2	-	1	3
	4.	-	-	-	-	-	-
Minimal	5.	-	-	-	-	1	1
	Total	-	-	2	-	2	4

where both parents were together showed a greater incidence of rejection and minimal involvement. Of the seven cases showing rejection and minimal involvement, six were unbroken marriages, while one was a broken marriage, as compared to sixteen unbroken and four broken marriages. The total of cases of rejected children was proportionately divided between broken and unbroken marriages. The total of cases with minimal involve-

ment was higher in the unbroken marriages. This would suggest that where the degree of involvement is low and rejection is present, the clinic was more likely to place where the marriage was broken. When the marriage was not broken, the clinic did not recommend placement until the rejection and lack of involvement were more pronounced.

Summary of Attitude Correlations and Characteristics

The comparison of the various attitude scales and their correlation to characteristics showed that the mothers who were the most disrupted by the symptoms were those who were the least involved in the process of seeking help and those who showed the most rejection of the children.

The mothers who were the most rejecting of the children were also the least hopeful about the results of clinic help. These were primarily the mothers of children with behavior problems. The mothers showing the greatest rejection of the children were also the most likely to project responsibility for the symptoms and these were again largely behavior problem children. Conversely, the less rejecting mothers projected less of the responsibility and were more frequently mothers of children with achievement problems.

The rejecting mothers also showed the least involvement in help and these were found to be primarily the mothers of younger boys and of boys with behavior problems.

The occurrence of seven coinciding cases appearing in the categories of least involvement on the part of the mother and the rejection of the child seemed highly significant. These cases were then studied

separately and tabulated according to their characteristics and to the ratings made on attitude scales other than those of involvement and attitude to the child. This material is included in Appendix 3.

CHAPTER VII

SUMMARY AND CONCLUSIONS

Summary of the Study

Twenty cases where the Worcester Youth Guidance Center recommended that the child be placed were studied. The impact of placement upon the personality of a child is widely recognized and it was assumed that placement was recommended because of a pressing need for the child to be removed from the home. The purpose of the study was to explore what factors were common to these cases which might form criteria for the making of the recommendation. Criterion had not been explicitly stated for the necessity of placement as seen by a guidance clinic. The recommendation was made, it was assumed, on the basis of the clinic's conviction that treatment in the form usually offered by the clinic would not be successful. It was questioned whether the criteria were drawn from external factors or internal factors and in either case which such factors.

Child-placing and protective agencies have established explicit criteria for making the placement of a child. These are based on external factors such as illness or absence of the parents, abusive treatment of the child, the child's unmanageability in the community and formerly the financial ability of the family. The area of these external factors in the sample was explored to determine if these same criteria were met by the cases placed by a guidance clinic.

It was hypothesized that the clinic was basing its recommendation not on such external factors but on factors which determined the inability of the family to accept or use treatment as a means of changing

the internal milieu of the child. These are the internal factors of the psychology of the family which form the basis of diagnosis and planning in all cases which come to the clinic for help.

The internal factors which might form the basis for the clinic's decision to recommend placement rather than offering treatment were approached through the evaluation of the mother's attitudes and feelings. The attitude and feeling areas assessed were those relevant to the milieu of the child; the marital situation and the mother's acceptance or rejection of the child; and those relevant to the possibility of change through clinic treatment; the mother's motivation through assuming responsibility for and feeling the seriousness of the symptoms, her hopefulness about being helped and her willingness to involve herself in the treatment process.

Conclusions

The evaluation of the external characteristics of the sample as a whole indicated that the families were not deteriorated. No individual external factor seemed to be a determinant in creating a need for placement. Only four of the twenty cases involved broken families. The families were largely small rather than large families which would make for difficulty in capacity to care for the children. Income was low but the families were mostly able to put out additional funds for the child in the form of clinic fees. Only four cases were referred by the court, indicating that in general the community had not been required to interfere in the family situation. The age of the children suggested that in some situations the clinic would place an older child where it would offer treatment for a younger child.

Although the clinic did not appear to be using individual external factors as criteria for recommending placement, correlations of these criteria suggested that in some cases combinations of external factors influenced the decision. A recommendation was more often made in cases where the mother was young if the family were large or if the income were low. If the family were small, the recommendation was more often made where the boy was older. Where the family was broken by divorce or separation, placement was more often suggested if the income were low. Where there was community pressure for change in the family, treatment was less often felt inadvisable where the income was higher.

Confirming the hypothesis that the clinic made its evaluation on the basis of internal factors, the maternal attitudes in the sample cases were markedly unfavorable to the success of treatment. The most striking factors were the predominance of rejection of the child, which would indicate the severity of the internal conditions of the home milieu, and the lack of involvement in the helping process on the part of the mother, which would indicate the lack of promise for the success of treatment.

The mother's attitude toward the father, which is also a part of the internal milieu since in most cases it has not become externalized as a separation, was markedly hostile. This again indicated the presence of difficulty in the internal milieu. The mothers were also markedly hopeless in their expectations of help from the clinic, which would confirm the lack of promise of treatment success suggested by the lack of involvement on the mother's part.

The mothers showed a trend to feeling that the symptoms were

very disrupting in the home but this was not a clearly predominant attitude. This would suggest that some consideration is given by the clinic to the motivation which comes from such pressure but that such external pressure is not clearly a criterion.

The correlation of the maternal attitudes in the sample cases with the characteristics of the cases indicated that where the internal factors are not too clearly contraindications for treatment the presence of unfavorable external factors may form a basis for the decision to recommend placement rather than offering treatment. Where the mother's hope of help indicates a possibility of treatment the consideration that her motivation is partly a result of external pressure, shown by referral from an authoritative source, may be a contraindication. Family disruption by the child's symptoms, not in itself a determinant, may lead to a recommendation of placement where it is accompanied by such factors as greater age of the mother, broken marriage or referral which demonstrates less motivation.

The motivation for treatment indicated by the introjection of the responsibility for the development of symptoms is seen by the clinic as counteracted by the existing of less capacity because of low income. A milieu which is more promising, shown by less rejection of the child by the mother is seen as counteracted by the reduced capacity for treatment indicated by greater age in the mother.

A more favorable milieu indicated by less rejection of the child combined with a greater promise of treatability indicated by some involvement in the helping process on the part of the mother makes for much greater

ter promise with treatment and the clinic does not frequently recommend placement in such cases. Where the recommendation is made in such cases the factors which emerge as criteria are the existence of an achievement problem in the child, his greater age and marital separation.

The correlations of the various attitudes of the mothers indicated a pile-up of attitudes unfavorable to the success of treatment. This pile-up indicated that these attitudes were the predominant criteria used by the clinic to determine whether placement was necessary. The closeness of the correlation made it impossible, however, to obtain any clear indication of the relative weight of some of the unfavorable attitudes in the making of the clinic decision. The most apparently significant items were the rejection of the child and the lack of maternal involvement in treatment, but it was not possible to weigh these against each other.

It did appear that a feeling that the symptoms were highly disrupting in the home, which would argue motivation for change, was outweighed by either a low degree of involvement or a marked rejection of the child. The factor of disruption is somewhat ambiguous, however, since the motivation may be less for changing the symptoms to relieve the pressure they create than for removing the symptoms by placing the child.

The projection of responsibility which indicated low motivation occurred most frequently in company with little involvement. Similarly, a hopeless attitude which would militate against treatment success was frequently accompanied by rejection of the child which would indicate a milieu requiring greater change. The low motivation indicated by projection also corresponded with rejection of the child, indicating need for change.

Summary of Conclusions

From the evidence of the twenty cases studied in which the Worcester Youth Guidance Center recommended placement, it can be concluded that the criteria for the decision were predominantly internal factors. The internal factors revealed that the mother's willingness to become involved in treatment, or the ability to approach the case situation through offering treatment was a major determinant. The internal situation in the home itself, the need for change, was the second major determinant. External factors did not in and of themselves determine the need for placement or determine that treatment would not be possible. Where the internal factors were not decisively unfavorable, however, the additional weight of unfavorable external factors was used as a criterion.

The Child's Problem

Throughout the study, interesting factors emerged around the differentiation of behavior and achievement problems. The cases where the problem was in the achievement area numbered only five. It could not be concluded whether this small number was representative of the clinic's using the existence of behavior difficulties as the criterion for placement or whether this proportion of achievement to behavior problems was normal for the clinic population. Generally, the cases with behavior problems conformed more closely to the criteria for recommending placement that emerged than did the cases with achievement problems. A more careful study of this area would be interesting in placing the type of problem shown by the child in its position as a criterion for the disposition of the case.

*accepted 5/26/57
Maxwell Schliefer*

APPENDIX 1

DATA SCHEDULE

Name: Case No.: Age: Sex: Grade: Religion:
 Complaints:
 Intake Date:
 No. Intake Interviews: Conference date: Conference Recommendation:
 Referral Source:
 Family: Mo's Age; Fa's Age; Marital Status; Age and Sex of Siblings;
 Social: Income; Fee; Education; Occupation; Years Married; Previous Marr?;

1. Client's comments on referral source:
2. Follow-up information:
3. Clinic Statements: Diagnostic; Prognostic;

ATTITUDES

- | | |
|---|---|
| <p>A. Mo's Attitude to Marriage</p> <ol style="list-style-type: none"> 1. Hostile to Fa. 2. Ambivalent-hostile 3. Ambivalent 4. Ambivalent-positive 5. Positive Feeling <p>Did Fa come to clinic?</p> | <p>D. Mo's Attitude to Symptoms</p> <ol style="list-style-type: none"> 1. Very Disrupting 2. Fairly Disrupting 3. Uncertain 4. Little Disrupting 5. Not Disrupting |
| <p>B. Mo's Attitude to Clinic</p> <ol style="list-style-type: none"> 1. Clinic will cure child 2. Clinic may cure child 3. Uncertain 4. Clinic unlikely to cure 5. Clinic won't help <p>Was mo controlling? Hostile?</p> | <p>E. Responsibility for Symptoms</p> <ol style="list-style-type: none"> 1. Entirely projected 2. Largely projected 3. Conflicted 4. Largely introjected 5. Entirely introjected |
| <p>C. Mo's Involvement in Help</p> <ol style="list-style-type: none"> 1. Maximal active participation 2. Fairly active participation 3. Vacillation in participation 4. Little, passive participation 5. Minimal passive participation | <p>F. Mo's Attitude to Child</p> <ol style="list-style-type: none"> 1. Accepting 2. Ambivalent-accepting 3. Ambivalent 4. Ambivalent-rejecting 5. Rejecting |

APPENDIX 2

DISTRIBUTION OF AGES OF CHILDREN AND PRESENTING PROBLEMS

No.	Age	A	B	C	D	E	F	Classification
1.	4½	x						Achievement
2.	6		x	x	x			Behavior
3.	7	x		x			x	Achievement
4.	7		x	x				Behavior
5.	8		x					Behavior
6.	9		x					Behavior
7.	9	x				x		Achievement
8.	9½		x		x			Behavior
9.	10		x					Behavior
10.	10½		x					Behavior
11.	10½		x	x				Behavior
12.	11		x	x				Behavior
13.	11½		x			x		Behavior
14.	12		x			x		Behavior
15.	12		x	x	x			Behavior
16.	12		x					Behavior
17.	13	x	x	x			x	Achievement
18.	13	x		x				Achievement
19.	13		x					Behavior
20.	13		x					Behavior

APPENDIX 3

SEVEN CASES WITH REJECTION OF CHILD AND MINIMAL INVOLVEMENT

A. BY CHARACTERISTICS

Characteristic	7 Cases	Total Sample
Age		
4½ to 9½	4	8
10 to 13	3	12
Age of Mothers		
25 to 39	3	10
40 to 50	4	9
Marital Status		
Together	6	16
Separated	1	4
No. of Siblings		
none	2	6
one	3	9
two	-	1
three or more	2	4
Religion		
Catholic	2	8
Protestant	3	6
Income		
Lower	2	7
Middle	1	6
Higher	3	5
Referral Source		
Self	1	3
Medical	-	7
School	4	6
Court	2	4
Presenting Problem		
Achievement	-	5
Behavior	7	15

APPENDIX 3 (CONT'D.)

SEVEN CASES WITH REJECTION OF CHILD AND MINIMAL INVOLVEMENT

B. BY MATERNAL ATTITUDES

Attitude-	7 Cases	Total Sample
To Marriage		
Hostile	1	4
Ambiv-Hostile	2	7
Ambivalent	4	4
Ambiv-Positive	-	1
Positive	-	1
To Clinic		
Will Cure	-	4
May Cure	-	-
Uncertain	2	5
Unlikely	-	2
Won't Help	4	6
To Symptoms		
Very Disrupting	4	6
Fairly	2	5
Uncertain	-	3
Little	-	3
Not disrupting	-	2
Responsibility		
Entirely projected	3	6
Largely	1	1
Conflicted	1	7
Largely introjected	-	2
Entirely	-	2

BIBLIOGRAPHY

- English, O. Spurgeon and Pearson, Gerald H. J. Emotional Problems of Living. Revised and Enlarged Edition. New York: W. W. Norton and Company, 1955.
- Friedlander, Walter A. Introduction to Social Welfare. Englewood Cliffs, N. J: Prentice-Hall, Inc., 1955.
- Hamilton, Gordon. Theory and Practice of Social Case Work. Second Edition, Revised. New York: Columbia University Press, 1951.
- Lavers, Elizabeth Kingsley: "Placement Recommendations for Clients of a Children's Psychiatric Clinic: A Study of Twenty Cases of the Children's Psychiatric Clinic of the Massachusetts Memorial Hospitals (January 1, 1949 - December 31, 1953)." Unpublished master's thesis, Boston University School of Social Work, Boston, 1955.
- Perlman, Helen Harris. Social Casework: A Problem-solving Process. Chicago: University of Chicago Press, 1957.
- Weiner, Betty Ann. "A Study of Fifty Children Needing Residential Psychiatric Treatment seen in the New Hampshire Mental Hygiene and Child Guidance Clinics During 1953." Unpublished Master's thesis, Boston University School of Social Work, Boston, 1954.
- Youth Guidance Center. "Annual Report, Nineteen fifty Seven." Two State Street, Worcester, Massachusetts.