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A study of the recommendations for disposition of cases discharged from the Bradley Home from January, 1952 to December, 1952.

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A STUDY OF THE RECOMMENDATIONS FOR DISPOSITION OF
CASES DISCHARGED FROM THE BRADLEY HOME
FROM JANUARY, 1952 TO DECEMBER, 1952

A thesis

Submitted by

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(B.A., Queens College of the City of New York, 1948)

In Partial Fulfillment of Requirements for
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1953

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CHAPTER I

INTRODUCTION

This is a study of the recommendations made regarding the disposition of twelve cases discharged from January, 1952 to December, 1952 at the Emma Pendleton Bradley Home, a psychiatric hospital for emotionally disturbed children.

Purpose of the Study. The purpose of this study is to determine what factors influenced disposition. The questions to be answered are: 1) What were the major recommendations for disposition after leaving the Bradley Home? 2) What factors influenced these recommendations? 3) What was the role of the social worker in helping determine disposition?

Method and Scope. The method has been to examine all twelve cases which were kept on beyond the six week period of observation and which were discharged between January, 1952 to December, 1952. The case records were studied to determine the factors which influenced recommendations for disposition. The Chief Psychiatric Social Worker at the Bradley Home was also interviewed with regard to additional reasons for disposition in these cases. A survey of pertinent literature has been included.

Limitations. There are several limitations to this study: 1) Because of changes in the functioning of the Social Service Department in the last three years these twelve cases

were the first feasible count of discharge recommendations under the current arrangement. The Social Service Department, as it currently exists in the Bradley Home, is in a key position in regard to discharge planning. This function is discussed in Chapter II. 2) Only those cases were selected which had passed the six weeks period of initial observation. These are the cases which were regarded as treatable to some degree in an in-patient setting.

CHAPTER II

DESCRIPTION OF THE EMMA PENDLETON BRADLEY HOME AND THE ROLE
OF THE PSYCHIATRIC SOCIAL WORKER

The Emma Pendleton Bradley Home was founded in 1931 under an endowment left by Mr. and Mrs. George Lothrop Bradley as a memorial to their only child whose name it bears. Their will stipulated that the hospital must not only help the individual, but must provide study and research for prevention and better treatment. As of 1942, it actively became a study and treatment home for emotionally disturbed children of four to twelve years of age. There was no discrimination because of race, color or creed. The requirements for admission were: 1) that the child have an emotional illness requiring in-patient treatment 2) that the child be of average intelligence or above 3) that he and his family have the potential for benefiting by the type of treatment offered. A child is not excluded because of physical illness provided that emotional illness is also present.

The Home is operated by a board of elected trustees as an independent non-profit children's service. It is financed out of the income from the endowment plus sums paid by the parents for whatever portion of the cost of their children's care they can afford.

The Emma Pendleton Bradley Home is a modern hospital building surrounded by forty acres of wooded grounds near upper Narragansett Bay in Riverside, Rhode Island. The

building has accommodations for fifty-four children. There are well equipped schoolrooms, a nursery, library, recreation rooms, hospital treatment and examination rooms, and offices. The grounds contain playing fields, a modern swimming pool, a pond, and picnic areas for outdoor activities. Evidences of institutional or hospital atmosphere have been minimized, and the living conditions have been made as homelike as possible. The Bradley Home is well equipped in both staff and physical facilities to care for the child whose emotional problems are further complicated by physical disabilities such as epilepsy, cerebral palsy, diabetes, etc.

At the point of intake, explanation is given to the parents of the necessity of their cooperation with casework either in Bradley or in their own communities, if residence is outside of Rhode Island.

The annual report of the Bradley Home for 1945 states:

It is obvious that the potential capabilities of a child to respond to treatment as well as the desire and ability of his family to accept and profit from guidance are prime considerations in determining whether or not extensive and time consuming psychiatric treatment in a hospital of limited capacity should be made available to a particular child.¹

The caseworker usually takes the intake interview although this responsibility is currently shared by the resident podiatrician. The interview consists of an appraisal of the

1. Annual Report for 1951, Emma Pendleton Bradley Home.

child and parent in terms of their need and potential for the type of care offered. Factors of concern are the nature and severity of the child's illness and whether other forms of treatment could be utilized.

The casework program grows out of the recognition that living in groups away from their parents is unnatural for both parent and child. The worker must be aware of the family's understanding of the child's need for care outside the home, their willingness to have the child accept this kind of placement, and their ability to work with the Home to make it possible for the child to return either to a better home situation or another placement.² From the beginning, the emphasis is on the possibility of the child's return to the community. The caseworker must be aware of the resources in the community if she is to make a wise choice as to the suitability of the Bradley Home for the particular child. Discharge plans for the child must begin at the point of intake. It is here that parental and court responsibility must be clearly defined and replanning in the light of changing the situation undertaken.

Upon admission, the child undergoes a complete neurological and physical examination. Extensive laboratory investigations are carried out. An electroencephalogram is obtained

2. Joyce Kirby, "The Child Placing Agency and the Court", Child Welfare, 27:7, June, 1948.

for each child and a psychological examination is given to determine the child's intellectual functioning and emotional makeup.

The admission history which is the basis for further decisions as to diagnosis and treatment is also the caseworker's responsibility. This duty is shared by the podiatrician and psychiatric nurse under the direction of the Chief Psychiatric Social Worker. The purpose of the admission history is to obtain a dynamic picture of the child parent relationship in order to understand the etiology and development of the illness. This history is useful in introducing the parents to the Bradley Home and future casework.

After a study period of six weeks, in which the child's behavior and reactions are carefully observed, a staff conference is arranged at which the different professional skills pool their knowledge about the child and decide if the Home can be of value to him. At this point treatment is prescribed and undertaken.

The treatment program for the child at the Home consists of group living, individual psychotherapy and narcotherapy in isolated instances. Therapy with the children is done by the social worker, the psychologists and the psychiatrists. All who do therapy are given consultation with a child analyst for help with the treatment plans. In working with the children the caseworker must have an understanding not only of his own function but that of the other workers on the

team consisting of a psychiatrist, psychologist, teacher and residential worker all of whom have as their focus the child and his problems.³

Casework with the parents is shared with the psychology department and is under the direction of the Chief Psychiatric Social Worker. It has for its aim the bettering of the home situation which has so often precipitated the child's illness. These contacts also help the parents in present adjustment to the child's being at Bradley and in future planning for the child.

The principal method of integrating the contributions of all those interested in the child's treatment is through two weekly conferences. In one, the director meets with all the staff who work with the children in order to discuss new cases and to review progress in the current ones. This is an information conference at which problems arising in all areas of treatment may be discussed. Other staff meetings which help integration are the teaching conferences and the psychotherapy seminars under the direction of an analyst.

The decision about a child's readiness for discharge is made by the director. This follows an evaluation conference in which all staff concerned in treatment participates. Discharge takes place when it has been determined that the child

3. Herschel Alt, "The Role of the Psychiatric Social Worker in Residential Treatment of Children", Journal of Social Casework, 32:365, April, 1949.

has received maximum benefit from the treatment program. Length of stay is determined entirely by the progress of the individual child. As a matter of actual experience, however, the maximum stay is generally about two years and the greater number of children stay six months to one year.

The caseworker is influential in recommending the particular disposition since his knowledge of community resources and child welfare practices in the community well equip him for this role. It takes careful planning with both parents and children to assure that recommendations will be understood and carried through. If placement is decided on, both parents and child must be helped individually on a casework basis to adjust to this new step. If return home is indicated, this too is taken up in individual casework interviews. Sometimes several weekends home before discharge are arranged so that the change will not be too abrupt.

We must sharpen our diagnostic skill to evaluate a parent's real feelings about his child in order to help him to reach a decision about his future. If we really believe that a child should have two parents and the security of his own home, then we must concentrate on helping the parents to strengthen their situation to the point where they can reaccept their child or help them to release the child in order that the child may be free to form new and secure ties in a substitute home.⁴

The caseworker at the Emma Pendleton Bradley Home is the

4. Irving Weissmann, "Children in Long-Term Foster Care," Child Welfare, 29:7, June, 1950.

link between the parent and the institution, the parents and the child, and the child and the community.

CHAPTER III

SURVEY OF THE LITERATURE

In this chapter, is presented the current thinking on the criteria for placing children in certain settings. It is assumed that home with parents or relatives is the arrangement of preference. A placement away from home should be regarded, if possible, as a transitional stage in preparation for the child's future adjustment to his own community and family. It should serve as a step in his rehabilitation, socially and emotionally. Placement should be thought of as a final measure to be taken only when there is no other alternative.

The major types of settings offered to a child who can no longer remain in his own home are: 1) individual foster homes 2) group placements. Each of these is not exclusive of the other and the same child may have need of different settings at different periods of his life.

The pendulum is now swinging to the balanced recognition that in the care of the child, both foster family and group placement have essential roles to play. Nearly twenty years ago, Prentice Murphy at the White House Conference, emphasized that the foster home versus the institution controversy was not valid and that both should be recognized for foster care. Child guidance clinics and casework skills are more and more focusing attention on selecting for each individual child, the type of foster care, family or group placement that will, at the particular stage of his development meet his

needs.⁵

Every child who must live apart from his own family and home must be considered individually. There are no absolute laws for deciding which child should be placed in a foster family and which in an institution. However, in working out a plan for an individual child, we can be guided, according to Florence Clothier, by our sound knowledge of the stages of personality development.

All indications point to foster home placement for a child who must be placed outside his own home during the first six years of life. It is in this period that foster family care has its greatest contribution to make.⁶

For children six to twelve years old who present such severe behavior or personality disorders that they cannot be cared for in their own homes or in foster homes, institutionalization may be both necessary and beneficial.⁷ However, this age group is also one that should be experiencing intimate family life rather than institutional care. In dealing with this age group, an effort should be made to treat the parents and the home situation so that when the child returns,

5. Florence Clothier, "Institutional Needs in the Field of Child Welfare," The Nervous Child, 7:154, April, 1948.

6. Ibid., p. 154.

7. Ibid., p. 158.

he will not meet with the same type of home situation which led to his difficulties. A really flexible program for disturbed children in this age group would allow for day care for some youngsters, particularly in the transitional period between discharge and full return. Summer camps integrated with the casework and psychotherapy programs as well as with the regular group or day care program can serve useful functions. Many institutions use foster homes in the community as a step in preparation for the child's eventual return home. Usually cottage types of programs are most recommended for this age group since this is nearest the familial setting which is so necessary at this stage.⁸

Thus it is thought that foster home placement is best for children up to pre-adolescence. However, there are some exceptions to this:

1) The child who shows such peculiar or difficult behavior that foster parents could not stand up under it, or the child who is a menace to the community or himself and needs supervision. There are many people in institutions to share the problem, whereas in foster homes, the parents have to take this type of child for twenty-four hours a day. For some emotional problems, the foster family and even the usual institution cannot offer the necessary care. Special study

8. Ibid., p. 165.

and treatment centers which are equipped with programs and the staff for observation, diagnosis and treatment, are gradually expanding and developing their facilities.

2) The child who has strong ties to his family can usually be better taken care of in a group setting. This category would include a great many neurotic and rejected children.

. . . the child who in reality is seriously rejected by his family and is unable to admit and accept this rejection . . . For many of these children, a foster home adjustment may be very difficult. This is particularly true if the foster parent's own children are in the home . . . This sets up an intolerable situation for the child whose compelling drive is the same type of relationship with his own family . . . He is afraid to trust too close a relationship with other people since his parents have failed him. In addition, he is being disloyal to his own parents by loving these substitute parents and is admitting to himself that he cannot expect love from his own parents and so must take it from the outside.⁹

For a child so hurt by previous experiences placement in a group setting is usually the best plan. A group of unrelated children living under the care of a group of unrelated adults "differs from a family in such essentials as individual care and unique relatedness of the family unit."¹⁰

This kind of care frees the child from the necessity of responding in the close relationships characteristic of family

9. Frank M. Howard, "Institutions or Foster Homes?", Mental Hygiene, 30:99, January, 1946.

10. Social Work Year Book, 1951, p. 206.

life.

The institution frees the child to test his capacity to give and take love without further rejection by the foster parents unable to bear his lack of response to their affection. It also spares the foster family the frustration caused by feeling that they have failed to help the child . . . In an institution, they may learn to live away from their own family until ready to take on new relationships with other family groups if then their parents can still not take them home. Placed directly in foster family homes, they tend to require further replacements each of which often leaves them less able to accept a foster home and more difficult to treat in an institution.¹¹

3) Children whose parents feel threatened by the relationship between their child and the foster parents. The natural parent often needs time free from such threats to assess his relationship to his child and his ability and interest in taking responsibility for rearing him, or he may need some help in deciding whether he can provide a home or must allow the child to live away from home.¹²

Because most of the children who are discharged from the Bradley Home are between the ages of eleven and thirteen and entering adolescence, it is especially interesting to review the literature in this area. The direction of the adolescent is away from the home.¹³ His major problems are to loosen

11. Ibid., p. 206.

12. James R. Dumpson, "Placement of Adolescents in a Foster Care Agency," Journal of Social Casework, 29:179, May, 1948.

13. John G. Milner, "Some Determinants in the Differential Treatment of Adolescents," Child Welfare, 29:5, October, 1950.

the ties of his family, to become self supporting, to develop a heterosexual attitude and to achieve correct sexual identification. Determination of how an adolescent feels about parents is important in helping to decide whether or not placement should be made away from his own home. If resistance to placement is met, the worker should remember that the adolescent is especially capable of defeating anything planned for him.¹⁴ The adolescent will generally be able to tell his worker which seems best for him if he has been allowed to participate fully in the preparation for placement. Certainly no adolescent must be institutionalized unless society wants to be protected from him or he needs protection from society.

Foster family placement of poorly adjusted adolescents is notoriously difficult.¹⁵ Agencies even find it hard to place boys and girls over ten and eleven who have had a stable environment and good identification. Thus we see that for both psychological and practical reasons, the pre-adolescent as well as the adolescent is often better suited for a group placement than an individual one.

In group placements, where personal hostilities with their origin in the remote past are mitigated, the adolescent

14. John G. Milner, "Some Determinants in the Differential Treatment of Adolescents," Child Welfare, 29:5, October, 1952.

15. Clothier, op. cit., p. 162.

(especially the disturbed adolescent who has revolted against an environment which was unyielding and controlling) is free to face and cope with his problems.¹⁶ Here, he is in a situation where, like everyone else around him, he is living apart from his own family. Restrictions, work, responsibilities and standards are alike for one and all. If they are generally accepted by the group, the individual adolescent is strongly influenced to accept these too. In conforming to the group, under socializing leadership, the youth experiences security. The flexible boarding school or residential home with a trained personnel and a good program can capitalize on the adolescent's enthusiasm and talents in a way that the ordinary foster home cannot. The adolescent finds reassurance and gains self-confidence when he can excel in some activity, academic, athletic, artistic, vocational, social, etc. The development of individual skills brings self-assurance and self-confidence. Thus some form of group care would be best to meet the adolescent's needs, especially those of the more disturbed adolescent. Casework services and psychiatric consultation should be available.

It is important to use group placement on a selective basis because of its own value rather than as a substitute for a foster home. We are beginning to recognize that in the care of children both foster family and group placement have

16. Clothier, op. cit., pp. 162-165.

essential roles to play, and that a given child may actually be able to utilize both at different time. Often the child is able to utilize therapy in the protected environment of a group placement where this has been impossible for him in the community. If a child must be placed outside his own home we have to decide which type of placement is best for the child, and this often takes a good knowledge of the community resources as well as of the child's problems.

As we have seen, foster care on an individual basis is pre-eminently for the young child. For those in or approaching adolescence, the group is a better placement.

The choice between the foster family and institutional care must be determined by each child's individual needs related to age and social and emotional conditions. Despite general acceptance of this principle, practice lags in many parts of the country; in some communities both types of care are so inadequate for meeting minimum conditions of the child, that no happy choice between them is possible.¹⁷

For institutional placement (we are not referring to boarding school or group foster placement, but custodial care) one must have verification of deviate behavior of sufficient duration and severity to disqualify other types of placement.

In summary, as the caseworker develops more diagnostic skill he is better able to see which child can best profit from group living and which can gain more from foster home care. It is not a question of either-or but of rather which

17. Social Work Year Book, 1951, p. 206.

and when. No single plan can meet the needs of every child for whom placement is necessary for each has different needs and these needs become modified as the child grows.

CHAPTER IV
CASE HISTORIES STUDIED

From January, 1952 to December, 1952, a total of twelve children were discharged who had been accepted for treatment after the initial six weeks of observation. The recommendations as to disposition of these cases was as follows:

TABLE I
RECOMMENDATIONS FOR DISPOSITION OF CASES DISCHARGED
FROM THE EMMA PENDLETON BRADLEY HOME
FROM JANUARY 1, 1952 TO DECEMBER 31, 1952

Initial Disposition Recommended	Number of Children
Foster Homes	2
Boarding Schools	2
Institutions	2
Own Homes	6
Total	12

Out of the twelve cases chosen from this study, six were chosen for presentation. The cases fall into two groups: In Group I, recommendations have been made for placement outside the home. In Group II, recommendations have been made for return home. All identifying data has been changed in order to preserve the confidentiality of the records.

Group I

Six cases were studied in this category and four are presented in detail. In all these cases recommendations have been made for placement outside the home. The age range in this group is from nine to twelve. The length of stay at Bradley was from eight months to two years. In two cases the fathers were deceased, in one case the mother was in a state hospital, and in another the parents were divorced. In the two remaining there was marital discord.

Case A

A, age 12 at discharge, was treated at the Bradley Home for two years with chief complaints of: 1) enuresis, 2) masturbation, 3) sex play, 4) shyness, 5) fire setting, and 6) nail biting. The home situation was a tense one.

Mr. A was an alcoholic who more and more deserted his family. Finally when A was two, the mother divorced A's father and went to work while the child was left in charge of the grandparents. When the mother later married Mr. X by whom she had become illegitimately pregnant, A was taken to live with her mother and stepfather. Mr. X was very rejecting of the child. Shortly after the marriage, he left for overseas duty and while he was away the mother had a child by another man. A few months before admittance, A started to go "on rides" with an older man. Her mother consented. This man practiced sexual perversions of various kinds on the child until this was discovered and he was sent to prison. A then became shy, furtive, seclusive and enuretic.

Psychological tests indicated that A was of average intelligence. Interpersonal contacts aroused anxiety which inhibited close relationships. There were feelings of inferiority, and the world was seen as threatening to her. Her anxiety did not disorganize her defenses, but the controls used constituted a neurotic personality structure. A showed progress in the group situation where her

earlier shyness and conformity gave way to more spontaneity and warmth. She was able to form a close relationship in her therapeutic interviews and was also able to work through some of her feelings toward her parents. At the time of the child's discharge her symptoms of enuresis and nailbiting were the only chief complaints still evident. In school, she was up to grade and doing well.

The mother showed no particular interest in the child during her hospitalization. She was seen in case work around discharge. At discharge, the mother agreed to placement for A either in an institution or foster home. At the time of discharge, the mother was also considering leaving her husband and placing the other two children. The mother was working and supporting herself and the children except for the one child that was Mr. X's.

Discussion:

This child's background contributed to her insecurity and instability. There was an alcoholic father, and an unstable, sexually promiscuous mother, a broken home situation at an early age and rejection by the step father. The similarity of the mother's and child's activities in the sexual area are evident, the mother apparently fulfilling some of her own drives through acting them out through the child. The home situation had not been remedied at discharge. The mother's attitudes had not changed toward the child, and another broken home situation would probably have awaited this child, who already had been shifted around continuously during the early formative years. Everything that had caused the child to be the way she was, was still in existence. Therefore recommendation was definitely for disposition outside the home. The particular recommendation of preference

was a foster home. In this type of setting, it was felt that A would have been able to consolidate the great gains she had made in interpersonal relationships. Certainly she had showed her ability to take foster home placements in her ability to form close relationships and her ability to utilize the adult's help. The alternative recommendation was boarding school placement, A had improved sufficiently to get along with her peers and could benefit from a group setting of normal children. The alternative recommendation was put into effect since there was a lack of foster homes in the community for a child of this age.

Case B

B, age 12 at discharge, had been treated at the Bradley Home for a period of two years and eight months. His chief complaints were: 1) temper tantrums, 2) unpredictable, aggressive and destructive behavior, 3) inability to form relationships, and 4) inability to tolerate frustration.

B's mother was the offspring of a broken home and seemed an insecure unstable person who rejected B and always seemed on the verge of allowing the child to develop an attachment but would then withdraw. When B was 9 months old the father was imprisoned. Mr. B was described as a psychopathic personality and never showed any responsibility for his family. In the first three years of B's life there were multiple placements of the child while the father was in and out of prison. B was the oldest of four siblings. When B was 5 years old the parents were divorced. At 7, he was placed in an institution because of his antisocial behavior.

Psychological tests indicated that B's intelligence was within the average range. B's marked personality constriction and apparently shallow affect was seen as his means of controlling a hostile

attitude. This hostility stemmed from a disturbed mother-child relationship which was generalized to the rest of the world. To some extent, individual therapy helped break through some of B's defenses and he was able to form a beginning relationship. His behavior in the group situation was characterized by moodiness, random unpredictability and an inability to relate to either adults or the other children. His only interaction with the group appeared to be as an instigator of mischievous acts of all kinds. He was considered to be negativistic, irritable and non conforming up to the point of discharge.

During B's stay at Bradley work had been attempted with the mother by the referring agency but it was found that the mother could and would not utilize help. The child was committed to state custody.

Discussion:

This history is replete with evidences of a life setting of insecurity and rejection. It was inevitable that B should have feelings of neglect and abandonment since he had known little else. Stemming from this rejection the child responded with antisocial behavior, his only way of relating to a hostile environment. Treatment led to some symptomatic improvement on the boy's part. In this case the home situation was definitely not improved though this had been attempted. There was actually no home to return to, and the mother was still unchanged in her attitude to the child. The only recommendation in this case was custodial care in an institution which could also offer the child some individual therapy. This boy with his acting out delinquent behavior would be considered a menace in any community. It was felt that if the child could continue for several years more in an

accepting environment it might be possible to prevent his developing into an adult psychopath.

Case C

C was twelve years old at discharge and had been treated at Bradley for two years. The chief complaints were: 1) restlessness, 2) running away, 3) sullenness, 4) stealing, 5) destructiveness, and 6) truancy.

C was an active child from infancy with a tendency to wander away. When the child was three, the father entered the service for a two year period and thereupon the child's wanderings increased. When he was seven, C's mother had an episode of acute psychosis. This resulted in the first of a long series of hospitalizations. The child was accused by the father of causing the mother's illness. His anti-social behavior increased and two years after Mrs. C's first hospitalization, C pulled a false alarm, stole some revolvers and then broke into a house. Referral was made to a child guidance clinic but the boy refused to go. At age ten, C was well known to the courts because of his continued elopements from home and school. C had always been an excellent student in spite of his trancies.

Psychological tests indicated a very superior intellect. They also indicated that C's contact with reality was well maintained. There were, however, indications of strong emotional pressures and an acting out type of response. Control over the expression of affect was not in keeping with either intellectual growth or chronological age. In the group situation, C showed himself to be a leader, one who never himself participated in unacceptable behavior, but who would stimulate it in others. Through individual therapy, C gained insight into his acting out behavior as symptomatic of hostility against authority. Individual treatment helped him cut down activism. It also helped him to a warmer relationship with a father figure. In school, he was excellent, and capable of doing ninth grade work. He had changed to the extent of being able to control himself and it was hoped that this would keep him out of difficulty in the community. However it was felt that close relationships were still threatening

to the child. The father was seen around discharge plans.

Discussion:

Most of C's difficulties centered around his mother's illness. From the child's early years, he had been exposed to a pre-psychotic mother who did little to give him a stable type of relationship. His feeling of rejection was probably intensified first by the father's going away to war and then by the father's accusation when the mother became psychotic. Upon discharge, the home situation was the same. The mother was still chronically ill in a state hospital and the other siblings were boarded out. The father's working hours were irregular and there was no one to care for the child. It was felt therefore that boarding school would be the best disposition. This would allow the child the type of impersonal relations which he could take and grow with. Certainly the child's new found controls could also be consolidated in a group setting.

Case D

C was 10 years old at discharge and had been at the Bradley Home for two years. The chief complaints were: 1) headaches, 2) tripping and falling heavily, 3) fainting spells, 4) dropping objects, 5) hand trembling, 6) head nodding spells, 7) hysterical episodes, 8) fear of boys, 9) fear of staircases, 10) attempted suicide, 11) difficulties in school, and 12) somatic complaints.

The father was called into service when C was about 18 months old and the mother and child then lived with the maternal grandparents for the next two

years. When the father returned the mother became pregnant and two hospitalizations followed. During the second hospitalization, D expressed the feeling that it was she who was really the wife of her father. D was resentful toward her mother when she returned. In her fifth year, D began having repeated bouts of high fever and episodes in which she might lose consciousness, might fall or have prolonged periods of screaming. She became increasingly hostile to the younger siblings, had difficulties in school and was disliked by her playmates. In the year before admission, the father had to leave home temporarily and the child made two apparent suicide attempts. C was placed in a boarding school several months before admission.

Psychological tests indicated that she was functioning in the average range of intelligence. She seemed to be functioning in a bizarre unhealthy fashion with poor integration and an autistic and immature kind of phantasy. There was loss of intellectual control in the face of both inner anxiety and emotional stimuli. It was noticed that the child suffered setbacks after the mother's visits. Interviews enabled the child to form a warm relationship with her therapist and she was able to express and be relieved of a great deal of anxiety. At the time of discharge she was improved. Instead of being overwhelmed by anxiety, psychological tests showed she used inhibition and repression to control it. However this was at the expense of restricted functioning. D was up to her school grade and had gained somewhat in the group situation. She was able to utilize adults in both the ward and interview situations. Mrs. D seemed progressively to be more disturbed herself and her basically rejecting attitudes toward her daughter were unaltered. Various psychiatrists and social agencies had worked with the mother to no avail.

Discussion:

The combination of an anxious, insecure mother and deprivation of the father were traumatic to the child. The mother was hostile and jealous of the attention given to D by the father. This was probably the case because of her own immature sexual development. The father was seen as

contributing to this situation by an over-seductive attitude toward D. Thus a disturbed oedipal situation grew out of deprivations in the earlier periods of psychosexual development of this child. At the time of discharge, also the marital situation was not too good, the parents avoiding each other as much as possible. It is interesting to note that D's seizures occurred only within the home. In the boarding school placement previous to admittance and during her stay at Bradley no seizures occurred. The seizures were thus seen as an attempt on the child's part to gain the attention she had missed so much. C was able to function more adequately in group relationships with her peers though this was not too pronounced at the time of discharge. The main factor in recommendations for this child was the mother who would under no circumstance accept foster home placement for the child. She was not able to accept a familial type of set-up though she rejected the child in an overt manner. The child also was tied in a web of guilt and hostility to the mother. A very poor prognosis was given if the child were to return to the same home situation which was far from remedied with more tension between the parents than had been evident at the time of D's admission. A boarding home placement was thought of in order to keep the child out of the damaging home situation. It was also thought that this might be more acceptable to the mother. D had shown both in her previous placement in a group situation and at Bradley that she could gain from this type

of situation.

Group Summary

Of the six cases surveyed the recommendations for disposition outside of the home were primarily decided on the inadvisability of the child's returning to the home situation. In two cases the children had been taken over by the court because of the inadequacy of their mothers. In another case, the mother was still in a state hospital and the father was unable to adequately care for the child because of his long working hours. In the other cases, the parents were newly divorced and in the two remaining there was marked marital incompatibility. In all cases, the attitudes within the parents that had caused the child's difficulty remained unchanged.

The reasons for the particular placement outside the home varied. Foster home placements were the primary recommendations in two of the cases. This recommendation was based primarily on the child's ability to get along in close relationships. In two cases the children were both twelve at discharge. Alternative recommendations had to be made in both cases for group placements since there was a lack of foster homes for this age group. There were two cases for which the primary recommendation was boarding school care. This was recommended in one case because the child was threatened by close relationships and was better able to get

along in a group. In the other case, the decision was emphasized by the mother's refusal to have any closer familial type of care for the child. Two cases were recommended for custodial care in an institution because of the behavior of the child. One of the children was psychotic, the other an active delinquent.

Group II

Six cases were studied in this category and three are presented in detail. In all six cases, recommendations have been made for the child's return home. The age range in this group was from six and a half to thirteen. The length of stay at Bradley was from five months to two years.

Case E

E was a twelve year old boy at the point of discharge from the Bradley Home. He had been treated there for two years. The chief complaints were: 1) difficulty in school, 2) negativism, 3) open defiance, 4) disobedience, 5) disregard of others, 6) attacks of severe anger, 7) repeated threats to kill his siblings and other children, 8) headaches, 9) nightmares, 10) enuresis, and 11) nailbiting.

He was the second of three children with an older brother and younger sister. Following a T&A at two, E became negativistic and disobedient. He started to have trouble in school in the second grade about the time his sister was born. The older brother had suffered with asthma from an early age, receiving considerable attention especially from the mother. Economically the family was secure, but emotionally it was far from stable. The father was alcoholic and the mother said that she had had several "nervous breakdowns". Both parents had been emotionally deprived in childhood.

Psychological testing indicated average intelligence.

Also indicated were basic feelings of rejection and a lack of proper sexual identification. There was a possibility of emotional outbursts. In the group E became a leader and often instigated unacceptable behavior. This symptomatology was relieved with the aid of individual therapy. Both parents were seen in casework at the Bradley Home.

Discussion:

E had been deprived at an early stage as was evidenced by early weaning and toilet training. This pre-disposed him to a poor solution of the oedipal situation. The brother's asthma and attention from the parents was very important in this boy's feelings about his family. Mr. and Mrs. E, with the help of casework gained some insight into the nature of their own familial problems and were better able to accept their son and each other. Mr. E was able to cut down on his drinking and also accept a better job. Mrs. E became a more adequate wife and mother. Since the home situation had become more stable and the boy had become more acceptable in behavior recommendations were made for return to his own home. Continued therapy with the child and contact with the parents was suggested.

Case F

F was an 11 year old boy who was at the Home for 5 months with the chief complaints of 1) spells since a year, and 2) nailbiting since infancy.

He was always a timid, fearful child according to the mother who has always been nervous herself and afraid of the child being hurt. The father was an alcoholic and there was some dissension between the parents over his drinking. About a year before

admission, the mother began to work for the first time in her marriage. At the same time the child began a new term in school with a teacher of whom he was fearful. He began to have nightmares. He developed spells for which he was hospitalized but nothing physically abnormal was evident. His seizures increased in frequency. The younger sibling had also had seizures of the same kind but they had stopped.

Psychological tests indicated that F had a superior intelligence and his basic personality was shown to be hysterical in nature. They showed that F was afraid to grow up and assume the adult male role. He was anxious over hostile and sexual drives. The conflicts seemed to originate during the oedipal stage of development. Individual psychotherapy was instrumental in stopping the seizures and there was increase in ego-control. F was a capable member of his group and was well liked by his peers. However he lacked confidence and was afraid of competition. At the time of discharge he had become more tolerant of his own aggressive impulses and was better able to express these. Casework interviews were arranged for the mother.

Discussion:

This boy was seen as the product of a marriage in which the mother not having received much satisfaction from her husband was seeking to obtain them from the boy. Her overly seductive attitude to him caused him to be burdened with a confusion of feelings at an early age. The mother could not accept the aggressive masculine impulses in the child and certainly identification was not furthered by the abusive alcoholic father. The seizures were F's way of taking care of the anxiety. The mother was worked with and seemed to be able to accept the boy more and see the nature of his problems in connection with her own attitudes. It was felt when the anxiety of the child subsided through individual therapy and

the spells ceased that the child would benefit no further from in-patient treatment but would best respond to treatment on an out-patient basis in the home situation in which he had to live and which he had to learn to handle.

Case G

G, age 10 at discharge, was treated at the Bradley Home for two years with chief complaints of: 1) nervous habits such as sucking of fingers, head-rocking and making peculiar noises with the mouth, 2) disturbed sleeping habits, 3) social relations in school disturbed by short attention span, restless activity and habit spasms, 4) open aggression against smaller children.

After a middle ear infection at two years which was accompanied by high fever the abnormal pattern of behavior became more noticeable. The father was punitive and demanding in regard to the boy, and the mother was inconsistent in her treatment of him. When six years of age he had grown to be a real problem in the neighborhood as well as at home.

Psychological tests given at admission indicated that the child was functioning at a dull normal level. They also indicated a severely constricted personality inhibiting outward expression of affect and using regressive fantasy in response to emotional pressures. There were hints of sexual conflict with the mother wishing him to be a girl. In the last year before discharge G improved in the group. He showed definite interest and a drive to succeed in school which had been lacking before. He became a much better accepted member of his group and learned to defend himself against the older boys. Personal interviews were given and these showed a close relationship, diminution of ties and increased ability to express his problems and feelings verbally. Both parents were seen in case-work interviews.

Discussion:

This case presented a mixture of organic and emotional factors with a brain injured child who would be difficult to

manage under the best of circumstances. There was a poor relation with the father and much fear of him. The father was driving and perfectionist and used his children as expressions of his own ego to get the things that he did not get. The mother is reported as having been unable to accept the child's expressions of aggression. Both parents had extremely high standards for this child which he felt he must live up to. Both parents were seen in preparation for discharge back to the home and the mother was seen after discharge. There was as a result of casework some acceptance of this boy as he was. It was thought that the best recommendation was return to the home and placement in a small class in school and continued out-patient treatment for parents and the child.

Group Discussion:

In all six cases recommendations were made for return to the home. This was based on the improvement in the home situation and the improvement of the child. In all six cases, the parents were living together at the point of discharge and there was no severe marital incompatibility. Five of the cases were involved with casework. In all the cases some improvement in the attitudes of the parent toward the child was noted.

CHAPTER V

SUMMARY AND CONCLUSIONS

The writer has attempted to study the recommendations for disposition of twelve cases that were discharged from the Emma Pendleton Bradley Home from January, 1952 to December, 1952. These twelve cases were chosen because they were the most feasible count of treatment discharges under the Social Service Department as it currently exists at Bradley Home. It was necessary to study thoroughly all twelve cases in order to extract the reasons for the recommendations given. The questions to be answered by the study were: 1) What were the major recommendations for disposition at discharge from the Bradley Home? 2) What factors influenced these recommendations? 3) What was the role of the social worker in helping determine disposition?

The recommendations were of two kinds, return to the child's own home or further placement outside the home. The chief factor which seemed to enter into this decision was the home situation. Return home was considered when the home situation was adequate enough to maintain the improvement the child had made. There appeared to be no marked marital dissension and both parents were living in the home at the point of the child's discharge. On the other hand, the group for whom placement was thought best was characterized by no improvement in an unstable home situation. This group contains

the two cases for which court custody of the child was obtained because of the inadequacy of the parental figures.

Recommendations for disposition outside the home were of three main types: 1) foster homes, 2) boarding schools, and 3) institutions.

The child for whom foster home care was recommended was characterized by the ability to utilize close relationships with adults and peers and by behavior which would be acceptable to a foster family as well as to the community. Also found to be of importance was the parent's ability to accept a familial type of placement for their child. Unfortunately, an alternative to this type of recommendations had to be given because there were few foster homes available for the pre-adolescent.

Boarding school was the recommended placement when the child's parents would not accept the familial type of setting, and was thought of when the child seemed to be able to benefit more from the impersonal relations characteristic of most group settings.

Institutional placement was considered on the basis of the severity of the deviant behavior of the child. The child who is a danger to himself or the community is a problem in other than a closely supervised setting. External controls are needed if none have been internalized. A custodial type of group setting in which therapy was also available would best contain the type of behavior described in Case D.

For the twelve cases studied, the following factors seemed to be of most importance in considering the particular setting best suited for a child needing further placement:

- 1) ability to form close relationships, 2) extent of deviant behavior, 3) attitudes of parents to the placement, and
- 4) community resources.

The caseworker's role in helping to determine the disposition is as follows:

- 1) At the point of intake, the worker decides which parents are most able to utilize treatment for themselves. In situations where the home seems irredemiable court custody may be indicated.

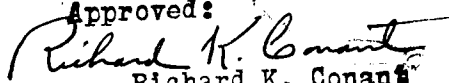
- 2) Through individual casework with the parents there is planning with both parents around the discharge disposition best for both the family and the child's needs. It is hoped that casework will help the parent to better understand the child as well as himself because return home ideally should be the plan decided upon.

- 3) At the conference dealing with discharge, the caseworker may suggest a recommendation based on the available community resources as well as on what he knows of the individual needs of the child and his family.

The importance of correct disposition is unquestionable. On it depends the future adjustment of the child and the furthering of the gains made at the Bradley Home. Correct disposition becomes as much of the treatment plan for the

child as do the individual contacts with parent and child around their particular problems.

Follow-up studies might clarify some of the thinking about the factors involved in correct disposition. Also of value might be research done on the use of temporary foster home services affiliated with the Home for use before discharge. This might be a way of bringing about a more gradual adjustment to the vicissitudes of the child's own home.

Approved:

Richard K. Conant
Dean

Appendix A

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Purpose and Functions of the Bradley Home

Appendix B

SCHEDULE OF STUDY

Age

Length of Stay

Chief Complaints

School Adjustment

Community Adjustment

Family Adjustment
attitudes and personality of parents
development of present illness

Psychological Test Results
intelligence
personality

Treatment Program and Results
group interaction
individual therapy
casework with parents

Appendix C

(Copy of form used in summarizing discharged cases)

EMMA PENDLETON BRADLEY HOME

East Providence, R.I.

- - - - -

ABSTRACT OUTLINE

NAME

ADDRESS

DATE OF BIRTH

REFERRED BY

RACE AND NATIONALITY

ADMITTED

DISCHARGED

CONDITION ON DISCHARGE: Must be improved or unimproved.

DISCHARGED TO: (Names, address and relationship of individual to the patient.)

DIAGNOSIS: This must follow verbatim the "Standard Nomenclature of Disease."

OPERATIONS: Mention only operations performed at the Bradley Home.

PRESENT ILLNESS: The positive outstanding features of the condition for which the patient was referred to the hospital.

PAST HISTORY: Very brief record of positive, abnormal, or unusual findings having to do with the pregnancy, birth, development, feeding, school history, past illnesses, operations, immunizations, family, and social background of the patient.

PHYSICAL EXAMINATION: A list of positive or abnormal findings

on routine examination and briefest sort of summary of any medical consultant's opinions.

CLINICAL LABORATORY REPORT: List briefly the general types of tests done on which findings were negative. List details of findings on tests which were abnormal. Summary of electroencephalographic and X-ray reports should appear here.

PSYCHOMETRIC REPORT: Tabulate date, name of test and I.Q. obtained on tests done upon admission and just before discharge. Briefly summarize other special tests when they are related to the clinical problem.

TREATMENT: Tabulate types and doses of treatment directed toward the patient's major problems. List starting and stopping dates of each. Do not include trial doses of medication which were not helpful. Include such things as school, therapeutic interviews, individual coaching, etc.

SCHOOL PROGRESS: Brief Summary mentioning grade levels in reading, spelling and arithmetic on admission and on discharge, noting special approaches used, such as individual tutoring, extra help, etc.

GENERAL COURSE IN HOSPITAL: Describe very briefly the patient's progress in general, social adjustment during his hospital stay, his outstanding problems or abilities in the group, in sports and in the classroom, and his response to special treatment. Give dates and nature of any significant intercurrent illness or accident.

RECOMMENDATIONS FOR FUTURE TREATMENT: Tabulate specific recommendations including details of school placement and dosage of medicine.

SUMMARIZING STATEMENT: Brief description of the patient's problem, the factor producing it, progress or lack of progress in overcoming it, and factors responsible for this in the hospital. State prognosis.