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Factors leading to emotional disorders in children.

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FACTORS LEADING TO EMOTIONAL DISORDERS IN CHILDREN

BY

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ABSTRACT

The focus of this research project deals with the etiological problems of children in the age group of twelve to seventeen years who are residentially placed and receiving treatment at Maryvale Vocational School in Windsor, Ontario. It also deals with those psychosocial components which have lead to these emotional disorders. Three hypotheses were formulated in order to determine whether emotionally disturbed children suffer from inadequate psychological supplies, came from disintegrated families where emotional needs were inadequately met, and exhibited social isolation, antisocial behavior, and insufficient educational achievement. These hypotheses were based on the assumption that emotional disorders in children are caused by a lack of adequate psychological and social supplies in the environment.

A check list was constructed to collect data from the case histories of the girls receiving treatment at Maryvale. The first part of the check list included questions which gathered basic information on the child's social and family history. The second part of the check list dealt with the child's prior placements, medical history, psychological history, and presenting behavioral problems. The data was then analyzed.

Many causative factors were explored with regard to emotional disturbances in children. Even though it is recognized that there are several factors associated with the development of emotional disorders in children, our data points out that the family plays an important role in the healthy emotional development of children. The data also indicates that the family provides basic psychological and social needs of the children. Families with a history of breakdown tend to produce emotional instability among children. The fifty girls used in this study provide a clear example of family instability, insecurity, and a lack of love and affection which has resulted in placement in a residential treatment centre.

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HUMAN DYNAMICS AND CHILDHOOD DISORDERS

This study focuses on the etiological problems of children in the age group of twelve to seventeen years who are residentially placed and receiving treatment. It also deals with those psychosocial components of the developmental process which have led to these emotional disorders. It assumes that the normal developmental process is essential for a healthy growth of personality in individuals.

Lapouse and Monk point out that "One of the psychiatric dilemmas of our time is the decision as to what is normal and what is abnormal in human behavior."[1] In a large-scale epidemiological study, they found a high prevalence of behavior characteristics, which were commonly considered indicative of pyschopathology, in a general population of children. They concluded that this wide variety of behavioral symptoms represented manifestations of developmental stress occurring in essentially normal children. They found a tendency for many children to develop symptomatic behavior during critical stages of development.[2]

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[1] Rema Lapouse and Mary A. Monk, "Fears and Worries in a Representative Sample of Children," American Journal of Orthopsychiatry, XXIX (Oct. 1959), p. 803.

[2] R. Lapouse and M. Monk, "An Epidemiological Study of Behavioral Characteristics in Children," American Journal of Public Health, XLVIII (Sept. 1958), pp. 1134-1144.

E. James Anthony in his analysis of behavior disorders in children suggests that there is a predominant trend to regard abnormal behavior simply as an extension of normal behavior. There is also a tendency to reduce the difference between abnormal and normal behavior to a value judgment or to an accident of the referral procedures. Anthony suggests that the dividing line between normal and disordered behavior is far from fixed and fluctuates with different social and cultural patterns.[3]

In One Million Children, a national study of Canadian children with emotional and learning disorders, it is suggested that the concept of emotional and learning disorders is a developmental one. This report states that "We become concerned about a particular child because he is not performing or behaving at a level, nor in a way that fits the expectations derived from normal development."[4] Temporary stresses and disturbances in behavior are part of development. However, when the disturbance cannot be overcome by the child, then its effects tend to spread into other areas of behavior and affects many aspects of development.[5]

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[3]E. James Anthony, "The Behavior Disorders of Childdren," Carmichael's Manuel of Child Psychology, Vol. II, ed. by Paul H. Mussen, (New York: John Wiley & Sons, Inc., 1970), p. 668.

[4]The Commission on Emotional and Learning Disorders in Children, One Million Children, (Canada: Leonard Crainford, 1970), p. 25.

[5]Ibid., p. 18.

Normal development is a highly complex process resulting from the interaction between internal or biological and external or cultural forces. Normal development depends upon a well-functioning biological organism operating within a sheltering and stimulating environment. In the process of development, adults must provide for the needs of the child and provide opportunities for learning.[6]

In discussing the etiological factors in the development of behavior disorders, Anthony distinguishes between high-risk heredity (genetic factors), high-risk constitutions (activity and reactivity patterns), high-risk environments (familial, institutional, poverty), high-risk situations and experiences (separation, hospitalization, illness, and other psychological traumata) and high-risk points in development (critical periods and critical stages of development).[7] Thomas, Chess, and Birch also stress the need to realize that behavioral disturbances in childhood are caused by the interplay of genetic, biochemical, temperamental, neurological, perceptual, cognitive, and environmental factors which influence the course of behavioral development.[8]

A longitudinal study conducted by Thomas, Chess, and Birch indicates the role which temperament plays in the

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[6] One Million Children, loc. cit., p. 20.

[7] Anthony, op. cit., p. 693.

[8] Alexander Thomas, Stella Chess, and Herbert G. Birch, Temperament and Behavior Disorders in Children (New York: New York University Press, 1968), p. 3.

development of behavior disorders in children. The authors define temperament as the behavioral life style of the individual child. It is a phenomenologic term which describes the characteristic tempo, rythmicity, adaptability, energy expenditure, moods and focus of attention of a child independent of the content of any specific behavior. They stress that both normal development and disturbances in development are not the result of any single factor such as the quality of family interaction but rather the result of complex interactions between the child and his environment. A recognition of the temperamental differences in children makes it impossible to accept explanations of emotional disorders which are based on a single causative factor. The authors warn against the error of stating that deficits in the mothering process or any environmental influence will lead to a specific disorder. They stress the need to clarify and define adequacy in terms of the goodness of fit between the organism cared for and the pattern of care. Their study demonstrated that the degree to which parents, teachers, pediatricians, and others handled the child in a manner appropriate to his temperamental characteristics significantly influenced the course of his psychological development.[9]

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[9]Thomas, Chess and Birch, loc. cit., pp. 3-4.

John Bowlby indicates that the prerequisite for normal mental health is the experience in infancy and early childhood of a warm, intimate, and continuous relationship with a mother or mother surrogate in which both the mother and child find satisfaction. It is this rewarding relationship with the mother in early years complemented by the relationship with the father and siblings that underlies the development of character and mental health.[10]

David M. Levy also claims that it is generally accepted that the most potent of all influences on social behavior is derived from primary social experience with the mother. Levy maintains that there is a relationship between parental attitudes and behavior and the development of childhood disorders. He studied maternal overprotection and delineated two types of the overprotection syndrome. Children who received an indulged type of overprotection were characterized by disobedience, impudence, tantrums, excessive demands, and varying types of tyrannical behavior. Children who received a dominated type of overprotection were characterized by excessive submissiveness, obedience, passivity, dependence, orderliness, and poor peer relationships.[11]

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[10] John Bowlby, Child Care and the Growth of Love (London: Penguin Books, 1951), p. 13.

[11] David M. Levy, "The Concept of Maternal Overprotection," Parenthood: Its Psychology and Psychopathology, ed. by E. James Anthony and Therese Benedek, (Boston: Little, Brown and Co., 1970), pp. 387-409.

It has long been recognized that the family is a transmitter of cultural values and standards from one generation to the next. Recently the transmitting function has been considered with regard to psychiatric disorders. Ehrenwald has described several generations of families in which neurotic modes of behavior have been passed from person to person in a sort of pseudo-heredity.[12] Anthony, after reviewing the research on the influence of physically or psychiatrically sick parents on children, concluded that children are sensitive to the variations of illness in the parent. It seems that sick parents often have sick children and the sickness is reactive. In Anthony's opinion, this supports the claim of Ackerman that psychiatric illness as a single or isolated instance does not occur in the family and that the sick behavior of the various members are interwoven and mutually reinforcing.[13]

J. Downes conducted a longitudinal morbidity study of families in Baltimore. He found an excess rate of illness in children as compared with the general population when there was a parent suffering from chronic psychoneurosis. The children of these psychoneurotic parents were found to have an excess rate of psychosomatic and behavioral disorders

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[12]Jan Ehrenwald, "Neurotic Interaction and Patterns of Pseudo-heredity in the Family," American Journal of Psychiatry, CXV (Jan. 1958), p. 134.

[13]Anthony, op. cit., pp. 700-702.

even when the factor of social conditions was kept constant. Neurotic mothers seemed to have a more harmful effect than neurotic fathers.[14]

In another study conducted by Kellner, he found a higher rate of psychiatric disorder in the children of neurotic parents. Kellner found an association between neurotic disorders between the parents in the family and between mothers and children. He did not find an association between neurotic disorders of fathers and children.[15] However, Hare and Shaw did find that physical and mental ill health in fathers was associated with an increased rate of behavior disorders in the children.[16]

Mishler and Waxler conducted a research study which investigated the extent to which family patterns are related to the occurrence of schizophrenia in childhood. The central aim of their research was to determine if there are distinctive patterns of interaction in families of schizophrenic patients. They reduced a large number of interaction indices to five variable clusters which were expressiveness, strategies of attention and person control,

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[14]Jean Downes, "Illness in the Chronic Disease Family," American Journal of Public Health, XXXII (June 1942), p. 589.

[15]R. Kellner, "Family Ill Health," cited by E. James Anthony, "The Behavior Disorders of Children," Carmichael's Manuel of Child Psychology, Vol. II, ed. by Paul H. Mussen, (New York: John Wiley & Sons, Inc., 1970), p. 701.

[16]E. H. Hare and G. K. Shaw, "A Study in Family Health: A Comparison of the Health of Fathers, Mothers, and Children," British Journal of Psychiatry, CXI (June 1965), p. 467.

speech disruption, and responsiveness. They found that normal families were more expressive and more positive in the quality of their expressed affect than were the families of schizophrenics. Normal families were also found to be more responsive than families of schizophrenics.[17]

Gerald Caplan indicates that there appear to be various discrete factors in the organic, psychological, and social dimensions which have a nonspecific harmful effect on children. He indicates that children in whom these factors are found to operate have an increased risk of suffering from some form of mental disorder in the future. A particular harmful factor can lead to entirely different outcomes in different children. This differential effect of harmful influences is a result of the highly complicated pattern of biopsychosocial forces involved in the unfolding of the child's personality.[18]

Further, according to Nathan Ackerman, research is needed to specifically define those pathogenic factors which cause mental illness in childhood and those factors which strengthen immunity and promote healthy development of children. He conceptualizes mental health as the plasticity and variability of adaptive behavior and mental disorder as rigid, constricted, automatized, stereotyped, and repetitive

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[17]Elliot G. Mishler and Nancy E. Waxler, Interaction in Families (New York: John Wiley & Sons, Inc., 1968), p. 154.

[18]Gerald Caplan, Prevention of Mental Disorders in Children: Initial Explorations (New York: Basic Books, Inc., 1961), pp. 9-10.

behavior. He sees mental health as a process and emphasizes the importance of interactions in the family circle in maintaining this process in all family members.[19]

In talking about emotionally disturbed children who require residential treatment, Fritz Redl raises the question as to whether anything good or lucky ever happened to such children prior to their admission to treatment centres. He observed that these children had been grossly and continuously exposed to traumatization on so many different levels. He found that with these children benign experience was the exception and trauma the rule.[20]

From his experience of working with emotionally disturbed children, Fritz Redl suggests that there were several "missing links" in their lives. These children lacked factors leading to positive identification with adults. They lacked feelings of being loved and wanted and encouragement to accept values and standards of the adult world. They lacked opportunities for a gratifying recreational pattern. They did not have opportunities for adequate peer relationships. They did not have opportunities for establishing community ties and establishing a feeling of being rooted somewhere where one belongs. Their family structures suf-

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[19]Nathan Ackerman, "Preventive Implications of Family Research," Prevention of Mental Disorders in Children: Initial Explorations, ed. by Gerald Caplan (New York: Basic Books, Inc., 1961), pp. 142-167.

[20]Fritz Redl, The Aggressive Child, (New York: Free Press, 1957), p. 57.

fered from basic disintegration. They did not have adequate economic security for their basic needs and necessities of life.[21]

Herschel Alt indicates that we have not been able to establish cause-and-effect relationships in mental health as we have for many physical illnesses. He maintains that because we are not sure of causation prevention in an absolute sense is beyond our reach. However, Alt draws upon his experience of working with disturbed children in residential treatment to provide some preventative guidelines. He stresses that children need warm personal care from their parents or parent surrogates. Children need a feeling of protection and they need to know that an adult always stands back of them to help them in any difficulty. Children need a sense of security which is reinforced by regularity and predictability. Children need understanding and tolerance of their behavior. They need opportunities for creative expression and approval of their peers.[22]

The causative factors of emotional disorders in children is still unclear. However, from the review of the literature, it has been found that the family plays an integral part in the development of positive mental health in children. Family security, good environment and meeting

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[21] Redl, loc. cit., p. 57.

[22] Hershel Alt, Residential Treatment for the Disturbed Child, (New York: International Universities Press, Inc., 1960), pp. 250-252.

the basic needs of children are important in normal development. We have examined the fulfillment of these needs through the collection of data from files. It appears that in the absence of adequate fulfillment of these needs there are possibilities of the development of emotional disorders in children.

Summary

This chapter deals with various biosocial and psychological factors that have a definite bearing on individuals in emotional growth and the development of emotional disorders. Specifically, family environment has been influential in the emotional development of children.

CHAPTER II

HISTORICAL DEVELOPMENT OF MARYVALE VOCATIONAL SCHOOL

This chapter deals with the historical development of Maryvale Vocational School at Windsor, Ontario (hereafter in this paper will be referred to as Maryvale). It shows the progress that has taken place over the past forty-two years. We consider it important to discuss the historical development of Maryvale Vocational School in order to provide a clearer picture of the growth and progress of a unique institution like this.

Maryvale was organized in 1929 by the Sisters of Good Shepherd. They were invited to Windsor by the Roman Catholic Bishop of the Diocese of London to open a residence for women. Originally they located in a house on McEwan Avenue and they received assistance from the Roman Catholic parish in the area and from the Basilian Fathers of Windsor, a Roman Catholic teaching order.

Their early work was designed to help transient women and women without means of financial support. Shortly after the Sisters arrived in Windsor, the Great Depression began and with it came a scarcity of jobs for women. The sisters offered refuge to many of these destitute women.

In 1930, the Sisters acquired their present property on Prince Road. They borrowed money from the Bishop of Lon-

don to purchase the old Essex Country Club. For several years they used the old buildings for their residence. The Department of Public Welfare recognized this project and assistance was granted under the Female Refuge Act of Ontario.

In order to help finance their operation, the Sisters opened a laundry on the premises. The Sisters and women operated the laundry into the 1940's. The laundry is still operating there but as a commercial enterprise and the residents of Maryvale are no longer involved in the operation.

During the years of the Second World War, jobs for women became plentiful and there was less of a need for the type of shelter which Maryvale offered. With fewer older women requesting admission, they moved towards accepting younger girls referred by priests, ministers, and juvenile authorities. At about this time they began reviewing their program. In 1949, they moved into setting up treatment facilities for girls between the ages of twelve and sixteen years. With this new program, they were eligible to receive operating grants under the Charitable Institutions Act of Ontario. Under this Act, they received five cents per day per child under sixteen years and ten cents per day per child over sixteen years of age.

In 1950, Maryvale hired their first professional social worker and a program for the treatment of emotionally disturbed girls was initiated. Once they initiated a planned program, the per diem rate was raised to one dollar and fifty cents. Maryvale's program is significant in that it

was the first time an attempt had been made in Ontario to work with emotionally disturbed teen-age girls in a residential setting. Since that time, other treatment centres patterned after Maryvale have opened up in the Province.

In 1956, the administrative personnel began looking towards building new facilities to house the staff and children. From 1956 to 1962, there were several administrative changes at Maryvale which resulted in a delay in proceeding with their building program. This delay was unfortunate in that the staff and children were required to stay in the old facilities longer but in the long run because of the delay, better plans developed and a better method of financing was devised. In 1962, the building program was completed and the staff and children moved into the new facilities.

The physical complex is comprised of six cottages on seventeen acres of property. There is a school with ten classrooms, indoor swimming pool and gymnasium. The administration building and a sister's residence with a chapel complete the complex. The capital value of the buildings and furnishings is $1,500,000.00 Present staffing can accommodate sixty girls in residence.

Maryvale offers an open cottage system, residential program for girls of any race or creed who reside in the Province of Ontario. The minimum age at admission is eleven. By age sixteen, it is hoped that a girl will be ready for discharge planning. The stay of a resident averages twenty

months. Upon arrival, a resident is placed in a receiving unit and is assessed for approximately two months in the living situation, school program and casework situation. A report is made to the referral source after completion of this period and recommendations are made for either continuation in treatment or return to the referral source. If continuation is warranted, the girl is placed in one of three other cottage units, one of which is an intensive treatment unit with specialized tutoring facilities within the cottage.

As treatment progresses favourably and the girl is ready for greater responsibilities, she is placed in one of two senior cottages. Visits from the referral source are encouraged at least every six weeks. Progress reports to referral sources are made every three months. Discharge is with mutual planning between the Maryvale caseworker, the referral source and the girl.

While a girl is at Maryvale three major departments work simultaneously on rehabilitation. The social service department, composed of six caseworkers and three part-time psychiatric consultants act as the therapists to the children and consultants to the teaching and child care staff. The child care department work in the area of surface behaviour modification. It is the main source for the provision of corrective relationship opportunities and a consistent, warm, stable milieu.

The residential school attempts to fill in learning gaps in order to ready a girl once more for community schools. A full time recreation director plans and carries out overall activities such as dances, outings, swimming, camping, and special occasion parties, etc. A full time nurse coordinates the medical services required by each girl.

The intake worker gathers information on a prospective admission. A social history, school reports, and up-to-date psychological tests are required before the application is presented before the Intake Committee. This committee is comprised of the Superior of the Governing Body, the Executive Director, the Treatment Coordinator, the Child Psychiatrist, the Principal of the residential school and the Supervisor of the Child Care Department. Meetings are held every Thursday. Acceptance or rejection of an applicant is conveyed by the Intake worker to the referral source after the intake committee meeting. A date of admission is arrived at and an institutional caseworker is assigned to admit the girl and carry the case while the girl is in residence.

Girls between the ages of twelve and sixteen are considered for admission. They should require an open institution rather than a closed setting such as a training school or hospital ward. Retarded or psychotic children cannot be handled in the program as it is now designed. There is no program designed to meet the needs of the seventeen to nineteen year old adolescent.

Discharges occur through the mutual planning between the referral source, the Maryvale caseworker, and the girl. Because of distance, the referral source is asked to continue contact with the family or foster parents of the resident in order to facilitate visits home or discharge back into the family constellation. A crisis discharge may occur occasionally when a girl does not go along with the plans worked out by Maryvale and the referral source. In effect the girl may discharge herself. In these unfortunate situations, the legal guardian is responsible for handling this situation because there is no way the Maryvale open setting can restrain a girl who is determined to leave against all planning to the contrary.

The overall goal of Maryvale is to return to the community, as soon as possible, a girl who is functioning more age-appropriately than when she was admitted. Maryvale does not have a program designed for the girl who will require long term institutional protection perhaps into adult life. The few they do admit require mutual planning into other institutions.

In 1971, the operational costs per child per day has been computed at $41.00.

Summary

This chapter explains the plans, and procedures of Maryvale and its changes over a period of forty-two years in serving different kinds of individuals. Maryvale changes consistently with needs in the community. Presently it

serves as a residential treatment centre for fifty-three emotionally disturbed children who have been referred by various agencies.

CHAPTER III

THE RESEARCH DESIGN

Purpose of the Research

On the basis of our review of the literature, several assumptions are being made. We assume that emotional disorders in children are caused by a lack of adequate biological, psychological, and social supplies in the environment. In order not to become emotionally disturbed, a child needs continual biopsychosocial supplies commensurate with his stage of development and growth. These assumptions are included in our study excluding the impact of the biological factor on the emotional development of children. Other factors like the psychological and psychosocial factors are considered important and have been practical to study since information on physiological development was not available. Specifically, family environment has been influential in the emotional development of children. In order to examine these factors, hypotheses and assumptions are made and data is collected from Maryvale Vocational School in Windsor, Ontario.

Hypotheses

Based on the above assumptions, the following hypotheses are made:

1. A lack of adequate psychological supplies prior to admission to a residential treatment centre will be found in

most children in the residential treatment centre.

2. Most children will come from families where emotional needs were inadequately met due to inadequacy in family relationships or total family breakdown.

3. Children who develop emotional disorders will be socially isolated and will exhibit antisocial behavior and insufficient educational achievement.

Working definitions

Adequate psychological supplies consist of love, affection, family security, and stability. The necessary social supplies consist of ongoing family structures which are not in some phase of basic disintegration at almost any given time in their lives. They also consist of opportunities for making community ties, establishing a feeling of being rooted where one belongs, where other people besides your parents know and like you. Adequate peer relationships are also an important factor in healthy social development.

Population

In order to test the hypotheses of the research, we examined a collection of data from Maryvale. We obtained permission from the Executive Director of Maryvale to use the existing population of Maryvale for our study. The total population consists of fifty-three girls between the ages of twelve to seventeen. Three of these girls are non-white and were eliminated from the study. The population includes only up to January 20, 1971.

TABLE 1

AGE ON ADMISSION

N = 53

Age Category	Number of Girls
16-17	4
14-15	29
12-13	20

TABLE 2

AGE ON ADMISSION EXCLUDING NON-WHITES

N = 50

Age Category	Number of Girls
16-17	4
14-15	28
12-13	18

Sample

Our sample consisted of the total population excluding the three non-white girls.

Method of Collection of Data

It had been our intention to use a check list to gather data from casework records and to follow this up with a personal interview with each girl. The agency did not agree to interviews for two reasons. First, they would not subject the girls to an interview with a stranger and it was impractical in terms of our time and the girl's schedule to spend enough time with each girl to establish a relationship. Secondly, they felt that in some instances we might obtain distorted or invalid information from a girl because of her own upset emotional state.

No personal interview - only leaves possible bias of records.

Initially, we read a random sample of the files and found them to be very complete. Each file contained a detailed social history, school reports, psychological and psychiatric reports, medical reports, and recording on the girl's functioning and involvement in Maryvale. We constructed a check list[23] and gathered data from the files. The agency had offered to obtain any missing information from the referring agencies or from the current caseworkers. This proved to be unnecessary. One of the difficulties which we encountered in the collection of data was inadequate information about the parents. Information on the income and occupation of the parents was generally lacking.

Analysis of data

The data was collected from fifty case studies of emotionally disturbed girls as to their education, residence, presenting problems, family problems, marital status of parents, peer relationships, teacher child relationships, psychiatric diagnosis and intellectual status, in order to determine the causative variables that might have been associated with their emotional disturbances.

Normally the sample does not follow the traditional pattern of educational achievement in relation to age. Analysis of Table 3 indicates that on admission to Maryvale, sixty-two per cent of the girls were performing below the expected educational level by one or more years. Twenty-

[23]Refer to appendix p. 41 for sample of check list.

two per cent of the girls were performing below the expected educational level by two years or more. Only twenty-four per cent of the girls were performing at or above the expected educational level.

TABLE 3

PERCENTAGE OF THE GIRLS ACCORDING TO AGE IN THE DIFFERENT GRADES

Age Category	Auxiliary Grade	4'th	5'th	6'th	7'th	8'th	9'th	10'th
16-17	..	..	..	..	2	2	4	..
14-15	6	2	..	..	24	16	6	2
12-13	2	4	6	14	6	4	..	..
Total	8	6	6	14	32	22	10	2

TABLE 4

PERCENTAGE OF THE GIRLS ACCORDING TO RELIGION IN THE DIFFERENT GRADES

Religion	Auxiliary Grade	4'th	5'th	6'th	7'th	8'th	9'th	10'th
Roman Catholic	4	2	4	4	10	12	4	2
Protestant	2	4	2	6	24	12	4	..
Other	..	..	..	..	..	2	2	..
Total	6	6	6	10	34	26	10	2

Table 4 shows that of the fifty girls in the sample, twenty-one or forty-two per cent are Roman Catholic, twenty-seven or fifty-four per cent are Protestant and four girls or eight per cent have other religious affiliations. This indicates that the residence is open to all religious groups. It accepts individuals from all denominations, irrespective of religious affiliation.

who cares !!

Analysis of the data in Table 4 indicates that sixty-two per cent of the Protestant girls are performing below the expected educational level by one year or more. It is assumed that in Ontario a child begins grade one at six years of age and normally advances one grade per school year. Fifty-two per cent of the Roman Catholic girls are performing below expected educational level by one year or more. There appears to be little significant difference between religion and academic performance.

TABLE 5

WISC SCORES OF THE GIRLS
ACCORDING TO AGE

Age Category	60-69	70-79	80-89	90-99	100-109	110-119	No Test
16-17	..	..	2	2	..	..	..
14-15	..	4	20	14	12	..	4
12-13	2	6	8	14	6	2	4
Total	2	10	30	30	18	2	8

All but four of the girls were administered psychological tests before entering Maryvale. The WISC scores shown in Table 5 indicate that fifty-two per cent of the girls have WISC scores ranging from ninety to one hundred which is within the average range of intelligence. They should be performing at an age appropriate educational level. However as seen from analysis of Table 3 we see that only twenty-four per cent of the girls were performing at an age appropriate educational level. Although more than half of the

girls have an average I.Q., slightly less than a quarter are performing at the expected educational level. Forty per cent of the girls have below average WISC scores but we found in comparison of age to education that sixty-two per cent of the girls were performing below expected level of educational performance. Less than half of the girls have below average WISC scores however more than half of the girls are performing below their expected educational level.

TABLE 6

AGE OF THE GIRLS AND TEACHER-CHILD RELATIONSHIP

Age Category	Satisfactory Relationship	Unsatisfactory Relationship
	Percentage	Percentage
16-17	8	..
14-15	24	32
12-13	10	26
Total	42	58

The teacher-child relationship is an important factor in educational development. A satisfactory relationship between teacher and child is necessary for educational and emotional development in children. Table 6 shows that fifty-eight per cent of the girls at Maryvale have had definite and unsatisfactory relationships with their teachers. However forty-two per cent of the girls experienced some degree of positive relationship with their teacher and yet they developed emotional disorders. This indicates that, even though the relationship with the teacher is an important

factor affecting the child, there may be other factors that may influence the healthy emotional growth of children.

TABLE 7

AGE OF THE GIRLS AND THEIR PLACE OF RESIDENCE PRIOR TO ADMISSION

Age Category	Urban	Rural
	Percentage	Percentage
16-17	8	..
14-15	46	10
12-13	34	2
Total	88	12

Table 7 shows that eighty-eight per cent of the girls are from urban areas and twelve per cent of the girls are from rural areas. It is difficult to determine the significance of this finding. Based only on the figures it appears that the incidence of emotional disorders in children from urban areas is seven times that of children from rural areas. However it is possible that emotional disorders go undetected in rural areas due to isolation and lack of diagnostic facilities.

Another important area in the emotional growth of children is the relationship with parents and the environmental factors which affect him during his growth and development. Factors like marital conflict, family breakdown, death of parents, alcoholism of parents, financial or housing problems, parent-child problems, child-child problems, and physical abuse are considered important in the development

of emotional disorders in children. Families having these problems generally tend to produce unstable family structures and unsuitable environments for the child.

TABLE 8

PERCENTAGE OF THE GIRLS ACCORDING TO AGE HAVING DIFFERENT PROBLEM AREAS IN THEIR FAMILY

Age Category	Marital Conflict	Family Breakdown	Death of Parent	Alcohol	Financial or Housing	Parent-child Conflict	Child-child Conflict	Physical abuse of Girl
16-17	4	..	4	4	4	4	..	2
14-15	26	16	12	26	8	24	4	18
12-13	20	18	2	16	10	16	2	16
Total	50	34	18	46	22	44	6	36

From Table 8, we find that fity per cent of the parents of the girls at Maryvale experience marital conflict. In thirty-four per cent of the cases, the families had broken down. Forty-six per cent of the parents of the girls have alcoholic problems. Twenty-two per cent of the girls came from families that were experiencing financial or housing problems. Under these conditions, the emotional needs of these girls were not being met in their own homes.

TABLE 9

MARITAL STATUS OF PARENTS OF THE GIRLS
ACCORDING TO AGE
(Percentage)

Age Category	Married	Separated	Divorced	Widowed	Unmarried	Both parents dead
16-17	4 2	..	..	..	4 2	..
14-15	14 7	18 9	12 6	4 2	6 3	2 1
12-13	12 6	8 4	10 5	2 1	4 2	..
Total	30 15	26 13	22 11	6 3	14 7	2 1

Table 9 shows that thirty per cent of the girls at Maryvale come from two parent families. Sixty-eight per cent of the girls come from single parent families where the parents were either separated, divorced, widowed, or unmarried. Two per cent of the children had both parents deceased. Thus seventy per cent of the girls come from families which suffer some form of family breakdown.

Table 10 shows that twenty-one of the girls are Roman Catholic. Of these, eight come from homes where the parents are married and living together, one is from a home where the parents are divorced, seven are from unmarried parents (according to The Child Welfare Act of Ontario, 1965), and five are from homes where parents are separated. Twenty-seven of the girls are Protestant. Of these, eleven are from homes where their parents are married and live together, two are from divorced parents, two are from widowed parents,

six are from unmarried parents and six are from parents who are separated. We saw in Table 9 that over half of the girls come from homes where the parents are either divorced, widowed, unmarried or separated. Table 10 shows that religious affiliation does not appear to be a significant factor in the parents' marital status. The data does substantiate the hypothesis that most of these children who are emotionally disturbed come from broken homes.

TABLE 10

RELIGION OF THE GIRLS AND MARITAL STATUS OF PARENTS
N = 50

Religion	Marital Status of Parents				
	Married	Unmarried	Divorced	Separated	Widowed
R. C.	8	7	1	5	..
Prot.	11	6	2	6	2
Other	2	..	..	..	..
Total	21	13	3	11	2

Table 11 shows that sixty per cent of the girls have three or more siblings, thirty-four per cent have four or more siblings and sixteen per cent have five or more siblings. The average number of siblings for each girl is 3.10. More than half of the girls come from homes in which there are more than four children. This finding does not relate directly to our hypothesis but it does raise the question as to whether the emotional needs of a child are met adequately in a large family.

TABLE 11

PERCENTAGE OF THE GIRLS ACCORDING TO AGE HAVING DIFFERENT NUMBER OF SIBLINGS

Age Category	Number of Siblings								
	0	1	2	3	4	5	6	7	8
16-17	2	2	..	2	..	..	..	2	..
14-15	2	8	10	18	6	2	4	2	4
12-13	6	6	4	6	8	2	4	..	..
Total	10	16	14	26	14	4	8	4	4

TABLE 12

RELIGION OF THE GIRLS AND NUMBER OF SIBLINGS
N = 50

Religion	Number of Siblings								
	0	1	2	3	4	5	6	7	8
R. C.	2	2	2	5	3	2	2	..	1
Prot.	6	5	5	6	3	..	2	1	1
Other	..	..	..	1	..	..	..	1	..
Total	8	7	7	12	6	2	4	2	2

Table 12 indicates that religion is not a significant factor in the number of children in the families. Sixteen of the twenty-one Roman Catholic girls come from families with two or more children, fourteen are from families with three or more children, and nine are from families with five or more children. Twenty of the twenty-seven Protestant girls are from families with two or more children, fifteen are from families with three or more children, and eight are from families with four or more children.

TABLE 13

PRESENTING PROBLEMS OF THE GIRLS
ACCORDING TO AGE

Age Category	Presenting Problems						
	Sex	School	Home	Steal-ing	Lying	Running Away	Drug Use
16-17	..	2	4	1	1	1	..
14-15	4	18	19	9	7	10	4
12-13	3	10	12	9	10	4	..
Total	7	30	35	19	18	15	4

Girls with many different types of emotional difficulties present themselves to Maryvale for treatment. However, not all of these girls are accepted. Girls with psychotic problems and retarded girls are excluded from the program. Exceptions are made to accommodate one or two psychotic girls. Because Maryvale is an open setting those who need constant supervision cannot be accepted.

In Table 13, we see that thirty of the girls were presenting behavioural problems in school prior to admission. Thirty-five of the girls were presenting behavioural problems in their homes. Nineteen of the girls had a history of stealing. Eighteen of the girls had a history of lying. Fifteen had a history of running away from home. Seven of the girls had acted out sexually. Four of the girls had tried drugs. There does not appear to be any significance between the age of the girl and the type of presenting problem reported. It is significant when we compare the high number of girls presenting problems in their homes to the high incidence of marital conflict reported in Table 9. From this, we can

conclude that a high incidence of marital instability is accompanied by a high incidence of children presenting problems in their homes.

Similarly there is a large number of children presenting problems in school. From this we can see that a high incidence of failure in school as reported in Table 3 is accompanied by a high incidence of girls presenting behavioural problems in school.

It is significant to note that a high rate of failure in school is accompanied by a high incidence of behavioural problems in school and these are accompanied by a high rate of poor teacher child relationships as reported in Table 6.

Table 13 shows that the home and school environments are the areas where girls presented most problems.

TABLE 14

AGE OF THE GIRLS AND PEER RELATIONSHIPS

Age Category	Satisfactory Peer Relationships	Unsatisfactory Peer Relationships
	Percentage	Percentage
16-17	2	6
14-15	24	32
12-13	10	26
Total	36	64

Table 14 shows that thirty-six per cent of the girls had satisfactory peer relationships at the time of admission to Maryvale. It is significant that sixty-four per cent had unsatisfactory relationships. This is in accordance with

Redl's observation that emotionally disturbed children do not have opportunities for establishing adequate peer relationships.

TABLE 15

PERCENTAGE OF THE GIRLS HAVING ACCORDING TO AGE DIFFERENT NUMBER OF PLACEMENTS PRIOR TO ADMISSION

Age Category	Number of Placements Prior to Admission					
	0	1	2	3	4	5 or more
16-17	2	..	2	2	2	..
14-15	12	12	12	10	6	4
12-13	2	10	10	8	..	6
Total	16	22	24	20	8	10

Since most of the girls at Maryvale come from broken homes, they have had experiences of either foster home placements or other institutional care prior to admission to Maryvale.

Table 15 shows that only sixteen per cent of the girls did not have placements away from their homes prior to admission to Maryvale. Eighty-four per cent of the girls had one or more placements prior to admission to Maryvale. Sixty-two per cent had more than one move prior to admission. Thirty-eight per cent had three or more moves prior to admission to Maryvale. Eighteen per cent had four moves or more prior to admission.

Redl has pointed out that children with emotional disorders are continuously exposed to traumatization and do not have a feeling of being rooted somewhere. These girls who

suffered through separation from family and community substantiate Redl's statement.

TABLE 16

PERCENTAGE OF THE GIRLS ACCORDING TO AGE HAVING DIFFERENT PSYCHIATRIC DIAGNOSES

Age Category	Psychiatric Diagnosis							
	Emotional Neglect	Personality Disorder	Emotional Immaturity	Mental Deficiency	Character Disorder	Immature Personality	Depression	Psychotic or Schizophrenic
16-17 . . .	..	..	..	..	4	..	4	2
14-15 . . .	6	..	12	2	14	4	18	..
12-13 . . .	8	6	4	..	12	..	8	..
Total	14	6	16	2	30	4	30	2

Psychiatric diagnoses are generally provided upon admission to Maryvale. Treatment plans are formulated and based upon the diagnosis made by the psychiatrist. The common diagnostic categories are emotional neglect, personality disorder, emotional immaturity, mental deficiency, character disorder, immature personality, depression, and schizophrenia.

The two most frequent psychiatric diagnoses as shown in Table 16 are character disorder and depression. Thirty per cent of the girls were diagnosed as having character disorders. Thirty per cent of the girls were diagnosed as having depression.

From the above tables our hypotheses are positively found to be significant. Most children who suffer from emotional disorders had difficulties in their psychosocial adjustment, they came from broken homes, and they exhibited antisocial behaviour in the home, school, and community.

lack of controls do not warrant such a statement

The data in Table 3 does substantiate the hypothesis that children who develop emotional disorders will exhibit insufficient educational achievement. It also supports the claim of the Commission on Emotional and Learning Disorders in Children which states that we become concerned about a particular child because he is not performing or behaving at a level, nor in a way that fits the expectations derived from normal development.

The data in Tables 8 and 9 substantiates Alt's theory that children need warm personal care from their parents or parent surrogates in order to develop emotional health. This data also substantiates our hypothesis that most emotionally disturbed children will come from broken homes where their emotional needs were inadequately met. It also supports Fritz Redl's assumption that disturbed children come from families which suffer from basic disintegration.

The review of the literature all pointed to the fact that family security is important in meeting the basic needs of children. Certainly the large percentage of girls at Maryvale who did not have this family security would seem to point to family insecurity as a causative factor in emotional disorders in children.

The large percentage of children who had unsatisfactory peer relationships also supports our hypothesis that children with emotional disorders are socially isolated.

The high percentage of girls who had separations from their families substantiates our hypothesis that most emotionally disturbed children come from homes where their emotional needs were not met.

Summary

This chapter deals with the emotional disorders in children, parental relationships, school adjustments, the child's peer-group relationships, the intellectual factors, and the teacher-child relationships of girls prior to their admission to Maryvale. It also deals with problematic areas which the girls exhibited prior to admission to Maryvale.

CHAPTER IV

SUMMARY AND CONCLUSIONS

The focus of this research project deals with the etiological problems of children in the age group of twelve to seventeen years who are residentially placed and receiving treatment at Maryvale Vocational School in Windsor, Ontario. It also deals with those psychosocial components that have lead to these emotional disorders.

These questions were examined by collecting information through a check list from the files of fifty-three resident girls of Maryvale Vocational School. Their files were made available to us by the Executive Director of Maryvale. This population consisted of girls currently in residence on January 20, 1971. Three girls were eliminated because they were non-white so that the sample would provide a homogeneous population of white girls.

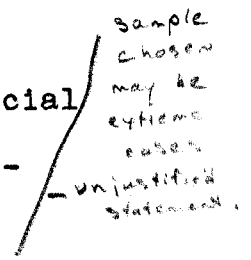
Three hypotheses were formulated in order to determine whether emotionally disturbed children suffered from inadequate psychological supplies, came from disintegrated families where emotional needs were inadequately met, and exhibited social isolation, antisocial behavior, and insufficient educational achievement. These hypotheses were based on the assumption that emotional disorders in children are caused by a lack of adequate psychological, and

social supplies in the environment.

The check list was constructed to collect data and divided into two parts. The first part included questions which gathered basic information on the child's social and family history. The second part of the questions dealt with the child's prior placements, medical history, school history, psychological history, and presenting behavioral problems.

We examined the historical development of Maryvale. Maryvale has evolved over a period of forty-two years. It has changed consistently to meet needs within the community. It presently serves as a residential treatment centre for fifty-three emotionally disturbed adolescent girls.

The hypotheses formulated in this research were found to be valid. In the light of these results, several conclusions can be drawn. Most children who suffer from emotional disorders had difficulties in their psychosocial adjustment, came from broken homes, and exhibited anti-social behavior in the home, school, and community.



From the results of the check list, it appears that the psychological needs of these children were not adequately met prior to admission to the residential treatment centre. Eighty-four per cent of the girls had one or more placements away from their homes prior to admission to Maryvale. Children with emotional disorders have been continuously exposed to traumatization with a resultant feeling of insecurity. Twenty-two per cent of the girls came from fami-

lies which were experiencing financial or housing problems.

Sixty-eight per cent of the girls came from single parent families where the parents were either separated, divorced, widowed, or unmarried. Fifty per cent of the girls came from families where the parents experienced marital conflict. Forty-six per cent of the girls had parents who had alcoholic problems. The data does substantiate the hypothesis that most emotionally disturbed children come from homes where their emotional needs were inadequately met.

Sixty-four per cent of the girls had unsatisfactory peer relationships and we conclude that they experienced social isolation. Sixty-two per cent of the girls were performing below the expected educational level by one or more years. Only twenty-four per cent of the girls were performing at or above the expected educational level. Thirty-five of the girls exhibited behavioral problems at home and school prior to admission to Maryvale. Nineteen of the girls had a history of stealing. Eighteen of the girls had a history of lying and fifteen had a history of running away from home. The data does substantiate the hypothesis that children who develop emotional disorders will be socially isolated, will exhibit antisocial behavior and insufficient educational achievement.

Many causative factors have been explored with regard to emotional disturbances in children. Even though it is recognized that there are several factors associated with

the development of emotional disorders in children, our data points out that the family plays an important role in the healthy emotional development of children. The data also indicates that the family provides basic psychological and social needs of the children. Families with a history of breakdown tend to produce emotional instability among children.

The fity girls used in this study provide a clear example of family instability, insecurity and a lack of love and affection which has resulted in placement in a residential treatment centre.

APPENDIX

CHECK LIST

PART I

1. Birthdate: _____

2. Admission Date: _____

3. Referral: Family _____
   Hospital _____
   Soc. Agency _____
   Other (Specify) _____

4. Legal Status: Non Ward _____
   Society Ward _____
   Crown Ward _____

5. Religion: Protestant _____
   Catholic _____
   Jewish _____
   Other _____

6. Ethnic Origin: _____

7. Racial Origin: Caucasian _____
   Negroid _____
   Mongoloid _____

8. Education: Grade Level _____

9. Residence: Urban _____
   Rural _____

SOCIAL AND FAMILY HISTORY

10. Marital Status of Parents: Unmarried _____
    Married _____
    Widowed _____
    Divorced _____
    Separated _____

11. Date of Marriage: _____

12. Father's Educational Background: Grade 8 or below _____
    Grade 9-10 _____
    Grade 11-13 _____
    Further Educational Training: _____

13. Mother's Educational Background: Grade 8 or below _____
    Grade 9-10 _____
    Grade 11-13 _____
    Further educational training: _____

14. Income: Father employed _____
Mother employed _____
Both employed _____
Public Assistance _____

15. Amount of Income: _____ per year

16. Number of siblings and ages: _____
_____
_____
_____

17. Problematic Areas in Family: Marital conflict _____
Family Breakdown _____
Death of Parent _____
Financial or Housing _____
Parent-child conflict _____
Child-child conflict _____
Alcoholism _____
Child neglect _____
Other (specify) _____

18. History of Involvement with Social Agencies: Yes _____
No _____
Unknown ___

PART II

CHILD

19. Number of placements prior to admission: 0 _____
1 _____
2 _____
3 _____
4 _____
more than 4 _____

20. Medical History: Excellent _____
Good _____
Physical Handicap _____
Chronic Illness _____
Neurological Problem _____

21. School History: Grade level on Admission: _____

22. Academic Achievement: Excellent _____
Good _____
Poor _____

23. Teacher-Child Relationship: Satisfactory _____
Unsatisfactory _____

24. Peer Relationships: Satisfactory _____
Unsatisfactory _____

25. Psychological Examination Date: _____
Type of Testing: WISC _____
TAT _____
Weschler _____
Peabody _____
Other (specify) _____

26. Test Results: _____
_____

27. Diagnosis: _____

28. Psychiatric Examination: Date: _____
Diagnosis: _____

29. Child's Presenting Problem: School Maladjustment _____
Behavioural problem at home _____
" " at school _____
" " at community _____
" " at all three _____
Stealing _____
Lying _____
Running Away _____
Sexual Acting Out _____
Other (specify) _____

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VITA

Arthur W. Hicks was born at Port Maitland, Ontario on January 29, 1940. He attended the Grandview Public School in Byng, Ontario and graduated in 1954. He then attended the Dunnville District High School, graduating in 1958. He graduated from the University of Windsor with the degree of Bachelor of Arts in 1965. He worked for two years with the Roman Catholic Children's Aid Society for the County of Essex as a social worker. In September 1969, he was admitted to the Master of Social Work program at the University of Windsor, School of Social Work and expects to graduate in May 1971.

VITA

Anastasia St. Amand was born April 25, 1941 at Windsor, Ontario. She attended St. Anne elementary school where she completed grade 8 in June, 1954, and then she went to St. Joseph Junior High School where she completed grade 10 in June, 1956. She obtained her senior matriculation from F. J. Brennan High School in June 1959.

From September, 1959 to May, 1962, she attended Assumption University at Windsor. In June 1962, she graduated with a Bachelor of Arts degree in psychology. She was admitted to the M.S.W. program at the University of Windsor in September, 1968, and expects to graduate in May, 1971.

Mrs. St. Amand was employed with the Roman Catholic Children's Aid Society for the County of Essex from June, 1962 until September, 1968. For the first five years of her employment she was a Social Worker in the Family Services Department of the Agency. For the next two years she was Supervisor of the Intake Department. During her last year at the Agency she was the Supervisor of Services to unmarried parents.

VITA

John David Joseph Tallon was born June 9, 1938 in Detroit, Michigan. He attended St. Luke's and St. Alphonsus elementary schools in Dearborn, Michigan. In 1952, he enrolled at Catholic Central High School graduating in 1956.

He graduated from Assumption University of Windsor with a Bachelor of Arts Degree in 1962. He graduated from the University of Toronto Graduate School of Theology with a Bachelor of Sacred Theology Degree in September 1967. He was ordained a Roman Catholic Priest of the Congregation of St. Basil in December 1967. He graduated from the University of Rochester with a Masters of Education Degree in 1969. In the fall of 1969, he was admitted to the School of Social Work at the University of Windsor and expects to graduate with the Masters of Social Work Degree in May, 1971.

He taught at Assumption College High School in Windsor, Ontario; St. Mary's College in Sault St. Marie, Ontario; Michael Power High School in Toronto, Ontario; Aquinas Institute in Rochester, New York. While attending the University of Toronto Graduate School of Theology, he was Secretary-Treasurer of St. Basil's College for four years. He has accepted the position of Director of the Social Service Department at Hotel Dieu Hospital, Windsor, Ontario.