1969

The Impact of Residential Treatment on Emotionally Disturbed Boys

Marilyn C. Ebert
Wilfrid Laurier University

THE IMPACT OF RESIDENTIAL TREATMENT ON EMOTIONALLY DISTURBED BOYS

A Research Proposal

A Research Essay

Submitted to The Graduate School of Social Work

Waterloo Lutheran University

By

MARILYN C. EBERT, B.A.

in partial fulfillment of the requirements for the

Degree of Master of Social Work

April, 1969

ProQuest LLC.
789 East Eisenhower Parkway
P.O. Box 1346
Ann Arbor, MI 48106 - 1346

TABLE OF CONTENTS

INTRODUCTION

Within the past four decades, social work has witnessed the development of increasingly specialized services to children, among these a sort of "total impact therapy" generally defined as residential treatment. In conjunction with basic social work values of the bio-psycho-social nature of human maladjustment, residential centres have attempted to help the child effect a happier adjustment to his life situation by meeting some ungratified basic need. Institutions for dependent children complimented those for custodial care or even isolation; contemporary residential treatment centres are designed to meet a broader range of needs of the child than those of forty years ago through a variety of approaches, often referred to as milieu therapy. Consideration of the common needs of children is basic to questions concerning the place of institutional treatment and the particular type of child for which this social work service is the most appropriate one.[1]

The residential treatment centre addresses the whole gamut of a child's needs from physical care to rehabilitation. Exposure to, and participation in, a group life experience simulating as closely as possible the family or community life experience is the element differentiating residential care from other treatment modes.

[1]S.Lerner, "The Diagnostic Basis of Institutional Care for Children," Social Casework. XXXIII (1952) p. 105.

By involvement in the realities of his daily situation and the working through or resolution of these, the child is helped to cope with his own growth and development - physical, emotional and social.

Problems and questions examined in this paper revolve around the residential treatment centre defined vaguely by the Child Welfare League of America as "A building....maintained and operated by a chartered agency, organization or institution, whose main purpose is to provide shelter and care to a group of unrelated children and youths up to eighteen years of age."[2] More specifically, the concern for research, the proposal and plans for implementation are focused on Mount St. Joseph, an autonomous, non-profit institution providing care for boys with moderate to severe emotional disturbances.

[2]Child Welfare League of America Inc., "Children in Institutions" (Toronto: undated), p. 8.

CHAPTER I

THE RESEARCH PROBLEM

The Basic Research Questions

The major concern of this research is what impact, if any, had treatment on boys who have been admitted to Mount St.Joseph? The basic questions that are the objectives of this research proposal, and of the agency are, more explicitly:

1. What changes have occurred in children during treatment at Mount St.Joseph?
2. Is there an appropriate tool for measuring these?
3. In what areas does the change show deterioration or progress?
4. What criteria can be established to measure the impact of residential treatment on emontionally disturbed children?

A search for patterns or relationships in answer to each of these questions will help evolve hypotheses with respect to which children are, or are not, effectively helped.

The Field of Study

Before proceeding, a brief description of the centre, its history and facilities, will be valuable to the later proposal of a research design developed specifically in relation to this organization.

Mount St.Joseph originated as an orphanage to neglected children in 1852, supported and staffed by the local Hamilton Sisters of St.Joseph. With the increasing pressure for specialized children's services and the wider use of foster placement for dependent children, the same physical facilities used in 1936 for the residence of 97 orphaned children, in 1961 was instituted as a treatment centre for emotionally disturbed boys. Recruiting of professional staff and phasing out of the orphanage program was initiated in 1959.

The physical setting, consisting of a four-storey residence and detached laundering plant presently houses seventeen boys divided into three somewhat separable units. Strategically located at the city's centre, the institution makes frequent use of community facilities - swimming pools, rinks, parks, churches, etc. to supplement its even more important internal programme. The majority attend school at the centre which includes one large and one small classroom. A fortified quiet room is employed only to calculated therapeutic ends.

The direct care of the children is the responsibility of a Child Care Staff of 12, about equal numbers of male and female. Approximately half, including three sisters, are qualified or experienced with two or more years in Child Care work. The ratio of staff to children is felt to be essential to the need for close, intensive child - adult

relationships. One child care worker is assigned to each of three units of six children for every morning and afternoon shift. In order to have a varied programme, child care workers also specialize in certain activities - music, drama, physical education, arts and crafts. Experienced workers serve as Unit Leaders for each of the three separate units of boys, in order to organize and regulate the daily living situation. All workers are required to participate fully in as many areas of the child's activity as possible.

Each section of boys is a unit, physically and socially. These are programmed and directed by the Child Care workers.

Other professional staff consist of a Psychologist (the director), a Social Worker, and consultant Psychiatrist. Weekly conferences and meetings at several levels are essential to good communication amongst all staff members. While the Psychologist and Social Worker work directly with children weekly for individual therapy, the Psychiatrist attends weekly conferences in a consultant role and attends to children's medicalproblems. The agency serves as a field placement for two Schools of Social Work and visits occur frequently to the centre by nurses, Psychology students, and Community Collegestudents as part of their training.

A fifteen member Board of Directors (including two members to represent the Sisters of St.Joseph) have authority

for the overall management of the agency. The treatment programme and administrative tasks are delegated, respectively, to the Director and Administrator (traditionally, a Sister of St.Joseph). The problems of Finance, Building, Personnel and Child Care are integrated through various committees. The Administrator has the final decision as to whether the child's stay is to be financed by his guardian or some other means. Children admitted as wards of Children's Aid Society are financed fully by that agency.

The Source of Interest

The author's concern with the problems of measuring progress, or change in this residential treatment centre is largely a by product of four months of social work field placement as a second year student at Mount St.Joseph. Throughout this period of time there was an obvious, sincere desire on the part of staff to follow-up children discharged from the agency in relation to the effectiveness of their treatment. From a more general survey of literature on the problem, the author saw the need for objective measurement of the treatment process in terms of its immediate implications for practice in several areas. Initial ideas were formulated about the evaluation of treatment through reading and consultation. The author searched for the questions, at this agency, that were actually researchable. It seemed that the

agency's proposed use of a follow-up study was not the best way to answer its questions concerning the effectiveness of its programme.

Research Objectives and Premises

Implicit in determining the effect of treatment on children at Mount St.Joseph, are three essentials: observation, inquiry and measurement. The centre, as many others, has generally shied away from the last of these for reasons later delineated in this paper. Determining the appropriate tool to measure the effect of therapy, then, is a critical task of the research proposal.

The research, it is anticipated, will clarify several intuitively felt but never substantiated concepts: agency objectives, especially their relation to therapy, the side effects of institutionalization, the reasons for maladjustment, etc., etc. Most significantly, the research will serve to point up areas that require further, more detailed objective investigation by the Mount if it is to maintain its belief in its ability to help a child, emotionally and psychologically deprived, to effect a better adjustment to his community.

The mature institution uses feedback from research to examine and improve the effectiveness of its service. Many children's institutions have used the follow-up study, alone, to do so; the contamination of two possible effects on the

child's behavior (1. the "stable" impact of treatment and 2. social pressures) makes this use of research an in appropriate way to test the success or failure of service to a disturbed child. Only an experimental study can evaluate treatment per se; few Canadian institutions in view of the nature of the problems handled, the lack of a definable treatment philosophy and of available finances have yet reached this stage of readiness.[1]

Questions of the value of the agency's treatment can be dealt with on a different pre-evaluative level of research in order to answer questions of: which children were helped, how much; in what basic need areas, how lasting was the help. A causal relationship of treatment and a child's adjustment, though implied, need not be validated to describe the "effect" or "impact" of therapy on the child.

A basic premise of this paper is that, associated with the total therapeutic process, is a relationship between the psycho-social state of a child at three points in treatment at Mount St. Joseph: 1) immediately prior to admission, 2) at the point of discharge and 3) at some predetermined point after discharge. The treatment process is a describable, intervening variable which, taken as a given, is not experimentally controlled. A major assumption is, then, that therapy at the Mount is primarily the same for all children who use its social services.

---

[1]N. Herstein, "A Critique of Current Research in Child Care," edited by M. Norris and B. Wallace, The Known and Unknown in Child Welfare Research. N.A.S.W., (1965), p. 82-104.

Relevance of the Research to Social Work

In view of the side effects of institutionalization, rates of progress, and its effect on the child's family, residential treatment is now being questioned as to its practicality, feasability, and desirability.[2] The assessment of the impact of treatment has relevance to Social Work beyond strict evaluating of services. Research, such as proposed, calls for the re-evaluation of agency and service objectives which are crucial at multiple points in the treatment of an emotionally disturbed child. Evaluation for example, of a child's progress in treatment provides feedback for selection of clientele, so the relationship is cyclical. Furst describes objectives as "the basis for learning experience and evaluation and procedures."[3] The on-going definition of objectives is critical to any progressive agency operation.

Clarification of agency goals, as required by the research proposal, can be employed professional and non-professional staff at Mount St. Joseph to most beneficially concentrate their efforts, in view of goals now more understood and, therefore, more readily accepted.

Analysis of the data obtained from measuring change in children will help delineate what types and degrees of growth

---

[2]G. Canter, M. Yeakel, and N. Polansky, Retrieval from Limbo: Intermediary Group Treatment of Inaccessible Children. C.W.L.A. (New York: 1967).

[3]E. J. Furst, Constructing Evaluation Instruments, (New York: 1958), p. 1.

can be expected from an emotionally disturbed child of a certain age, temperament, family background, and with certain manifest symptoms. The realtionship of these facts to the objectives and intensity of treatment, is a concern of all social workers. The value for admitting children and deciding when to discharge is obvious.

The clear definition of social work objectives and of the potential of both the client and the service cements the relationship of diagnosis, treatment and outcome thus maximizing the resources in helping the client, child and adult.

Relation to Existing Knowledge and Practice

A method of describing the effect of residential treatment is clearly related, by its concern with objectives, to Hollis' teaching of the relationship of assessment, diagnosis, and treatment. It is from the initial psycho-social assessment that a child's status is measured. A diagnosis of the problem leads to the establishing of treatment objectives which can be tested as worked through at the point of discharge of the child. If there is a large discrepancy this necessitates a more realistic examination of treatment goals and, hopefully in the future, better agreement between the second and third elements of Hollis' schema. The proposed research will assist the agency in tightening up and making explicit the diagnostic classification which determines which

children are or are not to be admitted.

The place of socio-environmental factors in pathology has been considered extensively in the field of social work by Hollis (person-in-his situation), Ackerman, and others. A valid assessment of the impact of treatment on a child must take into consideration the elements of family status and developmental history, family influence on or interference in therapy, and the demographical characteristics of ethnicity, religion, neighbourhood, etc., etc. In devising the research tool to measure change, these features of a child's pathology were considered to play a significant part.[4]

The proposed research problem is, in several ways, related to current social work research. Most notable of this is work by Hunt and Kogan[5] on the "Movement Scale" to examine the types of growth and adjustment occurring in treatment and develop an objective means to measure this. Polansky, Weiss, Blum, Weber and others have done extensive research on the treatability of children, and especially of the "accessibility" to treatment of emotionally disturbed children and the reasons for this. While these authors have hypothesized methods of assessing accessibility and increasing

---

[4]Many methods of assessing change through therapy make little or no consideration of these elements. Some, e.g., concentrate on the behavioral symptons of emotional disturbance without looking at family or community demands or elements that promoted the symptons.

[5]Hunt, J.N. and Kogan, L.S. "A Field Test of the Movement Scale" Social Casework. XXXI (1950), p. 267.

it, Canter has gone one step further in proposing a unique type of group method to increase a child's amenability to treatment and move him into casework treatment, thus avoiding residential treatment which is seen as costly and inappropriate.

In practice, too frequently ill-defined is the basis of referral to an institution by a social worker in an outside agency. The evaluative research method posed will help solidify a schema by which to refer a child for this type of particularized treatment. The values of family therapy vs. casework with an emotionally disturbed child is a further practice dilemna most important to this research problem.

CHAPTER II

SURVEY OF THE LITERATURE

Many authors have addressed the question of change, its correlates andmeasurement through some kind of treatment: psychoanalysis, psychotherapy, casework, group-work, relationship therapy, etc. Although the problem of examining change, (critical to this research proposal) has been approached from multiple points of view, the arguments generally involve basic issues which fall into six categories:

1. Diagnostic Classification
2. Determining Accessibility to A Specific Kind of Therapy
3. The Basic Needs of Children and their Relationship to Treatment Objectives
4. Objective Measurement of Change Through Treatment
5. The Success Failure Dilemna
6. Participation of the Family in Treatment

Diagnostic Classification

In spite of the importance of an accurate diagnosis in establishing and limiting treatment objectives, no standard-ized generally accepted diagnostic classification has been used by residential treatment centres. Disagreement begins with what factors in a child's emotional disturbance are to be diagnosed. While the majority of institutions categorize according to presenting symptoms, for example: aggressiveness,

withdrawal, bedwetting, stealing,[1] others diagnose intra-psychic functioning: ego integration, self image.[2] Residential centres seem to avoid explicating their diagnostic procedures bylisting gross eligibility factors as criteria: local and regional factors, committment of parents to treatment plan, age, absence of organic factors, for example.[3] Beyond this, there is often no objective schedule for diagnosing the child's problem; it is generally defined the literature reveals, by a loose grouping together of assessments at intake by the psychologist, psychiatrist, and caseworker involved.

A sound, categorical diagnosis at admission is essential in reviewing later what changes the child has made from his initial state of pathology;[4] it is essential, moreover, to evaluative research purposes of comparing data between child and child, problem and problem, and thus critical to experimental research where true evaluation is possible.

Quantitative and qualitive factors are essential parts of the diagnosis. While the former describes the severity of

---

[1]Astor Home, "Follow-up Basic Data Sheet," mimeo.

[2]C. Rogers and R. Dymonds, Psychotherapy and Personality Change. (Chicago: University of Chicago Press, 1954) J. Hunt and L. Kogan, Measuring Results in Social Casework. (New York: Family Service Association of America, 1950).

[3]Mount St. Joseph (mimeo, 1967), p. 8.

[4]M. Wolins, "Measuring the Effect of Social Work Intervention." Social Work Research, edited by N. Polansky. (Chicago: University of Chicago Press, 1960), p. 247.

a child's difficulty, the latter describes the type of problem and areas of the child's functioning affected. Assessments of parental attitudes, of the child's view of placement, and of the projected duration of treatment are seen by Lerner to be too little consideredby the treatment centre at admission[5] while Granick and Taylor include these as very significant in assessing the ramifications of a child's pathology.[6]

Admission procedures, argue some authors, always involve some calculated risk, but a mature institution does not deal in "undisciplined helpfulness."[7] On the basis of an accurate diagnostic procedure it can refuse admission to the child for which it cannot provide maximum help. When diagnosis is not well integrated, in this way, with treatment proposals and objectives, residential placement becomes an end in itself and thereby defeats the purpose it is established to serve.[8]

Determining Accessibility to Therapy

Consequent to a complete diagnosis is matching the diagnostic indicators with the appropriate form of therapy. Polansky and Weiss have extensively studied the determinants

---

[5]S. Lerner, "The Diagnostic Basis of Institutional Care for Children," Social Casework. XXXIII (March 1952), p. 105-111.

[6]S. Granick and J. Taylor, "Prediction of Adjustment in a Group Residence: A Pilot Study," Journal of Jewish Communal Services. XXXVIII (Spring 1961), p. 307-311.

[7]Ibid, p. 309.

[8]M. Dettelbach, "Criteria for Agency Referral of a Child to a Residential Treatment Centre," American Journal of Orthopsychiatry, XXVI (1954), p. 674.

of "accessibility to treatment".[9] Accessibility is seen as a psycho-social characteristic of the child which determines the kind of help he can use and from which he can benefit. If thechild is not even accessible, he is not "treatable". Through diagnostic group observation, the authors found a child's accessibility to casework could be partly determined by his verbal accessibility.

Since casework or psychotherapy is usually an integral part of residential treatment, the childs ability to integrate it will influence the possibility of movement occurring. Of some eight attempts, reviewed, to develop criteria for assessing change, only Granick and Taylor have considered "ability to use psychotherapy"[10] as can important predictive factor. The implications for admission policies are obvious.

Grace Canter, attempted to increase a child's accessibilityto treatment by increasing self-observation and impulse control.[11] Sixty percent of her sample of children, because of this, were spared of institutional care. Only where the facilitiesof the treatment centre can match the child's potential to use them, is the treatment method an appropriate one.

---

[9]N. Polansky and E. Weiss, "Determinants of Accessibility to Treatment in a Children's Institution, "Jewish Journal of Communal Services. XXXVI (Winter, 1959), p. 130-137.

[10]S. Granick and J. Taylor, "Prediction of Adjustment in a Group Residence: A Pilot Study. "Journal of Jewish Communal Services. XXXVIII (Spring, 1961), p. 307-311.

[11]G. Canter, M. Yeakel and N. Polansky, Retrieval from Limbo: (New York: Child Welfare League of America, 1967), chapter 4 and 5.

Basic Needs of Children
Their Relation to Treatment Objectives

In defining residential treatment, several authors have implicitly described the psycho-social needs of an emotionally disturbed child and how these can be met with this specific therapy. The psycho-dynamic viewpoint is represented by Hallowitz: residential treatment is a process of maturing thechild's ego development.[12] Deep and central problems are treated on a reality basis. Bowers calls residential treatment a learning experience, simulating family life, that moves the child back to the natural community.[13] Only the outward manifestations of the psychic problems are accessible, and treatable, so the emphasis is on meeting social needs and improving social relationships. Most significant, argues Canter, is intervention in the cycle of family neurosis.[14]

The three representative approaches emphasize that all these factors, the child's psychological and social needs, as well as those of his family are basic determinants of treatment. Love and affection from parent substitutes, says Lerner comes through stable relationships of child to adult.[15]

---

[12]D. Hallowitz, "The Element of Parental Identification in the Child Care Institution," Social Casework. XXXIII (January, 1952), p. 24-30.

[13]S. Bowers, "The Social Worker in a Residential Children's Treatment Programme", Social Casework. XXXVIII (June 1957), p. 283-295.

[14]C. Canter, et al, Retrieval from Limbo, (New York: 1967), p. 3-5.

[15]S. Lerner, "The Diagnostic Basis of Institutional Care for Children," Social Casework. XXXIII (March 1952) p.105-111

Healthy adjustment of a child comes with healthy, socializing peer relationships, identification with same-sexed adults, expression balanced with emotional control. The basic principles of the institution revolve around these needs which are met through relationships with peers and child care staff.

The rationale for residential placement over foster home involves a consideration of the child's needs. The former has the advantages of:

1. controlled environment, allowing
   a) close interpersonal involvement or
   b) involvements with a variety of staff
2. permissiveness for acting out or withdrawal
3. group living experience

A child's adjustment to institutional life is maximized as his needs are best met by these therapeutic tools. The child in treatment, is helped to recognize his basic needs and to learn how to best gratify them in socially acceptable ways. It is a prime agency responsibility, at intake, to help the parent's identify the child's needs in relation to how they can support treatment.

The needs of the family and community are also significant in deciding upon residential treatment. Although not the primary reason for placement,[16] the community's level of tolerance will affect the reality of the objective of re-integrating the child after discharge.

---

[16]Grace Canter critizes residential placement as too often based on the frustrations and criticisms of the family and community towards the child.

Assessing Change Through Treatment

The problem of criteria for evaluating change, growth, or progress comes out strongly throughout the literature. Standards of adjustment to socially acceptable behavior are characteristic of the "absolutic" criteria used in some evaluations. Opposing this is evaluation concerned, not with the child's successful accommodation of social norms, but with the inherent individual factors that make for healthy adjustment, defined as "relative" criteria.[17] In order to assess change in relation to a therapeutic helping process there must be clarity as to 1) what is change and 2) what base is used from which to describe it.

Change is defined by Herzog,[18] in a relative sense i.e. "change from one condition or set of circumstances to another condition or set of circumstances." The client moves from a state of psycho-social maladjustment to some level of psycho-social adjustment. Since the institutions "help" to a child is based on its ability to affect change, some objective attempt at measurement is crucial. Studies using absolute criteria focus on behavioral characteristics and symptomatology as basic units of measurement. The more progressive approach is to define change relative to the

---

[17]R. Perl and A. Simon, "A Criteria of Success and Failure in Child Guidance", American Journal of Orthopsychiatry XII (October, 1942), p. 642-655.

[18]E. Herzog, Some Guidelines for Evaluative Research. (New York: U.S. Department of Health Education and Welfare, 1959), p. 9.

individual child, emphasizing conflicts and emotional maladjustments which, if worked through, will lead to modes of behavior that will most profit him when re-introduced into community life.

Several attempts have been made at an objective scale for assessing change, all of which are inevitably based on the value and methodological orientation of the authors. Kogan and Hunt focused on biological, psychological and socialogical factors and, at present, appear to have the most complete and widely applicable scale. Herzog lists examples of criteria used in evaluative research (much along the lines of Hunt) totaling close to one-hundred. Wolins claims, in disagreement with the author of this paper, that such rating scales inevitably involve episodic counts of disordered behavior in the community before and after treatment.[19] The Astor Home developed a schedule so complex that a computer was essential to analyze some three-hundred variables. Preston evaluated a person's ability to communicate, to accept responsibility, his decisiveness, sense of well-being, hopefulness and efficiency as critical.[20] In formulating a scale it would seem both appropriate and feasible to extract the significant elements from each and

---

[19]M. Wolins, "Measuring the Effect of Social Work Intervention," edited by N. Polansky, Social Work Research (Chicago: University of Chicago Press, 1960), p. 263.

[20]M. Preston, "Factors Affecting Movement in Social Casework," Social Casework. XXXIV, (March, 1953), p. 107.

develop a schedule of ratings specific to one's agency and a specific group of cases.

Apart from scaling techniques other disciplines are now examining the place of intelligence tests and projective techniques as measures of a child's personality and progress.[21]

The specific definition of change described by Mount St. Joseph reads:

> "all free exchanges of lived experiences - free in the sense of unbound by internal conflicts and other compelling conditions - will lead to an increasing exploitation of and participation in the realities in which any two persons are involved. The resulting increase of greater personal investment (from person to person and from persons to realities) will yield an improved sense of mastery or a better capacity for adaptation. Thus the individual can adopt more productive patterns of behavior and free himself from defensive or less effective means of coping because of his enhanced adequacy."

Human growth, promoted by the force of interpersonal involvement, provides the strength to face more realities.[22]

The "Success-Failure" Dilemna

Evidences of change in the emotionally disturbed child, whether measured by a absolute or relative criteria, are often used to describe the success vs. failure, cure vs. non-cure of a case, or of therapy. The value judgment involved

---

[21]E. Fromm; L. D. Hartman; M. Marschak, "Children's Intelligence Tests as a Measure of Dynamic Personality Functioning," American Journal of Orthopsychiatry XXVII (January, 1957), p. 134-144.

[22]Mount St. Joseph, (mimeo. 1967), p. 11.

must be eliminated from research attempts. "Success" is a term inappropriate to science; it cannot be operationalized solely on fact. The ultimate objective of research is to define therapy operationally in "such and such away that tends to produce in the individual, changes a, b, c, d."[23] Consequent to actual measurement is a sound value judgment as to whether this or is not success as the agency defines it.[24] The client and or community may define success in a divergent manner.

Participation of the Family

The child's family can be seen as involved in residential treatment at multiple points in time. A scapegoat, the emotionally disturbed child may be the expression of a family neurosis. Institutionalized, the child may fantasize about rejection and have unrealistic perceptions of the parents; both are barriers to eventual re-admittance of the child to his family.[25]

The treatment centre has a responsibility to diagnose the family's maladjustment as part of the problem and elicit

---

[23]C. Rogers, and R. Dymond, Psychotherapy and Personality Change, (Chicago: University of Chicago Press, 1954), p. 26.

[24]G. Konopka, "The Role of the Group in Residential Treatment," American Journal of Orthopsychiatry. XXV, (October, 1955), p. 679. Konopka further describes agency success in terms of the developmental maturity of the institution as a helping environment. This requires a close harmony of clinical treatment and daily group life for working through the child's day-to-day realities.

[25]G. Canter, M. Yeakel, and N. Polansky, Retrieval from Limbo (New York: Child Welfare League of America, 1967) p. 3.

a family committment to therapy.[26] Ganter see the family's involvement as giving the "total push" to treatment with these children.[27] A vital link between the artificial therapeutic and the real community, the family status has implications for: selection criteria, therapy objectives, re-evaluation, discharge of the child from the residential centre.

The primary objective of residential treatment, the literature reveals, is to provide maximum opportunity to the emotionally disturbed child for a meaningful and responsible group life experience. Only when diagnostic classifications are based on the basic needs of the disturbed child will treatment objectives be optimally congruent with the presenting problem. Determining a child's capacity to change and adapt is a critical part of initial assessment which describes in which areas a child is or is not accessible to casework or milieu therapy. Assessment of the child's degree of change, through treatment is inevitably complex and value based. The potential of a reality based, group living experience to effect such change is well stated as the impact of residential treatment:

> The group is the major source for satisfying the basic social needs (of the emotionally disturbed child) and the chief influence on values, attitudes, and conduct...and one of the most potent social services in helping individuals achieve change.[28]

---

[26] Outlined in theory, this is not consistently practiced at Mount St. Joseph.

[27] Op cit, Chapter 6.

[28] A. Klein, "Individual Change Through Group Experience," The Social Welfare Forum (Columbia: Columbia University Press, 1959), p. 155.

CHAPTER III

THE RESEARCH DESIGN

An exploratory study is the design most appropriate to the complexities and the elusiveness of criteria[1] involved in judging the impact of treatment on a child at Mount St. Joseph. In the rationale for this choice, the following objectives of the research must be considered:

1. to increase familiarity with agency and client phenomenon, that are of significance in determining the direction of treatment for a child (i.e. change vs. no change); to identify and describe concepts (e.s. emotional disturbance, change, etc.), questions and characteristics without substantiating causal relationships

2. to establish priorities for further research, to formulate the technical tools (for example the rating measurement) pre-requisite to systematic evaluation.

Further latent objectives merit attention: re-affirmation of agency objectives and philosophy; encouraging experimentation with programme; a supportive function to director and staff; a test of the feasibility of research at Mount St. Joseph at this time.

Five features of the proposed design maximize the possibility of fulfilling all these objectives: 1) flexibility, 2) ex-post-facto, 3) episodic, 4) generalizability,

---

[1] E. Herzog, Some Guidlines for Evaluative Research, (New York: U.S. Department of Health, Education and Welfare, 1959), p. 20.

5) pre-evaluative.

The concepts of emotional disturbance, behavior disorder, or maladjustment in a child and of improvement, deterioration, and "help" are judgmental and unstable, necessitating great flexibility in research that purposts to describe and objectify them. The intervening variable of treatment programme can be conceptualized, but not minutely controlled. "The ultimate criterion of success.. (intreatment),[2] claims Herzog, 'is opinion;" considering the state of knowledge on how to assess client change and the lack of specifity defined in the conditions under which this happens to boys at Mount St. Joseph, rigid, experimental research is pre-mature. The research has advantages in the designing and implementing of a measuring instrument that can examine change in its broadest aspects while relating this to the specific practices of the institution.

Practical and ethical considerations were involved in the choice of an ex-post-facto study. Because, for example, the centre discharges about four children per year, it is clear that a projected period of six years might be essential to obtaining a fair enough sample to provide answers to beginning questions about what boys can or cannot be helped.[3]

---

[2]Ibid, p. 148.

[3]This is excluding use of intensive case study research.

In retrospect, this ex-post-facto study examines the dependent variables of behavioral and emotional change in children, observed in the "natural" setting of the institution and unhampered by research objectives to experimentally modify the child or agency's condition.[4]

Although some studies have attempted global judgments of client movement, objective measures of a child's psyco-social status before and after institutionalization are argued to be the most effective measurements of change in children at Mount St. Joseph. Episodic counts (for example, (+) or progress, (-) or deterioration) are essential aspects of the design attempting to objectively record psycho-social change.

As Sample[5] describes it, the tendency in research is strong to develop a design and methodology with wide applicability to Social Work. The limitations, here, of the exploratory study are outweighed by its specific import for knowledge, and practice in the Mount St. Joseph setting; this does not mean eliminating attempts to develop working hypothesis related to the broader social problems of emotional disturbance and delinquency, residential and milieu therapy. Generalizability of the research is here sacrificed, with the recognition of research limitations in the practice setting, for a more subjective approach.

---

[4]Refer to Preston (1950) for ethical concerns of caseworkers during prospective research studies.

[5]Wm. Sample, "The Findings on Client Change." Social Service Review, LXI (July, 1967), p. 138.

That the nature of the design is pre-evaluative cannot be overemphasized. True evaluation of the service given is contingent upon preliminary, pre-requisite study which need not establish the success or failure of the therapeutic programme, but will help define more clearly operationalized criteria for carrying out this objective.

CHAPTER IV

THE RESEARCH METHODOLOGY

The Major Variables

Basic to the construction of a means to examine and measure change in an institutionalized child are several concepts. The major variables will be defined in this first section. Consideration of the research population, methods of data collection, problems and limitations of the methodology will be included in following comments.

The Emotionally Disturbed Child

An accurate, all-encompassing definition of the emotionally distrubed child is non-existent; some of the aspects of disturbance were considered in the Review under Basic Needs and Accessibility. Some common features of emotional disturbance in boys served by Mount St. Joseph are:

1. aggressiveness and hostility
2. withdrawn and overconforming
3. delinquency
4. one or more tenacious symptoms requiring twenty-four hour per day attention
5. school underachievement (no organic factors)
6. inadequate peer and adult relationships.
7. lack of basic trust.

As earlier mentioned, these characteristics do not make a boy a potential candidate for treatment since external factors of parental attitude and involvement, regional factors,

and favorable prognostic indicators are other criteria in the selection of a child for treatment at Mount St. Joseph. Whether we define it in terms of relative or absolute criteria, the emotionally disturbed child is one whose basic needs are not being met with the result that he is manifesting behaviors which classify him as psycho-socially maladjusted.

Residential Treatment

Treatment for boys at the Mount is the intervening stimulus, and for the research, the independent variable assumed to be the causal link between changes in a boys symptoms, attitudes or behavior during his residence at the treatment centre. Treatment, here, is defined as:

> participation of the child in a group living situation and controlled environment which lead to the identification of problem areas and of the consequences of maladaptive behaviors; helping the child seek out new situations where he can experience success and cope more effectively with daily realities.[1]

A boy at the Mount is described as progressing through the four stages in treatment outlined in Table #3. At each stage, casework and milieu therapy are adapted to the needs of the individual child; the research does not purport to differentiate, in measuring change, among these four stages. The programme components of treatment involve:

---

[1]Mount St. Joseph Centre, (mimeo.: April, 1967), p. 11-12.

1. Casework

   For children, casework consists of one hour per week with a supportive, educational, or interpretive focus, largely proceeding through play therapy. Both professional and child care staff are responsible for these individual sessions. Selected parents receive casework as determined for the individual case.

2. Groupwork

   Aside from recreation and group discussions and events, group therapy is not employed, for children or parents.

3. Milieu Therapy

   The supportive feature of group living and confrontation to meet realities of daily situation in coping with routines, activities and schooling is the main thrust of milieu treatment twenty-four hours per day.

4. Educational

   Remedial and individual instruction depends on child's specific needs. A child preparing for discharge may be moved, several months before, to outside school.

5. Psychiatric Consultation

   In admission screening and treatment planning as well as decisions regarding the environmental

programme, consultation is employed.

6. Chemotherapy

Special medical care is assigned to individual cases. Chemotherapy is not viewed as a major element in treatment.

Change

Change, as seen in the Review of Literature, can be described from many points of view. For purposes of the research proposal change has been conceptually defined in Chapter II, page [illegible], movement, progress, or even deterioration from one set of psycho-social circumstances to another. This may involve any or all of:

1. disappearance or modification of disabling symptoms or problems
2. modification in the child's psycho-social behavior, social roles, personal relations
3. modifications in the child's attitudes or understanding of himself, of others or of his situation
4. change in the child's environmental circumstances.[2]

Change in basic personality may not be a goal of residential treatment. Changes in "response tendencies,"[3] the characteristic way the child reacts to his psycho-social environment are the criteria for progress or movement that

---

[2]These categories, adapted from the "Movement Scale," L. Kogan and J. Hunt, constitute the four basic sections of the proposed measuring scale.

[3]L. S. Kogan, "The Role of Objective Tests in Child Welfare Research." The Known and Unknown in Child Welfare Research, p. 139.

make up the research rating scale. This "response" can be operationalized to describe a specific change in a specific area of the child's daily functioning e.s. change in ability to accept mutual interdependence. Progress is defined, then, by the global ratings a child receives in all areas of functioning outlined by a rating scale. The net change experienced by a boy through residential care at Mount St. Joseph is:

> the algebraic sum of the ratings in each of the areas of (his) situation or functioning in which judgments could be made.

The Criteria for Change

An objective scale of criteria selected as indicators of psycho-social change, is the most effective way to measure the impact of treatment on a child, or groups of children in relationship to what were the child's diagnosed basic needs and what were the objectives of treatment. Authors have commented on the inevitable bias of the investigator in selection of such criteria; in this research, the authors involvement in and intimate knowledge of the treatment centre has been a definite factor in deciding what aspects of boys behavior, attitudes, and functioning must be assessed.

Each child will be assessed along ten dimensions included in the proposed Impact Scale on page 1) capacity

for change, 2) functioning in major social roles, 3) peer and adult relationships, 4) responsibility, 5) control of aggression, 6) attitude toward placement, 7) reality orientation, 8) self-determination, 9) dependency, 10) understanding.

"Status" and Diagnostic Classification

Change, as it has been defined, involves the further concept, "status". Status, refers to a child's level of psycho-social functioning or adjustment at a given point in time. In relation to the impact scale it is a boy's objective ranked position in each of the ten acreas of pscho-social functioning as judged at a specific point in time. The boy in treatment, as earlier described, has three statuses involved in the measurement of the impact on him of residential treatment - one at admission, one at the point of discharge, and one at some time after discharge, or at follow-up.

The Research Population

The research population includes all boys discharged from Mount St. Joseph in the first eight years of its existence as a treatment centre. The boys involved were discharged from the Mount, for various reasons, between the years 1963 and 1968; the number of boys for whom data is available totals thirty-one. In order to cover the range of cases that have been worked with at the Mount, it was felt that use of all thirty-one cases would be most fruitful in providing

answers to the basic questions of what type of child was or was not helped.

The limitations of this simple sampling method, later described, do not outweigh the value gained for immediate practice in examining relationships of the major variables in all thirty-one cases.

The sample of thirty-one boys can be described with reference to Tables #1 and #2, (p. 49 and 50).

1. Age at admission ranged from 7 to 12 years, approximating the normal curve in distribution.
2. Age at discharge ranged from 9 to 13 years.
3. Average length of stay at the treatment centre was 2 years (median).
4. The majority of children were admitted from their own homes, a foster home, or orphange in that order.
5. Most of the children had received no previous treatment.
6. The majority were society wards of the Children's Aid Society on admission.
7. The majority of boys fell within an I.Q. range of 80 and 110 at admission.
8. Over 50% of the boys were admitted with a diagnosis of "Primary Behavior Disorder of Childhood".

In this case of exploratory research, the sample serves as it's own control. The behaviors manifested by these children are highly variable, high reliable and rigorous sampling, therefore, may be an unnecessary ideal and, if insisted upon, might force the research to reveal a con-

sistency regarding the impact of treatment which does not exist.[4]

Methods of Data Collection

Having defined what attributes of a boy's behavior, or what area of functioning is to be evaluated or described, three steps to the research follow logically:[5]

1. selecting appropriate situations in which the behavior can be observed
2. describing a method of getting a record of the behavior
3. devising the means to summarize or evaluate the recorded behavior

The first of these occurs naturally in the daily routines of the boy in the institution; he relates to peers and adults in a specific way; he reveals in individual therapy what his self-concept is like; in the controlled environment of the centre he has an opportunity to work out problems of aggression and control.

The main source of data is material recorded on each individual child. The three status to be assessed must be kept in mind. Upon admission to Mount St. Joseph, the following typed records are provided for each boy and will be used, in combination, to determine status #1, at the point of admission:

1. Psychiatrist's Assessment and Tentative Diagnosis

---

[4]E. Furst, "Constructing Evaluation Instruments." (New York: Longmans, Green and Company, 1958)

[5]Ibid, p. 15.

2. Psychologist's Report Testing
   a) Bender-Gestalt
   b) Draw-a-Person
   c) Weschler Intelligence Scale

3. Bio-Psycho-Social History
   a) from the referring agency
   b) from the parents

4. Previous assessments by
   a) Mental Health Clinic
   b) Private Psychiatric Services or Institutions

At each three month period following admission, a boy's case is conferenced by the social worker, psychologist, psychiatrist, child care staff and teaching staff. These conference reports re-evaluate the child's progress in several areas: 1) daily routine with the group, 2) individual sessions, 3) school, 4) family followed by 5) recommendations for the treatment plan.

The final conference report before discharge deals with these broad areas and plans for placement. This conference will serve, for all cases, the source of data from which the boy's status #2 is assessed.

As follow-up of a child after discharge is not routine procedure, no recorded data is available for status #3, at some point after discharge. A follow-up interview (page 53) will serve this purpose.

With the sources of data defined, the major task is one of systematizing the data into readible form that will facilitate the drawing of conclusions and satisfy some or all of the basic questions.

A type of content analysis, albeit a flexible one, will be applied to the above named records of the child by four raters or judges. In increasing the reliability of these analyses, each judge will undergo a brief training session in how to select the pertinent facts from the records. The judge must look for evidences of the child's adjustment in the four main categories of functioning.

An extensive review of the literature revealed no existing scale to be complete enough or appropriate enough to the current concerns about the boys at Mount St. Joseph. The impact scale, therefore, proposed as a trial, pilot one, is considered to be most flexible and to include several limitations. Its significance as a starting point is here emphasized.[6]

The Movement Scale developed by Kogan and Hunt for assessing client change proved to be most useful, although somewhat or greatly modified to meet the requirements of the specific setting of the Mount, of the particular population of children (vs. adults) of the duration of treatment, and the kind of therapy.

Training and practice with example cases in application of the scale is critical. Preliminary testing re-testing will be necessary to establishing reliability. The five scale points

---

[6] E. J. Thomas refers to this type of measurement as a "methodological experiment".

for rating each item are guidelines for the rater in making his judgment and not absolute degrees of the behavior being rated. A judge, for example, can rate a boy on "Control of Aggression" at seven points ranging from -3 to +3. Zero, is a neutral point, the focal point of the rating scale; whether it is defined as "healthy", 'hormal", or even "average", the author recognizes the value judgment implied by the concept but also that this is inevitable in evaluative research. Acknowledgement of this bias will, hopefully, allay criticism against such application of a rating scale.

The Procedure in Application of the Scale

One rater examines the appropriate source material for each child and, with periodic referral to the "Assessment Model", immediately rates the child at one of seven points for each test item. Having done this for the point of admission, the rater repeats the procedure for the point of discharge. Section IV of the scale, "External Circumstances" constitutes a separate rating sheet each time. Application of the scale, at follow-up must be substituted by the follow-up schedule which must be coded later.

The follow-up interview will be held at Mount St. Joseph for each boy, following traditional telephone contact to explain the purpose. During an hour's interview, the interviewer (the same judge above) will follow the Post-Discharge Information sheet. The questions are purposefully open-ended; gains in

resonsiveness should outweigh the difficulties in then categorizing responses. Previous practice and research show great resistance to the follow-up interview is not likely.

In addition tothese three schedules, each case will be prefixed by the Basic Data sheet summarizing demographical material. The scale is applied at all three points by the same rater. A child's status at each one is very similar to a diagnostic classification (primary behavior disorder, for example) without traditional labels. The "status" judged provides a baseline for comparing and contrasting the degree of pathology before and after treatment, with objective figures. This will reveal specific behavioral or emotional changes that occur throughout the treatment phase and can be considered in relation to the initial diagnosis, presenting symptoms, prognosis and treatment plan in assessing what happened to the boy in therapy i.e. what was the impact of residential treatment.

Problems and Limitations

The limitations of the proposed research fall into four categories: 1) sources of data, 2) measurement, 3) reliability and relevance and 4) administrative.

Consistent availability of the necessary information is a drawback of historical data which a preliminary survey of agency records can help diminish. A rater's judgment, the danger exists influenced by information gaps.

The theoretical framework, personal and professional philosophy and degree of contact with the subjects are factors that will bias ratings. Training sessions for standardizing judgments will narrow the margin of error and where discrepancies continue, the conference method can be used to obtain consensus.

Problems of reliability may occur at several levels: 1) the reliability of the record which cannot be assessed, 2) of rater judgments, increased by training, 3) of the scale, improved by test re-test to obtain a co-efficient of reliability. The relevance can be determined concurrently with standardized personality tests and check-lists.[9] Predictive validity can be obtained by asking the child, at follow-up, whether or not he felt he had changed. Staff selection of criteria with application and re-application of the scale will increase the validity of the criteria items as measures of change.

Administrative problems encountered at Mount St. Joseph aretypical of service agencies. The agency director can serve as a "balance wheel", demonstrating to staff practical applications of solliciting acceptance of the research. Staff are highly identified with their programme as unique; staff participation and an honest research approach is essential. Renewed contact with discharged boys, for staff, will be a motivating force.

---

[9]For example: MMPI, C. Roger's Self-Image Scale, Draw-a-Person. These can only be used in future, on going research.

Feasibility and practicality are distinct problems in view of lack of funds for extensive research. Anticipated costs are: 1) clerical, 2) transportation for discharged boys, 3) work-hours, estimated at one hour per rated case, one hour per follow-up interview, several hours for training sessions and conferences. Such a proposal, however, could be significant in eliciting new funds for research. A final judgment as to the acceptability of these financial costs remains to be made.

The Proposed Data Analysis

In order to assess change in boys at the Mount the data obtained must be systematized, categorized, to maximize extra and inter-agency comparison of cases and make possible the search for correlational associations predictive of further research. A boy's maladaptive emotional state being the object of assessment, the nature, duration and impinging conditions of it and the inter-relations of these factors can be computed.

Data analysis, basically, will involve the comparison, along several variables of three groups of boys: 1) those who progress, 2) those judged to have deteriorated and 3) those showing no change. Simple tabulation (frequency counts) on the category sets of 1) change, 2) deterioration and 3) no change, will give a very rough measure of the number of cases at the Mount who do or do not seem to have been helped. Standard deviations can be done for each set, thus describing the mean overall rating score within each group, and how far each of the thirty-one boys' scores deviates from this mean. This will

give an idea of how greatly a boy progressed, for example, in relation to other boys who under went treatment.

Comparisons by overall ratings will not yield highly valid results; the use of subcategories for analysis will provide a more meaningful picture of the impact of treatment on a particular boy. Each of the three category sets can be broken into four subcategories according to the scale criteria; 1) adaptive efficiency, 2) disabling habits, 3) verbalized attitudes, 4) environmental circumstances. Median scores can be calculated for each as well as for each item within them, giving a categorical picture of where the greatest number of cases fall on the ratings. Quartile deviations will describe how different a boy's score is from the median on a particular item (for example, how, after several months of treatment the boy can control his aggression incomparison to the rest of the sample). These measures of variations are critical to establishing correlations.

Statistics can be used to determine the similarities of two cases on criterion items. The computations are endless, but since some are not relevant to the basic questions, a selective analysis is suitable. The main objective is to see what scores on what items seem to be associated with a boy's progress or deterioration.

Tests of significance on all correlations are essential. Tables will help make the results more visible.

CHAPTER V

IMPLICATIONS OF THE RESEARCH PROPOSAL

The objective in measuring the impact of treatment on children is to provide scientific answers, and not impressionistic guesses about the nature, degree and stability of change which has valuable implications for Social Work, practice, knowledge, and theory.

Preston's predictions seem to be in line with expected conclusions of this research:

Overall progress or change ..... 60 - 65%

No significant change ..... 25 - 30%

Retrogression 5%[1]

Situational and psychological factors will, likely, correlate; that is, poor economic and emotional health of the family, minimal family casework, poor parental support of placement will associate with deterioration or no progress. Personality and borderline states will show smaller developmental potential andbehavior disorders greater progress. Intellectual capacity should relate significantly to change. The following areas should show most significant change:

1. the child's hopefulness about his problem
2. the child's self concept and personal happiness

---

[1]M. Preston, "Factors Affecting Movement in Social Casework," Social Casework. XXXIV (March, 1953), p. 107.

3. the child's ability for constructive action and using help

4. the disappearance of disabling behaviors

5. the tolerance of the family and/or community for the child.

Boys with more than three years at the Mount are likely to show deterioration.[2] With progress, therefore, on all items onthe scale, a boy will show increasing positive rankings. School performance, peer relationship, social orientation and mental health will indicate significantly improved adjustment. Acceptance of the child by the family and community after discharge will be the most highly differentiating factor in the stability of changes that occur.

Most significant of all the predictions that could be made, is the feasibility of residential treatment for certain disturbed children. "Selection" processes of the institution, to prevent institutional side effects and maximize service resources, may need re-aligning. The agency's responsibility would be in determining a child and his family's accessibility or developmental potential. Prognostic devices should objectify the procedure and eliminate the risk based on impressions from previous agency experience. Admission priorities can be based objectively, on the suitability of the centre's facilities to pre-treatment factors in the child's life.

---

[2]Child Welfare League of America Inc., Children in Institutions. Toronto: undated

Such a schedule would contribute to knowledge of what factors associate will high amenability to treatment in the emotionally disturbed child and his family. Parental attitudes to the child's problem and therapy merit further research as features of the disturbance. Treatment facilities, in practice, can be geared to maximizing the developmental potential and, after discharge, maintaining it.

The significance of effective casework at the critical pointsof admission and discharge, in relation to this, is strongly indicatedby the research. At both points, the case-worker's responsibilityshould be to identify the child's basic needs and the potential of the family and community to meet or frustrate them. A more aggressive approach to involving families is desirable. In preparing for discharge, the Social Worker's community organizational task is too often dismissed.

Some conclusions re "measurement" of children merit attention. Traditional dogma regarding "normality," or "average" are irrelevant to the treatment centre, the research implies, since concepts of psycho-social adjustment and therapeutic "success" in achieving it can be made only in the agency's own terms. While its criteria must be specific and individual, it must also be made continually congruent with the community definition of success for its service to be effective.

The agency responsibility for on-going evaluation implied by the research necessitates, in practice, more detailed, systematized recording and daily use of check-lists. Shifts in treatment objectives and plans for discharge become, then, less subjectively determined. Objective tests to describe ego development anxiety and cultural factors of illness must be assessed as to their complimentarity with other scaled criteria. The research potential of this pilot study has been discussed. Only when the agency sees the necessity can experimental study follow. The instrumental value of agency appeal to the community may be a latent function of the mere conduct of a research study by the institution.

With the contribution to practice the primary value of the research, gains in specific knowledge areas may be noteworthy. The wisdom regarding manifestations of emotional disturbance in children, social development of institutionalized boys, growth and change of latency-aged boys may be expanded. The relationship of human change to premorbid and dynamic personality can be further examined and generalizations made for children and adults. Knowledge about the learning potential of the emotionally disturbed may develop into improved specialized education. Inter-disciplinary collaboration regarding theoretical concepts of change, deterioration,' etc. and its relation to the values of researchist and Social Work practitioner is implicit. Inclusion in the School of Social Worker Curriculum, of theory on childhood growth and emotional development and fixation is substantial need indicate

by this proposal.

Conclusion

In conclusion, a statement by Bowers seems peculiarly relevant:

> It may be that social workers and social agencies have had some part in the degree of emotional disturbance that makes residential treatment necessary. Usually this situation is related to the fact that the community requires of the worker an impossible task, since the volume of the load dissipates and diffuses his skills to the point of ineffectiveness. When society is prepared to recognize fully the contribution that social work can make, and then to provide the opportunity for social workers to do an adequate job, our basic contribution to the residential treatment centre will lie in our efforts to make it unnecessary.[3]

---

[3] S. Bowers, "The Social Worker in a Residential Children's Treatment Program." Social Casework, XXXVIII, (June, 1957), p. 288.

APPENDIX

I.
Table

II.
Schedule

TABLE 1

AGES AT ADMISSION, AGES AT DISCHARGE, LENGTH OF TREATMENT OF DISCHARGED BOYS FROM MOUNT ST. JOSEPH

Age in Years	Number of Boys		Years	Length of Treatment
	Admission	Discharge		Number of Boys
7	1	0	1 or less	7
8	7	0	up to 2	17
9	8	5	up to 3	5
10	6	7	up to 4	2
11	7	7		
12	2	7		
13	0	5		
Total	31	31		
Median				31

TABLE 2

RESIDENCE AT ADMISSION, RESIDENCE (TO) AT DISCHARGE, PREVIOUS TREATMENT AT ADMISSION, DIAGNOSIS AT ADMISSION CONFERENCE

Residence			Previous Treatment		Diagnosis	
Type of Residence	Number of Boys Admission	Discharge	Type of Treatment	Number of Boys	Type of Diagnosis	Number of Boys
Own Home	14		None	21	Primary Behavior Disorder of Childhood	18
Relatives	0		Institution:			
			Child Care	6		
Adoptive Home	0		Treatment Centre	1	Chronic Anxiety Stare	3
Foster Home	8					
			Observation Centre	3	Situational Maladjustment	3
Institution	6					
Orphanage	2				Primary Autism	2
Observation Home	1				Moderate Emotional Disturbance	2
Other	0				Childhood Schizophreria	1
					Mixed Psychoneurosis	1
					Neurotic Depressive Reaction	1
Total	31		Total	31	Total	31

TABLE 3

THE FOUR STAGES OF TREATMENT OF BOYS AT MOUNT ST. JOSEPH

	Child's Perception of self	Child's Perception of Worker	Child's Perception of Group	Childs Behavior
1.	begins to view progress as more and more desirable	worker seen as helpful - assists child to achievable goals in small, clear steps	begins to see necssity of expanding dependency to other individuals than workers	begins to occupy himself constructively
2.	desire for greater confidence	worker as guide -offers greater choice to child in areas where he is experiencing success	Testing out on group of new relationships, skills and behaviors	relies more on "successful" activities
3.	personal prestige increased	encourages child to identify areas of success and failure	sense of belonging	shares successes with group
4.	better awareness of interests -courage to make and execute own plans and anticipate repercussions	supportive	reference system	selects aspects from the group as point of reference for behavior and feeling

The table is developed from:

H. W. Maier, "Groupwork as a Part of Residential Treatment", edited by G. Konopka. (New York: NASW, 1965), and Mount St. Joseph Centre, mimeo. (April, 1967), p. 11-13.

MOUNT ST. JOSEPH CENTRE

BASIC DATA SHEET

Child's Name: Date of Birth:

Date of Admission: Age at Admission:

Date of Discharge: Age at Discharge:

Length of Stay: years months

Child's Residence at Admission:

Child's Status at Admission: Private Placement
Crown Ward
Society Ward
Other

Previous Treatment Received:

Intelligence Tests at Admission:

Diagnosis at Admission Conference:

Diagnosis at Discharge (if different):

MOUNT ST. JOSEPH CENTRE

POST-DISCHARGE INFORMATION

To whom discharged:

Responsibility for after care:

Known placements or movements: (place, date, length of stay, reasons for placement with whom)

Delinquencies and court involvements subsequent to discharge:

Whereabouts of child at present date. Source of information:

School or employment:

Other significant post-discharge information:

The Impact Scale

A Proposed Scale for Measurement of the Psycho-Social Status of a Child in the Residential Treatment Centre

Rater Instructions:

The following consists of a seven-point rating scale. There are ten items within Parts I to III. Please provide one response for each item. If you are unable to make a judgment, indicate this under "insufficient information." Part IV will be rated separately.

The Assessment Model should be before you at all times during your rating so you may refer specifically to it when marking each item.

RATER.....
DATE .....

CHILD'S NAME .....

PART I ADAPTIVE EFFICIENCY

1. Capacity for change

-3	-2	-1	0	+1	+2	+3	insufficient information
low			moderate			high	

2. Functioning in major social roles

(i) peer

-3	-2	-1	0	+1	+2	+3	i.i
non-satisfying			adequate			satisfying	

(ii) sibling

-3	-2	-1	0	+1	+2	+3	i.i

(iii) child (to adult)

-3	-2	-1	0	+1	+2	+3	i.i

(iv) son

-3	-2	-1	0	+1	+2	+3	i.i

3. Relationships

(i) with peer

-3	-2	-1	0	+1	+2	+3	i.i
unsatisfactory			neutral			satisfactory	

(ii) with adult

-3	-2	-1	0	+1	+2	+3	i.i

4. Responsibility

-3	-2	-1	0	+1	+2	+3
low			moderate			high

PART II DISABLING HABITS AND CONDITIONS

1. Control of Aggression

-3	-2	-1	0	+1	+2	+3	i.i
inhibited			balanced			impulsive	

2. Attitude toward Placement

-3	-2	-1	0	+1	+2	+3	i.i
negative, pessimistic			indifferent			positive, optimistic	

PART III VERBALIZED ATTITUDES

1. Reality Orientation

-3	-2	-1	0	+1	+2	+3	i.i
distorted			indifferent			realistic	

2. Self-Determination

-3	-2	-1	0	+1	+2	+3	i.i
weak			neutral			strong	

3. Dependency

-3	-2	-1	0	+1	+2	+3	i.i
subservient			balanced inter-dependent			over-dependent	

4. Understanding

(i) self

-3	-2	-1	0	+1	+2	+3	i.i
low						high	

(ii) others

-3	-2	-1	0	+1	+2	+3

(iii) situation

-3	-2	-1	0	+1	+2	+3

PART IV ENVIRONMENTAL CIRCUMSTANCES (narrative)

1. Family Casework

   (i) frequency of contact

   (ii) parental support of placement

   (iii) history of emotional relation to child

   (iv) changes in family configuration during treatment

      a. physical (economic)

      b. sociological

      c. psychological

   (v) emotional health of parents

   (vi) intrafamilial relationships

2. Summary of Child's Contact with Family and Impact on His Development

   -significant data during treatment

Assessment Model

The purpose of this section is to indicate, very specifically, what things you must consider when rating a child on each item. Refer to it before you make a decision on each one.

PART I ADAPTIVE EFFICIENCY

1. Capacity for change	a. motivation and efforts to move out of the past or to challenge it
	b. degree to which he can assess the past objectively
	c. degree to which he uses the past as an excuse not to change his behavior.
2. Social Roles	a. degree to which he seeks out rewarding (vs. frustrating) roles that will lead to self-criticism
	b. fear of failure
	c. how closely related is self-esteem to successes and failure
	d. how realistic are his goals in terms of his abilities.
3. Relationships	a. demands for attention and affection -anxiety about these
	b. self-directing vs. ingratiating -does he believe others have control of him or must do things for him
	c. degree of initiative in

4. Responsibility	a. acceptance of routines for disciplining himself because he feels they are helpful to him
	b. orientation to long-range, fairly difficult goals vs. immediate gratification
	c. acceptance of failure, understanding of failure
	d. avoidance of too high or too low expectations of himself which lead to self-punishment

---

PART II DISABLING HABITS AND CONDITIONS

1. Control of Aggression	a. impulsiveness vs. passiveness -how appropriate in view of degree of frustration
	b. fear of loss of control and fear of own symptoms
	c. channels for aggression -initiative, co-operation, etc.
2. Attitude to Placement	a. degree to which help is seen as positive and desired i.e. for his welfare or negative i.e. for revenge, benefit of others
	b. motivation to use help

PART III VERBALIZED ATTITUDES

1. Reality Orientation	a. way child copes with maturational changes
	b. acceptance of his situation and initiative to improve the present
	c. degree of contentment or depression

2. Self-determination	a. recognition and verbalization of feelings, attitudes, fears
	b. belief that he can control his own illness or disturbance
3. Dependency	a. acceptance of mutual inter-dependence
	b. constructive use of help
4. Understanding	a. ability to use common sense, judgment
	b. ability to accept compromise
	c. extent of extreme decisions or plans

BIBLIOGRAPHY

Allerhand, M., Weber, R., Polansky, N., "The Bellefaire Follow-up Study: Research Objectives and Method," Child Welfare. XL (September, 1961), p. 13.

Blenker, M., "Obstacles to Evaluative Research in Casework: Part I," Social Casework. XXXI (February, 1950), p. 54-60.

Bowers, S., "The Social Worker in a Residential Children's Treatment Program," Social Casework. XXXVIII (June, 1957), p. 283-295

Browne, C., "Some Problems of Children's Institutions in Achieving Maturity," Child Welfare. XLII (February, 1963), p. 77-81.

Canter, G., Yeakel, M., and Polansky, N., Retrieval From Limbo: The Intermediary Group Treatment of Inaccessible Children, New York: Child Welfare League of America, 1967.

Carter, G., "Problem Formulation in Social Work Research," Social Casework. XXXVI (July, 1955), p. 295-302.

Child Welfare League of America Inc., Children in Institutions. Toronto: undated.

Chin, R., "Evaluating Group Movement and Individual Change," in Use of Groups in the Psychiatric Setting. New York: N.A.S.W., 1960, p. 34-45.

Dettelbach, M., "Criteria for Agency Referral of a Child to a Residential Treatment Centre," American Journal of Orthopsychiatry. XXV (October, 1955), p. 669-674.

Eysenk, H., "The Effect of Psychotherapy: An Evaluation," Journal of Consulting Psychology. XVI (October, 1952), p. 319-324.

Frings, J., "Research and the Social Agency," Social Casework. XXXIII (October, 1952), p. 343-348.

Fromm, E., Hartman, L., and Marschak, N., "Children's Intelligence Tests as a Measure of Dynamic Personality Functioning," American Journal of Orthopsychiatry. XXVII (January, 1957), p. 134-144.

Furst, E., Constructing Evaluation Instruments. New York: Longmans, Green and Company, 1958.

Gil, D., "Developing Routine Follow-up Procedures for Child Welfare Services," Child Welfare. XLIII (May, 1964), p. 229-240.

Gordon, H., Casework Services for Children: Principles and Practices. Massachusetts: Houghton Mifflin Company, 1956.

Granick, S., and Taylor, J., "Prediction of Adjustment in a Group Residence: A Pilot Study," Journal of Jewish Communal Services, XXXVIII (Spring, 1962), p. 304-311.

Hallowitz, D., "The Element of Parental Identification in the Child Care Institution," Social Casework. (January, 1952), p. 24-30.

Hamilton, G., Psychotherapy in Child Guidance, New York: Columbia University Press, 1947.

Herstein, N., "A Critique of Current Research in Child Care," M. Norris (ed.), The Known and Unknown in Child Welfare Research. New York: N.A.S.W., 1965, p. 82-104.

Herzog, E., Some Guidelines for Evaluative Research. U.S. Department of Health, Education and Welfare, 1959.

Hunt, J., Blenker, M., and Kogan, L., "A Field Test of the Movement Scale," Social Casework. XXXI (July, 1950), p. 267-276.

Hunt, J., and Kogan, L., Measuring Results in Social Casework: A Manual for Judging Movement. New York: F.S.A.A., 1952.

Kitchener, H., Sweet and Citring, E., "Problems in the Treatment of Impulse Disorder in Children in a Residential Setting," Psychiatry. XXIV (1961), p. 347-356.

Klein, A., "Individual Change Through Group Experience," The Social Welfare Forum. Official Proceedings, 86th National Conference on Social Welfare. New York: Columbia University Press, 1959, p. 136-155.

Klein, G., "A Clinical Perspective for Personality Research," Journal of Abnormal Social Psychology. XLIV (1949), p. 42-49

Kogan, L., Hunt, Mc. V., and Bartelme, P., A Follow-up Study of the Results of Social Casework, New York: F.S.A.A., 1953.

Konopka, G., Group Work in Residential Treatment: An Historical Review, H. Maier (ed.), New York: N.A.S.W., 1965, p. 13-25.

Konopka, G., "The Role of the Group in Residential Treatment," American Journal of Orthopsychiatry, XXV (October, 1955), p. 679-684.

Lane, L., "The Aggressive Approach in Preventitive Casework with Children's Problems," Social Casework. XXXIII (February, 1952), p. 61-66.

Lerner, S., "The Diagnostic Basis of Institutional Care for Children," Social Casework. XXXIII (March, 1952), p. 105-111.

Levitt, E., "The Results of Psychotherapy with Children," Journal of Consulting Psychology. XXI (June, 1957), p. 189-196

Lovi, N., Holsopple, J., and Twik, E., "A Measure of Severity of Illness," Journal of Clinical Psychology. XII (1956), p. 384-386.

Maier, H., "The Social Group Work Method and Residential Treatment," (ed.) Group Work as Part of Residential Treatment. New York 8, N.A.S.W., 1965, p. 26-44.

Mayer, N., "A Research Attempt in a Residential Treatment Centre: An Administrative Case History," M. Norris (ed.), The Known and Unknown in Child Welfare Research. New York, N.A.S.W., 1965.

McDermott, J., Harrison, S., Schrager, J., and Wilson, P., "Social Class and Mental Illness in Children," E. J. Thomas (ed.), Behavioral Sciences for Social Workers, New York: Free Press, 1967, p. 332-340.

Mitchell, H. and Mudd, E., "Anxieties Associated with the Conduct of Research in a Clinical Setting," American Journal of Orthopsychiatry. XXVII (1957), p. 310-330.

Mount St. Joseph Centre, Hamilton: mimeo., April, 1967.

Ohio Committee on Children's Institutions, "Principles of Child Care in Institutions," Measuring of the Progress of an Institution. Ohio: 1941, p. 259-267.

Perl, R. andSimon, A., "A Criteria of Success and Failure in Child Guidance," American Journal of Orthopsychiatry. XII (1942), p. 642-655.

Polansky, N., Social Work Research. Chicago: University of Chicago Press, 1960.

Polansky, N., and Weiss, E., "Determinants of Accessibility to Treatment in a Children's Institution," Journal of Jewish Communal Services. XXVI (Winter, 1959), p. 130-137.

Preston, M., "Factors Affecting Movement in Social Casework," Social Casework. XXXIV (March, 1953), p. 103-111.

Preston, M., Mudd, E., Peltiz, Wm., and Froscher, H., "An Experimental Study of a Method of Abstracting the Content of Social Case Records," Journal of Abnormal and Social Psychology. XLV (1950), p. 628-644.

Rabinow, B., "The Role of the School in Residential Treatment," American Journal of Orthopsychiatry. XXV (October, 1955), p. 685-691.

Reid, J., and Hogan, H., Residential Treatment of Emotionally Disturbed Children: A Descriptive Study. Child Welfare League of America, 1952,

Rogers, C., and Dymond, R., (ed), Psychotherapy and Personality Change. Chicago: University of Chicago Press, 1954.

Rose, A., "A Behavioral Approach to Group Treatment of Children," E. Thomas, (ed.), The Socio-Behavioral Approach and Applications to Social Work. New York: Council on Social Work Education, 1964, p. 39-58.

Sample, Wm., "The Findings on Client Change," Social Service Review. XLI (July, 1967), p. 137-151.

Selltiz, C., Jahoha, M., and Deutsch, M., Research Methods in Social Relations. New York: Holt, Rhinehart and Winston, 1969.

Smith, C., "Childhood Emotional Disorder," Canada's Mental Health. IV (July-August, 1966), p. 12.

Suchman, E., Evaluative Research. New York: Russell Sage Foundation, 1967.

Thomas, E., and McLeod, D., "A Research Evaluation of In-Service Training andof Reduced Workloads in Aid to Dependent Children," E. Thomas (ed.) Behavioral Science for Social Workers. New York: The Free Press, 1967, p. 341-349.

Watson, R., "The Evaluation of the Effects of Psychotherapy Problems for Investigation," Journal of Clinical Psychology. VIII (January, 1952), p. 60-64.

Young, P., Scientific Social Surveys and Research. New York Prentice-Hall, 1966.