CHILD PLACEMENT: RESULTS OF RECOMMENDATIONS BY A PSYCHIATRIC CLINIC

A Thesis

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CHAPTER I

INTRODUCTION

There are many reasons why a child placement agency or a psychiatric clinic for children recommends placement of a child. There are probably equally as many reasons why parents often cannot accept this recommendation and why children once placed frequently cannot adjust in substitute family care. My search for some of the answers in this field of child placement has precipitated this study.

Many factors must be considered carefully when a worker tries to determine whether a child and his parents can gain from the placement experience. I believe that one of these factors, the earlier separation experiences of the child and his parents has significant relevancy towards the predicability of a successful placement. My working hypothesis, therefore, is that the nature and extent of previous separation experiences for both the child and his parents are related to their capacity to use placement as a meaningful treatment plan for the child.

One of the underlying implications of this hypothesis is that both a child and his parents must have considerable ego strength to be able to use placement meaningfully. This is an important factor we too often fail to consider when placement is recommended. We fail to look at the strengths in the family as we are often too preoccupied with the gross pathology which necessitates the removal of the child from the home. What we neglect is the realization that a child

and his parents cannot use placement if there is not sufficient strength in the child to "take hold" of the new relationships involved in substitute family care and if there are not enough strengths in his parents to "let go" of their child enough to allow the child freedom to establish other relationships away from them. Without these strengths, the placement is either precarious or already doomed to failure. For this reason we must be certain that the curative potential of separation for a disturbed child and family can be realized before plunging the child and family into the inevitable turmoil of separation through placement.

In the child welfare field, placement has become almost synonymous with separation and all the accompanying traumatic effects which such an experience implies for both the child and his family. Before a child can benefit from placement, he must first be helped to overcome his feelings of rejection and his own guilt based on unrealistic fantasies of why placement occurred. But what about the child who has prior to that time already experienced numerous separations from his parents? One would expect that feelings about previous separation experiences would be reawakened at the time of placement which would but maximize the traumatic effects. Such earlier experiences should effect the child's behavior in placement just as the parents' earlier separation experiences may effect their ability to assist the child in using placement. This study is then an inquiry into the meaning of loss and separation for the child and his parents as a diagnostic clue towards understanding their reactions to placement.

The second main area of concern to me is the role of the clinic in assisting the parents to accept the recommendation of placement

for their children. Of what value is such a recommendation if the parents cannot accept it? Derived from this question is my second hypothesis: the ability of parents to accept a recommendation for placement is directly related to the nature and extent of the involvement of the psychiatric clinic in assisting the parents to cope with the feelings which such a recommendation creates.

I believe the clinic has an important responsibility to assist parents in accepting the recommendation of placement. Where the clinic has followed through in assisting parents to cope with their intense feelings of guilt, shame, and loss of self esteem arising from such a recommendation, the parents will be better able to follow through with the placement of their child. Such follow up by the clinic may include additional interviews with the parents and more extensive collaborative efforts with other community agencies. Where the clinic has failed to assume this responsibility to the parents, I believe they have either failed to recognize the importance of this bridge between agencies or else they are not using the recommendation for placement with conviction, but rather with the idea that pathology is so severe that the family is untreatable. Thus the recommendation may become an escape valve for the therapist. He does not believe the parents will accept placement but makes the recommendation because he does not feel the parents will be able to use out-patient treatment either. Whether such an attitude does exist cannot be determined, but if so, it only serves to negate the value of the clinic's diagnostic evaluation and can only have a very harmful effect on the already extensive family disturbance.

Certainly there may be numerous reasons why parents cannot accept placement. As indicated earlier, the parents' earlier separation

experiences and their reactions to these may enter into the parents' decision about placement. Certainly the availability of appropriate placement resources becomes a factor here, too. I do feel, however, that the clinic's involvement at this point is an important factor to be considered. Where the clinic has continued to work with the parent, with the treatment goal being seen as the family's acceptance of placement, one would expect that placement will follow more frequently. Where the clinic has paved the way for the parent through collaborative efforts with other community agencies, all possible resources will be available to help the family accept placement, and one would expect that placement will occur with greater frequency.

CHAPTER II

REVIEW OF THE LITERATURE

Placement and Separation

In reviewing the literature as an aid in clarifying my first hypothesis, there are two distinct areas which are discussed. First we have the extensive material written in the child welfare field. Glickman, (14) Klein, (21) and Littner (22, 23) consider what placement and separation mean to a child. They describe fully the traumas of placement, the meaning of separation to the child, and while this literature suggests the link which I have offered between earlier separation experiences and their role at the time of placement, it is to a different area that we must turn in assessing how previous separations effect the child's later adjustment.

In addition, therefore, we have the voluminous literature of the psychoanalytic authors. Freud, (12) Bowlby, (3) Yarrow, (40) and others (13, 18, 19, 29) concern themselves specifically with separation experiences and ages and level of vulnerabilities in the child. These authors do not concern themselves directly with the problem of child placement although their studies of separation have many implications to this whole area. The gap in the literature exists between the contributions of the child welfare field and the psychiatric understanding of the meaning of separation for the very young child.

Thus, while Bowlby, Yarrow, and Freud have attempted to study the reactions of an infant to separation, they have not usually considered how the infant's or the older child's separation experiences will effect adjustment to later separations, i.e. placement.

To complicate issues further, it is indeed interesting to discover how little has been written specifically of the child guidance clinic and the difficulties such an agency encounters upon recommending child placement. The only study of direct applicability is that of Smith, Ricketts, and Smith (33) in which they attempted to delineate the dilemnas of the child guidance clinic in considering the advisability of placement for a child. Their suggestion for further diagnostic knowledge concerning the meaning of separation and loss for the child and his family is seen in their realistic appraisal that "there are as yet no consistently studied objective criteria for estimating capacity for healthy integration of separation experiences." (33, p. 44)

The broad statement of the first hypothesis is implied quite strongly in the literature. Authors who write from experience in the field of child welfare agree that placement is always traumatic for the child. (14, p. v; 4) With a child who is already emotionally disturbed, failure to recognize the strengths amidst the pathology in the family and prematurely deciding upon placement, may upset the already precarious balance not only for the child but for his entire family. While workers in their rescue fantasies may believe the child's problems will be solved by removal from a poor environmental situation, if as both Littner (23) and Hamilton (17, p. 160) illustrate, the child has internalized his parent-child conflicts, these conflicts will be

provoked by the child in placement and may precipitate yet another rejection from a foster home. Thus, not only in an effort to make a decision about the need for placement but also to assess the way in which the child will function once placed will be based largely on what has preceded him. By "what has preceded him," we would mean the nature of the parent-child relationship, the previous life time experiences of the child, and his capacity to cope with past and present experiences.

For the child who is to be placed, placement may not be the first time he has been separated from his family, either physically or emotionally. All of the intense feelings of helplessness, rejection, and anger which the child has experienced at previous points in his life from earlier separations and rejections will be reactivated at the time of placement.

> The gradester facing placement will react negatively in direct proportion to the degree of deprivation he has known in the earlier stages of his development....the deprived child... is asked to give up what he never has had. He is expected to develop a relationship to new parents when he has not learned from his own parents what this relationship should be. (4, p. 36)

In placement, feelings the child has not been able to cope with at earlier points in his life appear again to be expressed and worked through. As Littner indicates, the child's separation anxieties will be acted out in foster home placement with respect to the current trauma of separation in addition to all previous separation traumas occurring during his life. Littner very clearly states the dilemna of the placed child.

> The full future separation fantasy of a placed child will include not only the experiences of the actual physical separation from his parents but also the earlier experiences of his first major separation from his mother....Each child reacts differently to separation from his own parents. The feelings produced will

depend upon such factors as his age, the length and nature of his relationship with his parents, his other prior life experiences and his ability to understand what is happening. (22, p. 5)

Littner, I believe, has made an excellent attempt to combine the psychoanalytic knowledge with our present understanding of child placement. It is only appropriate that his views serve as an introduction to that literature which more specifically states the vulnerabilities of the young child to separation. There is consensus in the literature (3, 12, 24, 29, 40) that separation of a child from his parents is always traumatic in one way or another but that it is particularly so for the young child. One theoretically should be able to set up a continuum on which we can measure the ability of the child to integrate healthfully separation experiences according to these criteria: the child's age at the time of earlier separations, his psycho-sexual developmental level at the time of earlier separations, the length of previous separations, the parent-child relationships and its adequacy prior to separations. I have tried to consider a few of these factors in the study, although certain variables were not testable within the scope and limitations of this study.

Age of Child During Earlier Separations

Bowlby, (3, p. 26) Littner, (22, p. 20) and Yarrow (40, p. 33) state unequivocably that maternal separation which occurs before the child is five years of age is likely to be most damaging. Thus, we would have expected, according to our hypothesis, that the younger the child was at the time of earlier separations, the poorer prognosis would be in placement. We would expect two groups to appear in the study: the child of infancy to five years with separation experiences, and a group of children age six through eighteen with separation

experiences.

While it may not be possible to test in this study the reactions of children who had separation experiences at the ages of say, 1, 2, 3, etc. the literature raises some interesting questions concerning the vulnerabilities of children at each of these ages. Most authors concur, (3, p. 12) as would I, that for a child of less than six months of age, separation may not be traumatic as the child has not as yet been able to differentiate his mother from other women in his environment. Trauma would occur, however, if the substitute mother or the natural mother were incapable of supplying the child with adequate gratification of his utter dependency. (40, p. 33) Perhaps the most vulnerable age for the child (which in normal developmental growth would occur between nine and twelve months) occurs when the child is in the process of consolidating a relationship with his mother and is beginning to differentiate himself from her. (24, p. 67; 3, p. 12) When the child can sustain an image of his mother in her absence and can anticipate her return, the meaning of a brief separation may be less severe than at an earlier stage of development. When the child has been separated from his mother during the symbiotic phase, severe traumatization may follow, and the child will react with "anxiety, excessive need for love, powerful feelings of revenge, and arising from these last, guilt and depression." (3, p. 12) While Bowlby (3, p. 23) maintains that during the second and third years of life, separation for the child can be as traumatic as the first, I feel I must disagree with him here, as I tend to see the traumatic effects of separation as functioning on a continuum, with the maximum traumatic effect occurring between ten and twelve months, and decreasing trauma occurring as the child continues

up the age scale. The one exception to this is the infant of less than six months, an exception which was previously explained.

Other authors have disagreed with Bowlby. Yarrow (40, p. 33) suggests that the ability of the child to cope with separation at the age of two depends upon the degree of autonomy which he has achieved. If the child has acquired some locomotive skills and some degree of control over his environment, he may react with less severity to separation. Maas (24, p. 67-69) also suggests that, even further, the two year old may be able to cope with separation better than the three year old. The two year old who has achieved some autonomy, according to Maas, may be able to cope better with separation than the three year old who is already in the throes of resolving his oedipal conflicts. Maas's suggestion is in direct opposition to what I have stated as my hypothesis in this area. He does raise, however, an interesting question to be considered.

Child's Developmental Level at Time of Separation

While a child's chronological age carries some meaning in terms of expected developmental growth, the two terms are not the same. For the purposes of this study, however, it was necessary to equate the two terms since it was not possible to determine with any accuracy the level of the child's development at the time of separations.

Most authors agree that the developmental level of the child at the time of separations is an important factor in determining how well the child can cope with separation. The developmental level of the child seems to function in two ways. Certainly the higher the developmental skills of the child, the greater ego potential the child has to work with in his efforts to handle feelings about separation,

rejection, and abandonment. In addition, if a child is separated from his parents before he has reached a plateau in his developmental tasks, separation effects will be greater. As Anna Freud pointed out in her observations:

> It seemed that recent ego achievements were less likely to bear up under the influence of regression in the instinctual sphere than ego achievements of long standing. (11, p. 26)

The child who has been unable to separate himself emotionally from the symbiotic phase with his mother, will have greater difficulty coping with his sense of abandonment by the mother figure. Likewise, the child who has successfully reached this plateau in development, should, then, be able to cope with separation more successfully. A child who has been toilet trained, is walking, and enjoys a degree of autonomy and control over his environment has a greater capacity for coping with separation than a child who is in the process of learning these developmental tasks. Where the child is seeking autonomy and control, and separation occurs during this process, in his separation fantasies he may see separation as punishment for either his lack of control or for his strivings towards autonomy. With the child who has developed some verbal facility and some capacity to comprehend through language the meaning of separation, one would expect he would be better able to cope with this situation.

Separation for an adolescent has somewhat of a different quality. It is thought to be less painful for the adolescent to leave his family than it is for the younger child. The adolescent is able to understand what is happening, and the separation is in keeping with his strivings for independence. Certainly this theoretical base has some validity, but an adolescent is in a state of disequilibrium and is searching for

a sense of personal and sexual identity. The adolescent, while seeking independence, needs to be able to return to the parents for reassurance and gratification of dependency so that separations can certainly be difficult for him, too. I would agree, however, that separation is less traumatic for the adolescent than for the young child, as separation for him is more in keeping with the normal growth process. The adolescent's earlier separation experiences, by my hypothesis, would have more bearing on his adjustment upon placement than separations occurring closer to his present age level.

Duration of Separation

How long a child has been separated from his parents would seem to relate to his capacity to cope with separation successfully. Rochlin has suggested that "loneliness, isolation, or separation from others can be tolerated only temporarily without profound psychic changes taking place regardless of the phases of development or the age at which they may occur." (29, p. 462) It seems reasonable to suggest that the longer the separation for the child, the more traumatic the effects will be. For this study, this variable is being considered simply on the basis of whether the separation was permanent or temporary. Theoretically we would expect that permanent separations would have more traumatic effects on the child.

Authors seldom have indicated what constitutes "temporary" separation, although Yarrow (40, p. 33) suggests that if the child is reunited with his mother before the need for mothering is completely repressed (no critical time interval is stated), the behavior pattern is believed to be reversible. In citing Spitz, and Wolf, Yarrow (40, p. 33) says there is a critical time interval after which time

the effect of maternal separation is irreversible. He suggests that if the mother is reunited with the infant within three months, the process of deterioration may be arrested, but if the mother-child relationships has not been restored within five months, irreparable damage occurs. This time interval applies largely to infants, and no comparable intervals have been stated for children beyond this age.

Types of Separations

Duration of separation already implies in part the kind of separation experience the child has had. Any kind of separation experience can be traumatic for a child. Mahler, (25, p. 386) for instance, has indicated that brief separations of mother or child due to hospitalization, especially at the end of the first year, can produce considerable suffering for the child. Anna Freud (10, p. 154) points out that any separation may seem ostensibly minimal in terms of the reactions of the child. But each separation experience calls for mastery on the part of the child. When they occur, and how the child masters these separations will reveal the level of the child's development and his capacity to master current reality. The examples which she suggests are: separation from the mother or father of any kind, caused by birth of a sibling, illness, and surgical intervention for the child, hospitalization of each parent, divorce, separation of the parent, remarriage, entry into nursery school and school entry. All of these reality situations may confront the child and will have to be handled in some way by him. The degree to which these experiences were mastered, will indicate how the child will react to separation through placement.

Working with Parents

Separations Experienced by the Parents

We would expect that a parent who has suffered severe separation experiences during his childhood will be effected by this in his decision to either accept or reject the recommendation of placement for his child. In what direction the parents' feelings about separation will effect their decision for placement of their child is open to speculation. One might anticipate that the parent who was placed away from his own parents as a child, might have a great deal of feeling about making similar plans for his offspring. On the opposite end of the continuum, the parent who has had earlier severe separations may unconsciously provoke the same type situations for his child, and hereby necessitating placement. I would expect that we would find in this study examples of both groups of parents, with the common denominator being the fact that both groups have had permanent separations from their parents as children. Both Kline (21, p. 166) and Littner (23, p. 23) have assumed this theoretical base and have indicated quite clearly that the parents' separation experiences will have meaning for them, especially when they consider placement of their child.

Parents in the Placement Process

In all child placement literature, emphasis is placed upon involving the parents in the placement process and helping them to make an appropriate plan for their child. (7, p. 130; 16, p. 145; 26)

With direct applicability to the dilemna of the child guidance clinic, Glickman (15, p. 10-23) points to some interesting problems.

She feels it is always desirable for the referring psychiatrist, or whatever other referral source there is, to discuss the recommendation of placement with the placement agency before telling it to the parents. In this, she seems to be asserting the role of the child placement agency and their responsibility to diagnose and make decisions in this area. In this phase, the initial intake work of the placement agency, she feels the diagnostic thinking should be focused on the parents, especially the mother-child relationship. The psychiatric setting at which this study was made acknowledges and accepts responsibility for discussing with the parents, after the completion of the diagnostic evaluation, their findings and their treatment recommendations. Collaborative conferences are held with child placement agencies, but usually these are held after the therapist has discussed the clinic's recommendations with the parents. Certainly Glickman's point has some validity, but I doubt that it has ever become an issue considered by the majority of clinics. I would prefer to see the clinic continue to work with the parents until they are able to accept a referral to another agency rather than prematurely referring the parent to the child placement agency.

My main concern is that the clinic should serve as the bridge between the parents and the child placement agency. Thus, I would expect that where the clinic introduces to the parent the name of the appropriate child placement agency, and goes further in paving the way by collaborative contacts with the placement agency, the resistances of the parents will be more effectively handled. We know only too well that the child cannot accept placement unless both he and his parents are actively involved in the placement process, and unless

the child knows that the decision for placement has been made by his parents. It is in this way that the child can then be helped to work through his feelings in relation to his parents and not displace them inappropriately on his foster parents or other adult figures. Where the parent is extremely ambivalent towards the child, he will be ambivalent about placement and will require a great deal of support in accepting placement.

> A guilt-filled mother who half gives up her child and half holds onto him...brings to the agency a thoroughly confused, anxious child. Such a child may neither have nor give up his mother; such a child can neither totally accept nor reject substitute parents. (4, p. 40)

This whole area of service to the family by a psychiatric out-patient child guidance clinic was highlighted in a thesis written by Sarah Smith. (34) The study investigated the way in which the placement recommendation was given to a group of parents. It was significant that parents who did not place their children were not as well informed about the benefits expected of placement as parents who placed their children. The feelings about placement were not explored or recognized with approximately half of the parents who did not place their children. No adequate exploration of the available placement resources were made with approximately two-thirds of the parents who did not place their children. The clinic offered no assistance in consulting placement facilities in half of these cases. In contrast, all of the parents who placed their children were informed of the benefits placement might offer and received help in recognizing and understanding their feelings about placement. In over three-fourths of these cases, the parents were made aware of the facilities available to them. While Smith had a fairly small

sample of 34, the implications were dramatic, nevertheless, and further demonstration of this pattern, if it be true, seems indicated.

CHAPTER III

METHOD AND SCOPE

Hypotheses and Definition of Terms

Hypothesis 1

The nature and extent of previous separation experiences for both the child and his parents are related to their capacity to use placement.

The nature and extent of previous separation experiences is defined as any kind of separation experienced by the child and the parents, the age of the child and relative age of the parent at time of separation, and some knowledge of the length of separation.

A separation experience refers to any kind of separation had by the child and the parent of which we have knowledge. Entry into school will not be included in the study, as each child enters school at approximately the same time. Separation experiences to be considered are birth of a sibling, divorce, separation, or death of a parent, remarriage, absence of a parent because of hospitalization, incarceration, death of a sibling or other relative living in the child's home, hospitalization of the child.

It is difficult if not impossible to obtain specific information about the duration of separation. I, therefore, suggested the

terms "temporary" and "permanent" as a non-quantitative measurement of this variable, with "temporary" meaning any separation whereby the child is eventually returned to the absent parent, sibling, or relative (with whom the child has been living) and "permanent" referring to the death of a parent, sibling, or relative, or the divorce or abandonment of a parent which has resulted in complete separation for the child.

Child is defined as any child of eighteen years of age or younger.

A parent is defined as the legal guardian of the child. Thus, the "parent" may be the child's natural or adoptive parent. Also where a relative has reared the child and has been appointed legal guardian, the latter serves as the child's "parent."

Capacity to use placement is defined as meaning that the child, once placed, remained in this placement and was neither removed prematurely by his parents nor removed because of problems which the child was presenting in the foster home or institution. This then excludes those situations where the child was removed from a placement because of circumstances beyond his or his parents' control, such as problems within the foster home or institution which necessitated the termination of the placement.

The following are sub-hypotheses of the above hypothesis:

a) With the exception of the child under six months of age, the younger the child was at the time of earlier separations, the more difficulty he will have in using placement meaningfully.

(1) Children who have had separation experiences between the ages of 1-5 will fail in placement (will not use placement meaningfully) with greater frequency than children who have

had separation experiences between the ages of 6-18.

(2) There will be no difference between the children of less than six months and the children of 6-18 with respect to their ability to use placement, as long as there were no other significant separation experiences between the ages of 1-5.

b) The length of the earlier separation experiences is related to the child's capacity to use placement, i.e. the longer the separation, the greater the likelihood for failure in placement.

(1) There will be a significant difference between the children who have had permanent separations, with respect to their ability to use placement.

c) The kind of separation experience will effect the child's capacity to use placement.

(1) Birth of a sibling is less severe than death or divorce of a parent.

(2) Where the child has remained in his own environment, even though separated from a parental figure, separation is less severe.

d) The separation experiences of the parent will effect the parent's decision about placement of their child.

Hypothesis 2

The ability of the parents to accept a recommendation for placement is directly related to the nature and extent of the involvement of the psychiatric clinic in assisting the parents to cope with this recommendation.

By "accepting the recommendation for placement" the parent must be seen as actually having followed through with the placement plan.

It must be noted, however, that in some instances no placement facilities are available for the child even though the parent seems willing to accept the recommendation.

"Placement" is defined as the removal of the child from the parents' home followed by placement in a licensed boarding home or institution which is under the supervision of a child placement agency.

"The nature and extent of the involvement of the clinic" is defined as any activity of the clinic which involves follow-up planning for the child. This would then include any contacts made with the parent, and any contacts with other collaborative agencies which are involved in planning for the child. This would not include contacts with the parents or other agencies during the time of the diagnostic evaluation of the child, but only those activities which follow the diagnostic conference and those activities which pertain to the working through of plans for the child's treatment, i.e. placement.

The following are sub-hypotheses:

a) The more contacts the clinic has had with the parent following the diatnostic evaluation, the greater likelihood that the parent will accept placement of the child.

b) When the clinic refers the parent to the appropriate child placement agency, the parent will follow through in accepting placement more frequently.

c) Where the clinic has contacted the placement agency, the parent will accept placement more frequently.

    (1) Interagency conferences concerning plans for the child will result in the parents accepting placement more frequently than

letter or telephone contacts with the placement agency.

Agency Settings

This study was conducted at the Central Psychiatric Clinic in Cincinnati, Ohio with the cooperation of the Children's home of Cincinnati, the Hamilton County Welfare Department, Catholic Charities of the Archdiocese of Cincinnati, and Family Service of the Cincinnati Area.

The Central Psychiatric Clinic was organized in 1923 and is currently under the directorship of Dr. Maurice Levine, M.D., Professor and Director of the Department of Psychiatry, College of Medicine, University of Cincinnati. It is a community psychiatric clinic offering out-patient study and treatment of adults and children who reside in Hamilton and Clermont County and who could not afford non-clinic psychiatric care. The clinic cooperates with other social agencies and professional people in the community in furthering the understanding of mental health principles.

In addition to being the primary community mental health clinic for children and adults, the clinic serves as a psychiatric training center for the Department of Psychiatry, College of Medicine, University of Cincinnati, and for social work students from Smith College and from Ohio State University, School of Social Work. The clinic is a voluntary, non-sectarian agency. It derives financial support from the Community Chest, the University of Cincinnati, the State of Ohio, and special grants from the federal government and from other foundations. Financial eligibility is evaluated in terms of family income, and fees are based on income. No patient, however, is refused treatment because of inability to pay a fee while applicants who exceed the

financial ceiling of the clinic are referred for private psychiatric care.

Diagnostic and therapeutic services are offered to eligible persons who make personal application to the clinic after referral by physicians, social and health agencies, and other professional sources. After an applicant has called the Intake social worker, and initial financial, residency, and requirements concerning the appropriateness of the referral have been evaluated, an application form and letters requesting information from the personal physician, other referral sources and social agencies are forwarded to the patient, or, as in the children's clinic, to the parents. The application forms have been used since June, 1961 so that for some of the cases in the sample, this exact procedure was not followed. The material, once received, is reviewed to determine the appropriateness of the referral. The parents are then invited to an orientation group meeting after the case has been accepted for diagnostic evaluation. The group meeting is a relatively new innovation so that the cases in the study have not participated in this aspect of the clinic's planning. Parents are then seen by either a child psychiatrist or a social worker in order to obtain a complete psycho-social history of the child and his parents. The child is then seen for a psychiatric diagnostic interview.

Upon the completion of the diagnostic interviews, the case is then staffed at a diagnostic conference. The findings are discussed and treatment plans are formulated. The staff person who has seen the parents and child reviews with the parents the clinic's findings and recommendations. When psychiatric treatment is not recommended at the clinic itself, parents are referred to other appropriate resources in the community. Other agencies and professional people involved in the referral or in follow-up planning for the child are

also informed of the clinic's recommendations.

Since this study attempts to determine what plans were made for a child after placement was recommended by the clinic, other community agencies involved in planning for these children cooperated in supplying the additional material necessary for this study. The three child placement agencies in the community had most of the information available although it was necessary in some cases to utilize the information available through the Hamilton County Juvenile Court, the Hamilton County Welfare Department, and the Family Service of the Cincinnati Area.

The Children's Home of Cincinnati is a Protestant non-denominational, private child placement agency which provides services to children and to natural parents who are considering a plan for their children outside of the parental home, whether it be adoption, temporary boarding care or institutional placement. Group care for school age children who have no severe physical or mental handicap is given in the agency's institution.

Catholic Charities of the Archdiocese of Cincinnati has a wide program of social services for the Catholic community. It provides the service of centralization and coordination of the various Catholic charitable and social service societies and institutions. The Central Office provides direct casework services to families and individuals through its Family and Children's Division. It also serves as the child placement agency for Catholic children in need of placement outside their own home.

The Children's Services Division of the Hamilton County Welfare Department is the public agency in the community which offers foster

home and institutional placement for dependent and neglected children. This division is part of the county welfare department which coordinates and administers all public welfare and public assistance activities in Hamilton County. Parents who are not eligible for either Catholic Charities or Children's Home because of religious or financial ineligibility are referred to Children's Services Division for placement planning.

Several cases in the study had not been referred to a child placement agency and follow-up information was then obtained from either the Hamilton County Juvenile Court or Family Service. The Juvenile Court has jurisdiction of the delinquent, dependent, or neglected child under the age of 18 years. While the court does not serve as a child placement agency, it does have the responsibility to authorize the removal of a child from his home when such planning is seen as beneficial to the child. In such instances, the child is committed to a public or private child placement agency for such planning. The court thus cooperates extensively with the child placement agencies in planning for dependent or delinquent children.

Family Service of the Cincinnati Area offers casework services to families and individuals desiring help with their personal, social, or family relationship problems. If a child must be removed from the parental home, Family Service, when active in such cases, will usually try to refer the child and his parents to the appropriate community resources. Frequently Family Service will continue to offer casework services to the parents in an effort to assist them both in accepting placement and in establishing a home environment which will be beneficial to the child upon his return to his natural home.

Methodology

Case Selection

Cases to be included in the study met the following criteria:

1. All cases staffed at children's diagnostic conference from 1960-1962 in which the treatment recommendation was removal of the child from the home of the parents and placement of the child in a foster home or institution, both of which are under the supervision of a child placement agency.
2. These additional qualification were also met.
   - a) The parents of the child must request the diagnostic evaluation of the child. This requirement was virtually fulfilled by the policies of the clinic in that parents must request service even though another agency or professional person has referred the parent to the clinic.
   - b) Children must be either in their parent's home or in an emergency receiving center at the time of the diagnostic conference. While an emergency center or juvenile detention home might be considered a placement in itself, this is usually a temporary placement, pending further planning and was therefore acceptable for the study.
   - c) The child must not have been placed previously under the supervision of a community agency. This did not include adoptive placement, and also by definition did not include any arrangements for child care which the parent had made independently of an agency. I also maintained one additional exception to this qualification. There were a few cases where the child had been placed at a younger age by a child

placement agency in an emergency receiving center while the mother was hospitalized. These cases have been included, as placement was seen as being quite temporary, and no further discussion was had around more extended placement plans for the child. The involvement of the child placement agency was, however, necessary, since the parent had no other resource available to him.

d) Initially, only those parents or children who had had no previous contact with the clinic were to be included. This qualification, however, eliminated a number of cases. The reason for this initial plan was based on the second hypothesis, which might have been contaminated by the fact that parents who had previous contact with the clinic might therefore either accept or reject the clinic's recommendations as a result of some feeling about their previous contacts. Since, however, this could not corrupt the first hypothesis, such cases were accepted as long as the parents were not presently receiving psychiatric treatment at the clinic and as long as the child himself had not been evaluated previously at the clinic. There were eight cases in which the parents had had some prior contact with the clinic; however, in each case contact was brief, usually consisting of a diagnostic evaluation of the parent. In one case, the mother of a child was presently hospitalized on one of the psychiatric in-patient wards, and in yet another case, a father had previously been a patient in the psychiatric ward.

By reviewing the children's diagnostic conference sheets (which

indicated for each case discussed at conference, what the diagnosis and treatment plan had been), I learned there were 76 cases between 1960-1962 where child placement had been recommended by Central Psychiatric Clinic. By locating the cases for the sample in this way, it is possible that some cases were not included which should have been, but the only other way to have located the cases was to have reviewed the entire clinic's children's records for that period.

Of the 76 cases, 36 were eliminated after a review of the record and establishment of ineligibility for the sample. Twelve cases were eliminated because the child was either presently in placement or had been in placement some time previously. In three cases, the family was already active with a child placement agency. In seven cases the child had been seen before or the parent was presently in treatment at the psychiatric clinic. In four instances, either the child or the parent made a plan for the child themselves without the need for further involvement of a child placement agency. Of these four, two children were placed with their father, and the two other children joined the Army. Another child became pregnant which necessitated changes in future planning for her. Two children were seen for a diagnostic evaluation previously at the clinic, but it was not until they were seen again that the recommendation was for placement outside of the home. These two cases were eliminated by virtue of their previous contact with the clinic. The remaining six cases were eliminated for the following reasons: in two instances the recommendation for placement was indefinite, with further exploratory study being suggested; placement was already planned for a child by her mother; in one case, the mother had never actually cared for the

child but had left the child with relatives, and in two instances the case record could not be located.

After elimination of these 36 inappropriate cases, 40 cases remained. The majority of the information which was necessary for the study was taken directly from the clinic's records. (See Appendix A for the schedule.) The record contained material about the early separation experiences of the child and the parent, and dictation included any contacts by clinic personnel with parents or other community agencies during the follow-up period. In six cases, the child was re-evaluated after the original evaluation which recommended placement. This afforded the opportunity of learning through the clinic records what had happened to the child during the interim period.

In addition to the material obtained from the case record at the psychiatric clinic, it was necessary to obtain information from the records of the five other community agencies mentioned earlier. The information received involved mainly knowledge of the present whereabouts of the child, dates of placements, and reasons for any moves or changes. In some instances, however, it was possible to gain further information about earlier separation experiences which had either been omitted by the clinic record or were further clarified in other agency's records.

Twenty-eight of the 40 cases were either presently active with the Hamilton County Welfare Department or had been during the past three years. Of these twenty-eight, six families were known to both the Children's Services Division and the Public Assistance Division of the welfare department. Ten cases were known to Children's

Services Division alone, while twelve were known to the Public Assistance Division alone. There was certainly a large number of cases where families were known to several agencies. Families active with Catholic Charities, Family Service, Children's Home and the Juvenile Court were quite frequently known to the Welfare Department as well.

Nine cases had been active with Catholic Charities; eight with Family Service; five with Children's Home, and eight with the Juvenile Court.

Limitations of the Study

While some of the limitations of the study can best be discussed after the results have been presented, there are a number of limitations to the research method itself which must be considered before the results can be reviewed so that one may gain a proper perspective of their meaning.

The study of separations and its meaning to a child is a very complex one, as Ainsworth and Bowlby have aptly described.

> It has become increasingly clear that 'separation' is not a simple aetiological factor, and that the term refers to a wide range of events and an intricate complex of associated conditions, which in different constellations may have different effects on the course of development. (1, p. 105)

Noticeable by its absence in this study is any consideration of the parent-child relationship at the time of the child's earlier separation experiences or at the time of the diagnostic evaluation. Out of necessity the scope of the study had to be limited, and because of the methodology it seemed totally unrealistic to imagine that one could deduce the nature of the parent-child relationship at the time

of earlier separation. If comments from the parents were available in the record, there was the possibility of much distortion in their information. This is, indeed, a very serious limitation as understandably the strength of the parent-child relationship is an extremely important factor to the child when he is faced with any kind of separation experience. A child may be forced to handle a very traumatic and disturbing experience, but if the parent can assist the child through the difficult situation, the damage might be quite minimal.

No attempt was made to control for the substitute care which the child might have received during the absence of the parent or parents. This, too, can be a very important factor, as the substitute parent may have been an important person in either minimizing or accentuating the traumas of separation. We have no information as to how the child was prepared for these early separations, and this, too, would be an important variable. We have not attempted to control for varying degrees of ego strength in the child, such as intellectual functioning, emotional stability, or physical handicaps. Thus, each child approaches placement with varying capacities to healthfully integrate separation experiences. All of these additional factors cannot be controlled, but must be considered in the light of the findings.

Perhaps the most serious limitation is the fact that information from the case records is far from complete and does not readily comply with the demands of the research method. In attempting to obtain developmental history, this aspect of the study had to be completely eliminated because developmental material was simply not available or it was so distorted by the parents that it was virtually

useless for our purposes. Similarly, while we were able to learn of major separation experiences, the information was vague at times. A child might have been hospitalized, but frequently we could not learn the duration of the separations. Parents might have separated several times, but these separations could not be clarified with any exactness. More alarming in terms of the validity of the material is the realization that the child may have had additional separation experiences of which we had no knowledge. Thus, the material obtained was far from complete, and this realization causes one to question any results which followed. An addition to the inadequacies in the research method is the small sample size which also serves to limit the validity of any significant findings.

With respect to the second hypothesis, there are certain variables which could not be controlled, but which at least can be noted. In a few cases, while the parent seemed willing to accept placement, there was no appropriate facility available for the child. The question of voluntary or involuntary placement also becomes an issue. We cannot truly say the parent has accepted placement when the decision is taken out of the parents' hands by the court. These factors were not controlled for in the research, beyond stating their existence.

CHAPTER IV

ANALYSIS OF RESULTS AND INTERPRETATIONS

Of the 40 children in the sample for whom the clinic recommended placement, twenty-five were ultimately placed while the other fifteen children remained in their own homes. As shown in Table 1, seventeen of the twenty-five placed children have remained in placement (although technically, three children were returned home after having made a satisfactory adjustment). The other eight children, the "Failed Placement Group" were either moved to another placement because of their failure to adjust or were returned home prematurely because of the parents' insistence.

Ten of the placed children appeared to have made a good adjustment to placement. Five of them continue in placement with no present plans being made for any changes in their situations. Two of them have adjusted well in institutions and will be returning to their own home in the near future. The remaining three have returned home as part of a planned decision between the parents and the agencies involved.

The other seven children who were placed have made questionable adjustments. Four were probated to the state mental hospital. One was probated to an institution for the mentally retarded, and two were adjudicated delinquent and sent to a delinquent state institution, with one ultimately being probated to the state mental hospital. These seven undoubtedly were the most disturbed group of children in the

TABLE 1

LOCATION OF 40 CHILDREN FOR WHOM PLACEMENT HAD BEEN RECOMMENDED

Location		
Successful Placements		10
Continue in Placement	5	
To return home soon by plan	2	
Have returned home by plan	3	
State Institutions		7
Mental Hospital	4	
Institution for Mentally Retarded	1	
Institution for Delinquent Boys	2	
Failed Placements		8
Returned home because of parents' insistence or inability of child to adjust	5	
Moved to another institution because of inability of child to adjust	3	
Never Placed		15

study. These children, unlike some of the others, could not function outside of a closed institutional setting. In most cases, the parents, out of necessity had to decide upon placement due to the unmanageability of these children. This group of seven have, therefore, been designated the "State Institution Group." They fit reasonably into no other category and would serve to contaminate the results if included in the "Successful Placement Group."

Of the eight children who failed in placement, four were returned home prematurely both because the child was unable to adjust in his placement and because the parents insisted on terminating the placement. The four other children adjusted poorly in their placement and were moved to another placement facility with the exception of one, who was returned home even though the parents were not active in precipitating this move.

Table 2 shows where the twenty-five children were placed

TABLE 2

TYPES OF PLACEMENTS FOR 25 PLACED CHILDREN

Type of placement	Number
Catholic Institutions	9
State Institutions	7
Foster Home Placement	4
Children's Home	3
Public Institution	1
Out-of-Town Protestant Institution	1

It is interesting to note that of the 9 children who were placed in Catholic institutions, only two have remained in their original placement. The other seven children failed to adjust and were either returned home or moved to other institutions. One other child who

failed to adjust in placement had been in a foster home.

Types of Separations

Generally speaking, all of these forty children had had a great number of separation experiences before they appeared at the psychiatric clinic for help. (See Table 3.) The types of separation experiences which they had ranged from that of a temporary absence of a sibling to the divorce, separation or permanent desertion of a parent. The lengths of the separation vary from a period of one or two days to permanent separations. Table 3 describes the kinds of separations which these children have had although duration and ages at which they occurred are not indicated.

Since the sample size of the study was so small, it was difficult to note from Table 3 whether certain kinds of separation experiences were more meaningful in terms of later adjustment in placement than others.

Any attempt to analyze different kinds of separation experiences was unsuccessful, resulting in either insignificant findings or inconclusive evidence. For example, approximately the same number in each group ("Successful Placement," "State Institution" or "Failed Placement" Groups) experienced either their own hospitalization or the hospitalization of a parent or relative. Nine of ten in the "Successful Placement" Group had this experience; five of eight in the "Failed Placement" Group; six of the seven in the "State Institution" Group, and twelve of fifteen in the "Never Placed" Group. Thus, either such an experience has no bearing on a child's later handling of placement separation, or more likely, the research study has too many limitations to illustrate any relationship between these two factors. The same

TABLE 3

SEPARATION EXPERIENCES OF FORTY CHILDREN FOR WHOM PLACEMENT WAS RECOMMENDED

Type Separation	Placed Children (25)			Never Placed (15)
	Successful (10)	Failed (8)	State Inst. (7)	
Absence of sibling [a]	1	1	1	4
Child hospitalized	6	3	6	7
Mother hospitalized	5	3	3	5
Father hospitalized	2	1	2	4
Death of relative in the home (not parent	0	1	2	3
Permanent Desertion of Parent	3	1	2	1
Divorce or Separation of Parents	4	3	2	8
Temporary Separation or Desertion of Parents	4	4	3	9
Remarriage of Parent	3	1	2	3
Birth of sibling	9	7	4	10

[a] Table does not show duplication of the same types of separation experiences, where this is applicable, i.e. the child may have been hospitalized several times.

kind of difficulties and inconclusive findings presented themselves in the other separation experiences which were described on Table 3.

The only type of separation experience which seemed to be meaningful were those involving parental separations. Looking at Table 4, we see that the "Successful Placement Group" experienced slightly fewer parental separations than the "Failed Placement" and "State Institution" Group. Using the chi-square test, I combined the "Failed Placement" and the "State Institution" Groups and contrasted the difference between them. I felt the first two groups (Failed Placement and State Institution) could be combined for this purpose since the children in the State Institutions were not actually making good adjustments and could be considered the most seriously disturbed. Using the chi-square test, the results were almost significant at the .05 level.

TABLE 4

PARENTAL SEPARATIONS OF THE CHILD [a]

Length of Separation	Placed Children (25)			Never Placed (15)
	Successful (10)	Failed (8)	State Inst. (7)	
Temporary	5	4	1	2
Permanent	4	2	4	10
Neither	1	2	2	3

[a] Parental separations include divorce, separation, desertion, incarceration, or abandonment by the parent.

Again looking at Table 4, notice that the "Never Placed" Group experienced a high number of permanent parental separations. Why the "Never Placed" Group contrasts so strongly with the other groups is difficult to understand. Perhaps in this group, where one parent is left without a marital partner, she (and it invariably is the mother) is reluctant to let her child be placed. The child may, in these instances, be meeting his parent's dependency needs. The parent is then unable to surrender the child.

Age of Child at Time of Separations

With the exception of two children, all of the forty children in the sample experienced some form of separation experience between the ages of six months to five years (the age span hypothesized as being significant in terms of its traumatic effects).

When, however, we compared in the three groups the ages at which the children had their first separation from their parent(s), we did distinguish some interesting differences. (See Table 5.)

TABLE 5

FIRST SEPARATION EXPERIENCES NOT INCLUDING BIRTH OF SIBLING

Age at Separation	Placed Children			Never Placed (15)
	Successful (10)	Failed (8)	State Inst. (7)	
under 6 months	5	0	1	2
6 months - 2 years	2	4	4	8
3 years	0	2	0	1
4 - 14 years	3	2	2	4

The results show that five of those children who were placed successfully had their first separations at less than six months of age. None of these children had separation experiences for the first time at the three year level. In contrast, the "Failed Placement" Group or the "State Institution" Group had increasingly more separations at the age level of six months to two years. Using the chi-square test, and again combining the "Failed Placement" Group with the "State Institution" Group, the differences between these two groups in contrast with the "Successful Placement" Group were significant at the .05 level. This finding supports our hypothesis that separations which occur between the ages of six months to two years effect negatively the child's later adjustment in placement.

TABLE 6

FIRST SEPARATION EXPERIENCES INCLUDING BIRTH OF SIBLING

Age at Separation	Placed Children			Never Placed (15)
	Successful (10)	Failed (8)	State Inst. (7)	
Under 6 months	5	0	1	2
6 months - 2 years	4	8	5	9
3 years	0	0	0	1
4 - 14 years	1	0	3	1

When the birth of siblings was included as a separation experience (See Table 6), the same results demonstrated in Table 5 were found. The inclusion of this factor, i.e. the birth of a sibling, highlighted the

differences between the groups. Again, the "Failed Placement" and the "State Institution" Groups had significantly more first separations between the ages of six months to two years than the "Successful Placement" Group. Notice, also, that the differences between the two and three year old levels were enlarged. This seems to merely indicate that most children experienced the birth of a sibling before the age of three.

Reactions of Parents Who Had Early Separations

Of the forty children in the sample, twenty-six of their parents experiences severe (death of a sibling, parent, divorce, abandonment) separations as a young child. (See Table 7.) Furthermore, nineteen of these twenty-six parents who had had such separations accepted the recommendation of placement for their child. This finding demonstrates clearly that parents' childhood separations effect their decisions to place their own children. Using the chi-square test, the differences

TABLE 7

SEPARATIONS OF PARENTS AS YOUNG CHILDREN [a]

Parents Early Separations	Placed Children			Never Placed (15)
	Successful (10)	Failed (8)	State Inst. (7)	
Yes (26)	8	5 (19)	6	7
None Indicated (14)	2	3	1	8

[a] Separations experienced by the parent before age 19. Types of separations included death of a parent, sibling, or divorce and abandonment of child by one or both parents.

between parents who did or who did not have severe childhood separations was significantly related to these parents' decision about placement of their child at the .05 level.

Why the results mentioned above occurred can be interpreted in a number of ways. It illustrates the limited strengths of these parents who cannot meet the needs of their children when they themselves were not given to sufficiently as young children either. Although we do not have any additional information about the parent's dynamics or pathology, we might expect that these parents are the more severely impaired in their roles as parents and as individuals. This finding also reflects, as Kline (22, p. 166) has suggested, that the parent unconsciously provokes the same type situation, i.e. separation and placement, for his child as he experienced himself. This then reactivates the parent's feelings of guilt and hostility and displaces these feelings onto the child.

It is indeed interesting that of the seven children in the "State Institution" Group, six of them had parents with severe childhood separation experiences. If we recall that this group consisted of the mentally ill and the juvenile delinquent, speculation can be raised about the parent's pathology. Conceivably, such parents might not have been able to meet the needs of their emotionally disturbed children because of their own emotional deprivation. Also, as in the case of the delinquent, the parent may have provoked the child's acting out which in turn precipitated the child's removal from the home. Thus, both my speculations (mentioned above) about the effects of childhood separations in these parents seem justifiable.

From Table 7, we see that there were eight children who were

successfully placed, even though their parents had severe childhood separations. This would support my contention that the parent's pathology in these cases is great. Apparently, when the children were removed from their parent's home, their functioning improved. Perhaps these children had sufficient ego strength to separate from their parents and the latter's pathology.

In Table 7 we saw that previous separations in the parents' lives resulted more often in their children being placed. In at least two cases, the parents, however, dramatically refused to accept the recommendation for placement on the basis that they had experienced such separations and did not want this for their child. One parent whose mother had been hospitalized extensively for mental illness and whose grandmother (her substitute mother figure) died when she was nine, reacted strongly to the clinic's recommendation of placement of her child.

> Both parents reacted dramatically, mother immediately bursting into tears, pacing around the room hysterically, and almost screaming that no one would take her child away from her.

Another couple had had a number of severe separations as children. The mother had been placed herself from the age of 2-5, and at age 15, her father died. The father was placed in an orphanage at age 3, was then placed in a foster home from the age of seven to fifteen, and after that was in yet another institution. This couple would not accept placement for their child.

> The parents were able to express their bitterness concerning the periods in each of their lives when they were placed away from their parents and were agreed that they would not allow this to happen to their child.

The Clinic's Activity in Helping Parents Accept Placement

The results obtained about this factor are related to my second hypothesis. Here, I am not interested in whether the children succeeded or failed in placement. I simply tried to learn whether the child was placed as a result of the clinic's recommendation and the clinic's follow-up activity with parents and collaborative agencies. This created the need for a change in the way in which cases were organized. Instead of looking at the groupings described in the previous pages of this chapter, I organized three new groupings. (See Table 8.) The first was the "Placed" Group which consisted of nineteen children who were placed within a year of the diagnostic conference. To test this hypothesis it was important to know how soon after the diagnostic conference placement of the child actually occurred. I assumed that where a child was placed at least a year after the conference, the decision to place the child was not effected by the clinic's recommendations - made a year earlier. Thus, my second group was the "Later Placed" Group; six children who were placed from one to three years after the diagnostic conference. Had I included this second group with the first, I risked the possibility of contaminating the results. The clinic's recommendations apparently did not effect their later placement, and accordingly we would expect that the clinic's follow-up activity was less than that had with the "Placed" Group. The third group consisted of the fifteen children who were never placed.

The results shown on Table 8 indicate that where the clinic, in their follow-up contacts with the parents, referred the parents directly to a child placement agency, the child was placed with greater frequency. Where the parent was referred to any other agency

FOLLOW-UP ACTIVITIES OF THE CLINIC WITH PARENTS AND OTHER AGENCIES

	Placed (19)	Later Placed (6)	Never Placed (15)
Letter to Parent			
Yes	3	0	1
No	16	6	14
Telephone -Parent			
Yes	13	3	5
No	6	3	10
Interview-Parent			
Yes	14	5	11
No	5	1	4
Referral to Child Placement Agency			
Yes	15	1	7
No	4	5	8
Letter to Child Placement Agency			
Yes	12	0	1
No	7	6	14
Telephone to Child Placement Agency			
Yes	11	0	4
No	8	6	11
Interagency Conference			
Yes	5	2	1
No	14	4	14
Letter to other Community Agency			
Yes	9	5	5
No	10	1	10
Telephone with other Community Agency			
Yes	10	3	7
No	9	3	8

(Family Service, Juvenile Court, Public Assistance Division of the Welfare Department, Hospital Social Service and Visiting Teachers) besides a child placement agency, placement occurred less frequently. The statistical difference (using the chi-square test) between the "Placed" Group and the "Never Placed" Group with respect to "referral to a child placement agency" was not significant. I felt justified, however, in combining the "Never Placed" Group with the "Later Placed" Group to perform a chi-square test. This was done with the assumption that neither of these two groups had actually been effected by the recommendation of the clinic. The "Later Placed" Group were placed too long after their contact with the clinic for this to be true. We might, therefore, speculate, that as in the "Never Placed Group," less follow-up activity with this group might have been related to this group's inattention to the clinic's recommendations. Using the chi-square test, the difference between the "Placed" Groups, with respect to the factor of "referral to a child placement agency" 2as significant at the .05 level.

The extent of contact clinic personnel had directly with the parents was not significantly related to whether the child was placed or not (See Table 8 - 1st through 3rd columns.) The "Placed" Group showed more telephone contacts with the parents than the "Never Placed" Group, but this difference was not statistically significant. The findings, however, do show a tendency in the expected direction.
The difference between the "Placed" Group and the "Never Placed" Group, with respect to the factors of "letters to the child placement agency " and "interagency conferences" were both significant at the .01 level, using the chi-square test. In other words, placement occurred more

frequently when the clinic wrote to the child placement agency their recommendation of placement of the child. When Interagency conferences were held, and the clinic informed other active social agencies of their findings and recommendations, placement of the child occurred more frequently.

The other factors which are indicated on Table 8 seemed to have little effect on whether the child was placed or not.

As indicated earlier, there were eight children whose parents had had previous, but brief, contact with the clinic before the child's evaluation. Of these eight cases, five of the children were placed within a year; two within three years, and one was not placed at all. This, as anticipated, seems to produce a slight contamination of the results. I performed a chi-square test, in which I compared the differences between parents who had had previous contact with the clinic and those who had not, with respect to whether the child was placed. The difference was not statistically significant, but nevertheless, it is present.

On a case by case survey, there were occasionally some glaring examples of poor communication between agencies which resulted in decreased service to the children and families involved. In one instance a mother was referred to a child placement agency for placement of her children. She never followed through with this referral, but two years later requested emergency but temporary care of the children during her hospitalization. The two children were placed twice on this basis, but the child placement agency remained unaware of the fact that the children had ever been seen at the psychiatric clinic or that placement had been recommended. Fortunately, the

children seemed to function fairly well during these brief placements, and hopefully there may have been some change in the family picture and in the children which no longer necessitated more extensive placement planning for these two boys.

In two instances, a community agency closed their active case as the agency believed the child was now being seen at the psychiatric clinic. As a result neither child was placed, and neither agency offered treatment of the two children. In a third case, the psychiatric clinic's report was reviewed with a member from another agency, but there was no record on file at the latter agency that placement had been recommended by the clinic. These kinds of situations are alarming, but the possibility of this occurring seems less likely now than in 1960-1962, the year in which these children were seen at the clinic.

By the same token, a few comments in records at the clinic indicate quite clearly the important role of the clinic in this whole area of diagnostic evaluations and follow-up planning with the parents and the community. One couple expressed their positive feelings towards the clinic in an interview with the child placement worker. Both parents confided that if the psychiatrist had not told them that placement was necessary they would not have approved of the plan. If the psychiatric clinic thought placement was necessary, they did, too. Another mother told her welfare worker that she had thought about having the children placed but knew that if she did she would never get them back. She would never do this on her own but would agree to placement if this were recommended by a doctor. The psychiatrist who worked with this mother asked the mother to talk to her welfare worker, who would help her make arrangements for placement. The doctor requested

that the mother call him back later so that he might know what plans were being made for her child. This kind of planning and sensitivity, undoubtedly was part of the reason why both these children were placed. It also illustrates what the firm but kind professional authority of the clinic can mean to these parents, even though their contact with the clinic is relatively brief.

CHAPTER V

SUMMARY

In the early part of this thesis, a list of hypotheses and sub-hypotheses were stated. In this chapter, I have attempted to review these statements in the light of the research findings.

Hypothesis 1

Throughout, the entire first hypothesis proved exceedingly difficult to test. The inconclusiveness of the results indicates both the difficulty one encounters in attempting to assess the complexities of separation experience and the gross limitations of the method and scope of this study. All of the children studied had a large number of separation experiences, and the sample was too small to permit us to distinguish the varying effects of each.

Since all but two of the children had separation experiences between the ages of six months and five years, we could not demonstrate that children who had separations between the ages of six months to five years failed in placement more frequently than those with separations between six and eighteen years.

We did find, however, that more children who were successfully placed had first separation experiences before six months, while more children who failed in placement had first separation experiences between six months and five years. The difference was statistically significant. It gives some indication for support of our hypothesis

that age at time of earlier separations is related to later adjustment in placement. Also, it implies, as was expected, that a separation under six months of age carries less potential for failure in placement than separations occurring between six months and two years.

It was difficult to assess the length and duration of separations due to incomplete material. However, we did find that the children who failed in placement and the children who were placed in state mental and penal institutions had slightly more separations from their parents through desertion, divorce, and separation than the children who were placed successfully. The difference was slight and was not statistically significant. Children who were never placed had by far the largest number of permanent separations from their parents.

Except for the factor of "parental separations" no other type separation seemed related to later adjustment in placement. Scatter of separation experiences was large, and that, in addition to the small sample size, made it impossible to compare different types of separations.

As expected, the early separation experiences of the parents affected the parent's decision about placement of his child. More parents who had early childhood separations went along with the plan to place their child than parents who had had no such experiences. This difference between parental groups was statistically significant.

Hypothesis 2

The second hypothesis, concerning follow-up activity of the clinic, was more readily testable and proved ultimately to be more productive in terms of significant findings.

Increased direct contact with the parents during the follow-up period was not significantly related to more frequent placement of the

child. Where there have been use of telephone contacts with the parents, more children were placed, but this finding was not statistically significant.

Referral of the parents directly to a child placement agency resulted in more frequent placements of the children. This finding was significant. This was the anticipated finding, according to the initial hypothesis.

When the clinic wrote letters to the child placement agencies recommending placement of a child, placement occurred more frequently. The opposite was true of children who were not placed, i.e. fewer letters written to the child placement agencies were related to fewer placements of children. This difference between the two groups, "Placed" and "Never Placed" was significant.

Interagency conferences resulted in more frequent placement of the child, also a significant finding. No attempt was made, however, to compare the varying degrees of effectiveness of different types of collaborative contacts.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

Conclusions

Earlier in this paper, the limitations of this study were described. Some of these limitations were created because of the complexity of the subject matter being considered. Some rested in the faulty methodology of the research itself and in the fact that it was realistically impossible to measure the variables under consideration without potential distortion and inaccuracy. While other authors have done a vast amount of research in this whole area of separation and its meaning to a young child, I continue to feel a gap in our research approach to this issue. We need to continue to make the jump from looking not only at separation as it occurs but how it affects the child's later adjustment. This has been studied but not specifically in relation to the whole area of child placement. Yet we continue to ignore what placement means to a child and what strengths he must have at his disposal to be able to handle this reality situation in his life.

If I were able to repeat this study in a more extensive manner, I would again attempt to relate a child's reactions to placement with his previous separation experiences in an attempt to establish by what criteria a child healthfully integrates previous separation experiences. The data used in this study was not geared towards this specific research project, and if repeated, I would attempt to interview parents

and obtain their views of the child's earlier reactions to separations in the past. Certainly, this method would continue to present problems in terms of the parent's distortions of past events; however, the material gathered might be more accurate for our purposes. Also, we might be able to obtain some picture of the parent-child relationships at least at the time of placement. This might help us to draw some conclusions about the earlier parent-child relationship.

Recommendations

In terms of this research study, there is very little to be said about the significance of its findings. Perhaps its contribution, like any research, is broader than its small sample size in that it raises far more questions than it answers. How do we determine how well a child has handled separations in the past as we prepare him for placement? How do we help a distraught parent who comes to a clinic or a child placement agency in search of help for his child when his own childhood has been plagued with separations and deprivation? How do we recognize, too, that strangely enough the young child enjoys a splendid resilency, and he can, at times, tolerate and handle greater stresses than we ever considered possible? In other words, by what criteria can we estimate a child's capacity to integrate healthfully previously separations so that placement can be beneficial for him?

Yet we cannot continue to fool ourselves either, for as we reflect on the parents and children involved in this study, we can see a vicious cycle being created in front of our eyes. Twenty-six of these children's parents experienced severe separations during their childhood. Twenty-five of these children were removed from their own homes and were placed.

And what of their children, and where will the chain be broken? Certainly for some of these children placement may have been for them a flight into health. But how do we weigh the two sides of the scale, and will placement ultimately solve the problem for the majority of these youngsters? These frightening facts have to ultimately force us to question the values of placement for a child, and further, it must challenge us to find new ways of coping with old but ever present problems.

If the cycle is to be broken, removing the child from his home does not break the chain; it strengthens it all the more. The collaboration which resulted in the ultimate placement of twenty-five youngsters is to be recognized and lauded. How much more could we accomplish, however, if this collaborative effort were directed towards salvaging whatever strengths remained in the child and the parent, with the child in his own home? Is placement to be the panacea or is it possible to start from scratch and build on the minimum strength which the parent has to offer the child?

Certainly in some cases, placement is by far the best possible plan for the parent and the child. Some of these children could not be cared for in their own homes because of the degree of their pathology. Similarly the child who is mentally retarded can often fare better in a structured environment which is suited to his capacity and potentials. At home, such a child must contend with community pressures and unrealistic expectations on the part of his parents so that once removed from this environment, the child can be more relaxed and more prone to benefit from such a realistic placement setting.

For the children who might have been helped at home rather than

having been removed from their parents' home, the only community resource seems to rest in the increased protective work being done by our child placement agencies. Our out-patient clinics cannot pick up the slack here (2, 6, 30). They, too, have had to limit their functions, and are of necessity focusing their resources on patients that can utilize the kind of service which they can realistically offer. For the child placement agencies, protective work aimed at preventing placement of the child can be a very frustrating service, but it does not seem to have any greater potential for disappointment and frustration than our present dilemma. Clearly, this is the focus of our present child placement agencies, but such efforts cannot be done by such agencies alone. It must be accepted by all community agencies so that all potential resources are available for the family. Only in this way, through combined community effort, can we hope to ever break the chain of human events, so that somehow parents can be given the strength to prepare their children for adulthood.

APPENDIX

Study of Children's Cases from 1960-1962 in which Placement was Recommended by the Diagnostic Conferences in a Psychiatric Out-Patient Clinic

Name of Child__________________ Date of Diagnostic Conference____
Birthdate__________ Religion__________ Race______ Case No.______

Mother's Name__________________________ Birthdate______________
Father's Name__________________________ Birthdate______________

I. Developmental History

A. Oral Phase

1. Was child breast fed?_____ At what age was he weaned?_______

2. Was child bottle fed?_____ At what age was he weaned?_______

3. At what age did child get first tooth?__________________

4. Other information about first year's development with ages when possible.

____

____

____

B. Motor-muscular Phase

1. At what age did child sit up?__________________________

2. At what age did child turn over?_____ Crawl?_____ Walk?______

3. At what age was child bowel trained?____________________

4. At what age was child completely trained?____ Day?___ Night?___

5. Age when child first began to babble?____ spoke first words?___

Phrases?________________ Sentences?__________________

6. Other information about this phase of development with ages when known.

____

____

C. Genital Phase

1. Did child show curiosity about his own body?______When?______
2. Curiosity in anatomy of opposite sex?__________When?______
3. Interest in reproduction?____________What age?________
4. Masturbatory Behavior?______________What age?________
   a. Menstration______Age_____Breast development?___Age_____
   b. Beard growth?_____Age_____Change in voice?_____Age_____

II. Family Group

A. Ages of child at birth of siblings?____________________

B. Who cared for child?__________Did child stay at home?_______

C. Reaction of child to separation, if known.________________

____

D. Is child adopted?__________Age when placed in home?________

E. Is child living with a relative other than natural parents at the time of the diagnostic conference?________Specify__________

F. Was child living in an emergency shelter at the time of diagnostic?______________________________

III. Separation Experiences

A. Has child ever been hospitalized?__________Ages?__________

Was surgery involved?________How long hospitalized?________

B. Has mother ever been hospitalized, aside from pregnancy________

Age of child at time?_________Who cared for child?_________

How long was mother gone?_________Did child stay at home?_____

C. Have either the father, sibling, or other relative in home been hospitalized?

Specify which one __________ Age of child? __________

D. Deaths in the family. Specify who died. __________

__________ Age of Child? __________ Did child have to move? __________

E. Were parents divorced? __________ Age of child? __________

Does child see other parent? __________ How often? __________

F. Remarriage of mother? __________ Age of child? __________

Remarriage of father? __________ Age of child? __________

G. Have siblings left the home? __________ For how long? ___ Age of child ___

H. Other known separations __________ Age of child? __________

I. Any observed reactions in the child at the time of any of the above separations? __________

____

____

____

IV. Parents' Separation Histories

	Mother's Age at Time of Separation	Father's Age at Time of Separation
A. Death of mother.		
B. Death of father		
C. Divorce of parents		
D. Separation of parents		
E. Placement		
F. Death of Sibling		
G. Other known Separations		

____

V. Activity of Clinic during Follow-up Period

A. Contacts with Parents.

1. Letters to both parents?________Mother?______Father?________

2. Telephone contacts with both parents?_______Mother?___Father?__

3. Interviews with both parents together?___Mother?____Father?__

4. Was parent given name of child placement agency?_____________

What agency was family referred to?_________________________

B. Contacts with Other Agencies

1. Letters to other agencies?_________Which Agencies?__________

____

2. Telephone contacts with other agencies?____Which agencies?___

_____________________No. of contacts.____________________

3. Interagency conferences?___________Which agencies?__________

VI. Placement Information

A. Was child placed?_________________Date of placement?__________

B. What kind of placement?_____________________________________

C. Was placement voluntary or involuntary?_______________________

D. Was child removed prematurely by parents, without permission of placement agency?____

E. Was child removed from placement because of his behavior?________

if yes, why?____

____

F. How many placements has child had since diagnostic conference?

____

G. Where was child staying on December 31, 1963?__________________

H. Were parents prepared to accept placement, but no facilities were available?____

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