Family participation in the residential treatment of emotionally disturbed boys at the Regional Children's Centre, Windsor, Ontario.

Mary Theresa Poole
University of Windsor

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LA THÈSE A ÉTÉ MICROFILMÉE TELLE QUE NOUS L'AVONS RECUE
FAMILY PARTICIPATION
IN THE RESIDENTIAL TREATMENT OF
EMOTIONALLY DISTURBED BOYS AT
THE REGIONAL CHILDREN'S CENTRE,
WINDSOR, ONTARIO

by

MARY THERESA POOLE
and
RONALD DENNIS DOWHANIUK

A Thesis
submitted to the Faculty of Graduate Studies
through the School of
Social Work in Partial Fulfillment
of the requirements for the Degree
of Master of Social Work at
The University of Windsor

Windsor, Ontario, Canada
1980
Committee Members:  D. Rosemary Cassano, M.S.W.
Chairperson

John LaGaipa, Ph.D
Member

Robert G. Chandler, M.S.W.
Member
ABSTRACT

FAMILY PARTICIPATION
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and
Ronald Dennis Dowhaniuk
ABSTRACT

The purpose of this study was to examine family participation as a factor in the residential treatment of emotionally disturbed boys. The researchers developed two hypotheses in order to investigate the above area. Hypothesis one: the child's post-discharge social adjustment will positively correlate with family participation in treatment. Hypothesis two: family participation will correlate with demographic factors.

The researchers developed three instruments in order to investigate the two hypotheses. A parent interview schedule and a teacher questionnaire were developed in order to assess the child's post-discharge social adjustment. These instruments were based on several instruments which measure social adjustment of children. Specifically, the Manual of the Bristol Social-Adjustment Guides: The Social Adjustment of Children (1974) by D.H. Stott; and the social adjustment guides developed by Michael Rutter in Education, Health and Behavior: Psychological and Medical Study of Childhood Development (1970) were used. The researchers also developed the third instrument: a case review schedule - in order to assess family participation and to gather specific demographic data.

The sample was drawn from the children discharged from The Regional Children's Centre, Windsor, Ontario, during a one year time span, from June, 1978 to June, 1979. Female children and crown wards were eliminated from the...
sample. A sample of 47 cases, remained, from which 21 families were contacted and agreed to participate in the study.

Both hypotheses postulated were partially supported by the research. Home visits by the child were particularly significant in correlating positively with the child's post-discharge social adjustment. Pre-agency involvement was found to be a significant factor in parental involvement. The greater the number of agencies with which the family had had previous contact the less the family participated in the residential treatment of their disturbed child.
ACKNOWLEDGEMENTS

The researchers are indebted to many people for their assistance and support in this research project. Professor D. Rosemary Cassano was instrumental in the development and administration of this study, and her support, advice, sense of humour, and whip kept the researchers going. The original committee members, Dr. J. LaGaipa and Dr. P.K. Chatterjee's advice in instrumentation and support was appreciated; as was Professor R. Chandler's willingness to take over as internal reader when Dr. Chatterjee left on sabbatical leave.

The staff of Regional Children's Centre, particularly Kathryn F. Cianci, Supervisor of Clinical Records, Lillian Shery, M.S.W., Supervising Social Worker, and Dr. J.W. Johnson, Chief Administrator were especially helpful in their support and suggestions for the research.

Professor Bud Hansen's enthusiastic help with the data analysis procedures is gratefully acknowledged. And the project would never have been completed without the support and contributions of Ruby "Magic Fingers" Dowhaniuk who fed the researchers and typed the completed manuscript, (her whip was helpful as well).

Finally, the researchers would like to acknowledge their gratitude to the parents and teachers who willingly participated in the study.

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CHAPTER I
INTRODUCTION

The purpose of this research project is to examine the factor of family participation in residential treatment. The role of the family in the treatment of disturbed children is an area around which much theory has been developed, but in which little empirical research has been carried out.

An interest in this topic was the result of two factors: both researchers specialized in family intervention in their M.S.W. programme, and both had field placements in agencies providing residential treatment services to children. As a result, an interest developed as to the possible applications of family intervention theory to residential treatment. The study was carried out at the Regional Children's Centre of the Windsor Western Hospital Centre as the staff expressed an interest in the study.

Discussions were held with the therapists at Regional Children's Centre in order to assess their concerns and opinions around the use of family intervention in the process of residential treatment. Several therapists who were interviewed felt that family intervention could not be effective as residential treatment confirms the family's identification of the child as the problem. Other therapists interviewed were of the opinion that family intervention was the ideal treatment modality in a
residential setting as the child's disturbance was a result of family dynamics. From their knowledge of family systems theory, the researchers were in agreement with the latter point of view and family participation in residential treatment became a focus of the study.

The therapists who were interviewed also expressed difficulty around involving certain types of families in therapeutic contact. Several therapists suggested that a number of parents had sought help from other sources prior to becoming involved with the Regional Children's Centre. They appeared to the therapists as being disillusioned about the value of further therapeutic contact. Certain therapists also felt that specific demographic factors, i.e., family size, family income, and education may influence a family's commitment to treatment. Hence, the second focus of the study was to investigate the relationship between family participation in treatment and specific demographic information.

The first step in carrying out this study was an extensive review of the literature, which was carried out both manually and by a computer search. The areas of general systems theory, family systems' theory, child development, residential treatment theory, follow-up studies, and social factors are covered in Chapter II, the review of literature.

Chapter III outlines the methodology utilized in this study. Sections in this chapter include classification,
hypotheses, instrumentation, sampling procedure, the setting, and the sample.

Chapter IV reports the results of the research findings. The authors divided the chapter into five sections:

1. A description of the child who was admitted into residential treatment;

2. A description of the child's family;

3. A description of family participation in treatment;

4. A description of follow-up provided by the Regional Children's Centre; and

5. A description of the child's post-discharge social adjustment.

In chapter V the authors interpreted the findings reported in the previous chapter. Two main headings were used according to the two hypotheses used in this study, i.e.:

1. The child's post-discharge social adjustment will correlate positively with the amount of family participation in treatment; and

2. Family participation will correlate with demographic factors.

In chapter VI the authors discuss: the conclusions drawn from the research findings, and make recommendations for future research, for policy and practice in the field of children's residential treatment.
CHAPTER II

REVIEW OF LITERATURE

In this study the child in residential treatment is seen as a symptom of family dysfunction. Family systems theory, which is grounded in general systems theory, provides the foundation on which this assumption, basic to this project, is based. This theory posits that if the family is used as the unit of treatment the treatment will be more successful as the dysfunction is in the family relationship and not in the child. Consequently, in this section the literature pertains to family systems theory and general systems theory. The literature examined will also include child development, residential treatment, follow-up studies, and social factors.

General Systems Theory

Family systems theory evolved out of the concepts of general systems theory. General systems theory was founded in the 1950's by Ludwig Von Bertalanffy. He was impressed by his observation that similar viewpoints and concepts appeared in very diverse fields (1956, p. 1) He attempted to co-ordinate these concepts into a unified form so as to explain how all systems operate. He saw general systems theory as a skeleton theory that outlined similar concepts and ideas from a variety of fields and sciences.

General systems theory attempts to explore the interactions between systems and, its component parts,
subsystems. It attempts to describe how a system interacts rather than why a system interacts. (Watzlawick, 1967, pp. 130-131)

A system is described as: "a set of objects together with relationships between the objects and between their attributes" (Hall & Fagen, 1956, p. 18; Stein, 1974, p. 3).

In this definition "objects" means the component parts of a system, "attributes" refers to the properties of the objects, and "relationships" refers to the link that tie the system together. (Hall & Fagen, 1956, p. 18; Watzlawick, 1967, p. 120)

Systems have several qualities. They have the quality of being open or closed. A closed system refers to the fact that there is no input or output of energies between the system and the environment. (Hall & Fagen, 1956, p.23) Hence, there is no change within the system.

An open system has the quality of exchanging energy between the system and the environment. Therefore, change is an inherent part of the open system. "In other words open systems manifest a great deal of two-directional traffic with the larger environment" (Kantor, 1975, p.11).

The open system has several distinct properties. One being the property of wholeness.

Every part of a system is so related to its fellow parts that a change in one part will cause a change in all of them and in the total system. That is, a system behaves not as a simple composite of independent elements, but coherently as an inseparable whole (Watzlawick, 1967, p. 125).
A second quality of the open system is that of feedback. Feedback is a process by which a system informs its component parts how to relate to one another and to the external environment in order to facilitate the correct or beneficial execution of certain system functions (Kantor, 1975, p. 12; Watzlawick, 1967, pp. 126-127).

French states that, systems maintain their integrity through the use of feedback loops - arrangements of components that serve to move information from consequences to decision-maker, thus permitting the organism to correct deviations and stay on course (1977, p. 20).

Another quality of open systems is that of equifinality. This concept delineates that certain conditions of a system can be achieved through different means, that is, they are not determined by their original states. Simply stated this principle of equifinality means that the same results may spring from different origins, because it is the nature of the organization which is determinate (Watzlawick, 1967, p. 127).

It is the nature and quality of the relationship within the system and the relationship of the system with the larger environment which is determinate of the results and not the individual initial conditions.

**Family Systems Theory**

Family systems theory developed out of a number of disciplines such as psychiatry, psychology, anthropology, sociology, and social work. Increasingly mental health professionals began to examine the person-in-situation rather than the intrapsychic conflicts of the person.
Social workers like Mary Richmond and Charlottte Towle played a role in this development as they placed increasing emphasis on the significance of the family. As a result, the child guidance movement began in the 1920's which placed emphasis on the mother-child relationship. (Stein, Monograph One, p. 7)

Increasingly authors took note of the role that fathers played in the family. Writers such as Bowen, Jackson, Bateson, and Haley researched the families of schizophrenics and were able to delineate a pattern of family interaction which lead up to this system. Hence, family interaction became the focus of attention.

Authors and practitioners such as Satir (1967), developed a theory of family process. The family began to be the focus of treatment; particularly when an emotionally disturbed child was a presenting symptom. Minuchin (1974, 1978) wrote of the family dynamics of the psychosomatic child.

In the past twenty years, family systems theory has developed into several different and distinct schools; however, there are basic concepts which tie them together.

The family system is a living system.

Living systems are made up of matter and energy organized by information and they exist in space and time. They have boundaries which are at least partially permiable, thus permitting transmissions of matter, energy or information to cross them (Stein, 1974, p. 5).

The family is the most common and yet the most
varied and complex unit in our society.

Kantor states,

we contend that family systems, like all social systems, are organizationally complex, open, adaptive, and information-processing systems (1975, pp. 10-11).

By organizationally complex Kantor means that the relationships between family members are neither static or unchanging but rather they are "circular that is, reciprocally influencing" (1975, pp. 10-11).

By open Kantor means that family system manifests a great deal of two-directional traffic with the environment. Adaptive means the family is able to adjust to stress which may impinge on its functioning. Thus the family has the qualities of a system as defined by Hall and Fagen, i.e., flow of energy, wholeness, feedback, and equifinality.

Minuchin states the same:

It [the family] is a natural social group which governs its members' responses to inputs from within and without. Its organization and structure screen and qualify family members' experience. In many cases it can be seen as the extracerebral part of the mind (1974, p. 7).

From another perspective Minuchin states:

The individual who lives within the family is a member of a social system to which he must adapt. His actions are governed by the characteristics of the system, and these characteristics include the effects of his own past actions. The individual responds to stresses in other parts of the system, to which he adapts; and he may contribute significantly to stressing other members of the system. The individual can be approached as a subsystem, or part, of the system, but the whole must be taken into account (1974, p. 9).
Keys to understanding the family as an interacting system are the concepts of feedback and homeostasis.

Feedback is,

a process by which a system informs its component parts how to relate to one another and to the external environment in order to facilitate the correct or beneficial execution of certain system functions (Kantor, 1975, p. 12).

Jackson termed this as the rule of relationships within the family (1965, a, b) Rules of family interaction develops over time and establishes a pattern or redundancy. Homeostasis describes the stabilization of these rules.

Satir (1967) writes:

a. According to the concept of family homeostasis, the family acts so as to achieve a balance in relationships.
b. Members help to maintain this balance overtly and covertly.
c. The family's repetitious, circular, predictable communication patterns reveal this balance.
d. When the family homeostasis is precarious, members exert much effort to maintain it (p. 1).

She goes on to state that the marital relationship influences the character of family homeostasis.

The marital relationship is the axis around which all other family relationships are formed. The mates are the 'architects' of the family. A impaired marital relationship tends to produce dysfunctional parenting (pp. 1-2).

The families who are the subjects in this study have all had a child admitted into a residential treatment program. The child has been identified as a disturbed person in need of help.

From a family systems perspective, however, the child is viewed as the product of a disturbed or
dysfunctional relationship within the family unit.

The Identified Patient is the family member who is most obviously affected by the pained parental relationship and most subjected to dysfunctional parenting.

a. His symptoms are an 'SOS' about his parents' pain.

b. His symptoms are a message that he is distorting his own growth as a result of trying to alleviate and absorb his parents' pain (Satir, 1967, p. 2).

Also,

In this instance, the child's symptoms are considered to be the result, or the product of a disturbance or disruption in intrafamilial relationships and interactions, rather than the product of intrapsychic conflicts. Conflicts within the individual child, then, are viewed as being the end results rather than the causes of a disturbance (Stachowiak, 1965, p. 125).

A common pattern with these families is that of scapegoating. Defined by Random House Dictionary scapegoating means "a goat on whose head the high priest laid the sins of the people." This is, of course, a biblical definition of the term, however, the imagery it conjures up is particularly effective. The goat is sacrificed for the sake of the people as in families in which an identified client is sacrificed for the sake of the family members. In other words "scapegoating is a mode of adjustment whereby one person casts blame for his inadequacies on another who, for his own needs, accepts the role of the scapegoat, or person blamed" (Cornwell, 1967, p. 1862).

The scapegoated child performs several functions for the family. (Vogel & Bell, 1968, pp. 424-425) For the parents scapegoating helps to stabilize the marital
relationship by focusing the attention onto the child. In this way attention is drawn away from the parents' marital conflict. The child is being used as a means of preserving his parents' marriage. (Vogel, 1960, p. 12) Secondly, as conflict between parents is kept to a minimum the parents are better able to handle the obligations of the wider community. The function of the scapegoat is to maintain family solidarity.

By focusing on one particular child, the families were able to encapsulate problems and anxieties which could potentially disrupt various family processes (Vogel & Bell, 1968, p. 425).

The main contention behind the scapegoat concept is that there is strong tension between the two parents, and they are unable to resolve their conflict. The child becomes involved in the conflict in order to drain off some of the tension and establish a family homeostasis even though it may be dysfunctional. (Vogel & Bell, 1968, p. 413)

Satir provides an interesting analysis of the family dynamics of scapegoating. Basically she states that the parents are not getting their needs met by their spouses, and therefore seek to get them fulfilled by their children. (1967, pp. 1-62)

Usually this dynamic develops out of an uncultivated marital relationship. She states that in these families each parent enters the relationship with low self-esteem, which they have inherited from their parents. They both
hold to illusion that the other spouse is strong and will be able to support their low self-esteem and sense of insecurity. Communication of these fears are kept underground, as they are fearful that to expose their thoughts or feelings will destroy themselves and their marriage. (1967, pp. 9-10)

When children come into the family they become a means by which the parents get their needs met, and raise their self-esteem. They see the child as "a vehicle for representing their worth in the community and for maintaining esteem about self and family" (Satir, 1967, p. 28). The child becomes an extension of the parent to be used to fulfill his needs. With both parents, however, seeking the coalition of the child or children a conflict arises as to whom the child will serve.

In addition to the problem of who will side with whom in the family triangle, we have found that the mates themselves seem to share the same basic conflicts even though they may often appear at opposite poles in relation to each other (Satir, 1967, p. 31).

As both parents are at each end of the conflict they disagree on many subjects including basic disciplining and care of the child. This results in inconsistency of rules and basic care of the child. (Satir, 1967, p. 31; Vogel & Bell, 1968, p. 420)

Vogel and Bell describe two different types of inconsistencies. "The most common inconsistency was between the implicit and the explicit role induction (1968, p. 420)."
In other words, the parents contradicted each other by explicitly punishing their child for a behavior while at other times they implicitly supported the very behavior that they had criticized. The implicit permission can take many forms, i.e., failure to follow through on threats, delayed punishment, acceptance of the symptom, and offering secondary gradification to the child.

Another more overt type of inconsistency is when one parent encourages a certain type of behavior and the other parent opposes the behavior. Again the child becomes caught up between the marital conflict. "This also permits one spouse to express annoyance to the other indirectly without endangering the marital relationship" (Vogel & Bell, 1968, pp. 420-421). The child is forced into trying to maintain a balance between two warring parents.

As the child grows up in such an environment he soon internalizes these conflicted behaviors. This sets a vicious cycle in motion.

Once a child was selected as a deviant, there was a circular reaction which tended to perpetuate this role assignment. Once he had responded to his parents' implicit wishes and acted in a somewhat disturbed manner, the parents could treat him as if he really were a problem (Vogel & Bell, 1968, p. 422).

Why is a specific child in a family chosen to be a scapegoat? Vogel and Bell (1968, p. 416) listed several reasons: child's position in sibling group, certain physical or intellectual characteristics, sex, and the
value-orientation conflict between parents.

The researchers of this study believe that in order to resolve the symptomatic problems of a child, a family therapy approach is most beneficial.

Family therapy is largely based on the premise that the symptomatic behavior of the identified patient is merely a symbolic representation of a disturbed system of family relationships. It would then follow that psychotherapy will be most effective if it is oriented toward bringing about changes in the family system (Stachowiak, 1968, p. 124).

Stachowiak continues on to state:

The inclusion of both parents is seen as being an important requirement, even though the identified child patient himself may not be directly involved in the treatment process (p. 124).

Family therapy does not necessarily mean that the therapist will only see the whole family. It is more important that the therapist take a family interaction focus when interviewing. The therapist may work with the marital pair, a dysfunctional triad, the parents in a parental group, or in a multiple family group, depending upon individual circumstances and the therapist's bias. (Stachowiak, 1968, p. 124)

The family therapist attempts to: 1) shift the problem focus from the symptomatic child to family problems; 2) expose family myths; 3) explore relationships in parents' family of origin; and 4) free the children from their role as judge, mediator, or decision maker for parents. (Spark, 1968, p. 117) The family therapist takes
a positive stance, i.e., family is stuck in a dysfunctional relationship pattern, however, through their own strength and power to grow they can change.

The body of literature available on family systems theory suggests that the family therapy approach can be effective especially when treating children. Children in residential treatment have been labelled as so problematic that they have been removed from their home. The child, however, is the symptom of a 'deeper' dysfunction in the family system. Therefore, it appears essential that the parents participate in residential treatment if the child's problems are to be resolved.

Child Development

The population of this study includes a large age span; 7 to 18 years of age. This age group can be broken down into two basic age groups: the school aged child, and the adolescent.

Erikson states the main focus of development for the school age child is the working out of the industry versus inferiority dilemma. (1963, pp. 258-261) As the child enters the school from the safety of home he faces a world with a new set of rules. He must learn to survive in a world which will now evaluate him in relation to those around him.

Erikson states the child faces the potential to realize his sense of industry, or worthiness in the things
he does.

He now learns to win recognition by producing things... He develops a sense of industry...
... He can become an eager unit of a productive situation. To bring productive situation to completion is an aim which gradually supercedes the whims and wishes of play (Erikson, 1963, p. 259).

On the other side of this dilemma is the sense of inferiority. If the child is not able to achieve a sense of industry he will feel inferior. A feeling which may possibly greatly effect his personality development.

The child's danger at this stage, lies in a sense of inadequacy and inferiority. If he despairs of his tools and skills or of his status among his tool partners, he may be discouraged from identification with them... (Erikson, 1963, p. 260).

Children with learning disabilities or other factors which complicate their ability to function at their peer level could result in a sense of inferiority and thus disturb their intellectual and emotional development.

The child enters a new stage in which peer interaction is thrust upon him, hence, he must learn to survive in cooperation with others around him. He develops a sense of belonging;

the assurance a child gains of being an accepted and integral part of the group and of the broader society, in contrast to feeling like an outsider. ... It concerns an identification with the society in which a person lives and a commitment to its values and ethics (Lidz, 1976, pp. 275-276).

Lidz states that in this stage of development the child also develops a sense of responsibility. "It involves a willingness and capacity to live up to the
expectations one has aroused" (1976, p. 276).

The child at this stage of development is gaining a clearer concept of the self; in particular with relationships to peer groups and achievement.

**Adolescence**

The adolescent is primarily concerned with his identity. Erikson states that adolescents face an identity versus role confusion crisis. (Erikson, 1963)

The sense of ego identity, then, is the accrued confidence that the inner sameness and continuity prepared in the past are matched by the sameness and continuity of one's meaning for others, as evidenced in the tangible promise of a 'career' (Erikson, 1963, pp. 261-262).

Role confusion manifests itself if the adolescent is unable to establish a satisfactory sexual identity and occupational identity.

Lidz states there are three stages in adolescence: early, middle, and late. Early adolescence is characterized by a growth spurt, however, their patterns of behavior is essentially the same as the preadolescent. Middle adolescence is marked by the movement towards the opposite sex. In late adolescence the person is concerned with planning their future. This is done by sampling identities, career exploration, and a desire for intimacy (1976, p. 311).

The essential work of adolescent is the establishment of an identity in relation to occupation and sexual intimacy. The adolescent does this through a process of reintegration and reorganization of thoughts and feelings.
so that they might move from childhood dependency to adult responsibility.

It becomes clear that the child has many developmental tasks which he must master as an individual as well as functioning as a member of a family system. A disturbance in the family system will result in making these developmental tasks difficult for a child to carry out. For example, an eight year old child who has been made a scapegoat in a family system will have difficulty mastering the industry versus inferiority dilemma. Children who manifest difficulty in carrying out developmental tasks are frequently referred to a residential treatment centre. Residential Treatment

In this section, areas of residential treatment where family or parental participation is considered important will be examined. These areas are: 1) pre-admission arrangements, 2) work with the family during the course of treatment, 3) weekend visits home, and 4) discharge planning.

Pre-Admission Arrangements

The decision to refer a child to a residential program is not one to be made lightly. The literature suggests that residential treatment is the treatment of choice when the child cannot continue to grow and develop in his home situation, or when the community is unable to tolerate the behavior of the child. (Weinstein, 1974)

However, no residential program can meet the needs of all
children referred to it, and for this reason, an intensive screening process is recommended. Weinstein suggests that the child and his family should be involved in outpatient treatment for this purpose.

The Menninger Clinic (1969) suggests that the factors leading up to a referral for residential treatment may relate to the entire family, especially the parents. They [parents] may suspect that it is they who need psychiatric help but come to get help for the child since he is the focal point of disturbance; he absorbs and reflects the conflicts in themselves (p. 24).

For this reason, the Menninger Clinic evaluates the entire family before admitting a child.

"The prospect of a child's admission to a psychiatric residential unit represents a crisis for the entire family" (Weinstein, 1974, p. 54). Mandelbaum (1972) suggests that the parents may interpret the recommendation of residential treatment as meaning that they have been of no value as parents. Because separation is so stressful for the parents, as well as the child, he suggests that the assessment process should continue until the parents are able to accept separation from the child. He suggests that:

When the study process deeply involves the parents and when their rights for making any decision are held foremost, treatment once embarked upon is less likely to suffer disruption (Mandelbaum, 1972, p. 587).

Thus the child is seen as being more likely to remain in treatment as long as necessary if separation issues are dealt with prior to admission.
A pre-admission process is also seen as necessary to facilitate parental understanding of the residential treatment program.

Parents are confused as to what a children's residential program is like, and are threatened that they will be accused of being inadequate or incompetent people (a feeling many possess) (Weinstein, 1974, p. 60).

He suggests that the parents and their child should become gradually introduced to the program by a series of pre-placement visits. He also sees the assessment/admission process as laying a base for work with the parents during the actual residential treatment.

Family systems theory suggests that work with the system must continue particularly with the identified child and parents, if intervention is to be successful. This perspective is also supported by the literature on residential treatment. Evangelakis (1974) states:

I believe that it is the parents' interest and concern which motivates the treatment process and that a child becomes an active participant only after the parent has become involved in the plan (p. 77).

Increasingly, the literature suggests that family therapy is the treatment of choice in residential facilities, in contrast to earlier writings which advocated a "child guidance" model wherein parents were seen separately from the child.

In a 1972 report, the American Association for Children's Residential Centers stressed the importance of evaluating and treating the family of the disturbed child.
There seems to be consensus in the field of residential treatment that the family of the child requires thoughtful and comprehensive attention, and that treating only the child may seriously neglect other deeply troubled members of the family and may seriously neglect the difficulties of the family in their functioning as a unit and in the community (p. 118).

They further suggest that ongoing involvement with the family has the two-fold benefit of facilitating more constructive parent-child interaction, and improving the staff's understanding of the child in his environment.

Letulle (1979) reporting on the Menninger Clinic experience, suggests that family therapy aids in integrating the treatment process, and that knowledge of the child's family environment will produce better understanding of the child, and thus better treatment.

Koret (1973) suggests that family therapy is the treatment of choice for the child in residential treatment. He suggests that family therapy will benefit the parents as well as the child.

They are no longer relatively impotent participants dependent upon therapist or caseworker for a lifeline of understanding with their children. They can actively construct or alter relationships, the rationale for which they can observe in a human but scientifically presented family pattern (p. 237).

Weisfeld and Laser (1977) discuss the use of family therapy with divorced parents in a residential setting. They stress that involving both parents is necessary for successful treatment of the child.

We concluded that our avoidance of the divorced
parent outside the home increased the possibility of recidivism in the child and in the future malfunctioning of the family and that including both divorced parents in the family therapy component of the program gave the family a greatly increased opportunity for success (Weisfeld & Laser, 1977, pp. 230-231).

Matsushima (1965) suggests that parental participation in treatment of the child is of paramount importance in determining success of treatment. He suggests that children tend to idealize a missing parent, and that contact with the parents facilitates the child dealing with reality. "In our view, the paramount treatment advantage of contact with parents is the continuous reality of parental proximity to the child" (p. 275). He also suggests that working with the family increases the likelihood that the child will maintain treatment gains after discharge.

Although it is acknowledged that parents may not be able to modify consciously their handling of a child, overall strengthening of the family may result in a less stressful situation (p. 275).

Much of the literature on psychotherapeutic treatment of children stresses the role of parents in the development of pathology. Wolman (1975) states that "the intraparental relations of the sick family are probably the main cause of the difficulties so many children have in their lives" (p. 150). He describes three clinical types of families associated with disturbed children. These are 1) parents who expect their children to meet all of their needs, 2) rejecting parents, and 3) parents who inconsistently accept and reject their child. It would follow
then, that dealing with these issues with the parents would benefit the child.

Barnes, in discussing "parental force" in treatment, suggests that the child's relationship to his parents and their parenting of the child is of primary importance.

The need of a child for adequate parenting takes precedence by far over any other, and when it is not met, to at least a minimal degree, it presents both the child and the potential therapist with a difficult, often unsoluble, practical and theoretical problem (1972, p. 133).

In a 1961 article, Cohen, Charney, and Lembke discuss parental issues to be dealt with if the child's therapy is to be successful.

The parents of these children are almost always motivated in their search for help by serious unconscious resistances which reflect and derive from the original distortions of the child's needs which were central to the development of his problem (p. 477).

They suggest that parental conflict generally falls into one or more of the following categories:

1) Conflict over unresolved dependency needs.
2) Conflict over the emerging impulse life of the child.
3) Conflict over destructive or rejecting impulses toward the child.
4) Conflict resulting from confusion of the basic identity of the child.
5) Conflict over unresolved impulses toward their own parents and/or society (pp. 472-475).

If these parental difficulties are not resolved, it is unlikely that the child's treatment will be successful.

There is also much reference in the literature to
utilizing the parent in treatment of the child. Goodman (1975) describes a program used at the New Hampshire Hospital, where parents are trained in behaviour management and modification techniques to use with their child, in conjunction with individual and milieu therapy for the child. Goodman found that in contrast to a control group where parents received no training and reinforcement in child management skills, children in the experimental group were ready to be discharged approximately three months earlier.

Reisinger, Ora, and Frangia (1976) after reviewing the literature on the utilization of parents as change agents for their children concluded that the theoretical orientation of the therapist determined, in large part, the extent to which parents were utilized as change agents. However, they found that in all three models reviewed (behavioural, psychodynamic, and client-centred) acknowledgement of the potential usefulness of the parent was made. "The degree of such acknowledgement has ranged from the recognition that parental consent is necessary for treatment to the explicit advocacy of parents as primary change agents" (p.116).

Goocher (1975) states that the residential treatment setting at Edgefield Lodge, Oregon, has three components: "academic, living on unit, and parent effectiveness training" (p. 85). The parents are trained in behaviour management techniques to be used in the home.
The overall goal of the parent-training behavior setting is to shift the child's behavioral milieu from aversive or inappropriate consequences for symptomatic (disruptive) behaviors to a positive environment surrounding the child because he is now meeting the expectations of his family environment (p. 86).

Goocher states that "in part, the child's progress through the program is determined by his parents' performance in designing and implementing home intervention programs" (p. 89). To complement the parents program, Edgefield Lodge operates on a five day week so that both parents and child have an opportunity to practice new skills in their natural environment.

**Weekend Home Visits**

The subject of weekend home visits is an area of some contradiction in the literature. Generally, however, long term treatment facilities, where children remain up to five or more years, do not utilize the weekend home visit extensively. This is also true for almost all facilities when the child's parents are also seriously disturbed, and visits are likely to be harmful for the child, emotionally or physically. (American Association for Children's Residential Centers, 1972; Evangelakis, 1974)

However, the majority of available literature is in favour of home visits, and this is especially true for short-term facilities. Evangelakis (1974) feels that there are several advantages to weekend and holiday home visits. "It keeps the family fully aware of the child's problems and their own feelings about them" (p. 316). In addition, home visits will help to decrease the child's feeling of
being rejected by his parents, and facilitate discharge planning as the parents will be aware of their child's present functioning.

Weisfeld and Laser (1976, 1977) have described the residential program at Alpha House, which operates on a five day week with weekend home visits.

The visits facilitate parental involvement in the overall treatment plan for each child, and they complement the program's residential and family therapy aspects in a variety of ways (1976, p. 398).

They feel that maintaining parental involvement with the child is of primary importance, and home visits are "not contingent on fulfilling the requirements of a reward or point system" (1976, p. 398). As parents must change along with their child, "this change is facilitated by making them an essential part of the treatment team" (1976, p. 398).

Weisfeld and Laser also state that home visits are essential in contributing to the gains made by the child. "The program's use of weekend home visits instead teaches him that he cannot run away from his family but rather must confront the problems he finds there" (1976, p. 399).

Koret (1973) is also strongly in favour of weekend home visits, and suggests that they are an integral part of work with the family.

Since his (child's) visits were of relatively short duration, parents and child tended to impose upon themselves constraints that they could not sustain over a long period of interaction. It introduced an increasing awareness of the expectations of each of the principals (p. 259).
Weisfeld and Laser also see the home visits as a preparation for the child's ultimate return to the family home.

Interaction between family members during weekend visits supports the residential treatment process through which children and their parents learn new psychological and social skills. It is the authors' opinion that such support is crucial to the ultimate success of a treatment program (p. 400).

**Discharge Planning**

Discharge planning is an integral part of the residential treatment program.

It (discharge planning) includes the home to which the child is to be discharged (family, foster home etc.), the school he will attend, and the responsibility of a plan for continued treatment after discharge (Evangelakis, 1974, p. 80).

All aspects of the child's future living arrangements must be carefully planned for and organized, if the child is to maintain the gains made in the course of treatment.

If the community has few or no resources designed to offer the child and his family further treatment and protection against current and future conflicts, the work of the residential treatment center may be placed in jeopardy. Thus it is important to have good outpatient treatment facilities, good boarding homes, good group home facilities, good educational programs (American Association for Children's Residential Centers, 1972, p. 124).

This extensive planning is especially important for children who are returning to a less than ideal home environment. These children in particular will require as much structure and support as the community is able to provide.

Often these are children from deprived social environments who have received treatment and have been able to benefit in many respects,
yet have to return to their former living situations and try to get along with their families and others in the community. Although work with the parents of children in residential treatment is, in most instances, recognized as being necessary to the child's functioning after he leaves the center, not all parents are willing or able to be involved in therapy. Some children who were treated at the center and have returned to their homes are asked in a sense to be therapist to their family. This is a great responsibility for a child, and such situations point up the importance of having sources of continued treatment and support available for these children (Evangelakis, 1974, p. 85).

Just as separation from parents is an issue in placing the child in residential treatment, separation from the institution may become an issue at discharge.

Because leaving the center is in itself an emotionally charged event for the children, careful preparation is required before they return to their own homes or are placed in foster family, group home or other institutional care (Evangelakis, 1974, p. 80).

The child needs to be given an opportunity to work these feelings out.

The family too has many adjustments to make as the child's discharge impends.

The parents should have an opportunity to express all of their mixed feelings and apprehensions about the possibility of their child coming home and living with them. This can be done adequately only when their has been a process of work with the family and where the ambivalences have been carefully explored by both the family and the staff members (American Association for Children's Residential Centers, 1972, pp. 122-123).

Some of the child's and family's uncertainties about upcoming discharge will be eased or eliminated through the
use of weekend home visits. "Going home each weekend facilities his smooth transition from a residential to a family setting" (Weisfeld and Laser, 1976, p. 400).

Follow-Up Studies

Few follow-up or outcome studies of children in residential care are carried out. A number of difficulties face the researcher. Most residential centers focus on treatment; hence, they have little interest in research. (Johnson, et al., 1976, p. 282)

Because of this the staff at residential treatment centers are resistant to research. Research studies are seen as foreign, and ongoing conflict between evaluation staff and practitioners can sometimes occur. (Johnson, et al., 1976, p. 285)

As most treatment centers have no built-in research or evaluation programs further problems arise. Records often lack the information necessary to carry out meaningful research. Records are often vague and descriptive rather than concrete and goal-oriented which would make evaluation and research easier. (Johnson, et al., 1976, p. 282) Researchers would prefer direct behaviour related goals which will often put them in conflict with practitioners who are less goal-oriented.

For example, it is far simpler to determine whether a person is enabled to 'leave his home for at least 30 minutes per day, 5 days each week' than to assess whether he has achieved greater self-confidence and trust in adults. Evaluation therefore favors theoretical orientations that emphasize
observables in behavior over orientation that stress mediating intrapsychic interpersonal variables. As a result, the advent of evaluation is frequently accompanied by considerable staff tension and disagreement, because the clinical modes of evaluation are incompatible with the empirical thrust of the evaluation (Herstein, 1975, p. 144).

There are also specific dangers when doing research in treatment settings. Most agencies are receiving more public funds in order to operate. This results in a cry from the community for concrete benefits from the treatment facilities. Hence this could change the focus of some agencies to quantitative results and ignore the qualitative aspects.

Since evaluation presses toward concrete results, it may ignore the less-tangible qualities of object-relatedness, problem-awareness, trust, insight. . . . The benevolence component of residential treatment may become eroded, because it has come to be regarded as nonmeasurable and hence, inconsequential. Happiness, love, warmth, nurturance, intimacy, pain, anguish may cease to be vital aspects of group living. . . . Since program evaluation as a basis for financing tends to implicate the totality of institutional life, there is a danger that these qualitative aspects may erode through disuse (Herstein, 1975, p. 145).

A second danger is that evaluation tends to favor externally-imposed goals rather than internally developed goals. "The politics of justification requires the establishment of goals that are primarily community-determined rather than child-centered" (Herstein, 1975, p. 146).

Evaluation tends to focus on output: "Does Johnny read better? Does he behave better?" - rather than on
input, i.e., inner development: "Does he feel better? Does he relate better? Does he trust more?" (Herstein, 1975, p. 146)

The humanistic concern with good care is displaced by the pragmatic concern with good behavior. Sensitivity to the needs of children is the key to nurturance; sensitivity to the needs of the community is the key to evaluation (Herstein, 1975, pp. 146-147).

These difficulties, plus the fact that social welfare researchers are still groping for satisfactory methods of carrying out meaningful research, has limited researchers from attempting treatment outcome studies.

Taylor and Alpert (1975) concluded that children discharged from residential treatment have a more positive adaption to the home environment if they have the continued acceptance and support of his family. "Feeling this acceptance he is more able to cope with internal and external stresses, and continue to develop emotional strength" (p. 29).

Thus family support is extremely necessary if the child is to positively adapt after discharge. Taylor and Alpert also noted that it is parental participation in treatment, i.e., contact with the child and contact with staff, was significantly associated with post-discharge adaption (p. 53).

Davids and Salvatore (1976) in their residential treatment outcome study noted that "a greater percentage of the cases in the 'good adjustment' category had parents who participated in psychiatric casework" (p. 67).
In a study by Genevieve B. Oxley (1977 a, b) "a significant positive association (p < .05) was discovered between the beneficial use of treatment by mothers and the boys adjustment at follow-up" (1977 a, p. 497). Another finding of the study was that a statistically significant positive outcome association (p < .01) was found for boys whose parents recognized their own involvement in their son's problem. "The boys who parents did not recognize their involvement in their son's problem were doing much less well than the other boys at follow-up" (1977 a, p. 497).

Boys who were involved in formal or informal family treatment showed better adjustment at follow-up than those boys who did not experience the process of working through their problems with their parents (Oxley, 1977 a, p. 497).

Oxley's follow-up study concluded that an important first step in treatment was to involve parents and the child "in a long and carefully planned pre-placement study and preparation period" (1977 b, p. 609). The boys whose social workers focused on the reasons why the boys were in treatment during this admission process, were doing better at follow up. (1977 b, p. 612)

In order to treat 'the child in context', it is necessary for an agency to support its philosophical commitment with sufficient funds and allocation of staff time for work with the parents. It is also necessary for the social workers to have a firm belief in, and commitment to, the importance of parents in the treatment system of children (1977 b, p. 609).
Christensen's study on the effectiveness of a family systems treatment program in a residential treatment setting concluded that family members in the family treatment group perceived significantly more family cohesion and less family conflict. Adolescents perceived more social conformity, self-control, family harmony and less social deviency, impulsiveness and family discord (1977, p. 6092A).

Thus children's post-discharge social functioning has been found to be related to parental participation, at some level, in treatment and family support during and after discharge.

Studies also indicate that the best predictor of discharge functioning was the severity of the emotional disturbance.

These findings suggest that the main factors determining outcomes of psychiatric treatment may not be the specific therapies employed, but the kinds of symptoms and behaviors the patients bring with them to the treatment setting (Davids, Ryan, and Salvatore, 1968, p. 475).

More specifically, Taylor and Alpert (1973) indicate that neurotic children have a better outcome in residential treatment than character-disordered and psychotic children and that character-disordered children do better than those who are psychotic (p. 7).

Another factor which was associated with positive discharge functioning was the age of the child at admission. Children who are admitted to residential treatment at a younger age were judged to be making a
"good" follow-up adjustment. (Davids & Salvatore, 1976, p. 67) Taylor and Alpert indicate that younger children adjust better to the institution while in care (1973, p. 6).

Davids and Salvatore also indicate that there was no significant association between the types of therapist and long range variables. It is interesting to note, however, that NSW social workers had a greater percentage of good outcome cases: 40% NSW, 50% PhD. psychologists, and 30% M.D. psychiatrists. (1976, p. 70)

Davids and Salvatore (1976) also indicate that in their study, children who had been in treatment for a period of two years or more reported a good outcome. Children who had been in treatment for less than a year were less likely to report a good outcome.

Outcome studies of children in residential care tend to be largely descriptive. As indicated in Herstein's evaluation Strupps suggests that studies should be more specific. He states the questions raised by researchers should ask: "what specific therapist interventions produce specific changes in specific patients under specific conditions" (Herstein, 1975, p. 144).

Herstein (1975) recommends that that follow-up studies be done on a short-term period following discharge, as determining the effectiveness of treatment is difficult after a long period of time as many intervening external variables may be of greater influence on the child.
Social Factors

In their review of literature the authors were unable to locate information on parental education or occupation and its relationship to emotionally disturbed children or children in residential treatment. Hence, in this section the authors discuss father absence in the home, family size, birth order, and their relationship to emotionally disturbed children.

Wolkind and Rutter (1973) in their study found that children who had been in care came from disturbed family situations and concluded that it was the family difficulties which led to a higher rate of antisocial disorder in the children.

Wolkind (1974) found that children who had an intermittently present or absent father were more likely to have an antisocial disorder.

Watzlawick (1970) indicates that in larger families the identified patient is more likely to be a middle child, rather than the oldest or youngest. Scapegoating in general is minimal when the identified patient is the youngest child; and smaller families tend to use scapegoats less than do medium or large size families.

Gallagher and Cowan (1977) in their study on birth order and school adjustment problems concluded that:
1. First born children were more likely to have fewer problems in school;
2. Middle children showed less acting out problems but exhibit more shy-anxious behaviors or learning problems.
Thus, while there is little literature on the relationship between social factors and emotionally disturbed children, the ones noted exhibited an effect on the child in the family system.
CHAPTER III

METHODOLOGY

The following chapter discusses and explains the research design and methodology used in this study. Specific topics discussed are: the classification of the study, the hypothesis, instrumentation, sampling procedure, the setting, and the sample.

Classification of the Study

In developing the methodology of the study, the researchers elected to utilize a quantitative-descriptive design, of the hypothesis testing subtype. According to Wechsler, Reinherz, and Dobbin there are two major factors operative in the decision as to which type of research design is most appropriate to the study.

The most important factors in the ultimate decision on what type of design should be used are the present level of knowledge about the program, group, or phenomena to be studied, and concomitantly, the degree to which one wishes to be able to generalize the findings of a particular study to encompass a broader group of people, agencies, or programs (Wechsler et al., 1976, p. 65).

Further, a quantitative-descriptive design is appropriate when "the variables in question are known with some precision, but their inter-relationship has not been measured in detail" (Wechsler et al., 1976, p. 66). In reviewing the literature pertaining to this study, an abundance of articles describing theory and beliefs about the residential treatment of children and the value of
family participation, based on clinical experience, was found. However, few empirical studies investigating these theories have been conducted. Thus, variables thought to be significant in determining the outcome social adjustment of children in residential treatment are known, but have not been extensively tested, and a quantitative-descriptive design would seem to be most appropriate for studies in this area.

According to Tripodi, Fellin, and Meyer

the category of quantitative-descriptive studies is similar to that of experimental studies in that both seek quantitative-descriptions among specified variables. Quantitative-descriptions are obtained through the use of measuring devices to describe relationships among variables; hence statistical concepts such as correlation, proportions, and so forth are employed. With respect to the empirical methods employed, quantitative-descriptive studies differ from experimental studies in that they do not use randomization procedures in assigning subjects to experimental and control groups. In addition, they do not employ the experimental manipulation of independent variables (Tripodi et al., 1969, p. 23).

Tripodi et al. state there are four major subtypes of the quantitative-descriptive design. These are: "1) hypothesis testing studies, 2) program evaluation studies, 3) population description studies, and 4) studies that search for variable relationships" (Tripodi et al., 1969, p. 38). Of these possible alternatives, the researchers elected to use the hypothesis testing subtype.

Hypothesis testing studies are those quantitative descriptive studies which contain in their design of research specific hypotheses to be tested. The hypotheses are typically derived from theory,
and they may be either statements of cause-effect relationships or statements of association between two or more variables without reference to a casual relationship (Tripodi, et al., 1969, p. 39).

The Hypotheses

Based on the review of literature, the researchers developed two hypotheses, as described below:

**Hypothesis One:** The child's post-discharge social adjustment will correlate positively with family participation in treatment.

For the purposes of the study the terms "social adjustment" and "family participation" were operationally defined as follows: Social Adjustment refers to the extent to which a child exhibits socially desirable behaviour, including the absence of behaviour indicative of psychopathology, both at home and at school. Family participation refers to any contact the child's parents and/or siblings have had with the child's primary therapist, including both office visits and telephone calls, as well as any direct contact the parents and siblings have had with the child for periods of at least 12 hours (home visits). These definitions were derived from the literature on residential treatment, as well as family systems theory.

**Hypothesis Two:** Family participation will correlate with demographic factors.

The term demographic factors, as it relates to this study, means specific characteristics of the child and his family, specifically the child's age at admission, the
child's birth order, the family size, the parents' education level, the parents' marital status, previous agency involvement, and the existence of financial problems. With this hypothesis, the underlying assumption has been made that family participation is desirable in residential treatment.

It was decided to include this hypothesis in the study as a paucity of information on factors relating to family participation exists in the literature. The factors considered in the term "demographic factors" were selected from the literature available on the dynamic of scapegoating in families, as well as a survey of therapists at Regional Children's Centre. The researchers were concerned that this information could be valuable in determining the prognosis for each child, as well as developing a treatment plan.

Null Hypotheses

The specific null hypotheses to be tested are:

1. The child's post-discharge functioning will not correlate positively with family participation in treatment.
2. Family participation will not correlate with demographic factors.

The level of significance selected for this study was .05. A probability of .05 or less would be interpreted as indicating support of the hypotheses, and rejection of the null hypotheses.

Instrumentation

Three instruments designed by the researchers were utilized in this study: a parent interview schedule, a
teacher questionnaire, and a case review schedule. Each instrument served a different purpose. The parent interview schedule was designed to measure the child’s social adjustment in the home; the teacher questionnaire was designed to measure the child’s social adjustment at school; and the case review schedule was designed to measure parental participation and collect demographic data from the child’s case record.

Development of the Instruments

1. The Parent Interview Schedule; and
2. The Teacher Questionnaire: The researchers initially developed statements indicative of socially desirable behaviour and of psychopathology, based on literature on child development, as well as the work of D.H. Stott in designing The Bristol Social Adjustment Guides (1974) and Michael Rutter in Education, Health and Behaviour (1970). Social workers and psychologists with clinical experience in the field of children’s mental health were also consulted.

These items, once selected, were grouped into categories as follows:

1. The Parent Interview Schedule:
   a) Relationship with parents;
   b) Relationship with siblings;
   c) Relationship with peers;
   d) Participation in group activities;
   e) Attitude towards school;
   f) General behaviour;
   g) General attitude; and
   h) Attitude towards work (to be completed for children no longer attending school).
2. The Teacher Questionnaire:
   a) Relationship with teacher(s);
   b) Relationship with peers;
   c) Attitude towards school;
   d) School behaviour; and
   e) General information.

When this step was completed, the preliminary instruments were submitted to a panel of ten judges, consisting of child care workers, social workers, and psychologists experienced in clinical work with children. The judges were asked to select the three or four most relevant and least relevant items in each section of the instruments, as well as comment upon phrasing, clarity, and any items that were missing but might be relevant.

The judges' results were compiled, and used to select items for inclusion in the second draft of the instruments. Each instrument was pre-tested on four subjects to determine clarity of phrasing.

The parent interview was administered to two subjects by each researcher. The subjects were read each item by the researcher and asked to interpret it. Items that were mis-interpreted in the pre-test were noted by the researchers, and a list of explanations were drawn up to maximize reliability between researchers.

The teacher questionnaire was administered to two teachers in a city school, and to two student teachers during their second practice teaching experience. They were asked to complete the instrument on a child in their class,
and to indicate any difficulty they had in understanding
the items. As no difficulties were reported, the question-
naire was not changed.

Both parent and teacher questionnaires were designed
so that answering "certainly applies" would indicate a
positive, or socially desirable adjustment in some items;
and a negative, or socially undesirable adjustment in
others. Items were scored on a three point scale, with 3
(three) being assigned to the most desirable response and 1
(one) to the least desirable response. The questionnaires
were scored both by section, as well as overall. As not
all items were applicable to each child, the final score
was calculated as a percentage of the total possible score
for the individual child. Thus, the highest score would
indicate the highest degree of social adjustment.
Theoretically, scores on either instrument could range from
33 to 100.

It should also be noted that it is assumed that
both the parent interview schedule and the teacher question-
naire are in fact measuring the child's post-discharge
social adjustment accurately.

3. The Case Review Schedule: The case review schedule was
developed to gather information available in the subjects'
clinical record at Regional Children's Centre. The

*NOTE: Section D on the parent interview schedule and
Section E on the teacher questionnaire were not
included in the scoring as they served to gather
demographic data, not to measure social adjust-
ment.
information gathered included demographic data, such as the child's age at admission, time spent in residence, parents' education level, etc., as well as measures of family participation in the treatment process.

Several assumptions were operative in designing the case review schedule. The first assumption is that other factors operative in the therapeutic milieu of residential treatment were constant for each child, and thus irrelevant to this study. Secondly, it is assumed that recording within the clinical record is accurate, and therefore a valid and reliable source of data. Finally, it is assumed that children were discharged at the therapist's advice, and thus this factor was not included in the data collected.

From reviewing a selection of closed clinical records at the Regional Children's Centre, the researchers became aware of many limitations on the data available in measuring family participation from the clinical record. For example, the researchers' original intention was to compare the effects of parent counselling and family therapy on the child's post-discharge adjustment; however, this information was not readily available, as progress notes consisted mainly of brief summaries of conversations. However, the researchers were still interested in the content of the contacts, and a decision was made to classify contacts by focus. The study assumes that the focus of each contact can be accurately determined from the material contained in the clinical record. Six foci were operationally defined,
as follows:

1. Child Focus: The interview was considered to have a child focus where the content consisted of the therapist reporting on the child's behaviour and/or progress to the parent(s) or vice versa, as reported in the monthly progress notes.

2. Parent-Child Focus: The interview was considered to have a parent-child focus where the content of the interview consisted of discussion of the interactions between the parent(s) and the child in residential treatment, as reported in the monthly progress notes.

3. Family Focus: The interview was considered to have a family focus where the content of the interview consisted of discussion of the interactions between the parent(s) and children other than the child in residential treatment, or between the child in residential treatment and other children in the family, as reported by monthly progress notes.

4. Marital Focus: The interview was considered to have a marital focus where the content of the interview consisted of discussions of interaction between the parents, as reported in the monthly progress notes.

5. Admission Focus: The interview was considered to have an admission focus where the content of the interview consisted of discussion of problems and concerns about the child's admission to the Regional Children's Centre.

6. Discharge Focus: The interview was considered to have
a discharge focus where the content of the interview consisted of discussion of problems and concerns about the child's discharge from the Regional Children's Centre.

The preliminary drafts of the case review schedule were pre-tested by one of the researchers to determine whether it would indeed gather the information required. The case review schedule was revised several times in order to facilitate the collection of data.

The information gathered by the case review schedule was treated in several ways:

1. A raw score for number of contacts and number of home visits was obtained;

2. The raw scores were divided by the number of months spent in residence to determine the average number of contacts and home visits per month; and

3. The average number of contacts and home visits per month was grouped into five categories, as follows:

   i) 0 - 0.50
   ii) 0.51 - 1.50
   iii) 1.51 - 2.50
   iv) 2.51 - 3.50
   v) 3.51+

This was done to facilitate the analysis of data. The same procedure was carried out for child, parent-child, family, and marital focus, as well as assigning each case a focus equivalent to the most frequent focus of contact.

**Sampling Procedure**

A purposive sampling procedure was utilized in this
study. This decision was made in consideration of the limitations of time and money connected with the project. Also, a purposive sample would enable the researchers to generate sufficient data to answer the research questions.

The basic assumption behind purposive sampling is that with good judgment and an appropriate strategy one can handpick the cases to be included in the sample and thus develop samples that are satisfactory in relation to one's needs (Selltiz, et al., 1975, p. 521).

The researchers elected to choose a sample from discharged residential patients at the Regional Children's Centre of Windsor Western Hospital Centre, as this site was readily accessible to them. The Regional Children's Centre, residential treatment program, serves a catchment area encompassing Essex and Kent counties in Southwestern Ontario.

The Setting

The Regional Children's Centre is a diagnostic centre for emotionally disturbed children, for mentally retarded children, as well as for children with organic, learning, and speech disabilities. It offers treatment services to emotionally disturbed children and to children with organic, learning and speech disabilities. The Centre serves both children and their families (Shery, 1979, p. 2).

The Regional Children's Centre of Windsor Western Hospital Centre opened in November of 1970. At this time, it included three residential units totalling 40 beds, as well as outpatient and day treatment services, and was funded by the Ministry of Health. In July of 1977, funding was transferred to the Ministry of Community and Social Services as part of an amalgamation of all children's services aimed
at providing better coordination of services.

The three original residential units were Dunvegan Lodge, for adolescent boys up to the age of 17, Esperanto Lodge, for younger boys, and Chimo Lodge, which served the youngest children, and girls up to the age of 12. Emotionally disturbed girls over the age of 12 years are automatically referred to Maryvale for treatment.

Residential placement in the Regional Children's Centre is a temporary measure and aims to effect changes in psychosocial functioning which will enable the child to return to community living as quickly as possible. Home visits on weekends are planned for all residential children where feasible in an attempt to effect the latter. Once a child is discharged from the residential programme, out-patient follow-up services are offered by the case manager to the child and his family (Shery, 1979, p. 9).

In March of 1979, the planned phase out of Chimo Lodge was begun, as a result of budgetary cut backs. This 14 bed unit was closed in August of 1979, and the children in treatment there were either discharged or transferred to other programmes, such as Esperanto Lodge or the Day Care Programme. All possible resources were used in an attempt to ensure that the therapeutic needs of these children were met.

The treatment of troubled children varies according to the child's needs, the family's needs, and the therapist's training. The child's needs should determine whether play therapy, psychotherapy, group therapy, or family therapy will be the treatment of choice. In all situations an attempt will be made to work with the child's parents (Shery, 1979, p. 7).

Generally, each child in residential treatment is
seen in individual therapy two or three times a week. The parents are seen as often as necessary or possible, generally on a weekly basis.

Children in residential treatment at the Regional Children's Centre also receive special schooling. Children who are functioning at a grade school level academically attend an on-grounds school, with a teacher-student ratio of one to five (approximately). This enables them to receive the attention and special programming they require to work up to their academic potential. Children who are at the high school level academically attend special classes at a neighbouring high school.

The Sample

The researchers elected to choose as a sample children who had been discharged between June, 1978 and June, 1979. It was felt that a one-year time span was appropriate, as this would supply ample cases for the study, and allowed an 11 to 23 month discharge period.

Female children were eliminated from the sample for several reasons. First, female children were a minority group during the time frame selected; secondly, female residential children were only accepted into the programme up to the age of 12 years; thirdly, there seemed to be a possibility that some female children may have been discharged prematurely due to the closing of Chimo Lodge; and finally, the literature suggests that there may be different factors which are important to the social adjustment of
males and females. For these reasons, the researchers felt that including females in the sample population would serve only as a confounding variable.

Likewise, crown wards were excluded from the sample. This was done as the research was focused on the effect of parental and familial involvement during treatment, a variable that could not be available to crown wards by definition. It was felt that other factors would be operative in the post-discharge functioning of crown wards, such as stability of foster placement, and these would serve as confounding variables.

Once crown wards and female children were eliminated from the sample, a total of 47 cases were available to the researchers. Introductory letters were mailed to the parent(s) or guardian(s) of these subjects during April, 1980, and were followed up with a phone call two weeks later requesting their participation in the study. Of these only 26 could be located by phone or by mail. In 21 cases where contact was made with the parent or parents, an agreement to participate was made. In five of the cases where contact would be made, the researchers were refused permission to include the child in their research.

Once an agreement was made to participate in the study, an appointment was made for one of the researchers to interview one or both parents in their home. The home was chosen as the location of the interview as it was felt that parents were most likely to agree to participate if
their inconvenience was minimized.

The interview began with the open-ended question: "Is your son having any difficulties now?" The parent(s) was encouraged to discuss any concerns about the child in order to ventilate their concerns before moving on to the structured interview. Once this was completed, the meaning of the terms "Certainly Applies", "Somewhat Applies", and "Doesn't Apply" were discussed. The parent(s) was encouraged to discuss any statement he/she was uncertain of with the interviewer. When all items on the interview schedule were completed the parent(s) was asked: "Was Regional Children's Centre helpful to you?" Responses to this question were measured on a five point scale ranging from one (1), indicating a very negative attitude towards Regional Children's Centre, to five (5), indicating a very positive attitude towards Regional Children's Centre.

After the interview, the parent(s) was told about the case review schedule, and the teacher questionnaire, and asked to sign a release of information form allowing the researchers access to the clinical record and/or permission to contact the child's teacher and have the teacher questionnaire completed. All parents interviewed agreed to allow the researchers access to the clinical record.

Fourteen (14) of the parents interviewed reported that their children were currently attending school, and eleven (11), parents granted the researchers permission to
contact their child's teacher with the teacher questionnaire. The reason given for any refusal of permission was invariably that the child had made only a borderline academic adjustment, and the parent(s) felt that a questionnaire sent out under the auspices of the Regional Children's Centre would only serve to prejudice the teacher.

The eleven (11), teacher questionnaires were distributed in late May, 1980, by the Regional Children's Centre's Education Liaison, Mr. S.P. Mann. The questionnaire was part of a package containing a cover letter outlining the purpose of the study and instructions for questionnaire completion, a signed release of information form, as well as the questionnaire.

Of the eleven questionnaires distributed, nine were completed and returned. A tenth questionnaire was returned uncompleted, as the child in question was no longer attending school.

Case review schedules were carried out by only one of the researchers to minimize the problem of inter-rater reliability. These were completed following the parent interview.

Limitations of the Study

As a purposive sampling procedure was used in this study, findings cannot be generalized to similar groups. The study is further limited in that all case records were not complete, and thus data on home visits was not available for all subjects.
CHAPTER IV
REPORT OF THE RESEARCH FINDINGS

Sample Description

The sample description was intended to give a general overview of the research findings. Univariate descriptive statistics such as the mean, median, mode, and standard deviation will be utilized in presenting this material. The sample description has been subdivided into five sections for clarity as follows:

1. A description of the child who was admitted to residential treatment;
2. A description of the child's family;
3. A description of family participation in treatment;
4. A description of follow-up provided by the Regional Children's Centre, and
5. A description of the child's post discharge social adjustment.

The Child

The first variable examined regarding the child was his age at admission. Admission age varied from 9 to 16 years, a range of 7 years. The mean age was 13, with a mode of 12. As can be seen from Chart One age is not normally distributed, rather, there are two peaks, one at age 12 and one at age 16.

The length of time spent in residential treatment varied between 1 and 13 months, with a mean of 8 months, a median of seven months. Thus, the distribution is slightly
CHART 1

ADMISSION AGE

N = 21
Standard Deviation = 3.4
positively skewed (skewness is .05). Generally, children seemed to spend five or more months in treatment, as seen in Chart 2.

Time spent in residential treatment was also grouped into three month intervals with results as follows:

<table>
<thead>
<tr>
<th>TIME</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 - 3</td>
<td>2</td>
</tr>
<tr>
<td>4 - 6</td>
<td>8</td>
</tr>
<tr>
<td>7 - 9</td>
<td>4</td>
</tr>
<tr>
<td>10 - 12</td>
<td>6</td>
</tr>
<tr>
<td>12+</td>
<td>1</td>
</tr>
</tbody>
</table>

Time since discharge from residential treatment varied between 11 and 25 months - a range of 12 months. This variable was essentially normally distributed, with both a mean and a median of 16 months.

Five major categories of final diagnosis were identified. These were:

- personality disorder \((N = 7)\),
- behaviour disorder \((N = 6)\),
- learning disorder \((N = 3)\),
- adjustment reaction \((N = 2)\), and
- other \((N = 3)\).

The majority of the children in the sample were living with both natural parents, or with a single natural parent \((N = 11)\). The second most frequent family situation was a child living with a natural parent and a step-parent \((N = 6)\). Of the rest of the sample, three children lived with adoptive parents, and one with a legal guardian.
CHART 2

TIME IN RESIDENTIAL TREATMENT BY MONTHS

AGE 0 1 2 3 4 5 6 7 8 9 10 11 12 13

N 4 7 6 9 7 8 9 5 6 5 4 3 2 1

Mean: 8
Mode: 5
Median: 7
The majority of the children in the sample were middle children (N= 12), with three being youngest children, four being oldest children, and one an only child.

Families of the Children

Family size ranged from one child to 11 children. Six families had three children and six families had four children. Two families had two children, and two families had eleven children. The remaining families had one, five, seven, nine, and ten children, respectively. The mean family size had 4.8 children, and a median of four. As Chart 3 illustrates distribution is abnormal with the majority of families grouped at three and four children. When the families were grouped according to size it was discovered that nine children came from small families (1-3 children), six came from medium sized families (4-6 children) and, five came from large families (7 and more children).

The second variable examined was the marital status of the parents in the home. Twelve children had parents who were married. One child came from a home in which his parents were divorced. Two children came from families in which the parents were involved in a common-law relationship. One child came from a single parent family. Four children came from a home in which the parents were re-married, and one child came from a family in which one parent had died.
The education level of the parents varied as follows:

Five mothers had an education level of zero to grade eight. Eight mothers had a grade 9 - 10 level of education, and six mothers had a grade 11 to 13 level of education. Nine fathers had an education level of zero to grade eight. Six fathers had an educational level of grade 9 - 10, and five fathers had grade 11 to 13.

The majority of the fathers (15) were employed in blue-collar occupations with only one father employed in either a professional or other occupation. The majority of the mothers (14) were homemakers. Five of them, however, were employed in blue-collar jobs; and one mother held a white-collar position.

Most of the families did not report any financial problems. However, six families did report financial difficulties.

All of the families were previously involved with at least one other agency before they came to the Regional Children's Centre. As can be seen by Chart 4, 15 families had previous involvement with two or more agencies in the community.

At the time of admission most of the parents (14) perceived that the problems they were having focused around the child. Three parents felt that difficulties were parent-child related, and three parents perceived the difficulties to be family related.

The last question on the parent interview schedule
CHART 4

AGENCIES INVOLVED PRIOR TO ADMISSION

N = 21
asked the parents how helpful they found the treatment received from the Regional Children's Centre. Their answer was rated by the interviewer on a five point scale ranging from very negative to very positive. As can be seen in Chart 5, 11 of the parents interviewed felt positive to very positive about the treatment they received from Regional Children's Centre. Seven, however, felt negatively; and the remainder were neutral.

At the time the parent interview was completed the majority of parents (12) were interviewed together, seven mothers were interviewed alone, and two fathers were interviewed alone.

**Family Participation in Treatment**

The first variable to be examined in this section is the raw number of family contacts over the entire period the child was in residential treatment. These varied between four and 40 contacts, a range of 36 contacts. The mean number of contacts was 20, with a median of 22 contacts. As very few numbers were repeated it was decided to determine an average number of contacts per month by dividing the number of contacts by the number of months spent in residence. The scores thus obtained were scored as follows:

1. 0.0 - 0.4
2. 0.50 - 1.4
3. 1.5 - 2.4
4. 2.5 - 3.4
5. 3.5+
CHART 5

PARENTS' ATTITUDE TOWARDS TREATMENT

Number of Parents

Parents' Attitude:


N = 21

Note: Neg. = Negative
This distribution is illustrated in Chart 6. The data then took on a normal distribution.

The number of contacts with the child's father were scored in the same way, and are presented in Chart 7. As can be seen by this chart, contact with father by month varied around a score of one, and a score of three, indicating a bimodal distribution.

The number of contacts with the child's mother were also scored in this manner. The distribution is illustrated in Chart 8. This can be seen to be a slightly skewed distribution. It is also interesting to note that mothers as a group tended to have more contact with the child's therapist than did fathers.

Originally, contact with the child's siblings was intended to be used as a variable in this study. However, as contact with siblings was reported in only one case, examination of this variable was eliminated.

The focus of contact with the family was also determined, with the main focus being the most frequent focus of contact as operationally defined, excluding admission and discharge. Focus was distributed as illustrated in Chart 9; as can be seen, most contacts focused on the child.

Admission and discharge focuses were examined separately, as the literature review indicated that these foci of contact were particularly significant. These foci were examined in their raw form.
CHART 6
AVERAGE NUMBER OF FAMILY CONTACTS PER MONTH

N

Family Contacts: 1 2 3 4 5

N = 21
Mode = 3
Skewness = 0
Chart 7

Average number of father contacts per month

Father Contacts: 1 2 3 4

N = 21
CHART 8
AVERAGE NUMBER OF MOTHER CONTACTS PER MONTH

N

\[ N = 21 \]
\[ \text{Mode} = 3.3 \]
\[ \text{Skewness} = 0.2 \]
CHART 9

FOCUS OF TREATMENT

N = 21
The number of contacts focused on admission varied between zero and three, with a mean of one. The mode and median were also one, although the distribution was slightly positively skewed.

The number of contacts focused on discharge varied between zero and five, a range of five contacts. The mean, rounded to nearest number, and mode were both zero, with a median of one, indicating a slightly positively skewed distribution.

The number of home visits made during residential treatment was obtained for 16 subjects. For these subjects, the number varied between zero and 52, a range of 53 visits. The mean number of home visits was 29, with a median of 26, and a mode of 18. As the number of home visits was largely idiosyncratic, the data was collapsed as described for family contacts, and a home visit score was obtained.

The home visit score varied between one and five, a range of five. The mode, median, and mean were all five. Distribution was extremely negatively skewed, as illustrated in Chart 10. It can be seen that most children had very frequent home visits (3.5 or more per month).

A participation score was obtained by summing the raw number of family contacts and the raw number of home visits. This score was obtained for the 16 children for whom data on home visits was available. These scores varied between six and 74, giving a range of 68. The mean score was 52, with a median of 57 and a mode of 57.
CHART 10
AVERAGE HOME VISITS PER MONTH

N

Visits Per Month

0
1
2
3
4
5
16
-2.08

Skewness
resulting in a negatively skewed distribution.

A second participation score was obtained by adding the per month family contact score and the per month home visit score. This score varied between three and ten, with a range of seven. The mean score was eight, with a median of eight. The distribution is illustrated in Chart 11; as can be seen this distribution is essentially normal.

Follow-Up and Current Agency Involvement.

Two measures of follow-up were obtained for all subjects, these being the number of telephone contacts with the therapist after discharge, and the number of office interviews with the therapist after discharge.

The number of follow-up phone contacts varied between zero and eight, with a range of eight. The mean number of phone contacts was one, with a median and mode of zero. Thus, the distribution was positively skewed, as can be seen in Chart 12. The number of follow-up office interviews varied between zero and seventeen, with a mean of two, a median of one, and a mode of zero. The frequency was highly skewed in a positive direction, as can be seen in Chart 13.

Information of current involvement with social service agencies was obtained through the parent interview schedule. The number of agencies currently involved varied between zero and four, with a resulting range of
CHART II

PARENTAL PARTICIPATION PER MONTH

N = 16
Skewness = -0.3
CHART 12

FOLLOW-UP PHONE CONTACTS

\[ N = 21 \]

Skewness = 2.0
CHART 13
FOLLOW-UP
OFFICE INTERVIEWS

N 5
4
3
2
1
0

Office Interviews

N = 21
Skewness = 3.1
four. The mean number of agencies currently involved was one, with a median and mode of one. The frequency distribution is illustrated in Chart 14. As can be seen from this Chart the distribution of current agency involvement is slightly positively skewed.

Post Discharge Social Adjustment of Children

This section of the sample description deals with the level of post discharge social adjustment as indicated by the parent interview schedule and the teacher questionnaire.

The parent interview schedule scores are given in percentages as can be seen in Chart 15. The parent scores ranged from a low of 48% to a high of 92%. The mean is 73% and the median is 78%. The distribution of the data has a skewness score of -.68.

The parent interview scores were grouped in order to make the data more manageable. They were grouped in the following manner:

1 = 41 - 50%
2 = 51 - 60%
3 = 61 - 70%
4 = 71 - 80%
5 = 81 - 90%
6 = 91%

The grouped parent interview scores, as illustrated in Chart 16, had a median of four meaning that one-half of the cases fell above and below a score of 71 - 80%.

This distribution was also skewed to the right on
**CHART 14**

**CURRENT AGENCIES INVOLVED**

\[ N = 21 \]

Skewness = 0.8
CHART 15

PARENT INTERVIEW SCORE

N

Skewness = -0.68

N = 21
CHART 16

GROUPED PARENT INTERVIEW SCORE

\[ N = 21 \]

Skewness \[ = -.58 \]
the graph with a skewness score of -.58. The highest number of scores (7) were located in the fourth category.

The teacher questionnaire scores ranged from a low of 56% to a high of 86%, as can be seen on Chart 17. The teacher scores had a mean of 71%, and a median of 72%.

Since there were only nine teacher scores recorded the scores were idiosyncratic. The distribution of the scores was highly abnormal with a kurtosis value of -1.7.

The teacher questionnaire scores were also grouped in order to make the data more manageable. They were grouped in the same way as the parent interview scores. The median of the grouped teacher questionnaire scores as Chart 18 illustrates was 4. The distribution of the data again was highly abnormal with a skewness value of -.23 and a kurtosis value of -1.5.

Hypothesis One: The child's post-discharge social adjustment will correlate positively with family participation in treatment. The child's post-discharge social adjustment was determined in two ways:

1. Parent-Interview Scores:
   a) raw scores,
   b) grouped scores.

2. Teacher Questionnaire Scores:
   a) raw scores,
   b) grouped scores

Three measures of family participation were devised:

1. Family Contacts During Treatment:
   a) raw total,
   b) grouped total,
CHART 17

TEACHER QUESTIONNAIRE SCORE

Scores in Percentages

N = 9

Kurtosis = -1.7
CHART 18

GROUPED TEACHER QUESTIONNAIRE SCORE

Teacher Questionnaire Score

N = 9
Skewness = -0.23
Kurtosis = -1.5
c) grouped father contacts,
c) grouped mother contacts.

2. Number of Home Visits:
   a) raw total,
   b) grouped total.

3. Total Participation: Summation of Home Visits Total and Family Contact Total:
   a) raw total,
   b) grouped total.

The first measure of family participation, i.e., the number of family contacts during treatment, showed no significant level of correlation with either the parent interview scores or the teacher questionnaire score.

The second measure of family participation, i.e., the number of home visits, showed a positive correlation with a measure of social adjustment (see table 1). Specifically the raw number of home visits positively correlated with the grouped parent interview scores. (Correlation coefficient = .0.606, Spearman correlation = 0.538, and Probability = 0.0067 - see Chart 19). There was also a positive correlation between the raw home visit total and the raw parent interview score. (Correlation coefficient = 0.509, Spearman correlation = 0.466, and Probability = 0.0197.

No correlation was found between the second measure of family participation (home visit total), and the teacher questionnaire either raw or grouped.

The third measure of family participation (total participation - summation of home visit total and family
### Table 1

**Home Visits by Parent Interview Scores**

<table>
<thead>
<tr>
<th>Measures of Family Participation</th>
<th>Measures of Post-Discharge Social Adjustment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Grouped Parent Interview Scores</td>
</tr>
<tr>
<td>Raw Number</td>
<td>1. 0.606</td>
</tr>
<tr>
<td>Of</td>
<td>2. 0.538</td>
</tr>
<tr>
<td>Home Visits</td>
<td>3. 0.0067</td>
</tr>
</tbody>
</table>

| Raw Number                      | 1. 0.381 | 1. 0.294 |
| Of                               | 2. 0.357 | 2. 0.309 |
| Home Visits                      | 3. 0.2781 | 3. 0.1911 |

**Key:**
1. Correlation Coefficient
2. Spearman
3. Probability
Correlation Coefficient = 0.538
Spearman = 0.538
Probability = 0.0067
N = 16
contact total), exhibited a positive correlation between the parent interview scores (see table 2). Specifically the total participation measure correlated positively with the raw parent interview scores. (Correlation-coefficient = 0.618, Spearman correlation = 0.615, Probability = 0.0033)

And the grouped parent interview scores (Correlation-coefficient = 0.662, Spearman correlation = 0.665, Probability = 0.0017).

The total participation measure showed no correlation with the teacher questionnaire scores.

**Time in Residence**

The number of months that a child spent in residential treatment exhibited a positive correlation with the grouped parent interview scores. (Correlation coefficient = 0.447, Spearman correlation = 0.380, and Probability = 0.0420 — see Table 3 and Chart 20).

**Focus of Treatment**

As Chart 21 illustrates the majority of cases (11), were primarily child focused during treatment. Four cases were focused around parent—child difficulties; two around marital difficulties and four around family problems. No correlation was found between the focus of treatment and the grouped parent interview scores.

Chart 22 illustrates that there was no set pattern between focus of treatment and the teacher questionnaire scores. There was no correlation between the focus of treatment and the teacher questionnaire score.
### Table 2

**Total Family Participation**

*By Parent Interview Scores*

<table>
<thead>
<tr>
<th>Measures of Family Participation</th>
<th>Grouped Parent Interview Scores</th>
<th>Raw Parent Interview Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>1. 0.662</td>
<td>1. 0.618</td>
</tr>
<tr>
<td>Participation</td>
<td>2. 0.565</td>
<td>2. 0.615</td>
</tr>
<tr>
<td></td>
<td>3. 0.0017</td>
<td>3. 0.0035</td>
</tr>
<tr>
<td>Grouped Total</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>1. 0.409</td>
<td>1. 0.410</td>
</tr>
<tr>
<td>Participation</td>
<td>2. 0.304</td>
<td>2. 0.331</td>
</tr>
<tr>
<td></td>
<td>3. 0.1955</td>
<td>3. 0.1675</td>
</tr>
</tbody>
</table>

**Key:**
1. Correlation Coefficient
2. Spearman
3. Probability
TABLE 3

TIME IN RESIDENCE BY
PARENTS INTERVIEW SCORES

<table>
<thead>
<tr>
<th></th>
<th>Grouped Parent Interview Scores</th>
<th>Raw Parent Interview Scores</th>
</tr>
</thead>
<tbody>
<tr>
<td>Raw Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Residence</td>
<td>1. 0.340</td>
<td>1. 0.233</td>
</tr>
<tr>
<td></td>
<td>2. 0.252</td>
<td>2. 0.155</td>
</tr>
<tr>
<td></td>
<td>3. 0.1437</td>
<td>3. 0.2700</td>
</tr>
<tr>
<td>Grouped Time</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In Residence</td>
<td>1. 0.447</td>
<td>1. 0.336</td>
</tr>
<tr>
<td></td>
<td>2. 0.380</td>
<td>2. 0.290</td>
</tr>
<tr>
<td></td>
<td>3. 0.0420</td>
<td>3. 0.0902</td>
</tr>
</tbody>
</table>

Key: 1. Correlation Coefficient
2. Spearman
3. Probability
## CHART 20

**TIME IN RESIDENCE BY PARENT SCORE**

<table>
<thead>
<tr>
<th>Grouped Parent Scores</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>XX</td>
<td>XX</td>
<td>XXX</td>
</tr>
<tr>
<td>3</td>
<td>XXX</td>
<td>XX</td>
<td>XX</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Correlation Coefficient = 0.447
Spearman = 0.580
Probability = 0.0420
N = 21
### Chart 21

**Primary Focus of Treatment by Grouped Parent Interview Score**

<table>
<thead>
<tr>
<th>Grouped Parent Scores</th>
<th>Child</th>
<th>Parent-Child</th>
<th>Marital</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>XX</td>
<td>X</td>
<td>X</td>
<td>XX</td>
</tr>
<tr>
<td>4</td>
<td>XXXX</td>
<td>X</td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>3</td>
<td>X</td>
<td>XX</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>XX</td>
<td></td>
<td></td>
<td>X</td>
</tr>
<tr>
<td>1</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Focus of Treatment*

- N = 11
- N = 4
- N = 2
- N = 4
## Chart 22

**Focus of Treatment by Grouped Teacher Questionnaire Score**

<table>
<thead>
<tr>
<th></th>
<th>Child</th>
<th>Parent-Child</th>
<th>Marital</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>N = 3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 0</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>N = 2</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Focus of Treatment
No correlation was found between the number of admission focused interviews and the parent interview scores. Ten cases had one admission focused interview. Eight cases had two or more admission focused interviews. There was no correlation between admission focused interviews and the teacher questionnaire scores.

Data gathered showed no correlation between the number of discharge focused interviews and the parent interview scores or the teacher questionnaire scores.

Statistics gathered when the parent interview scores were correlated with the teacher questionnaire scores showed no level of correlation.

The parent interview total score exhibited a positive correlation with all sections within itself (see Table 4). Also, the majority of sections correlated positively with all other sections.

The teacher questionnaire total score positively correlated with all sections within itself (see Table 5). The majority of sections positively correlated with all other sections.

**Hypothesis Two:** Family participation will correlate with demographic variables. In this section the variables admission age, position in the sibline, family size, mother and father's education level, the child's relationship to the adults in the home, previous agency involvement, the presence or absence of financial problems, the
<table>
<thead>
<tr>
<th>Relationship with Mother</th>
<th>Relationship with Father</th>
<th>Relationship with Siblings</th>
<th>Relationship with Peers</th>
<th>Attitude towards School</th>
<th>General Attitude</th>
<th>General Behaviour</th>
<th>Attitude towards Work</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>0.6635</td>
<td>0.5524</td>
<td>0.8552</td>
<td>0.7700</td>
<td>0.6971</td>
<td>0.7227</td>
<td>0.6811</td>
</tr>
<tr>
<td>Score</td>
<td>0.0009</td>
<td>0.0174</td>
<td>0.0001</td>
<td>0.0001</td>
<td>0.0056</td>
<td>0.0002</td>
<td>0.0007</td>
</tr>
<tr>
<td></td>
<td>21</td>
<td>18</td>
<td>20</td>
<td>21</td>
<td>14</td>
<td>21</td>
<td>21</td>
</tr>
</tbody>
</table>

Key: 1. Correlation Coefficient
2. Probability
3. n
### Table 5

<table>
<thead>
<tr>
<th>Relationship with Teacher(s)</th>
<th>Attitude towards School</th>
<th>School Behaviour</th>
<th>Total Score</th>
<th>Probability</th>
</tr>
</thead>
<tbody>
<tr>
<td>Relationship with Peers</td>
<td></td>
<td></td>
<td>0.9557</td>
<td>0.0001</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.564</td>
<td>0.0508</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>0.9633</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

Key:
1. Correlation Coefficient
2. Probability
length of time the child spent in residence, and the parents' initial perception of the problem will be discussed in relation to the various measures of family participation.

**Admission Age**

The first variable to be considered, admission age, did not correlate significantly with any measures of family participation, although it did come close to significance with father's contacts with the therapist. Product moment correlations are detailed in Table 6.

**Position in Sibline**

The second variable examined was the child's position in the family i.e., oldest, middle, youngest, and only child. As can be seen in Table 7 there are no differences in average grouped scores for any measure of participation. Although there are some differences in the average total scores, these are not at the significant level.

**Family Size**

Family size correlated significantly with the average number of contacts with father per month, (correlation coefficient = 0.44750, Probability = .0419), although not with the total number of father's contacts (correlation coefficient = -.37698, probability = .0921). These are illustrated in Charts 23 and 24. Family size did not correlate significantly with any of the other measures of participation.
### Table 6

**Measures of Family Participation by Admission Age**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Correlation</th>
<th>Probability</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participation Score</td>
<td>-0.15432</td>
<td>0.5682</td>
<td>16</td>
</tr>
<tr>
<td>Participation Score By Month</td>
<td>0.31964</td>
<td>0.2275</td>
<td>16</td>
</tr>
<tr>
<td>Number of Home Visits</td>
<td>-0.38773</td>
<td>0.1378</td>
<td>16</td>
</tr>
<tr>
<td>Grouped Number of Home Visits/Month</td>
<td>-0.14087</td>
<td>0.6028</td>
<td>16</td>
</tr>
<tr>
<td>Number of Family Contacts</td>
<td>-0.14323</td>
<td>0.5357</td>
<td>21</td>
</tr>
<tr>
<td>Grouped Number of Family Contacts/Month</td>
<td>-0.09695</td>
<td>0.6759</td>
<td>21</td>
</tr>
<tr>
<td>Number of Contacts with Father</td>
<td>-0.41804</td>
<td>0.0593</td>
<td>21</td>
</tr>
<tr>
<td>Grouped Number of Contacts with Father/Month</td>
<td>-0.37857</td>
<td>0.0905</td>
<td>21</td>
</tr>
<tr>
<td>Number of Contacts with Mother</td>
<td>0.07309</td>
<td>0.7529</td>
<td>21</td>
</tr>
<tr>
<td>Grouped Number of Contacts with Mother/Month</td>
<td>0.14624</td>
<td>0.5270</td>
<td>21</td>
</tr>
</tbody>
</table>
### TABLE 7

**Average Participation Scores by the Child's Position in the Family**

<table>
<thead>
<tr>
<th>Participation</th>
<th>Oldest</th>
<th>Middle</th>
<th>Youngest</th>
<th>Only</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Family Contacts per Month</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
<tr>
<td>Total Family Contacts</td>
<td>27</td>
<td>3</td>
<td>19</td>
<td>12</td>
</tr>
<tr>
<td>Participation by Month</td>
<td>8</td>
<td>3</td>
<td>8</td>
<td>8</td>
</tr>
<tr>
<td>Participation Score</td>
<td>59</td>
<td>3</td>
<td>49</td>
<td>8</td>
</tr>
<tr>
<td>Home Visits by Month</td>
<td>5</td>
<td>3</td>
<td>5</td>
<td>8</td>
</tr>
<tr>
<td>Total Home Visits</td>
<td>32</td>
<td>3</td>
<td>27</td>
<td>8</td>
</tr>
</tbody>
</table>

*Note: N values for each position may vary.*
CHART 23

FATHER'S MONTHLY CONTACT SCORE BY FAMILY SIZE

Number of Contacts Per Month

Family Size

Correlation Coefficient = -0.44750
Probability = 0.0419
N = 21
**Chart 24**

**Contacts with Father by Family Size**

- **Family Size**
  - 1
  - 2
  - 3
  - 4
  - 5
  - 6
  - 7
  - 8
  - 9
  - 10
  - 11

- **Raw Number of Contacts**
  - 10
  - 20
  - 30
  - 40

**Correlation Coefficient** = -0.37698

**Probability** = 0.0921

**N** = 21
Parent Education Level

Mother's education level correlated significantly with the participation score (correlation coefficient = 0.65194, probability = 0.0084, N = 15), and with the number of home visits (correlation coefficient = 0.58487, probability = 0.0220, N = 15), although not with the other measures of participation.

Father's education level did not correlate significantly with any measures of family participation, although the correlation between father's education level and his involvement approached significance (correlation coefficient = -0.38255, probability 0.0960, N = 20).

Child's Relationship To Adults In The Home

The child's relationship to the adults in the home was not significantly correlated with any measures of family participation. The average number of family contacts per month by the child's relationship to the adults in the home is illustrated in Chart 25.

Previous Agency Involvement

The number of previous social agencies with which the child and his family were involved correlated negatively and significantly with all measures of family contact with the therapist, although not with home visits, or the total participation score. Family contacts as they correlate with previous agency contacts are illustrated in Chart 26. As illustrated the strongest negative correlation was with father's monthly contacts.
CHART 25

FAMILY CONTACTS PER MONTH BY CHILD'S RELATIONSHIP TO THE ADULTS IN THE HOME

Average Family Contacts Per Month

<table>
<thead>
<tr>
<th>Natural Parents(s) Only</th>
<th>Adoptive or Foster-Parents</th>
<th>A Natural Parent &amp; A Step-parent</th>
</tr>
</thead>
<tbody>
<tr>
<td>( N = 11 )</td>
<td>( N = 4 )</td>
<td>( N = 6 )</td>
</tr>
</tbody>
</table>

\( N \) refers to the number of cases in each category.
CHART 26

PREVIOUS AGENCY INVOLVEMENT
BY CONTACT WITH FAMILY

Number of Previous Agencies

Key: ——— Family Contacts/Month (Average)
     ——— Father's Contacts/Month (Average)
     ——— Mother's Contacts/Month (Average)

<table>
<thead>
<tr>
<th>MEASURE</th>
<th>CORRELATION COEFFICIENT</th>
<th>PROBABILITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Contact</td>
<td>-0.56650</td>
<td>0.0092</td>
</tr>
<tr>
<td>Father's Contact</td>
<td>-0.66120</td>
<td>0.0015</td>
</tr>
<tr>
<td>Mother's Contact</td>
<td>-0.57330</td>
<td>0.0082</td>
</tr>
</tbody>
</table>

N = 20
Financial Problems

The presence or absence of financial problems did not correlate with any measures of family participation. This is illustrated in Chart 27.

Time in Residence

The number of months the child spent in residential treatment did not correlate with the number of contacts with the family, either in total or grouped. Although the number of months in residence correlated strongly with the participation score and the number of home visits, it did not correlate with the grouped scores for these measures, as illustrated in Table 8.

Perception of Problem

The initial perception of the problem, as reported in the applicant information form, did not correlate with grouped family contacts per month. It did, however, correlate significantly with the grouped participation per month and grouped home visits per month scores, as indicated by gamma and chi square scores. This relationship is illustrated in Chart 28.
CHART 27

AVERAGE MEASURE OF PARTICIPATION BY
FINANCIAL PROBLEMS

<table>
<thead>
<tr>
<th>Average Total Participation</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>0</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARTICIPATION</td>
<td></td>
<td></td>
</tr>
<tr>
<td>SCORE PER MONTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>FAMILY CONTACTS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PER MONTH</td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOME VISITS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PER MONTH</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Key: YES - Financial Problems Reported
NO - Financial Problems Not Reported
### TABLE 8

**CORRELATIONS OF PARTICIPATION MEASURE WITH MONTHS IN RESIDENTIAL TREATMENT**

<table>
<thead>
<tr>
<th>Measure</th>
<th>Correlation Coefficient</th>
<th>Probability</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Contacts with Family</td>
<td>-0.06393</td>
<td>0.7665</td>
<td>21</td>
</tr>
<tr>
<td>Monthly Family Contacts</td>
<td>-0.10754</td>
<td>0.6424</td>
<td>21</td>
</tr>
<tr>
<td>Number of Home Visits</td>
<td>0.92612</td>
<td>0.0001</td>
<td>16</td>
</tr>
<tr>
<td>Monthly Home Visits</td>
<td>0.43549</td>
<td>0.0916</td>
<td>16</td>
</tr>
<tr>
<td>Participation Score</td>
<td>0.73945</td>
<td>0.0011</td>
<td>16</td>
</tr>
<tr>
<td>Monthly Participation Score</td>
<td>0.19389</td>
<td>0.4602</td>
<td>16</td>
</tr>
</tbody>
</table>
### Chart 28

**Initial Perception of the Problem**

**By Family Participation**

<table>
<thead>
<tr>
<th>Child</th>
<th>Parent</th>
<th>Family</th>
<th>Child</th>
<th>Parent</th>
<th>Family</th>
<th>Child</th>
<th>Parent</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>Score/Month</td>
<td>Grouped Home Visits/Month</td>
<td>Grouped Family Contact/Month</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chi Square: 20.136</td>
<td>Chi Square: 9.394</td>
<td>Chi Square: 2.536</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DF: 10</td>
<td>DF: 4</td>
<td>DF: 8</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Probability: 0.0280</td>
<td>Probability: 0.0522</td>
<td>Probability: 0.5256</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Gailia Standard Error: -0.500</td>
<td>Gailia Standard Error: -0.346</td>
<td>Gailia Standard Error: -0.382</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0.288</td>
<td>0.192</td>
<td>0.305</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
CHAPTER V
INTERPRETATION OF FINDINGS

In the following chapter, the authors discuss and interpret the research findings based on the data collected and the literature available. The two hypotheses used in this study will be examined by looking at the correlation between parent interview scores, teacher questionnaire scores, family participation, and demographic factors.

Hypothesis One

The child's post-discharge social adjustment will positively correlate with family participation in treatment.

This hypothesis was partially supported by the research findings. Examples of support for the above hypothesis are listed, as follows, and are then discussed individually.

1. The total number of home visits correlated positively with the parent interview scores.

2. The total measure of family participation (number of home visits plus number of family contacts), correlated positively with the parent interview scores.

3. The length of time the child spent in residential treatment correlated positively with the parent interview scores.

Parent Interview Schedule Social Adjustment Scores

Family Contact

The number of contacts that the family had with the
therapist did not correlate with the parent interview scores of the child's post-discharge social adjustment. The literature would lead one to expect that there would be a high degree of correlation between these two variables. However, the literature deals mainly with family therapy involving the parents, the child in treatment, and his siblings. The researchers found only one case in their sample where this type of treatment was given. Possibly therapeutic contacts involving one or both of the child's parents are not as effective as are therapeutic contacts with the family unit, and this accounts for the lack of correlation.

Home Visits

The number of home visits correlated positively with the parent interview scores of the child's post-discharge social adjustment. The literature has emphasized the importance of home visits in the treatment of emotionally disturbed children and this has been supported by the research findings.

The number of home visits per month does not correlate with the parent interview scores of the child's post-discharge social adjustment. This may indicate that frequency of visiting is less important than the total number of visits.

Total Family Participation

The measure of total family participation (number of home visits plus number of family contacts), showed a
positive correlation with the parent interview score of the child's post-discharge social adjustment. As this measure is a composite of measures of home visits and parent contact with the therapist, the finding could be interpreted as indicating that both measures are related to the child's post-discharge social adjustment. When this finding is taken in conjunction with the previous two findings it could be interpreted as indicating that home visits are the more significant factor in the child's post-discharge social adjustment. Home visits were the only opportunity for transferring gains made in residential treatment to the family system. Also, home visits enable the child to remain an active member of the family system - the family does not have the opportunity to shut the child out of the family.

The grouped participation scores were not correlated with the child's post-discharge social adjustment as measured by the parent interview schedule. This can be interpreted in the same manner as the findings for grouped home visits: The total amount of participation is more important than the frequency of participation.

**Time In Residence**

The grouped measure of time spent in residential treatment correlated positively with the grouped parental measure of post-discharge social adjustment (probability 0.0420) although the grouped measure of time spent in residential treatment did not correlate significantly with
the raw parent measure of post-discharge social adjustment. The total number of months spent in residential treatment did not correlate with either measure of post-discharge social adjustment based on the parent interview. This is interpreted as indicating that while the length of treatment is to some extent significantly associated with the parental measure of post-discharge social adjustment, it is by no means the only significant factor. In conjunction with previous research findings and the review of literature time spent in treatment may be significant only in the sense that it is utilized in providing more family participation in the treatment process.

Focus of Treatment

No correlation was found between the focus of treatment and the parental measure of post-discharge social adjustment. This seems surprising in view of the literature on family systems theory. However, two possible explanations are offered below. First, only four cases were judged to focus primarily upon family interactions, as opposed to 11 focused primarily upon the individual child, four focused primarily on parent-child interactions, and two focused primarily upon marital interactions. This scattering of scores may be related to the lack of a significant correlation. Secondly, the primary focus was the focus most often found by the researchers in the monthly progress notes. It may be that the focus of contact was judged incorrectly.
No correlation was found between the number of admission focused interviews and the child's post-discharge social adjustment as measured by the parent interview schedule. The literature suggests that the pre-admission process is important to the child and family's adjustment to the treatment process. Based on the findings, it appears that little pre-admission work is done at the Regional Children's Centre as the mean number of admission focused interviews was one. It would seem likely that one interview would not contribute significantly to the child or family's adjustment to the treatment process.

Similarly, the number of discharge focused interviews was not found to correlate with the child's post-discharge functioning. As with admission focused interviews, few interviews focused on discharge, with a mean of less than 0.5. Again it seems unlikely that this could contribute to the child's post-discharge social adjustment.

**Teacher Questionnaire Social Adjustment Scores**

No significant correlations were found between the social adjustment scores obtained from the teacher questionnaires and any of the measures of family participation. In addition, no significant correlation between the teacher questionnaire measure of social adjustment and the parent interview schedule measure of social adjustment was found.

Several possible explanations for these findings are outlined below. The teacher score was obtained by
questionnaire, rather than by interview. It may be that quite different results would have been found with a teacher interview, as the teacher would have had an opportunity to clarify items and may have responded differently in some cases.

The researchers were more familiar with what constitutes a good social adjustment in the home, as were the panel of judges chosen to evaluate the instruments. The teacher questionnaire therefore may not have been as valid an instrument for judging classroom social adjustment. Had teachers been used to evaluate the instrument, it may have been developed quite differently.

In addition, the teacher questionnaire was much shorter than the parent interview schedule (24 items as opposed to 45 items on the parent interview schedule), and thus each item contributed a higher percentage to the teacher score. This may have contributed to the difficulty in correlating the measures obtained with each instrument.

Only nine completed teacher questionnaires were obtained as opposed to 21 completed parent interview schedules, and the results were quite scattered. This may also be a factor, and it is possible that different results may have been obtained had 21 teacher questionnaires been collected.

The possibility that post-discharge classroom social adjustment is not related to family participation in treatment must be considered. It may be that other factors
are related to an acceptable classroom social adjustment.

Furthermore, the parent interview schedule and the teacher questionnaire measure post-discharge social adjustment of the child in two different contexts - one at home and the other at school. Because of different social contexts, the findings from the parent interview may not be comparable with the findings from the teacher questionnaire. It may be that each instrument provides a measure of a particular aspect of the post-discharge social adjustment of the child.

**Hypothesis Two**

Family participation will correlate with demographic variables.

This hypothesis was partially supported by the research findings. Examples of support for the hypothesis are listed, as follows, and then the variables examined with regard to hypothesis two are discussed.

1. Mother's education level correlated positively with the total participation of the family (i.e., number of home visits plus number of family contacts).

2. Mother's education level correlated positively with the total number of home visits.

3. The number of months in residential treatment correlated positively with the total participation measure.

4. The number of months in residence positively correlated with the number of home visits.
5. The initial perception of the problem correlated with the monthly participation score.

6. The initial perception of the problem correlated with the monthly home visit score.

7. Family size correlated negatively with the father's monthly contact score.

8. Previous agency contacts correlated negatively with all measures of family contact.

Admission Age

Admission age did not correlate with any measure of family participation, although a negative trend was found for father's contact with the therapist. This would seem to indicate that fathers were somewhat more likely to participate in therapeutic or counselling contacts where the child was younger. Mothers however, appear to be equally likely to participate in therapeutic or counselling contacts regardless of the child's age. Home visits, in total or by month, were not correlated significantly with admission age. This is likely a result of the Regional Children's Centre's policy of sending each child home each weekend, when possible.

Position in Sibline

The child's position in the sibline did not correlate significantly with any measure of participation. Although the literature suggests that this may be a factor in developing symptoms, it does not appear to be a factor in treatment of the symptoms. It is interesting to
note, however, that the majority of subjects (N=12) were middle children, as could be expected from the literature.

**Family Size**

Family size correlated significantly and negatively with father's monthly contacts with the therapists. In other words, the larger the family size, the less often father had contact with the therapist. As with admission age, family size did not correlate significantly with other measures of family participation. This may indicate that father's participation is more frequently related to family-related demographic factors. It is also interesting to note that the sample children tended to come from large families (12 children had three or more siblings, of these, four had eight or more siblings).

**Parents' Education Level**

Mother's education level was significantly positively correlated with the total participation score, and with the number of home visits, although not with other measures of participation. As indicated previously, these two measures were also significantly correlated with the number of months spent in residential treatment. This appears to indicate that as the level of education of the mother increases the length of time a child spends in residential treatment increases.

Father's education level did not correlate significantly with any measures of family participation. It is interesting to note, however, that all parents in
the sample had grade 13 education or less.

**Relationship to the Adults in the Home**

The child's relationship to the adults in the home did not correlate significantly with any measure of family participation. In other words, whether the parents were both natural parents, both adoptive or foster parents, or one natural and one step-parent made no difference in the measures of participation.

**Previous Agency Involvement**

The number of social agencies with which the child and/or his family was involved prior to admittance to Regional Children's Centre was significantly negatively correlated with all measures of family contact with the therapist. It is suggested that prior agency contact may have been perceived as not being helpful, and thus parents were less likely to perceive contact with a therapist at Regional Children's Centre as being potentially helpful.

It should be noted that Regional Children's Centre residential treatment facilities are considered a secondary setting to be utilized when other community resources have been exhausted.

Previous agency involvement did not correlate significantly with either home visit measures, or with overall participation measures. This is interpreted as indicating that although previous agency contacts may affect the parents' perception of the therapist, it does not affect the parents' desire to have their child home to
Financial Problems

The presence or absence of financial problems did not correlate with any measures of family participation. It could therefore be concluded that although financial problems may contribute to family stress, it does not relate to participation in treatment.

Time in Residence

The number of months the child spent in residential treatment correlated positively at a significant level with the total participation score and the number of home visits, although not with the number of family contacts with the therapist. The first two correlations can be expected, as the longer the child spends in treatment, the more opportunities for participation and home visits exist. However, this is also true for contacts with the therapist, and the lack of a significant correlation is unexpected. Possibly, parents whose children remain in treatment for a longer period of time gradually decrease their contacts with the therapist. Or, alternatively, as the child improves, possibly the therapist begins to decrease his/her intervention with the parents, and the child remains in treatment with the goal of stabilizing his gains.

The number of months the child remains in treatment does not correlate with any of the monthly scores of family participation. This can be explained by the fact that the number of opportunities per month for home visits are not
increased or decreased with the number of months spent in treatment.

**Initial Perception of Problem**

The parents' initial perception of the problem as being either a child, parent-child or family problem did not correlate significantly with grouped family contacts.

However, a significant relationship was found between initial perception of the problem (as child, parent-child, or family) and grouped home visits per month. This was also found for the grouped participation per month score. Perception of a child problem was associated with the highest level of scores, and perception of a family problem was associated with the lowest score levels.

The literature indicates that parents often feel guilty when their child is admitted to residential treatment. Possibly parents feel less guilty when they perceive their child as a problem by himself, as this indicates that they are in no way associated with the difficulty he is experiencing. For example, states like "Johnny is unable to control himself in school" or "Johnny is hyperactive" were interpreted by the researchers as indicating parental perception of a child problem.

Statements like "We are unable to control Johnny's violent temper outbursts" or "We are unable to discipline Johnny effectively" were interpreted as indicating parental perception of a parent-child problem. It appears that this type of statement would indicate parental perception of
themselves as playing a role in the problem. Likely this would lead to some feelings of guilt over perceived inadequacy of parenting.

Similarly, statements such as "Johnny is continually fighting with his siblings" or "Johnny always picks on his little sister, and has begun to physically abuse her. We are unable to cope with this" were interpreted as indicating parental perception of family problems. Here too, it is likely that parents perceive themselves as playing some role in the development of the problem, and thus feel some guilt.

The literature suggests that parental guilt feelings must be dealt with in the pre-admission phase of treatment if parental participation is to be utilized effectively. If parental guilt feelings are not dealt with by the residential treatment centre, this may lead to defensiveness and possibly avoidance of contact on the part of the parents. This is a possible explanation for the findings that home visits occur less frequently where a parent-child or family problem was initially perceived.
CHAPTER VI

CONCLUSIONS and RECOMMENDATIONS

In this chapter, conclusions drawn from the research findings, suggestions for future study, and recommendations for policy practice will be presented.

Conclusions

Hypothesis One, the child's post-discharge social adjustment will correlate positively with family participation in treatment was partially supported. The null hypothesis is thus rejected. Measures of total family participation and total home visits correlated highly with a parental measure of post-discharge social adjustment. Parental contacts with the therapist did not correlate with this measure, and a measure of social adjustment obtained from the teacher's questionnaire did not correlate with any measure of parental participation.

While total family participation was found to be significantly correlated with post-discharge social adjustment, the total number of home visits made during treatment seemed to be the most significant factor associated with post-discharge social adjustment. Parental contacts with the therapist appeared to be the least significant factor associated with post-discharge social adjustment. Family contact, including the child and/or his siblings, as well as the parents, with the therapist was found in only one case, and was therefore
not included as a variable in the study.

Although therapist contact with parents was not significantly correlated with the child’s post-discharge social adjustment this should not lead to the assumption that family therapy, involving the parent(s), child, and siblings would not correlate with the child’s post-discharge social adjustment, as family therapy per se was found in only one of the 21 cases.

Hypothesis Two, the family’s participation in treatment will correlate with demographic variables, was also partially supported. The null hypothesis is then rejected. Specifically, the mother’s education level, the initial perception of the problem, the length of treatment, the size of the family, and previous involvement with social agencies correlated significantly with some measures of parental participation.

The most significant correlation found was a negative correlation between previous agency contact and parental participation in treatment with the therapist.

Suggestions For Future Study.

The researchers suggest that there is a need for further follow-up research on family participation as it relates to the child’s post-discharge social adjustment. Ideally such research would incorporate a comparison of social adjustment measures both before and after treatment. Family participation and post-discharge social adjustment scores would be obtained at regular intervals.
(i.e., three, six, nine, and twelve months), to determine the stability of gains made in treatment. Further studies on family participation as it relates to the child's post-discharge social adjustment would also benefit from obtaining a larger sample drawn from several residential treatment centres. Also, family focused intervention and its effect on parental participation could be investigated.

The researchers also recommend that further research be carried out in order to elaborate on those demographic factors which relate to family participation in residential treatment of children.

**Recommendations For Policy and Practice**

Six recommendations for policy and practice have been developed from this study. The first recommendation developed from the research findings; the second from difficulties encountered during the data gathering phase of the study, and the remainder from the review of literature.

The first recommendation is that Regional Children's Centre continue its policy of encouraging home visits on weekends for all children in treatment. The research findings indicate that these home visits are the single most influential factor associated with post-discharge social adjustment.

Secondly, it is recommended that the Regional Children's Centre implement a systematic model of recording for monthly progress notes, should future practice oriented research be desired. It is suggested that such
areas as treatment modality to be used, goal(s) of treatment, progress towards the goal(s), and clients present in the interview be included.

The following recommendations are based upon discrepancies noted between practice at the Regional Children's Centre and suggested practice as detailed in the literature.

First, it would be beneficial for Regional Children's Centre to develop and implement a more extensive pre-placement programme for the child and his family. Specific areas of focus for pre-placement are detailed in the literature review (Chapter II).

Pre-placement home visits by the therapist may prove to be beneficial in helping the parents with their guilt feelings around placing their child in a residential treatment centre. Also, it may aid in hooking the parents into treatment faster and facilitate a commitment to be involved on their part.

Secondly, the literature suggests that family therapy is an important mode of treatment in residential treatment. It is recommended that the Regional Children's Centre adopt and implement a policy of making more extensive use of family centred intervention.

Thirdly, very little evidence of family or parental participation in discharge planning was found in this study. As the literature suggests this is an important treatment focus, the researchers suggest that therapists at
Regional Children's Centre involve the family in discharge planning to a greater extent.

Finally, there is some suggestion in the literature that follow-up is important in maintaining treatment gains. The researchers found no evidence of systematic follow-up while gathering data. Thus, it is recommended that a policy of systematic follow-up after discharge be implemented at the Regional Children's Centre. A large number of parents interviewed expressed concern that their contact with the Regional Children's Centre ended so abruptly and they would have liked some follow-up contact.
Dear Parents:

As part of the requirements of our Master of Social Work programme at the University of Windsor, we are researching the outcome of residential treatment at the Regional Children's Centre. We understand that one of your children was involved in treatment at the Regional Children's Centre and we would like to involve you in our study. We would appreciate your consideration of this project.

Ideally, we would like to complete a one hour interview with you, regarding your child's present behaviour, and your feelings about the treatment he received. We would also appreciate your permission to complete a short interview with your child's teacher (if applicable) for the purpose of determining your child's school behaviour. We also plan to look over your child's treatment record to determine the types of treatment he received.

We would like to assure you that confidentiality will be maintained in this study. Names and identifying data will be eliminated. You will be free to withdraw from this study at any time.

We will be contacting you by phone within the next few weeks to discuss any concerns you might have about this study, and hopefully to set up an appointment with you. If you have any questions or concerns at this time, please feel free to contact Mary Poole at the Regional Children's Centre, 253-4261, extension 536, or Ron Dowhaniuk at Maryvale School, 252-2707, extension 53, on Mondays or Wednesdays. If you are unable to speak with us, please leave your name and phone number with the secretary and we will return your call as soon as possible.

Thank you for your consideration and co-operation.

Mary Poole, B.S.W., Social Work Intern, Regional Children's Centre.

Ron Dowhaniuk, B.S.W., Social Work Intern, Maryvale School.
Dear Teacher:

Re: ___________________________ Name

In order to facilitate a follow-up evaluation of our intervention with the above named child, we would ask your assistance in completing the attached questionnaire. The questionnaire is a series of statements concerning the children's school behavior and attitudes. Beside the statements are three columns. If you check the first column you are saying the statement doesn't apply to the child. If you check the second column you are indicating the statement applies somewhat to the child. If you check the third column you are indicating that the statement certainly applies to the child. Please check only one column. If you feel unable to decide on a statement please indicate this by writing 'not applicable' (N/A) beside the statement. There is also a section for your comments.

This study is to evaluate the post-discharge social adjustment of children who have been in residential care at the Regional Children's Centre.

Thank you kindly for your cooperation.

Sincerely,

S.P. Hann
Liaison Consultant
Regional Children's Centre
in trust with
Mary Poole
Ronald Dowhaniuk

Enclosure
SP/i/bv

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CONSENT TO RESEARCH

I, ______________________, do hereby give my consent for Mary Poole and Ronald Dowhaniuk to have access to my child's, ______________________'s, records at the Regional Children's Centre in connection with their research project on post-discharge functioning. I do, do not, give my permission for the above named researchers to conduct an interview with my child's teacher. I understand that all information gathered will be kept strictly confidential, and data will be presented only in summative form.

Witness ______________________

Signed ______________________

parent

parent

date

125
## PARENT INTERVIEW SCHEDULE

### Section A.

<table>
<thead>
<tr>
<th></th>
<th>Applies</th>
<th>Somewhat Applies</th>
<th>Doesn't Apply</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Expresses affection towards mother.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Expresses affection towards father.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Is comfortable with affection from mother.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Is comfortable with affection from father.</td>
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<td></td>
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<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Talks freely with mother.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Talks freely with father.</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Openly expresses anger towards mother.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Openly expresses anger towards father.</td>
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<tr>
<td>5.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td>Does not take discipline from mother.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td>Does not take discipline from father.</td>
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</table>

### SECTION B.

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<table>
<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Gets along well with other children in the family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Tends to &quot;pick on&quot; another child in the family.</td>
<td></td>
<td></td>
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<tr>
<td>3.</td>
<td>Wilfully destroys brothers' and sisters' belongings.</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td>Is willing to share his belongings.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Plays well with brothers and/or sisters.</td>
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</table>


Section C.

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Has several friends.</td>
<td></td>
<td></td>
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<tr>
<td>2.</td>
<td>Friends are mainly a good influence.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Plays mainly with older children.</td>
<td></td>
<td></td>
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<tr>
<td>4.</td>
<td>Plays mainly with younger, children.</td>
<td></td>
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</tr>
<tr>
<td>5.</td>
<td>Participates frequently in group activities with friends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Gets his own way with friends, most of the time.</td>
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<td></td>
</tr>
<tr>
<td>7.</td>
<td>Tends to be a loner.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td>Is willing to share his belongings with friends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td>Tends to be a leader with friends.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td>Plays consistently with the same group of friends.</td>
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</table>

Section D.

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<thead>
<tr>
<th></th>
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</thead>
<tbody>
<tr>
<td>1.</td>
<td>Participates in formal group activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Scouts/cubs</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Religious groups</td>
<td></td>
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<td></td>
<td>School teams</td>
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<tr>
<td></td>
<td>Organized sports</td>
<td></td>
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<tr>
<td></td>
<td>Clubs at School</td>
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<tr>
<td></td>
<td>Y.M.C.A.</td>
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<tr>
<td></td>
<td>Other (please list)</td>
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</thead>
<tbody>
<tr>
<td>2.</td>
<td>Participates in formal individual act activities.</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Music Lessons</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Art Lessons</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other (please list)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Section E

1. Gets along well with classmates.

2. Likes teacher.

3. Tends to be absent from school a great deal.

4. Works at his ability level.

5. Complains that other children pick on him at school.

6. Complains that teacher picks on him.

### Section F

1. Has difficulty controlling his temper.

2. Wets bed at night.

3. Has been known to steal.

4. Has speech difficulties, i.e., stutters, stammers, lisps.

5. Tends to save meaningless objects for a long period of time.
6. School has notified parents of problems at school.

7. Often tired or listless, complains of being bored.

8. Generally in good health.

Section G.

1. Generally has a positive outlook on life.

2. Enjoys a challenge.

3. Enjoys family outings.

Section H. (To be completed where child is not in school).

1. Refuses to work.

2. Tends to be absent from work a great deal.

3. Has been fired or walked out.

4. Expresses satisfaction with job.

Are you currently involved with:
(ROC) CAS
F.S.B.
Financial Assistance
Windsor Group Therapy
Public Health
R.C.C.
Probation or Diversion
Other (please list)

Did you find your involvement with the Regional Children's Centre Helpful?
<table>
<thead>
<tr>
<th>TEACHER QUESTIONNAIRE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Talks freely with teacher.</td>
</tr>
<tr>
<td>2. Asks for extra help when needed.</td>
</tr>
<tr>
<td>3. Accepts directions well.</td>
</tr>
<tr>
<td>4. Requires excessive attention.</td>
</tr>
<tr>
<td>5. Tends to be a leader with classmates.</td>
</tr>
<tr>
<td>6. Gets along well with classmates.</td>
</tr>
<tr>
<td>7. Tends to be a loner.</td>
</tr>
<tr>
<td>8. Tends to bully other children.</td>
</tr>
<tr>
<td>9. Participates appropriately in group activities.</td>
</tr>
<tr>
<td>10. Tends to be absent from school a great deal.</td>
</tr>
<tr>
<td>11. Appears to be happy in classroom.</td>
</tr>
<tr>
<td>12. Often restless or fidgety in class.</td>
</tr>
<tr>
<td>13. Spends much time daydreaming.</td>
</tr>
<tr>
<td>14. Uneasy with new things or new situations.</td>
</tr>
<tr>
<td>15. Gets along well with classmates out of class. (i.e., in playground or hallways)</td>
</tr>
<tr>
<td></td>
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<tr>
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</tr>
<tr>
<td>16.</td>
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<td>17.</td>
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<td>18.</td>
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<td>19.</td>
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<td>20.</td>
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<tr>
<td>21.</td>
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<tr>
<td>22.</td>
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<tr>
<td>23.</td>
</tr>
<tr>
<td>24.</td>
</tr>
</tbody>
</table>

**OTHER COMMENTS:**

---

How well do you know this child? Very well, moderately well, not very well. (Please Circle)
CASE REVIEW SCHEDULE

Birthdate of Child
 Date of Admission
 Date of Discharge
 Time in Residence
 Time since Discharge

CHARACTERISTICS OF FAMILY

1. Parents' Occupation: Father __________________________
   Mother __________________________

2. Financial Problems Reported: ______________________
   Financial Assistance Received: _____________________

3. Parents' Education Level:
   Grades 0-8  Grades 9-10  Grades 11-13  Secondary Post-
   Mother __________________________
   Father __________________________

4. Size __________  Number of Children at Home __________
   Number of Children Out of Home __________
   Birth Order of I.P. __________ of __________

5. Marital Status of Parents:
   Married __________________________
   Separated _________________________
   Divorced _________________________
   Common Law ______________________
   Single Parent _____________________
   Remarried ________________________

6. Languages Spoken at Home:
   English __________________________
   French __________________________
   Other (specify) __________________
7. Child's Relationship to Current Marital Status:
   Natural (both parents)
   Natural (one parent)
   Adopted
   Foster-Child
   Step-Child of Father
   Step-Child of Mother

PARTICIPATION IN TREATMENT

1. Number of Contacts with Family________

2. Who Present: Father
   Mother
   Siblings
   Other (specify)

3. Type of Problems Focused on During Contact:
   Child________
   Parent-Child________
   Marital________
   Family________
   Admission________
   Discharge________

4. Parents Perception of Problem at Admission:
   Child________
   Parent-Child________
   Marital________
   Family________
5. Agencies Involved Prior to Child's Admission:
   (RC) CAS
   F.S.B.
   Financial Assistance
   Windsor Group Therapy
   Public Health
   R.C.C.
   Other (specify)

6. Agencies Involved During Child's Time in Residence:
   (RC) CAS
   F.S.B.
   Financial Assistance
   Windsor Group Therapy
   Public Health
   R.C.C.
   Other (specify)

7. Contacts Made After Child Discharged:
   Number of Phone Contacts
   Number of Direct Contacts
   Number of Mail Contacts

8. Final Diagnosis

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HOME VISITS

Number

Length:
   0 Nights
   1 Night
   2 Nights
   3 Nights
   4 or more Nights
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VITA AUCTORIS
MARY THERESA POOLE

Mary Theresa Poole was born on June 26th, 1957, in Woodstock, Ontario, the dairy capital of Canada. She received her Secondary School Honours Graduation Diploma from Woodstock Collegiate Institute, while working part-time as a produce clerk at Poole & Co. (Since 1895) Ltd.

Ms. Poole enrolled in the Bachelor of Social Work programme at The University of Windsor in September of 1975. She worked during the summers as an assistant residential counsellor at Oxford Regional Centre.

Ms. Poole received her Bachelor of Arts in psychology in September of 1978, and her Bachelor of Social Work in May of 1979. She spent the following summer touring Europe, then enrolled in the Master of Social Work programme at The University of Windsor. Ms. Poole did her Master's field placement with the Outpatient Department of Regional Children's Centre. Ms. Poole is currently employed with the Day Care Programme at Regional Children's Centre. She expects to graduate in October of 1980.
VITA AUCTORIS
RONALD DENNIS DOWHANIUK.

Ronald Dennis Dowhaniuk was born in St. Thomas, Ontario on August 4th, 1954. He lived in Alymer, Ontario for the following eight years and in Waterloo, Ontario for his remaining childhood years. He received his Secondary School Honours Graduation Diploma from St. Jerome's High School in Kitchener, Ontario. Following high school he travelled in Europe for a couple of months. Upon his return to Waterloo he worked framing houses for two years.

In 1975 Ron enrolled in a Bachelor of Arts program at the University of Waterloo. The following year he transferred to The University of Windsor in order to enroll in the Bachelor of Social Work programme. During his years at school Ron worked part-time as a group home relief staff for the Roman Catholic Children's Aid Society for the County of Essex. His field placements during his Bachelor studies included Downtown Mission, Hiatus House, Children's Center of Wayne County.

In Ron's first year at the University of Waterloo he met his future wife Ruby at the famous St. Jerome's coffee shop. Three years, hence, they were married in May of 1978.

Ron received his Bachelor of Social Work in May of 1979. The following year he enrolled in the Master of Social Work programme at The University of Windsor. His field placement was at Maryvale School. During this
period Ron and Ruby were employed as group home parents for the Roman Catholic Children's Aid Society for the County of Essex. Ron expects to graduate in October, 1980.

Ron is currently employed as a social worker in the Family Service Department at the Children's Aid Society for the Regional Municipality of Halton. Ron and Ruby currently live in Oakville, Ontario, and are soon to be blessed with the birth of their first child.