PATERNAL DEPRIVATION IN TREATMENT OF CONDUCT DISORDERS

A Study to Determine the Effects of Active Paternal Involvement in the Treatment of Children Diagnosed as Conduct Disorders

A Thesis

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by

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A b s t r a c t:

A STUDY OF THE EFFECTS OF ACTIVE PATERNAL INVOLVEMENT IN THE TREATMENT OF CHILDREN DIAGNOSED AS CONDUCT DISORDERS

by

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This study is concerned with examining the father's responsibilities for the disturbance of the child, and the increasing trend toward drawing him into the center of corrective child guidance procedures. It is an individual thesis written on a research project at a child guidance clinic undertaken by a student of the Maritime School of Social Work.

It investigates the relationship between cases in which the father of a child-patient diagnosed as a conduct disorder becomes actively involved in the treatment of this child, as compared to those cases in which the fahter is not involved actively in treatment. Fifteen cases from the total of 247 cases that were assessed and diagnosed within the classification of Conduct Disorders at the Halifax Mental Health Clinic for Children during the calendar year 1962 through April, 1965 were the source of data. The 15 cases were divided into two unequal groups and the t-ratio was the statistical test used to test the significance of difference between their means.

It was found that whether the father of a child diagnosed as a conduct disorder was involved in active treatment of that child or not, had no significant difference on the length of treatment time. The small number of patients (whose treatment was terminated by the therapists) at the clinic gave some indication of the many difficulties in treating conduct disorders, and also the great need for implementing new techniques and resources.

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CHAPTER I

INTRODUCTION

> It is self-evident that to whatever extent the father feels threatened, insecure, and anxious about his adequacy in any of his several significant masculine roles in life, to that same extent will his functioning as a father be impaired. Throughout life the male person strives to demonstrate his worth as a man and thereby win a certain status. Failure in proving sexual adequacy, in earning prestige and authority in the family or a position of merit in the work world, any measure of failure in any of these roles will arouse anxiety and so interfere with the man's fulfillment of the paternal function. To be a good father a man must be sure of himself in all these spheres. To whatever extent he becomes plagued with doubt, he will wrap his energies in the task of neutralizing this doubt and thereby be unfree emotionally to derive positive value and pleasure from fatherhood. 1/

On the basis of such established theory as expressed in the preceding quotation, during the past two decades there has been an increasing trend toward examining the father's responsibilities for the

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1/ Nathan W. Ackerman, THE PSYCHODYNAMICS OF FAMILY LIFE; Basic Books, Inc., New York, 1958, pp. 181-182

disturbance of the child; and there is now more pressure to draw him into the center of corrective child guidance procedures. More and more it is recognized that child-rearing is a joint venture between both mother and father and that the responsibilities are shared responsibilities.

The purpose of this study was to assess the validity and the effectiveness of the above recent trend. This was implemented through testing the hypothesis which stated that if the father of a child-patient diagnosed as a conduct disorder becomes actively involved in the treatment of this child, it would show a significant difference in terms of the length of treatment as compared to those cases in which the father was not involved in treatment.

A basic assumption of this study was that social casework contacts with fathers have a contribution to make to the knowledge and understanding of the child and that fathers participation would enhance the treatment plan.

A child with a conduct disorder displays an inability to handle aggressiveness in a socially approved manner. Typically, he would be a very self-centered, very aggressive man with no guilt feelings of his aggressive acts. This behavioral pattern

represents a failure on the part of parents with respect to the socialization of the child. Parental hostility, rejection, and inconsistent handling of the child are considered to be the chief causes of this disturbance.

Aggression is a fundamental characteristic of all living organisms. The theories on the origin of aggression vary. Their main point of contention is whether aggression in the destructive sense is a reaction to experiences or whether it is a constitutional, original drive. 1/ However, all schools and theories agree that even hostile and destructive aggression can be converted to useful and constructive ends; it can be redirected. There has developed in Child Guidance a greater understanding of the social nature of the problem from the sensitive identification with, and willingness to learn from, what parents and children have been demonstrating to the clinics as they have come for help over the years. "The problem is not one merely of cause and effect, nor of recommending what changes in relationship are essential for the child's

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1/ Otto Fenichel, THE PSYCHOANALYTIC THEORY OF NEUROSIS; Norton, New York, 1945; pp. 59 ff

development. The problem is, rather, one of taking the parents and child where they are as they come to the clinic, caught in an impasse with each other, and struggling to find a way to new relationships to each other, as parent and child." 1/

This project was of a probative nature. It was based on a theoretical approach which was subsequently tested with files of children who were treated at the Halifax Mental Health Clinic for Children. It was an individual thesis conducted by a second year student of the Maritime School of Social Work, Halifax, Nova Scotia in partial fulfillment of the requirements for the Masters Degree in Social Work, and to help increase knowledge and understanding of research methods. As far as it was known, no identical study had been made but there have been many relevant studies, several of which were reviewed throughout the following chapters.

Through the analysis of data upon which the findings of this study were based, the null hypothesis could not be rejected. However, it cannot be said that this study absolutely disproves the theoretical basis of this thesis emphasizing the importance of the father's

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1/ Almena Dawley and Frederick H. Allen, "Social Aspects of Personality in Child Guidance Clinic Practice", POSITIVE ASPECTS OF CHILD PSYCHIATRY; W.W. Norton & Co., Inc., 1963; pp. 185-186.

active role in the treatment of a child diagnosed as a conduct disorder, which is evident by his importance in the child's normal emotional development.

The subsequent chapters will help to bear what has been said in the preceding introductory pages. The following chapter, Dynamics of Child Personality Development, begins to set the theoretical framework on which this study was based.

CHAPTER II

DYNAMICS OF CHILD PERSONALITY DEVELOPMENT

This chapter is not a venture in pure science but in applied science. The applied science of child-personality development is not a mere assemblage of wise hints on child care, nor is it to be just an organized citation of the practical deductions that can be made from a miscellaneous array of experiments. An applied science is based upon and guided by scientific theories as well as by established facts.

It is often distressing to discover how many diverse ways there are of conceptualizing personality. The myriad of theoretical systems is so confusing that one is frustrated in his desire to have simple, authoritative statements about the structure and dynamics of personality. This multiplicity of theories reflects two things:

(1) The great richness and complexity of personality,

and

(2) the early stage in which the science of personality still is.

Personality is that which permits a prediction of what a person will do in a given situation. The goal

of psychological research in personality is, therefore, to establish laws about what different people will do in all kinds of social and general environmental situations.

The personality of an individual is established as the sum total of all observable reactions. Although the individual's personality is no doubt with him at all times, it is demonstrated only when one is interacting with other individuals and reacting to a situation. Some characteristics of the individual are usually considered more important than others when personality is discussed, but the complete study must include all factors and all criteria by which one can be described.

In the form of a concise definition we may use the following:

> Personality is the unique pattern of mental and physical traits bound together within a living organism which seeks expression in the self-directed pursuit of values and which makes the organism capable of entering into the complex relationships of human society as an active and responsible member. 1/

Personality as Biologically or Culturally Determined:

There are two extreme positions on the matter of personality being either biologically or culturally

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1/ Timothy J. Gannon, PSYCHOLOGY: THE UNITY OF HUMAN BEHAVIOR; Ginn and Company, New York, 1958; pp. 416-417

determined. Between these two poles lie many gradations. Freud took a stance very close to the biological pole. His theory of personality is completed by his view of the three stages of human development. The significant steps in the development of personality reflect the three levels of psychosexual growth which are attitudes towards sex and the directions of sexual interests. Freud considered many routine activities of childhood to have a sexual significance. He believed it is the direction of sexual interest that determines personal maturity. The first period, the narcissistic period, begins with the oral satisfaction of sucking movements, proceeds to the pleasurable exploration of the members of the body, and finally centers upon the sex organs. This leads to gratification in self-stimulation. The next period is the homosexual stage which usually occurs at the age of about five or six years. This period is characterized by interest in persons of the same sex. The preadolescent period is when it is at its peak. It is at this time that groups of boys and girls tend to be most exclusive and most intolerant of the opposite sex. Interest normally focuses on the opposite sex beginning at adolescence. This is known as the heterosexual or mature stage. The immature personality is the result of failure to pass through the first or second stages of

development. Homosexuality is cited as an example of this failure to reach maturity but such an explanation of homosexuality suffers from over-simplification. For Freud, culture is man's attempt to establish patterns within society that permit him to proceed through the various universal stages of psychosexual development with as little conflict as possible, and with acceptable and satisfactory discharge for the sexual instinct at each of the various stages. Therefore, the forms of culture that come about are expressions of the universal biological laws behind the development of individual personality.

The biological influence on personality is represented most clearly through the effect of glands on physique and temperment, the relation between physique and temperment, and the role of the nervous system in acquisition of personality traits. Injuries to the brain, as in syphilis, senility, and alcoholism, often lead to marked changes in personality. The autonomic nervous system also plays a role in personality, but how much weight should be given to its influence is promblematical.

In elaborating further on the above, we see that Freudian psychoanalysis seems to affirm that the essential elements of personality have already become

firmly established within the first five years of life. The Neo-Freudians have been critical of Freud's stress on the early establishment of a fixed personality structure. They have re-emphasized the importance of later experience in shaping personality, arguing that personality structure is not really as set in the early years as Freud had suggested.

Actually both points of view are valid, and they are not so contradictory as they might appear. From some recent developmental studies of persons from childhood to adulthood, it has become increasingly apparent that substantial changes in personality do indeed take place during adolescence and early adulthood. What is ambiguous is which personality structures are formed and fully established early in life and how they function or alter later in life.

Many sociologists and social psychologists emphasize the concept of social role and show little interest in the native biological conditions stressed so much by Freud and the Neo-Freudians. The units of analysis are the interactions of people and the affects of these interactions on the development of the self. Such interactions are largely governed by the organized social roles of the various cultures. Social institutions are thought to comprise role patterns which prescribe how a person

must behave and how he must regard himself.

The writers who conceive of personality in terms of role theory and the interaction of self and roles, appear indeed to exhibit little interest in man's biological nature. They occupy a position closest to the culture pole on the biology-culture continuum. Yet, while their analysis is made at the level of social interaction rather than biological dispositions, they usually leave room for the universally recognized interplay of biology and culture in the development of personality, just as the more biologically oriented writers always accord some place, however small and underemphasized, to the effects of learned social experience.

Erich Fromm would be illustrative of this approach. He tends to a greater degree than Freud or Kardiner to regard personality as a product of cultural variation. Cultural variation for Fromm, however, is important not because of its effect on the biologically determined psychosexual stages, but because of its influence on the atmosphere of the parent-child relationship. For example, whether love and affection or coldness and rejection are offered to a child would have an important bearing on how the child handled inherent needs for security and autonomy. Patterns of parental authority

are also central in importance. A child's response to an autocratic parent is likely to be either excessive submissiveness to, or complete rejection of, authority.

Interrelationships with the Family and Their Effects On Development:

The family as a group of interacting individuals fulfills certain basic functions. First, it provides the biological means of perpetuating the race. Second, it acts as the chief agency in the socialization of a new generation, that is, it conveys to the growing boy or girl the fundamentals of the culture of a given society; its customs, traditions, skills, and moral values. These are necessary to enable the new member to play his role as a participant in society.

Yet the family is more than the means of reproducing the species and of training the offspring for their place in the world. As a functioning group, the family provides its members with a number of basic satisfactions. Among others are the outlets of love between the spouses, of love between the parents and children, and finally, love between or among the children themselves. Such affectional expression has been long regarded as important for the emotional development of the individual.

The child learns to love by being loved. He is

drawn out of his primary narcissism when the parents reach out for him and want his love in return for the gift of their own. He absorbs parental standards as part of his own make-up in return for the affection and care given him. He learns to deal with his early jealous and angry feelings and the fear of retaliation they arouse because the parents continue to love him despite his hostile wishes and behavior. He identifies predominantly with father, or she with mother, because the parents want this and encourage it. Later the child gradually relinquishes his overly close ties to his parents for many reasons: partly because he has been satisfied by these relationships, partly because he has unconsciously accepted the fact that in some ways they will never fully satisfy him, and partly because he meets satisfying response from others outside the family triangle, since he has already achieved some capacity for giving as well as receiving.

There are some situations in family life marked by competition and, under severe stress, by conflict. We see that interpersonal opposition is quite as normal in group life as are co-operation and mutual aid. Therefore, we may say that the family is also the initial proving ground of co-operative and oppositional habits bound up with satisfying needs for affection, security, and status.

Social psychologist Martha Ericson writes of her own research findings which typify work done on the child rearing practices as a function of social-class membership:

> Middle class families were generally found to be more exacting in their expectations for children with reference to the learning of habits of feeding, cleanliness training, environmental exploration and control and age and sex-roles. Training was generally begun earlier in the middle class than in the lower class families. In the middle class families, there was more emphasis on the early assumption of responsibility for the self, closer supervision of children's activities, and greater emphasis on individual achievement. 1/

Margaret Mead, an eminent anthropologist, wrote that children absorb during infancy and early childhood the whole pattern of family interrelationship which they will be able to repeat, subject to the distortions introduced by gaps in their own experience, or idiosyncracies of their own constitution and personality.2/ Even in a society which changes as rapidly as our own, a large proportion of our patterns of family life are

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1/ Newcomb & Hartly, READINGS IN SOCIAL PSYCHOLOGY; Holt, Rinehart and Winston, Inc., New York, 1947; p. 498

2/ Margaret Mead, "The Contemporary American Family as an Anthropologist Sees It", SOCIAL PERSPECTIVES ON BEHAVIOR; The Free Press of Glencoe, New York, 1963; pp. 20-27

attempts to reproduce the family behavior learned in childhood. A large part of the disorganization of family life today, the frequency of divorce, the incidence of neurosis and disease, may be due to the discrepancies and contradictions between the expectations learned in childhood and the actualities of the present time.

This study will conclude this section on "interrelationhip with the family and their effects on development", with a seemingly very appropriate quotation by Alfred Adler. In his book, "What Life Means to You", being in accord with the above, he states the following:

> Wherever I have studied adults, I have found impressions left on them from their early childhood and lasting forever. The position in the family leaves an indelible stamp upon the style of life. Every difficulty of development is caused by rivalry and lack of co-operation in the family. If we look around at our social life and ask why rivalry and competition is its most obvious aspect then we must recognize that people are everywhere pursuing the goal of being conqueror, of overcoming and surpassing others. This goal is the result of training in early childhood, of the rivalries and competitive striving of children who have not felt themselves an equal part of their whole family. We can get rid of these disadvantages by training children better in co-operation. 1/

1/ Adler, Alfred, WHAT LIFE SHOULD MEAN TO YOU; Capricorn Books, New York, 1958; p. 87

The Role of the Father:

Much has been said in past studies about the role of the mother in producing greatness in the human personality. The pathogenicity of maternal deprivation and its effects in terms of developmental retardation and distortions are also well known. Since the pioneering work of Spitz and Bowlby, many have investigated the nature of "the mother to infant and child relations" and have described both the many ways in which this relation can be disturbed, and the numerous and varying untoward consequences of these disturbances. But very little has been said about the role of the father.

It should also be stated at this point that the roles of fathering and mothering are interdependent, and reciprocal in nature; that is, any change in the role performance of one parent must immediately be echoed by a related change in the other parent role. The roles of fathering and mothering do not exist in isolation; rather, they are continuously related to each other. Furthermore, complementarity exists in parental roles. The interaction of the male and the female as a parental couple is inevitably influenced by the interaction of the male and female in other social roles. The relationship of the mother with the child and of the father with

the child must be considered within the frame of relationships of the mother and the father in roles other than the parental role, and at other levels of shared experience.

There are some facets of personality that grow and develop only in a home where there is a father playing his various roles in a mature way. When he is a genial participant in family life, he serves to introduce these elements more surely into the life of the growing child.

In order for the mother to accomplish her role properly and consistently there are certain contributions that a father should make. Not only does he provide materially for his wife to enable her to devote herself unrestrictedly to the care of the infant and toddler; but, by providing love and companionship, he supports the mother emotionally and helps her maintain that harmonious contented mood in the atmosphere of which her infant thrives. This he does uniquely, as a male, in the fulfillment of his role in society.

Father must play his own psychological role with his child. He should prepare himself to teach, mold, influence, inspire and develop his child so that the child may become a mentally healthy, good citizen who will be able to love and be loved, to enjoy life and be creative. By showing interest early in the life of the infant, he

awakens a corresponding interest in the infant toward him. In the beginning, this may be only a small awareness, but it is an important one. Boys and girls develop their earliest and most decisive ideas about masculinity from their fathers. It is father who evokes a process in his child which might be called "animating the mind" toward the male sex. It has been shown that in families where the father is absent the male child is slower to develop male sex-role traits then in families where the father is present, a finding predictable from the fact that there is no father whose role the child needs to take. 1/ Another study has shown that father role-playing, identification with the father, and masculinity of attitudes are positively related to the father's being warm, affectionate, and rewarding. When fathers interact more with their sons, it follows that the sons have more experience in taking their role. 2/

All children between the ages of 3 and 7 have the problem of learning the difference between masculine

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1/ Sears, Pintler, Sears, "Effects of Father Separation on Preschool Children's Doll Play Aggression", CHILD DEVELOPMENT, V 17, 1946; pp. 219-243

2/ S. Sears, "Childbearing Factors Related to Playing of Sex-Typed Roles", AMERICAN PSYCHOLOGIST, V 8, 1953; p. 431

and feminine traits and patterns, and of incorporating them into their own personalities. It is in this phase of development that the Oedipus complex is usually solved. Although many people question its validity, astute observers notice that a real problem exists here in learning to love and learning to relate oneself to the parent of the opposite sex. The solution of the Oedipus complex for the boy is a gradual "giving up" of his mother and an acceptance and desire to be like his father. This is made easier when the father becomes someone that his son would like to emulate.

The unresolved Oedipus complex is a frequently encountered pathodynamic state. Assqciated with it are retardation in maturation, an inadequate ego, and not infrequently a cruel, exacting and perverted superego. The superego has its origins long before that in the early and initial awareness by the child of the presence of the father and of the father's unique position and behavior in the family constellation, most notably in his relations with the mother. In a normal family, the developing child experiences the mother as a source of nourishment, of warmth, of comfort and affection; and the father as one who makes things happen, who is strong, motoric and directive. The superego begins with and as an early imprinting experience. It is for this reason

that the early consistent and effective presence of the father within the family complex, of his effective male relation to the mother, and of his function as arbiter in issues of ethics, morals and social mores, are of such vital importance to the healthy psychological growth and maturation of the child. Paternal deprivation is in these respects a grievous experience, and the source of a many-form pathology.

It should be clarified at this point that by the term superego we are referring to "the internal representative of the traditional values and ideals of society as interpreted to the child by his parents, and enforced by means of a system of rewards and punishments imposed upon the child." 1/ It represents the ideal rather than the real and it strives for perfection rather than pleasure. Its main concern is to decide whether something is right or wrong so that it can act in accordance with the moral standards authorized by the agents of society. With the formation of the superego, self-control is substituted for parental control.

What is all too commonly misunderstood, is that the development of a superego involves the distinctive attainment of an instrument quite independent of the particular commitments by which its existence and operations

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1/ Calvin S. Hall & Gardner Lindzey, THEORIES OF PERSONALITY; John Wiley and Sons, Inc., New York; 1957; p. 35

later become manifest. The superego instrument is male manifest in the individual's capacity to be committed, irrespective of what the particular nature and quality of the commitments may be. In this respect, the significant role of the father is to foster the development in the child of a superego instrument. If the commitments of the father's own superego, which the child is so very likely to introject, are sound, reasonable, socially desirable, and effective, so much the better. But ethical and moral commitments may be cancelled out and changed. The superego, however, if not adequately developed during the early years of the individual, may never be attained in latter life.

Sears, et al., [1/] conducted a study of the effects of father separation on preschool children's behavior. On the basis of these findings, it was concluded that the father serves not only as a mode (ego ideal) for the boy but also as the principal source of social control. This control produces inevitable frustrations which result in fantasies of self- and father-directed aggressions. Girls, on the other hand,

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1/ Sears, Pintler, Sears; op. cit. pp. 219-243

appear to have few conflicts with their fathers. Probably the majority of their conflicts are related to maternal controls, although conclusive data on this point are unavailable. However, this latter conclusion does not imply that a father's behavior is unimportant to his daughter's psychological growth.

There is no question of the father's role as a socializing agent, transmitting and improving upon the child a multiform discipline, the process involving supervision, prohibition and at times punishment. However, it must also be remembered that the father shows affection, encourages, supports, evokes and applauds. This, too, the child "identifies with and introjects". The initial impact may have been a prohibition, but with the prohibition observed there came the reward of approval. The child ultimately introjects both the prohibition and the reward of observance. In this combination we find the fountain sources of ego strength and of adequate body image which enable the maturing individual to tolerate and withstand adversity, frustration, uncertainty. Socialization also embraces ideal, aspiratory elements, and these are fostered not by prohibition but by evocation.

The appreciation of the superego as a source of ego strength is important, for the individual who has suffered paternal deprivation is generally poor in ego

strength and impoverished in ego capital. He is also likely to lack "direction," to be diffuse, uncertain and unstable both in his immediate and in his long-term goals. The paternal-deprived individual, thus, not only is lacking in his superego but has meager resources for healthy ego satisfactions and reinforcement.

We now come to a special aspect of the father's relation with his child, namely paternal deprivation which has been mentioned in the above on occasion. In the light of the kind of distinction we have already drawn between mothering and fathering, a deprivation of a child by a father carries a connotation different from a deprivation of a child by a mother. That is to say, paternal and maternal deprivation are different psychological entities and therefore have different emotional and social consequences for the child.

Paternal deprivation may be suffered in different degrees, and by virtue of a wide variety of circumstances and conditions. It may be total or partial. It may be due to the periodic, physical absence of the father from the home for long or short periods, or it may be due to the ineffectual relation of the father, present but inadequate in his role playing. It may be due to the aggressive interposition of the mother between

the child and the father, rendering his characteristic operations ineffectual. In the latter example, the child is likely to be imprinted by the attitudes and values of the mother, presumptively and by definition not suitable for the development of an effective super-ego device. Paternal deprivation may, and in our socio-economic system does, in a measure derive from the inextension and obscuration of the role of the father in the family. 1/

Two scholars, B. O. Rubenstein and M. Levitt, studying the effects of paternal deprivation and maternal domination upon disturbed children, investigated this problem. They found that fathers were reacting in one of several ways: "(1) withdrawing from any situation of stress and letting mother handle it; (2) staying away from home as much as possible or becoming hypochondriacs to avoid responsibility; (3) doing what they think is expected of them by their wives and society." 2/ The observed results were sons who were extremely weak, anxious, overaggressive and antagonistic.

1/ Iago Galdston, "Paternal Deprivation", (A Presentation); AMERICAN PSYCHIATRIC ASSOCIATION, 1965.

2/ R. P. Goldman, "What's Wrong With American Fathers?", PARADE, October 18, 1954; p. 10

> There is evidence suggesting that, where the father is absent the boy is (1) more immature; (2) shows poor age-mate adjustment; (3) is insecure in his identification with the father, and so strives more strongly toward masculine identification; (4) lacks the masculine model in the home, and hence his masculine behavior is largely bravado. 1/

It should be apparent that whatever may be the effective reason or combination of reasons that result in paternal deprivation, the pathologic effects are to be witnessed in the ego instrument of the individual and in particular in the superego component. The gravity of the pathology is generally believed to be in accord with the severity of the deprivation. The more obvious pathological categories deriving from a defective superego are well defined, particularly those involving anti-social behavior. What perhaps is less appreciated are the less obvious, less notorious forms of pathology, which are more asocial than antisocial, and which in terms of the patient are as much self-defeating as imposing on the environment.

The anti-social personality is generally

1/ David B. Lynn, "The Husband-Father Role in the Family", MARRIAGE AND FAMILY LIVING, V 23, no 3, August, 1961; p. 296

dominated by an underlying hostility to all forms and orders of authority, to inhibition, to conformity. His perverse superego would appear to be one fashioned by cruel exactions and experiences. The asocial deviant, however, is in effect lacking in superego. He does not plan nor intend his behavior, he acts witout any marked self-awareness. When those about him react adversely to his asocial behavior, it may surprise him, but he seldom reacts with any intensity, and is more likely to accept the consequences with the passivity of a somewhat bewildered child. 1/

In conclusion, we have seen that the father contributes greatly to every area of the child's experience. In order to obtain optimum development in a child, his psychological ambivalence must be well balanced. A world in which both the male and female principles are represented, and where their respective qualities are composites of life experience. Only if both parents are in vital contact with the child can he obtain an integrated view of the world in which he will soon take his place and where he is already expected to function to some extent.

1/ Galdston, op. cit.

CHAPTER III

CONDUCT DISORDER WITHIN A DIAGNOSTIC CLASSIFICATION AND TREATMENT APPROACHES

> Interest in child psychiatry has developed rapidly over the past quarter of a century. During this time management of disturbed children has shifted from juvenile courts, schools, and churches into the psychiatric setting of child guidance clinics. Great inspiration has come from the mental hygiene movement where it has been hoped that early attention to the disorders of childhood would prevent the major neuroses and psychoses in later adult life. 1/

Although the verity of such an assumption has not yet been affirmed substantially because of insufficient statistical data, it is now recognized that in treating emotional disorders of childhood one must devote attention not only to the child patient, but also to disturbed members of the child's family.

The Diagnostic Process in Child Psychiatry:

As in general medicine and in other medical

1/ George A. Wett & Wells Goodrich, A SYNOPSIS OF CONTEMPORARY PSYCHIATRY; The C. V. Mosby Co., St. Louis, 1956; p. 169

specialties, diagnosis in child psychiatry takes into account the multiplicity of etiological factors which may be involved in the emotional disabilities of any one child. The concept that a child's behavior reflects his attempts to adapt to a series of tension-producing situations is fundamental to the diagnostic study of children. The well-adjusted child's methods of adaptation are personally gratifying and socially appropriate. The emotionally disabled child's adaptive attempts are ineffectual and only partially satisfying, and they may be experienced internally as distressing symptoms. As outer signs of the disability they may be manifested in behavior which is socially unacceptable and often disturbing to others.

It is a distinctive feature of child psychiatry that all findings are weighed against the developmental norms for the successive, changing stages of growth. Basic to this concept is the belief that normal personality patterns evolve out of interpersonal relationships. From the parents the child needs some actual protective limitations, along with their support and guidance, in becoming aware of socially approved standards and in learning the skills and techniques required for gratifying and acceptable behavior. In a sense, the outcome of infant development is the increasing ability to bear

tension, The child needs parents who--first individually and somewhat differently as man and woman, then together as husband and wife, and later as father and mother--have attained the maturity of enjoying and sharing their mutual creative responsibilities in fostering his continued growth.

Particularly in child psychiatry it is not enough to seek information about the parent-child relationship from direct observation of the patient alone. Diagnosis in child psychiatry is directed at an understanding of past and present interactions and at the strengths and weaknesses of the major persons in the child's constellation, such as the parents or parent substitutes, siblings, other key relatives, and the personnel of schools and other social institutions who may influence his maturing personality.

The diagnostic process must therefore include two essential areas of investigation, each with its special characteristics but each understood more fully in its reciprocal relationship with the other. These are (1) the child himself, his basic physical and intellectual endowment and the inner biological and psychological forces and behavior patterns or ego mechanisms which emerge in the development of his own identity; and (2) the environment and its social forces

which influence the child as he matures. In the exploration of dynamic and genetic factors, any unilateral approach precludes accurate diagnosis. Both the child and his society must be understood separately and in their interactions. The recognition of this necessity for including the family in the diagnostic process has differentiated child psychiatry from "traditional" adult psychiatry. In contrast to the adult with a more structured ego, the child is still developing as an individual and is not only more flexible but also more vulnerable to the environmental forces around him.

When the child fails to deal adequately with these external conflicts or environmentally-stimulated anxieties, the process of symptom formation is set in motion. The type of emotional or behavioral disability which may result is determined by the specific configuration of ego mechanisms utilized by the particular child. It is manifested in physiological, psychological or conduct disturbances which are the clinical signs and symptoms of anxiety itself or of the child's attempts to allay the anxiety.

In conclusion, the diagnostic study is a dynamic process in child psychiatry which offers new relationship

and potentially meaningful experiences to the child and his parents as they are helped to face their problems together and to reveal the various biological psychological, and social factors involved. It is based on a sound knowledge of both normal and pathological development and function and on an awareness of the continuous interaction of all the psychobiological, and psychosocial forces. This understanding demands a multi-facetted approach. Therefore, the psychiatric clinics for children are staffed and structured on the basic assumption that the diagnostic process is a collaborative process utilizing the specialized methods of several professional disciplines, to investigate the various diagnostic areas. 1/

Conduct Disorder:

The term "conduct disorder" (which will be used interchangeably throughout this thesis with the term, "conduct disturbance") is in the group of primary behavior disorders classified as Adjustment Reactions of Childhood under the general heading of transient situational

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1/ THE DIAGNOSTIC PROCESS IN CHILD PSYCHIATRY; Report No. 38, Group for the Advancement of Psychiatry, New York; 1790 Broadway, August 1957.

personality disorders. "This grouping includes: habit disturbance such as nail biting, thumb sucking, enuresis, soiling, masturbation, and tantrums; conduct disturbance such as truancy, stealing, destructiveness, cruelty, sexual offenses, and use of alcohol; and neurotic traits including tics, habit spasms, somnambulism, stammering, overactivity and phobias." 1/ The conduct disorders share their etiology with the psychoneuroses, which are also clearly reaction formations, and they partly share their symptomatology with certain psychopathic abnormalities. In fact, their differentiation from these two categories presents the most frequent differential diagnostic difficulty.

A child with a conduct disorder displays an inability to handle aggressiveness in a socially approved manner. Typically, he would be very self-centered, very aggressive with no guilt feelings of his aggressive acts. This behavioral pattern represents a failure on the part of parents or parent surrogates with respect to the socialization of the child. Parental hostility, rejection, and inconsistent handling of the child are considered to be

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1/ Ulett and Goodrich, op. cit., p. 170

the chief causes of this disturbance. Consequently, the characteristic reaction to these frustrations is to attack the environment and to achieve gratification, if possible, impulsively rather than through socially acceptable means.

The theories on the origin of aggression vary. Their main point of contention is whether aggression in the destructive sense is a reaction to experiences, or whether it is a constitutional, original drive. 1/ However, all schools and theories agree that even hostile and destructive aggression can be converted to useful and constructive ends; it can be redirected. Aggression is a fundamental characteristic of all living organisms. This elemental quality enables the living organism to reach out and utilize its environment for the satisfaction of needs essential for sustaining life. As this quality emerged into action from the unorganized, undifferentiated potential characteristic of the newborn infant, relationships essential for the physical and emotional growth of the individual started. In this way the developing child is brought under the influence of the more established and

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1/ Otto Fenichel, THE PSYCHOANALYTIC THEORY OF NEUROSIS; Norton, New York, 1945; pp. 59ff.

purposeful aggression of the culture necessary for organizing and helping him to utilize the life force inherent in him.

This emphasis upon aggression in the normal emotional development of the child is essential for a deeper understanding of the integrating and differentiating nature of growth which, itself, is a process involving interplay between living people, aggression in relation to aggression. What factors impinging upon the developing child enable him to retain and to develop the creative potential inherent in the capacity for aggression? How do pathological deviations of aggression gain the ascendancy? These are basic questions important for the whole field of child psychiatry and fundamental for understanding the elements essential for mental health.

One sees in a conduct disturbance the operation of a dynamic process, insidiously feeding on the interaction between forces essential in every human growth process, but in these instances operating in opposition to each other. The disturbed behavior, rather than being evidence of a constitutionally determined pattern, develops out of the life experiences of the individuals involved. These patterns are modifiable only as those involved can break up the slowly but firmly developed

projections which serve to protect both parent and child from their own responsible place in the problems that enmesh them. In so many instances of this type of progression psychogenic factors that subtly start in early experiences do not get uncovered because no move is made to open up the deadlock to a potentially clarifying service.

In psychiatric clinics many parents, acting on their anxiety about a seriously disturbed child, set in motion a helping process that breaks up these projections and sustain that theropeutic service to find new and healthier qualities in their living together as individuals rather than as projections. In many instances, we see seriously disturbed young children where there is no obvious organic or psychogenic factor to explain the early organization of destructive patterns of behavior. The fact that such psychogenic factors are not obvious is in no sense proof of their absence. The very subtle way in which these factors operate serves to disguise their existence. Professional experience emerging out of a clinical structure that allows a fuller participation of parent and child in a program designed to be theropeutic for an emotionally disturbed child serves to bring more understanding of these subtle factors, while at the same time helping both parent and child to move

ahead with greater clarification of their mutual and individual capacities for responsibility. 1/

Treatment:

Comprehensive treatment evolves directly from the diagnostic formulation which gives purpose and direction to therapeutic goals, prognostic speculations, and appropriate plans to ameliorate or correct the child's emotional disability. The plan will vary depending on the child's needs, the family relationships and potentialities as well as on the resources within the community and clinic. The choice of professional personnel to carry out the treatment plan requires consideration of the training, experience, skills and personality of the available staff members.

Children Who Present Problems in Behavior and Personality:

In the study of techniques and results of treatment of children who present problems in behavior and personality, a number of points regarding the orientation of treatment effort have emerged. It is dependent on

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1/ Frederick H. Allen, POSITIVE ASPECTS OF CHILD PSYCHIATRY; W. W. Norton & Company, Inc., New York, 1963; pp. 95-113.

the following points. The treatment of children who present such problems usually involves not only treatment of the child, but also the manipulation of a great many situations in which the child is living. In the latter attempts, it has to do not only with the mobilization of all types of social resources to affect one or all of the situations in which the child is, but to influence the attitudes of the persons with whom the child is most importantly in contact. 1/ This would refer primarily to the attitudes of members of the family to whom the child may present a problem. Very few children come directly for treatment; most of them are brought by some interested adult who sees a problem in the child, and may feel that it is completely the child's problem, with no contributing problems in the home, schools or community in which the child may be spending some of his time. The problem which the parents or other adults see is not necessarily seen by the child who may, on the other hand, see or feel a different one. However, careful study of the case usually reveals that there are factors to be met in more than one of the areas in which causation lies.

1/ L. G. Lowrey, "Environmental Influences on the Behavior of Children", AMERICAN JOURNAL OF PSYCHIATRY, v. 6, 1926; p. 476.

It is therefore found that a usual case is one in which a situation is being treated involving two or more personalities particularly in their relations with each other. The child is regarded as the patient and no matter what treatment techniques are adopted or who is being treated, the child remains the center of treatment effort. Therapeutic work is directed toward correcting an existing situation which is affecting the child. The long range goal is either curative for the child, or the prevention of further more serious difficulties, either in behavior or in terms of personality disorder. While these are the general goals of treatment effort, there are all sorts of factors which limit the amount of progress which may be made, such as factors within the situation, limitations in treatment techniques, or both.

The Parents' Co-operation in Relation to their Child's Treatment:

In cases where parental co-operation is enlisted from the first, every step for the child from beginning to end seems to be easier. Where the concern, however small, of a parent for a child is made the center of attention in intake; where the parent is helped to assume a responsible and understanding role in bringing the

child for treatment; there are fewer case failures and a more efficient use of the time of the therapists. Where a child feels a parent's support in entering the treatment situation and has been given a positive and genuine reason for coming, his beginning may be many times more meaningful, and he seems to present the inner problem in relationship more quickly and with a milder and more constructive type of anxiety. As treatment progresses, the effects of good collaboration can be felt everywhere. The parent is ready to see change and support it; the impulsive child can find a positively given limit at a place where he needs it.

There exists a general conviction in the field of child psychiatry today that unless the milieu of a relationship that is central to the child can undergo favorable modification, the most skilled therapeutic measures are of little avail. The dependency of a child on the central interpersonal relationship is not for just a permissive feeling but for an active recognizing milieu which gives meaning and definition to intrapsychic integrative processes. The active love given by the interested parent has greater value than that negative virtue of not traumatizing, which is sometimes held to be the single parental contribution to a child's growth. The tendency has been to bring both parents more often

into the treatment process of the child; for even where split family situations or divorce exists, it is recognized that divorced or separated parents are significant figures in a child's milieu. The child can experience around the treatment situation a unity of hierarchy which really supports what he is able to do.

The nature of children's dependency on parent figures for their growth and development is such that therapeutic work with children must constantly be related to that inescapable reality in their lives. Where the parent constellation can be supportive or even permissive, direct psychotherapy or casework with children has an opportunity to succeed. Where the basic need of a child even for a clear rejection by the parent cannot be realized, the results of therapy are disappointing.

The Role of Fathers in Child Psychotherapy:

The growing awareness that the father should play a part in treatment has had to contend with the belief that the mother is primarily responsible for the child's development. Because of the mother's physical closeness to the child and because of the child's reliance on her through the pre-school period, she is

seen as the basic parent. When the caseworker works mainly with the mother of the child in treatment, he obtains only a secondary picture of how the father reacts to the mother and towards the child.

Some believe that many fathers, even if given the opportunity, would not come in for treatment; that their interest is not great enough, or that their work responsibilities prohibit the channeling of energy sufficient in amount to make the experience meaningful and constructive. 1/, 2/, 3/ Others have found through studies that the father did not independently and stubbornly refuse to go on in treatment. It was found that the father's failure to engage himself in treatment did not arise from his lack of interest or the demands of his outside responsibilities. Rather he seemed to have been driven out, forced into an isolation pattern that was characteristic of the interaction between him and the rest of the family. 4/

1/ Ben O. Rubenstein & Morton Levitt, "Some Observations Regarding the Role of Fathers in Child Psychotheropy", BULLETIN OF THE MENNINGER CLINIC; V 21, #1, Jan. 1957

2/ Mary E. Richards, "When to Include the Father in Child Guidance", SMITH COLLEGE STUDIES IN SOCIAL WORK; V 19, 1949; pp. 79-95

3/ Suzanne T. Van Amerongen, "Initial Psychiatric Family Studies", AMERICAN JOURNAL OF ORTHOPSYCHIATRY, V 24, 1954; pp. 73-83.

4/ H. Plotsky & Shereshfsky, P.M., "An Isolation Pattern in Fathers of Emotionally distrubed Children", AMER. J. ORTHOPSYCHIATRY, V 30, # 6, October, 1960, pp. 780-788

Bearing directly on this thesis, the importance of the father-relationship, especially in the re-education of delinquent children, has been demonstrated in the therapeutic work of Makarenko (1935), Aickhorn (1925), and Slavson (1943), all of whom worked on the basis of establishing a relationship of tolerant, infallible paternal friendship with delinquent boys and girls; using this relationship both as a model for identification and for the focusing of filial attitudes; and exerting a parental-educational influence over the child on the basis of this emotional tie. 1/ The articles of Macdonald (1938) and of Menaker (1939) have thrown considerable light on the role of the absent father in the case of criminally aggressive boys with a passive-effeminate type of character structure. 2/

In 1942, Mildred Burgum published a paper in which she demonstrated by statistics from a child guidance clinic that the father's role was ignored in the early approach to the family and that this fact

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1/ Ivy Bennett, DELINQUENT AND NEUROTIC CHILDREN; A Comparative Study with One Hundred Case Histories; Basic Books Inc., 1960; pp. 163-164

2/ Ibid.

might account for a high dropout rate. 1/ It has also been recognized that the child who is labeled by the family as the patient is not necessarily the "sickest" in the family. Such datum as the above casts doubt on the wisdom of seeing only the identified patient and the mother throughout the treatment process.

In concluding this section on the "Father's Role in Child Psychotherapy", it should be emphasized that the importance of the father's active role in the treatment of a child diagnosed as a "conduct disorder" is evident by his importance in the child's normal emotional development. As had been mentioned in the previous chapter, it should be apparent that whatever may be the effective reason or combination of reasons that result in paternal deprivation, the pathologic effects are to be witnessed in the ego instrument of the individual and in particular in the superego component.

1/ Mildred Burgum, "The Father Gets Worse: A Child Guidance Problem", AMERICAN JOURNAL OF ORTHOPSYCHIATRY; V. 12, No. 3, 1942; pp. 474-485.

CHAPTER IV

STUDY DESIGN

It is believed that the importance of the father's active role in the treatment of a child diagnosed as a "conduct disorder" is indicated by the father's role in the child's personality development. As had been mentioned in the previous chapters, it is believed that whatever may be the cause or causes that result in paternal deprivation, the pathological effects are to be witnessed in the ego instrument of the individual and in particular in the superego component.

The importance of the father relationship, especially in the re-education of delinquent children, was demonstrated in the therapeutic work of Makarenko (1935), Aichhorn (1925), and Slavson (1943), all of whom worked on the basis of establishing a relationship of tolerant, infallible paternal friendship with delinquent boys and girls. 1/ Lawrence Kubie has

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1/ Ivy Bennett, op. cit., Pp. 163-164

stressed the fact that healthy adaptation in family relationships can never come exclusively from one side. 1/ David Levy found that with fathers who had affection for the child the use of psychotherapy to secure their co-operation and to strengthen the paternal role was quickly successful. 2/

More recently, Rubenstein and Levitt published an article in the Bulletin of the Menninger Clinic dealing with the subject of the father's influence in the child's treatment.

> An obvious contradiction appears: Child analytic literature has paid little notice to the father as a potent force in the treatment of his child. Yet our own experience indicates that he wields not inconsiderable influence upon the course of treatment. 3/

The authors say further:

> Our impressions lead us to believe that while the father appears to be a neglected object in the treatment of his son, he continues to maintain the prerogatives of the primal father in his son's unconscious. 4/

1/ Lawrence S. Kubie, PRACTICAL ASPECTS OF PSYCHO-ANALYSIS; W. C. Norton & Co., New York, 1936; p. 169

2/ David Levy, MATERNAL OVERPROTECTION; Columbia University Press, New York, 1943; p. 238

3/ Rubenstein & Levitt, op. cit., p. 16

4/ Ibid.

The concensus among these and other authors is that effective use of the father as a participant in the treatment situation has yet to be perfected. It is hoped that a study such as this one may offer answers to some questions in regard to the most helpful conditions under which the father can participate.

This study was based on one hypothesis which was tested through data collected from the files at the Halifax Mental Health Clinic for Children from January, 1962 through to and including April, 1965. This setting is a diagnostic and out-patient treatment centre for children who are experiencing difficulty in adjusting to their home, school, or social environment. The Clinic is also a teaching centre for resident doctors and students from the Schools of Medicine, Nursing and Social Work. 1/

The hypothesis was stated as follows:

> If the father of a child-patient diagnosed as a conduct disorder becomes actively involved in the treatment of this child, it will show a significant level of difference in terms of duration of treatment time as compared to those cases in which the father is not involved in treatment.

1/ This information was taken from the Halifax Mental Health Clinic for Children, "Form Letter" which may be found in the Appendex.

For the purpose of this study, the phrase "actively involved in treatment" was defined to mean that the natural father was being seen regularly or intermittently, either individually, jointly, or in a group throughout the course of the child's treatment by a "team" 1/ member of the Clinic.

The cases obtained for this study were selected from the discharge diagnoses on the Clinic's files. Discharge diagnoses were used because it was felt that at that time if any other significant findings had been uncovered they would have been recorded. The definition of "conduct disorder" in Chapter III was used in the Clinic for diagnostic purposes.

The "duration of treatment time" was calibrated in months. The unit of measurement would have been more appropriate and more specific if it was recorded by interview sessions rather than months; however, this was not possible with the data available for the study. The cases selected were limited to those terminated by the therapist himself, stating in the closing summary that an appreciable improvement in the child had taken place.

1/ Leo Kanner, CHILD PSYCHIATRY; Charles C. Thomas, Illinois, 1948; p. 252

The following extraneous variables were recorded so that their possible interference and/or relationship might be assessed in relation to the statistical results tabulated:

(1) age
(2) intelligence
(3) school grade
(4) religion
(5) father's occupation
(6) mother's involvement

Some limitations inherent in this type of study lie in the very fact that the material was gathered from case records kept by various social workers and other clinical staff, none of whom were recording with research purposes in mind. Therefore, in some cases the information was not as complete on specific points as in others.

In this study, the t-ratio was used to test the significance of differences between means. Croxton and Cowden [1] state that when the standard deviation of a population is known, the normal curve is appropriate for samples of any size. When the standard deviation of a population is not known, and when the estimated standard deviation of a population is computed from a

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1/ Frederick E. Coxton & Dudley F. Cowden, APPLIED GENERAL STATISTICS; Prentice-Hall, Inc., Englewood Cliffs, N. J.; 1960; p. 657

sample, the t distribution is always the proper distribution to use. As the degrees of freedom increase, the t distribution approaches the normal curve, so that in large samples the normal distribution is sometimes applied. However, even when the degrees of freedom are large, the normal curve is an approximation. Because of thes reasoning, the t-ratio was employed in this study.

When computing this statistic, it is necessary to obtain the arithmetic mean, standard deviation, the standard error of the means, the standare error of the difference for each group, and finally, the significance of the difference between the two means.

The two-sample statistical tests are used when the researcher wishes to establish whether one treatment is "better" than another, as was the case in this study. The group which has undergone a different treatment was compared with the one which has not. In such comparisons of two groups, sometimes significant differences may be observed which were not the results of the treatment. 1/

1/ Sidney Siegel, NONPARAMETRIC STATISTICS FOR THE BEHAVIORAL SCIENCES; McGraw-Hill Book Company, Inc., New York, 1956; p. 61

One way to account for this difficulty imposed by extraneous differences between groups was to compare the means and standard deviations of these variables where ever possible.

It is believed that casework contacts with fathers contribute to the knowledge and understanding of the child and that fathers would enhance the treatment plan. On the basis of the following case studies the above assumption was tested to determine whether or not the fathers made significant use of casework services. This factor should be indicated by a shortening of their children's treatment at Clinic.

CHAPTER V

THE ANALYSIS OF THE DATA

As it is impossible to prove the validity of any causal relationship in the social sciences, this study attempted to reject the following null hypothesis: 1/

> When the father of a child-patient diagnosed as a conduct disorder becomes actively involved in the treatment of this child, there <u>will not</u> be a significant level of difference in terms of duration of treatment time as compared to those cases in which the father is not involved in treatment.

When the null hypothesis can be rejected at a certain level of significance, the study's hypothesis would have some degree of validity. The level of significance that was set for this study was the .05 level.

From the calendar year 1962 through to and including April 1965, there were 942 cases referred to

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1/ Sanford M. Dornbusch and Calvin F. Schmid, A PRIMER OF SOCIAL STATISTICS; McGraw-Hill Book Co., Inc., New York, 1955; p. 127

the Halifax Mental Health Clinic for Children. Out of this number, 247 were assessed and diagnosed within the classification of Conduct Disorders. Six of the 942 cases were not available. This was a sample selected at random from the total number of files at the Clinic. Originally, the sample was to include only those cases in the calendar years 1962 and 1963. However, since the testable sample of cases was not large enough from this original sample it was extended to all cases up to April 30, 1965.

As shown in Table I, out of the 247 cases, 157 of them were either not treated or treated but terminated before completion of treatment as designated by the therapist. Of these 157 cases, 93 were terminated because of "lack of parental motivation" as quoted from the closing summaries. Others were referred only for assessment by other agencies or could not become involved, or continue treatment because the families were not within commuting distance of the Clinic. Fifty-three of the 247 cases were referred to other agencies or institutions for treatment. Twenty cases are still open or have been re-opened at the Clinic. Only 17 cases had been terminated by the therapist, stating in the closing summary that an appreciable improvement in the child had

TABLE I

DISTRIBUTION OF 247 CHILDREN DIAGNOSED AS CONDUCT DISORDERS AT THE HALIFAX MENTAL HEALTH CLINIC FOR CHILDREN BETWEEN JANUARY 1, 1962 AND APRIL 30, 1965 BY FINAL DISPOSITION

TOTAL	247
Cases not treated or treated but terminated before completion of treatment as designated by therapist. a/	157
Cases referred to other agencies or institutions.	53
Cases still opened or re-opened	20
Cases terminated by the therapist and showing an appreciable improvement	17
a/ Terminated because of lack of parental motivation	93

RAR/new

taken place. Of these 17 cases, two were girls. These were discarded because of sex difference which left 15 cases to be tested.

The 15 cases were divided into two unequal groups according to whether or not the fathers were involved in treatment. In 7 cases the fathers were not involved and in 8 cases they were involved in treatment. By applying the t-test to these two groups with 13 degrees of freedom, a value for t of 1.40 was obtained. At the .05 level of significance t=1.77 and at .10 level t=1.35 (see Table II). Thus, the null hypothesis at the .05 level of significance could not be rejected. There was no significant difference evident in the duration of treatment time between the two groups. However, at the .10 level of significance the difference between the groups was significant.

The means and standard deviations of the extraneous variables, age, intelligence, and school grade, are shown in Tables III and IV, respectively. By inspection it was obvious that none of these differed to a significant degree between the groups. The difference in religious faiths is shown in Table V. In all 15 cases the mothers were involved in the treatment plan. An accurate account of the father's occupations was not available from the files.

TABLE II

RESULTS OF TEST OF SIGNIFICANCE OF DIFFERENCE BETWEEN MEANS IN THE DURATION OF TREATMENT TIME ON CASES WHERE FATHERS WERE INVOLVED IN TREATMENT AND 7 CASES WHERE FATHERS WERE NOT INVOLVED IN TREATMENT

FATHERS INVOLVED		FATHERS NOT INVOLVED	
N_1	= 8	N_2	= 7
$\leq X_1$	= 70	$\leq X_2$	= 88
$\leq X^2_1$	= 726	$\leq X^2_2$	= 1290
M_1	= 8.75	M_2	= 12.57
M^2_1	= 76.56	M_2^2	= 146.00
SD_1	= 16.21	SD_2	= 30.62

$S.E._{dm}$ = 2.53

t = 1.40 df = 13 p = .05, < .10

RAR/new

TABLE III

MEANS OF THE EXTRANEOUS VARIABLES IN CASES WHERE THE FATHERS WERE INVOLVED IN TREATMENT AS COMPARED TO THOSE CASES IN WHICH THE FATHERS WERE NOT INVOLVED IN TREATMENT

EXTRANEOUS VARIABLES	MEANS (Fathers Involved)	MEANS (Fathers NOT Involved)
Age	11 years	10.71 years
School Grade	4.75	4.43
Intelligence	91.28 I.Q.	92.8

RAR/new

TABLE IV

STANDARD DEVIATIONS OF THE EXTRANEOUS VARIABLES IN CASES WHERE THE FATHERS WERE INVOLVED IN TREATMENT AS COMPARED TO THOSE CASES IN WHICH THE FATHERS WERE NOT INVOLVED IN TREATMENT

EXTRANEOUS VARIABLES	S.D. (Fathers Involved)	S.D. (Fathers NOT Involved)
Age	2.0	2.6
School Grade	2.0	2.8
Intelligence	46.0 a/	12.25

a/ For this value only, N = 5; intelligence tests were not included in the psychological battery for two of the children.

RAR/new

TABLE V

DISTRIBUTION OF THE 15 CASES USED FOR THIS STUDY ACCORDING TO RELIGION

RELIGION	TOTAL	FATHERS INVOLVED	FATHERS NOT INVOLVED
Total	15	8	7
Roman Catholic	5	2	3
Protestant	7	4	3
Jewish	2	1	1
Not recorded	1	0	1

RAR/new

The implications of some of these findings will be considered and discussed in the following and final chapter of this thesis, Conclusions and Recommendations.

CHAPTER VI

CONCLUSIONS AND RECOMMENDATIONS

Out of the total population of patients referred to the Halifax Mental Health Clinic for Children from January 1962 through to April 30, 1965, there were 247 patients assessed and diagnosed within the classification of Conduct Disorders. Only 17 cases fulfilled the criteria of the testable hypothesis. A further breakdown of the 247 cases was illustrated in the previous chapter in Table I. (The possible implications of these findings will be commented on below.)

The hypothesis which stated that there should be a significant difference in the length of treatment between child-patients diagnosed as conduct disorders whose fathers are actively involved in treatment as opposed to those who were not, was tested by the *t*-ratio. The results did not support the testable hypothesis. The accepted level of significance for this study was .05.

The conclusions drawn by Makarenko, Aichhorn and Slavson on the importance of the father-relationship in the re-education of delinquent children which was discussed in Chapter III, were not found to hold true for the samples selected for this study.

It cannot be said, however, that this study absolutely disproves the findings of the above mentioned authors. Nor did it absolutely disprove the theoretical basis of this thesis emphasizing the importance of the father's active role in the treatment of a child diagnosed as a conduct disorder which is evident by his importance in the child's normal emotional development. It may only be said that these findings did not hold true for the groups studied.

The small number of patients whose treatment was terminated as successful at the clinic gave some indication of the many difficulties that must be encountered in treating conduct disorders, and also, the great need for implementing new techniques and resources. One worker stated, "A therapist tends to identify more easily with a neurotic child". A social caseworker directly treating emotionally disturbed children of this sort needs to be well trained in psychodynamics and in all the details of therapy. The caseworker working as

a child therapist must have great patience and perseverence, and be content with small gains. He must accept the child who continues with dissocial behavior, recognizing that the child is behaving in the only way possible for him and it remains for the clinical team to discover why the child continues with dissocial behavior.

Another appropriate area of investigation may lie in the question, "Why were such a large number of cases terminated because of lack of parental motivation?" How much of this could have been caused by an inability of the clinic to reach out to these families? In an earlier study done at the Clinic 1/ it was found that families in the lower class had hostility towards the helping people in the fields of mental health and many did not understand the function of a clinic or the background of the workers. Lower class parents often were found not to see their children's behavior problems as problems and were accepting of them. It was when they became visible to the community that the children were

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1/ Mary Bernardine Conloque, SOCIOECONOMIC STATUS AND EMOTIONAL DISTURBANCE IN CHILDREN; Unpublished thesis, Maritime School of Social Work, 1964; pp. 50-52

referred to the Clinic by a community resource.

A new community service which may in the future enhance the Clinic in treating families in the lower class in the metropolitan area is the Neighbourhood Center Project. 1/ Through the workers at the Center, the Clinic should be better able to understand and assess the needs of families referred from this area. Also, through the Center, treatment may be carried over into the community from which the family comes.

A study already mentioned by Mildred Burgum 2/ demonstrated by statistics from a child guidance clinic that the father's role was ignored in early approach to family and that this seemed to account for a high dropout rate. This same factor may have contributed to the significant number of dropouts in this study. However, presently the Clinic has taken measures to help alleviate this possible problem by inserting section II in their initial letter form to parents. (Appendix B) It states, "If the assessment of your child indicates

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1/ Halifax Neighbourhood Center Project, THE WELFARE COUNCIL (Halifax-Dartmouth Area); Board of Directors, 1965

2/ Mildred Burgum, "The Father Gets Worse: A Child Guidance Problem", AMERICAN JOURNAL OF ORTHOPSYCHIATRY, V 12, No. 3, 1942; pp. 474-485

the need for treatment, it will be necessary for BOTH parents to be involved in the treatment plan on a regular basis". This may still be further improved upon if it was emphasized that BOTH parents should accompany the child to the assessment and when either parent can not attend, he or she will be interviewed at home before the assessment will be considered complete for diagnosis.

It should be mentioned here that from the schedule used for this study it could not be accurately determined how many patients actually were only assessed at Clinic as opposed to those who were assessed and began treatment. (Appendix A) The only dropouts that were recorded as such were those who dropped out because of lack of parental motivation. For a more accurate account of the total number of dropouts, the present schedule would need to be improved.

If research is to be encouraged, there seems to be a need for more comprehensive and accurate recording practices at the Clinic. This was indicated by the actual data that was available for this study. Illustrations of this were evident by some of the indices that had to be used, such as, having to measure duration of treatment time in months rather than sessions. In the Appendix C there have been inserted two forms that

illustrate possible practices that may be improvised by the Clinic: (1) Application Form, and (2) Caseworker's Monthly Work Sheet. Both froms have been designed by the Family Service Association of America. Through such ramifications as these suggested, the Clinic can more objectively measure the efficiency and effectiveness of their clinical process as a whole. It will also be an inducement for others interested in research studies to use the Clinic as their setting for such projects.

In conclusion, it has been realized that the social worker involved in therapy with children and their families must know and be able to use his community. He needs to know a whole spectrum of existing resources such as health and welfare services, as well as resources for recreation, athletics, the arts, and education. He should understand the destructive influences which promote delinquent behavior and the weaknesses which precipitate problems. He must be ready and willing to fight for changes which will provide social advantages and eliminate areas of dysfunctioning.

There has developed in Child Guidance, a greater understanding of the social nature of the problem from the sensitive identification with, and willingness to learn from, what parents and children have been demon-

APPENDIX A

STUDY SCHEDULE

Sex: M ( ) F ( )

Treatment Time: ____
(months)

Age: ____

Intelligence: ____

School Grade: ____

Father Involved:
yes ( ); no ( )

Religion: _____

Father's Occupation:

_____

Mother Involved:
yes ( ); no ( )

1. Case not treated and/or treated but terminated before completion of treatment:

yes ( ) no ( )

* Reason:

Lack of parental motivation ( )

2. Case referred to another agency or institution:

yes ( ) no ( )

3. Case still opened or reopened:

yes ( ) no ( )

4. Case not available:

yes ( ) no ( )

THE HALIFAX MENTAL HEALTH CLINIC FOR CHILDREN

5970 University Avenue, Halifax, N.S. Phone 423-7254

TO:_____ Date_____

_____

_____

Your child, _____, has been referred to the Child Guidance Clinic for an assessment. The following information will be of interest to you. Please read it carefully.

(1) The Child Guidance Clinic serves all children (who have not yet reached their 16th birthday) in the Halifax-Dartmouth area, the County, and the Province.

(2) The Child Guidance Clinic is a Diagnostic and Out-Patient Treatment Centre for children who are experiencing difficulty in adjusting to their home, school, or social environment.

(3) The Child Guidance Clinic is also a Teaching Centre for resident doctors, and students from the Schools of Medicine, Nursing and Social Work. The information obtained during the evaluation is always handled with professional discretion.

(4) Our Clinic Nurse may contact you during the waiting period of your first appointment. This would depend on the nature of the child's problem, urgency, etc.

(5) Parent(s) or guardian MUST accompany the child on his/her first visit to the Clinic. Usually the Social Worker will interview the parent/guardian to obtain a social history regarding the child. At the same time the child will be seen, separately, by the psychiatrist. The results of all assessments, psychological testing, etc. done at the Child Guidance Clinic will be interpreted to you by the Social Worker, as soon as the results are known.

(6) PLEASE DO NOT BRING OTHER CHILDREN IN THE FAMILY WITH YOU AT THE TIME OF YOUR CHILD'S APPOINTMENT. There are no baby-sitting facilities at the Child Guidance Clinic and your full attention will be required at the time of your child's assessment. Your first appointment will take approximately 2 to 2½ hours so plan on being free to spend this time at the Clinic.

(7) There is a minimal fee of 50¢ per visit, and those financially able to pay this fee are expected to do so. Insurance schemes do not cover this 50¢ fee at present.

(OVER)

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Due to the large number of children being continually referred to this Clinic for assessment, you may have to wait from 6 to 8 weeks for your first appointment time. If an appointment time cannot be kept, we would expect at least 72 hours notice in order that some other child may benefit from this valuable assessment time.

In order that we may assess your child's case in the best possible manner, it may be necessary for us to obtain additional information from other sources - i.e. school, social agencies (i.e. Family Service Bureau, Children's Aid Society, Department of Public Welfare, etc.), doctor, hospitals, etc.
Written permission will be requested before any source is contacted. Please list below any of these sources with which you have had contact.

_____

_____

_____

_____

If there is any specific source(s) you do NOT wish to have us contact, please list below; also reason -

_____

_____

_____

We will only release information regarding your child's assessment here at the Child Guidance Clinic, with your consent. This may be discussed with the social worker.

If the assessment of your child indicates the need for treatment, it will be necessary for BOTH parent(s) to be involved in the treatment plan on a regular basis. This will be discussed with you in more detail when the assessment is completed, and questions relating to the assessment or treatment may be discussed with the social worker at any time.

PLEASE RETURN ONE COPY OF THIS LETTER PROPERLY SIGNED AND WITNESSED AT YOUR EARLIEST CONVENIENCE. WE WILL THEN CONTACT YOU WITH AN APPOINTMENT TIME. A self-addressed envelope is enclosed for your convenience.

"I have read the above information, understand and agree to the procedure regarding my child's assessment at the Child Guidance Clinic."

(Signed) .....
Parent/Guardian

(Witnessed by) ..... Dated .....

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APPENDIX C

ME	FIRST NAMES	WOMAN'S MAIDEN NAME	ALIAS—PREVIOUS MARRIAGE	RECORD NO.

SS	TEL. NO.	AREA	DISTRICT	INCOMING DATE

	INCOMING STATUS
	____NEW TO AGENCY
E OF APPLICATION TEL. NO.	____SERVICE LAST TERMINATED—PRIOR YEAR
MARITAL STATUS	____SERVICE LAST TERMINATED—THIS YEAR
MC UC W DES DIV SEP S OTHER	

FAMILY	BIRTH DATE	OCCUPATION OR SCHOOL OR WHEREABOUTS IF AWAY	BIRTHPLACE	RACE	RELIGION	CITIZEN YES | NO	RESIDENT YES | NO
N							

OF SINGLE CHILDREN	SEX		

FAMILY	EDUCATION	MARRIAGE DATE	CROSS REFERENCES
MAN			
WOMAN			

EMPLOYER	FAMILY MEMBER

S IN HOUSEHOLD		RELATIONSHIP TO HEAD	INCOME	FEE	CASEWORKER

PRIMARY FOCUS OF SERVICE

FAMILY AND INDIVIDUAL RELATIONSHIPS

1. ____ MARITAL RELATIONSHIPS
2. ____ PARENT-CHILD RELATIONSHIP OR RELATIONSHIP OF INDIVIDUAL CHILD UNDER 18
3. ____ OTHER FAMILY RELATIONSHIPS OR RELATIONSHIPS OF INDIVIDUAL ADULTS
4. ____ TOTAL FAMILY RELATIONSHIPS

ENVIRONMENTAL OR SITUATIONAL CONDITIONS

5. ____ FINANCIAL DIFFICULTY
6. ____ PHYSICAL ILLNESS OR HANDICAP
7. ____ MENTAL ILLNESS
8. ____ INTELLECTUAL RETARDATION
9. ____ ARRANGEMENTS FOR PHYSICAL CARE OF FAMILY MEMBER
10. ____ OTHER ENVIRONMENTAL OR SITUATIONAL CONDITION

OTHER

11. ____ REPORT GIVEN ON TERMINATED SERVICE
12. ____ INQUIRY MADE FOR OUT-OF-TOWN AGENCY

REASON FOR TERMINATION

I TEL. OR CORR. ONLY WITH FAMILY OR CONTACT ON BEHALF OF FAMILY

1. ____ FAMILY DID NOT FOLLOW THRU
2. ____ REFERRED ELSEWHERE
3. ____ PRESENTING REQUEST OR NEED MET BY AGENCY
4. ____ REPORT GIVEN ON TERMINATED SERVICE
5. ____ INQUIRY MADE FOR OUT-OF-TOWN AGENCY
6. ____ SERVICE NOT AVAILABLE

II IN-PERSON INTERVIEW(S) WITH FAMILY

7. ____ REFERRED ELSEWHERE
8. ____ SERVICE TERMINATED BY CASEWORK PLAN
9. ____ FAMILY WITHDREW OR TERMINATED SERVICE
10. ____ FURTHER SERVICE NOT POSSIBLE

FINANCIAL ASSISTANCE GIVEN

____ YES ____ NO

DATE TERMINATED

CATEGORY OF SERVICE AT TERMINATION

- ____ TEL. OR CORR. ONLY WITH FAM.
- ____ ONE IN-PERS. INTERVIEW WITH FAM.
- ____ 2–5 IN-PERS. INT. WITH FAM.
- ____ 6 OR MORE IN-PERS. INT. WITH FAM.

} THRU CONTACT WITH FAMILY

- ____ THRU CONTACT ON BEHALF OF FAMILY

ASSIGNED TO OTHER WORKERS
ED DURING MONTH

CASEWOR
OF WORK

FAMILY NO. OR FIRST NAME	JOINT SERVICE FAMILIES CONTACTED	OTHER WORKERS' FAMILIES CONTACTED	CONTACTS DURING MONTH							
			WITH FAMILY				WITH COLLATERAL			
			IN-PERSON INTERVIEWS		TELEPHONE	CORRES.	IN-PERSON INTERVIEWS		TELEPHONE	CORRES.
			IN OFFICE	OUT OF OFFICE			IN OFFICE	OUT OF OFFICE		
TOTALS	NO. OF FAM.	NO. OF FAM.				XXX				XXX

IAL ASSISTANCE IN MONTH

FAMILY NO. OR FIRST NAME	FAMILIES RECEIVING PUBLIC ASSISTANCE ALSO	OTHER ASSISTANCE FAMILIES	TOTAL AMOUNT FROM AGENCY	OF TOTAL AMOUNT FROM AGENCY	
				HOMEMAKER SERVICE	FOSTER CARE PAYMENTS
	$	$	$	$	$
TOTALS — NO. OF FAMILIES					
AMOUNTS	$	$	$	$	$

FAMILY CO

1. CARR
2. INCO
   A. T
   B. I
      (1
      (2
      (3
3. TRAN
4. TOTA
5. TRAN
6. TOTA [4 —
   A.
   B.
      (
      (
      (
7. OUT
   A.
   B.
8. CAR

FAMILIES
CONTACT

9. JOI
10. OTH

SUMMA

11. IN-P INT
    A. I
    B. C
12. TE

CASEWORKER'S SUMMARY OF WORKSHEET

CASEWORKER	POSITION	MONTH

FAMILY COUNT:

	NUMBER OF FAMILIES
1. CARRIED OVER FROM LAST MONTH	
2. INCOMING IN MONTH: TOTAL [A + B]	
A. TRANSFERRED FROM OTHER DISTRICT	
B. INCOMING TO AGENCY: [(1) + (2) + (3)]	
(1) _____	
(2) _____	
(3) _____	
3. TRANSFERRED FROM OTHER WORKERS WITHIN DISTRICT	
4. TOTAL FOR CASEWORKER: [1 + 2 + 3]	
5. TRANSFERRED TO OTHER WORKERS WITHIN DISTRICT	
6. TOTAL AS COUNTED FOR AGENCY (OR DISTRICT): [4 − 5 OR A + B]	
A. ACTIVE IN MONTH	
B. INACTIVE IN MONTH: [(1) + (2) + (3)]	
(1) _____	
(2) _____	
(3) _____	
7. OUTGOING IN MONTH: TOTAL [A + B]	
A. TRANSFERRED TO OTHER DISTRICT	
B. TERMINATED IN MONTH	
8. CARRIED FORWARD TO NEXT MONTH [6 − 7]	

FAMILIES ASSIGNED TO OTHER WORKERS. CONTACTED DURING MONTH:

9. JOINT SERVICE FAMILES CONTACTED	
10. OTHER WORKERS' FAMILIES CONTACTED	

SUMMARY OF CONTACTS DURING MONTH:

	TOTALS FROM PAGE 1		TOTALS FROM PAGE 2		TOTALS	
	FAM.	COLL.	FAM.	COLL.	FAM.	COLL.
11. IN-PERSON INTERVIEWS: TOTAL						
A. IN OFFICE						
B. OUT OF OFFICE						
12. TELEPHONE						

CATEGORY OF SERVICE AT TERMINATION:

	NUMBER OF FAMILIES
13. THRU CONTACT WITH FAMILY: TOTAL [A + B + C + D]	
A. TELEPHONE OR CORRESPONDENCE ONLY	
B. ONE IN-PERSON INTERVIEW WITH FAMILY	
C. TWO–FIVE IN-PERSON INTERVIEWS WITH FAMILY	
D. SIX OR MORE IN-PERSON INTERVIEWS WITH FAMILY	
14. THRU CONTACT ON BEHALF OF FAMILY	
15. TOTAL TERMINATIONS [13 + 14, SAME AS LINE 7B]	

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