CLINICAL TREATMENT OF ADOLESCENT WITH
BEHAVIOUR DISORDERS

An Evaluative Survey of Patients Admitted
To Crease Clinic, (British Columbia), 1956-1958.

by

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Thesis Submitted in Partial Fulfilment
of the Requirements for the Degree of
MASTER OF SOCIAL WORK
in the School of Social Work

Accepted as conforming to the standard
required for the degree of
Master of Social Work

School of Social Work.

1959

The University of British Columbia.
ABSTRACT

As a short-term psychiatric centre, Crease Clinic was designed for the treatment of adults. In common with many other adult mental institutions in North America, however, it has increasingly been asked to assume responsibility for the care of adolescents, because of the lack of more appropriate resources for young people. Conscious of the fact that the younger patients need a type of treatment different from that of adults, the Clinic has, at various times, tried to introduce modifications within its main psychiatric programme for the benefit of this age-group. Nevertheless, adolescent patients have continued to pose problems to both the hospital and community, and there are serious questions on both sides as to what legitimate achievements can be expected from their treatment in the Clinic.

Accordingly, this study surveys the problems and needs of a selected group of adolescent patients, namely, those suffering from behaviour disorders. In the light of dynamic knowledge of their personality structures, it seeks to evaluate the degree to which the Clinic is meeting the needs, and the directions in which its programme might be strengthened or modified. The group of adolescents, those thirteen to nineteen years of age who were admitted to Crease Clinic in the period 1956 - 1958, numbers forty-four in all. Information derived from the clinical records covers the problems they presented, their family backgrounds, and their living circumstances at the time of admission. The clinical treatment programme is examined in its basic aspects of: (1) "milieu" and activity programmes;
(2) psychotherapy and somatic therapies; (3) participation of parents; (4) the role of social service. Data were obtained on this portion of the study from the files of the sample group of patients, from interviews with staff members, and from the writer's personal experience as a social worker in Crease Clinic.

The main conclusion reached is that there is a clear need for a specific unit for the treatment of adolescents, whether it be attached to the mental hospital, or established separately within the community. The treatment currently available within the Clinic for these young patients is not adequate to meet their needs; some of the primary deficits appear to be: (1) the limit upon the period of residence in the Clinic; (2) insufficient structuring and coordination of the various therapeutic programmes, and (3) the lack of individually planned treatment related to each patient's particular needs and problems. There is evidence that Crease Clinic can offer this type of patient limited service as an emergency resource for suicidal or assaultive youngsters, as a diagnostic resource for those needing immediate assessment or a period of observation, and as a treatment unit for the minimally-disturbed adolescent whose "acting-out" seems to stem from current situational stresses. However, to effect permanent treatment gains for this group of disturbed adolescents, an appropriately-staffed in-patient resource, designed specifically to meet their needs, is essential.
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Date April 13/59
ACKNOWLEDGEMENT

I should like to express my appreciation of the interest shown in this study by the Social Service Department staff at Crease Clinic. My particular thanks are to Miss Dorothy Begg, the Assistant Director of Social Services for the Mental Health Services, who was not only helpful throughout with suggestions and encouragement, but who was also ever available for minute queries about clinic policy and problems. My appreciation is also expressed to Dr. Ian Kenning, Clinical Director of Crease Clinic, for his kindness in providing information about policy and regulations.

I should like to express my gratitude to Miss Muriel Cunliffe and to Dr. Leonard C. Marsh for their many helpful suggestions and criticisms of both content and structure of the study.
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CLINICAL TREATMENT OF ADOLESCENTS

WITH BEHAVIOUR DISORDERS
CHAPTER I

ADOLESCENTS WITH BEHAVIOUR DISORDERS

Because of the lack of research and statistical material available, it is difficult to estimate, even approximately, the number of adolescents who suffer from a behaviour disorder. One group in the United States suggested there were 1,134,000 children so afflicted in that country; in Canada, no comparable figure has been computed. While statistics are readily available concerning mental hospital residence of adolescents with behaviour problems, this in no way delineates the total prevalence of the disturbance, for only a minority ever enter public institutions. In discussing the great need for research in the field, the American Psychiatric Association states: "One major difficulty ... is that no reliable data exist on the incidence and prevalence of childhood psychiatric disorders..." What can be said with certainty is that youngsters with behavioural problems exist in sufficient numbers to be of great concern to those who work with teen-agers in various agencies, recreational or educational, and to those who encounter their problems in the community at large. In speaking of the need for service to these children,

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the Psychiatric Association goes on to say: "Lack of valid data in all these areas makes it impossible to do more than venture a crude guess as to the extent of the need for psychiatric ... service for emotionally ill children. It is known, however, that the need exists, and that it is great."

It is necessary to consider what is meant by the term "behaviour disorder", and, for the purposes of the study, to consider its occurrence in the adolescent years. Unfortunately, it is a descriptive term which has been used with some looseness. In general, it has been used to describe children who characteristically "act-out", rather than internalize their emotional conflicts, and who show symptoms in their behaviour rather than in mental, physical, or emotional spheres. However, in the adolescent period, by its nature a time of instability and flux, it is rare to see a "pure" problem in behaviour, or one that does not also evidence some degree of disturbance in the other areas mentioned. Speaking of the difficulties of diagnosing the disturbed adolescent, Nathan Ackerman notes: "...differential diagnosis in the adolescent era presents great difficulties. It is highly complicated by the infinitely changing facades of personality that are characteristic of this period." So complex does Ackerman find the problem that he

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4 Ibid., p. 134.

goes on to ask: "When is adolescent behaviour, with its inevitable accompaniment of anxiety, conflict, confusion, and multi-coloured disturbances, 'normal'? When is it 'abnormal' and for what specific reasons?"

Today in North America, it appears as if almost all adolescents at times show unusual behaviour, are occasionally defiant, rebellious, withdrawn, moody, or anti-social. The key to whether this is "normal" or not is the extent, duration, and context of these symptoms. Transitory, relatively mild disturbances need not constitute clinical pathology. On the other hand, a consistent pattern of, for example, hostility to parents, law-breaking activity, or inability to control sexual or aggressive drives is far more likely to indicate a profound type of disturbance.

In the present study, the term "behaviour disorder" will be used to refer to those youngsters whose primary symptoms are shown through disturbed behaviour patterns, rather than by internalized conflict, although the latter may be present in some degree.

Having arrived at a descriptive statement about the disorder, it may be asked what are the causes of these symptoms. What has gone wrong with these children, and why is their disturbance shown in this way? From the viewpoint of dynamic psychology, the behaviour disorder can be seen to

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6Ibid.
arise from disturbances in the development of the personality structure. It is possible to distinguish four primary areas of impairment.

1. **Failure to develop a strong ego structure.** That most of the youngsters with behaviour disorders suffer from weak egos is demonstrated by their inability to consistently control their basic sexual and aggressive drives, by distortions in their perception of reality, by their tendency to retain infantile feelings of omnipotence, and by their basically ego-centric orientation. These are all characteristics normal to the first year of life; but, when personality development is satisfactory, they are replaced by more mature and more socially-acceptable modes of functioning. It has been well established that if a child is to mature emotionally, he must have a climate of love, encouragement, and security. If these qualities are lacking within his environment, he will tend not to develop and will remain "fixed" at a primitive, infantile level of operation. Damage to this maturation process can have its start within the first year of the child's life. During infancy, manifestations of love and security are perceived by the baby through physical contact with his mother and through having his need for food met without prolonged frustration. Brenner notes that "... if the infant is deprived of normal, physical handling and stimulation by a maternal figure..., many of its ego functions will fail to develop properly and its capacity to relate and to deal with its external environment may
be impaired..." Pursuing the causes of failure in ego development further, he goes on to say: "... even after the first year of life, the development of necessary ego functions may be marred by a failure to develop the necessary identification, owing either to excessive frustration or to overindulgence..."

2. **Failure to make adequate identifications.** The preceding citation leads to the second area of impairment found in the personality structure of those youngsters having a behaviour disorder.

Failure in identification occurs in the absence of warm, affectionate parental attitudes. Ackerman points this out in his statement: "\(\text{When}\) the child simply does not get the needed emotional acceptance and the usual social rewards for submitting to restraint... the parents' standards of social conduct and control are not internalized, and there is a corresponding failure of or impediment to the process of identification with the parents." The lack of impairment of the identification process can be reflected in many ways: confusion about sexual identity, distortions of self-image, difficulty in forming close and stable relationships, or failure to learn and accept social values. The process of identification with parents is implicit to both intra-psychic and social adjustment; consequently, a failure in this process is severely damaging to the

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9 Ackerman, pp. 201-202.
child's personality and to his functioning within society.

3. **Failure in the development of the super-ego.** This is another major outcome of disruption of the normal growth process.

Once again, the reward of parental approval provides the earliest motivation for the child to curb his aggressive drives and to postpone the desire for immediate gratification of his needs. If the parents are loving and consistent in their handling, the child learns and accepts their demands with a minimum of difficulty. As he identifies with them, he is gradually able to internalize their moral standards concerning right and wrong and to incorporate their prohibitions into his own personality, so that he decreasingly needs to rely upon external forces for guidance in moral and social conduct. With a basic failure in identification, however, internalization does not take place and the child develops an imperfectly realized set of values and controls. With an impaired super-ego, the youngster tends to be at the mercy of his own impulses, and necessarily, has to continue to look to outside sources for controls, which are generally perceived purely in terms of punishment and reward rather than in terms of inherent morality. Since the child has few internal guideposts by which to judge his own behaviour, he is inclined to feel little anxiety about actions which his culture may deem "anti-social". Again, it must be stressed that few youngsters fail totally in the matter of developing a super-ego, but some impairment in its functioning is evident in most children who suffer from behaviour disorders.
Another aspect to this matter of identification and internalization is, of course, the adequacy and consistency of the parental values themselves. The parents' standards represent for the child his first contact with the expectations of the society in which he lives. If they are out of harmony with the generally prevailing values of the society, conflict and confusion must inevitably be in store for the youngster in his career as a social being. Similarly, if the parents are highly inconsistent in either their own standards or in their handling of the child in terms of rewards and punishment, confusion and frustration will result.

While the problem of inadequate learning of moral values, or the learning of socially unacceptable values, usually reflects parental failure, so, too, can it reflect problems within the wider society. In a society undergoing rapid change or disorganization, the moral values are frequently changing, too. Present-day North America offers a picture of this sort, with the result that there are relatively few absolute values to turn to, and that there is much uncertainty and contradiction concerning standards of behaviour. That the lack of firm rules and standards provokes anxiety and insecurity is well-known, but how much more difficult it is for the child who also lacks the security of strong, protective parents.

4. Failure to learn adequate social roles. This reference to difficulties in social learning leads directly to the fourth area of impairment exhibited by many adolescents with
behaviour disorders.

Like the learning of values, the acquiring of social roles depends in large measure upon successful identifications. Impairment in the process can occur through the above-mentioned forms of parental inadequacies—failure to provide the motivating forces of love and security which encourage the child to develop, inconsistencies in their handling and expectations of the child, or confusion as to their own roles. However, this is another area in which the society also plays a paramount part. It is obvious that in a society where roles and role-expectations are clearly defined and rigidly adhered to, the role-learning process will be facilitated. Conversely, in a quickly changing society such as contemporary North America, the process is less easy. A brief, but cogent illustration can be seen in the uncertainty surrounding the respective roles of parents. Less and less is the husband the sole wage-earner or the wife the sole home-maker. Each has gradually invaded what were once regarded as distinct precincts of the other—the husband to undertake household tasks, the wife to contribute to the family income. How, then, is the child to comprehend which roles are appropriate to mother, and which to father?

Having outlined some of the major causative factors of behaviour disorders in general, it is, perhaps, pertinent to add some observations about the problems of the North American adolescent in particular, since this is the focus of the present study. Realizing the dangers involved in attempting to
generalize about so disparate an entity as "North American society," there nevertheless seem to be several elements in the perception of adolescence which are peculiar to this continent. The tendency to isolate teen-aged children into a group apart from the rest of society, and the lack of clear-cut role expectations of them, are two important cultural manifestations. Concerning the latter, there seems to be an imbalance between the responsibilities and privileges assigned to North American adolescents. On the one hand, they are given many privileges generally ascribed to adult status—personal freedom, economic power as a purchaser, and opportunities for sophisticated social contacts. On the other hand, few demands are placed on them to contribute financially to their own or their families' support, or to devote time or energy to adult responsibilities within the home. This may pose at least two problems: first, the lack of stated duties within the family may afford the adolescent lessened opportunity to identify with adult roles; second, it may impede his motivation to give up the sheltered, privileged life he has enjoyed in order to take on the responsibilities of adulthood.

Another characteristic of contemporary North America is the tendency to view adolescence as an intrinsically "difficult" period. Both lay and professional people have come to consider the teen-age years as conflict-laden, and to anticipate disturbance as an almost inevitable outcome. Yet it is known that there are countries in which children manage to enter adulthood
with much less Sturm und Drang than is generally true of this continent. In societies where the expectations of performance in all age-groups are more clearly defined, where the time between childhood and adulthood is neither protracted nor crystallized into a specific "period," the conflict of "growing up" seems minimal. Furthermore, in many other cultures, the responsibility for child-rearing is not left wholly to the parents, but is diffused among many persons within the tribe, village, or community. Under this system, the failure of parents to meet their children's needs might be counteracted by the participation of other significant persons. In the North American "nuclear" family such a second chance seems to be rather rarely available.

The attempt to examine some of the major emotional and social causative factors in the development of behaviour disorders in the adolescent is pertinent in order to understand what is behind his aggressive "acting-out" behaviour. It is only through such examination that the needs of these youngsters can be recognized, and an adequate plan of treatment can be arrived at. Through the above outline, it can be seen that the adolescent with a behaviour disorder has had two large areas of deprivation: a lack of affection and parental love; and, a lack of consistency in his handling. Not being able to discover what is expected of him, and unable to gain consistent love by any

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action, the child is likely to give up the unequal struggle. Accordingly, though he grows physically and mentally to adolescence, he retains an infantile emotional orientation towards his world. Uncomprehending of many of his society's admittedly confusing values, and having only limited control of his own drives, his "acting-out" may result from child-like impulsiveness. On the other hand, it may reflect an attempt to gain attention from his indifferent parents—to coerce them into noticing him. For some of these youngsters, their major experience of attention has been in receiving punishment; yet, even this is better than being completely overlooked.

Still another type of "acting-out" is seen in the neurotic youngster. In his case it does not stem from lack of controls or values, but is a symbolic way of expressing his wishes or needs. Since such desires may be highly threatening to him, he cannot express them verbally. If they are too strong for him to contain, he may then regress to a pre-verbal level of functioning, wherein he can demonstrate them symbolically. Since the primarily neurotic youngster is excluded from the present study, this "symbolic acting-out" will receive little further discussion, but it is important to differentiate the underlying dynamics of apparently similar symptoms.

The Costs to the Community

When discussing the implication this large group of disturbed youngsters has for the community, it has become common
to estimate the financial costs involved in maintaining services for their treatment, in the property damage they wreak, and in their loss as contributing members of society. When such figures are added up, they can represent a staggering total. It has been estimated that a disturbed child who remains untreated may easily cost the community $40,000 in his lifetime.

Perhaps more important, if more difficult to measure, are the emotional costs—to the child himself, to his family, and to those he comes into close contact with. Unlike physical pain, emotional suffering is not measurable in dollars, but its intensity has never been doubted.

For the social work profession, the problems these youngsters present are manifold and all too familiar. The adolescent with a behaviour disorder is found in child welfare, recreational, correctional, and psychiatric settings; indeed, he is ubiquitous in all social agencies. He is rarely seen alone in his problems; his family, too, is known to the social worker. Many, though not all, of these youngsters come from "multi-problem" families whose histories may include long-term contact with diverse agencies. Perhaps the most discouraging feature of such families is their almost inevitable reproduction of the social problems concerned. Empirically, social workers have found that, without help, these problem children will

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11 As quoted in a pamphlet printed by the Children's Foundation of British Columbia, *This Child is Ill*, (Vancouver, Children's Foundation, 1958.)
almost certainly become problem parents who, in turn, will produce more problem children. For this reason, it is demonstrably economical of both finances and human emotions to assist these youngsters in finding a healthier level of emotional adjustment.

Some Attempts at Solution

The majority of adolescents with behaviour disorders are at present treated on an out-patient level, and probably will continue to be. Wherever possible, it is desirable to keep the youngster in his own home, and to attempt both treatment of the child and modification of damaging parental attitudes therein. Almost all community social agencies offer service to disturbed youngsters on this basis. Within British Columbia there are no set rules among agencies as to which will provide service for this type of child. Most often which agency is involved, depends upon the specific symptoms the child is showing, and the allied problems for which his family may have sought social service help. For example, if the youngster's anti-social attitudes bring him into conflict with the law, he may be seen by the Provincial Probation Service; if his parents seek help for a marital problem, he may become a client of the Family Service Agency; if his school work suffers, the Metropolitan Health unit may be called in. While the Child Guidance Clinic is the agency designed for the treatment of emotionally disturbed children, it can, in effect, offer treatment service to only a
relatively small number of cases, and only those within the Victoria and Vancouver areas. As a consequence, many agencies who offer a broad "family service" are called upon to treat these children.

The management of the "acting-out" youngster in the community poses numerous difficulties. The "acting-out" may take the form of running away, stealing, lying, sexual misdemeanours, hostile attacks upon others, or suicidal attempts. Depending upon the depth and duration of these symptoms, the question may arise as to whether the child's behaviour can be contained within the family and community, without endangering himself or the people around him. It is often on the basis of a need for custody that institutionalization is considered. While this may be a valid reason for initiating in-patient care, too often the assessment of the youngster ends there. Only rarely is there a carefully-worked-out evaluation of his problems and treatment needs as a basis for admission to the care of an institution; more frequently, referral is made as a last resort, or in the face of a particularly severe episode of "acting-out". That admission to institutions occurs on this basis, is, perhaps, largely the result of the lack of in-patient facilities specifically for this type of adolescent. Having no institution with a programme designed for "acting-out" youngsters, and realizing the limitations of the adult psychiatric units in treating them, both community physicians and agencies are loath to consider in-patient care except as a last resort.
Historical Development of Adolescent In-Patient Care

The in-patient treatment of adolescents with behavioural difficulties has followed two paths of development. In one direction, it has grown along with the experiments in residential treatment centres for children; in the other direction, with experiments in the setting up of adolescent units within adult psychiatric institutions.

Both are relatively recent developments in child-care and mental health. The first treatment centres in North America were established after the first World War to care for children who developed behaviour disorders as a result of the 1918 epidemic of encephalitis. These began in the eastern United States, and as the influence of August Aichhorn's work with delinquents was felt, their original clientele expanded to include youngsters whose disturbances sprang from psychological, rather than neurological causes.

Another element in the establishment of these centres was that children's institutions and orphanages were gradually losing their clientele as the alternative of foster homes became accepted as a preferable form of child-care. After the foster home programme was effected, there remained, however, a core of disturbed children whose emotional problems prevented placement in family units, and who were thought to need psychiatric treatment. To fill this need, some of the child-care institutions modified their programmes to ones of treatment orientation, employing psychologists, social workers,
and psychiatrists to effect the therapy. Other treatment centres came into being through the evolution of delinquent training schools, and through the endowment of private institutions designed specifically for child therapy.

Additional stimulus for this interest in disturbed children was the developing psychobiological concept of personality development which emphasized the importance of the childhood period in determining later personality.

The other path of development came from the growing realization that the treatment needs of children and adolescents differed from those of adults, and that, particularly for youngsters, the therapeutic setting is itself a form of treatment. Resulting from these concepts, many state psychiatric institutions established separate units for the treatment of children. This development was later in initiation than were the residential treatment centres, being primarily a product of the 1940’s.

With regard to the adolescent patient, in the adult psychiatric unit, it is only very recently that experimentation has been carried on. Stimulus for interest in the adolescent patient has come, in part, from the growth of knowledge about the needs of this age-group, but equally as much from the pressures of increased numbers of adolescent patients within the state and provincial mental hospitals. While the residential treatment centre movement has been growing, such facilities remain rarae aves in most areas, and at present cannot hope
to offer service to all youngsters in need of in-patient care. Moreover, many centres are privately operated, with fees which place them far out of reach for many children. As a consequence, the public mental hospital has become a not too willing host to many disturbed youngsters whose behaviour has made them untenable to the community. While the adolescent patient represents a small proportion of the total admissions to mental hospitals, frequently his problems in aggression and in lack of controls make his presence felt out of all proportion to his numbers within the adult wards. Dr. D.H. Miller, who has worked with adolescent patients at the C.F. Menninger Memorial Hospital in Topeka, notes "the paucity of literature about hospital treatment of non-psychotic adolescents, ... and ... the reluctance of hospitals to treat this type of patient." He states further that the hospitals "tend not to be able to deal with the individual who has, as an immediate goal, the obtaining of pleasure and satisfaction and who constantly externalizes his aggressive feelings without regard for others."

In the adult psychiatric hospitals which have done experimental work in the treatment of adolescents, there have

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12 For example, in Crease Clinic, the percentage of patients in the 13 to 19 year age-group has never exceeded 6.6 per cent of the total admissions.


14 Ibid.
been varied approaches. In 1949 the Bethlem-Maudsley Hospital in England established two sixteen-bed units for male and female adolescents, with activity programmes designed especially for them. On the other hand, both Dr. Miller at Topeka, and Greaves and Regan at the Payne Whitney Clinic, conducted their programmes with the youngsters living on the adult wards, and taking part in regular adult activities. There is as yet no common agreement as to whether integration or segregation of adolescent and adult patients is most satisfactory, but Dr. Miller has advanced two reasons for the integrated approach:

(1) in normal living, adolescents group together but spend large parts of their time with adults with whom they have important and significant relationships, and (2) the stability of an adult hospital setting should provide for disorganized adolescents a favourable environment in which they could be helped.15

Two factors common to the experimental hospital programmes were the provision of intensive psychotherapy, and the establishment of controls to prevent destructive behaviour. In the three projects discussed, individual psychotherapy was available to all the youngsters, although not all were able to use it immediately upon admission. In these instances, preliminary therapy through the use of groups and the milieu was undertaken to deal with resistances and to support the

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patients towards involvement in psychotherapy.

Unlike Aichhorn's approach, which used permissiveness in the early stages of treatment, the hospital programmes imposed limits and controls from the time of admission. These were a practical necessity if the larger psychiatric programme was not to be disrupted. Miller comments on the problem thus:

Special treatment needs of the adolescents must be met without disturbing the structure of the hospital society and making them, in the eyes of other patients and staff, a specially preferred group.16

Aside from their practical desirability, controls are a help to the youngsters in reducing the anxiety arising out of their destructive impulses. Hacker and Geleerd in their work at the Southard School have stated:

The fact that adolescents of the acting-out type do better in an atmosphere of restrictions rather than of unlimited freedom is an indisputable empirical finding.17

From the above, it can be seen that the treatment of the "acting-out" adolescent within the adult psychiatric setting is a very recent development. As yet, the empirical findings of experimental programmes in this field are far

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16 Miller, "The Etiology of an Outbreak...", p. 428.

from definitive. However, from awareness of the earlier indicated dynamics of the condition, some knowledge about the youngsters' treatment needs has been acquired which few mental hospitals have attempted to put into practice. On the whole, hospitals have indeed shown the "reluctance" to treat this group of patients which Miller noted, perhaps because their symptoms fall somewhat outside the usual psychiatric problems. Their disturbance is shown by aggressive behaviour rather than by neurotic conflict or psychotic disorientation. They are often hostile and difficult to reach in interviews; they are rarely helped by traditional somatic therapies.

There may be reasonable doubt that a mental hospital is the best place to treat these youngsters; yet, at present, few communities offer any alternative when institutionalization becomes necessary. Because of this, there is an increasingly pressing need for the hospital, and the community which it serves, to come to some agreement upon their mutual responsibilities in the treatment of these adolescents, and to arrive at an adequate programme of in-patient care for them.

Crease Clinic

A 312 bed unit within the British Columbia Mental Health Services, Crease Clinic is designed for the diagnosis and short-term treatment of the mentally ill. The period of hospitalization is limited to four calendar months, and for this reason, community physicians are requested to refer "only
those patients who, in their opinion, have a reasonable prospect for recovery and discharge in the four month period."

Admission of a patient can be of two types: by the certification of two physicians; or by voluntary application of the patient himself, in which case approval of his admission must be given by one physician. In general, the following types of patients are thought to be suitable candidates for entry:

a. early psychotics;
b. psychoneurotics;
c. psychosomatic disabilities;
d. all psychotics except those of long-standing duration and those demonstrating marked deterioration and having poor prognosis.19

Crease Clinic was opened in 1951; and, as it was envisaged as an adult treatment unit, little thought was given to it as a centre to serve adolescents. No minimum age limit has ever been imposed, but because of the numbers of adolescents who have entered the Clinic, and because of the management problems they have been found to pose, the policy was established of limiting the type of youngster admitted. Both emotionally disturbed children and adolescents are considered admissible when the following conditions exist:

a. The presenting problem should be part of a constellation of symptoms regarded as a psychiatric entity which is treatable;


19Ibid.
b. The disturbed child should be isolated from his social group by his symptoms rather than be one of a group all of whom are exhibiting the same behavioural symptoms;

c. There should be no other community resource available to deal with the problem presented, and, as a rule the Child Guidance Clinic are in a strong position to make this assessment. If a child has made a definite suicidal effort, we have endeavoured to make provision for hospital care.

d. We have had to place a ceiling on the number of patients we can manage as it is often difficult to include emotionally disturbed children on hospital wards for adults. We have had as many as thirty such patients at one time.

e. There must be a rehabilitation resource.

In keeping with this screening process, it has also become established that any community practitioner referring a patient under eighteen years of age must first clear the admission with the Clinical Director and an Assistant Clinical Director. In practice, this generally involves a telephone discussion of the youngster's problem, symptoms, and situation, at which time a decision is made as to his admissibility.

Purpose and Terms of the Present Study

As can be implied from the above measures to govern admission, the adolescent patients, particularly those with behavioural disorders, have posed special problems to Crease Clinic. On the part of both Clinic and community there has been some confusion and differences in viewpoint; first,

20Ibid., sec. 3.6.
about the purposes of the adolescents' admissions; second, about the actual treatment the Clinic can offer to them. The purpose of the present study is to attempt some clarification of this confusion through the examination of a selected group of adolescents with behaviour disorders who have been recent patients in Crease Clinic. Specifically, the scope of the study is worked out as follows: (a) to explore the patients' backgrounds, environmental situations, and problems; (b) to assess their treatment needs; and (c) to evaluate the services they received at the Clinic, in the light of these needs. Some of the implications may well throw light on the future treatment of this special class of patients.

The group studied consisted of adolescents whose diagnoses came under the heading of the "personality disorders", standardized in the diagnostic manual of the American Psychiatric Association. The purpose in using this classification was to exclude from the study youngsters who were found to be psychotic, neurotic, or mentally retarded, and to focus upon those whose primary symptoms were evidenced by disturbance in behaviour pattern. Within the general category of "personality disorders", there is a continuum of disturbances, ranging from deep-seated pathologies of the personality structure to apparently transient disorders arising from situational stress. More detail of the diagnostic classifications to which the patients were assigned (Tables 1a, 1b) will make clear the variety of descriptions which are possible, but also the important point that the "personality disorders" comprise less than half of the total disabling
Table 1a  Types of Mental Disorders of Patients between the Ages of 13 to 19 Years, admitted to Crease Clinic during the period, September 1, 1956 to February 28, 1958.

<table>
<thead>
<tr>
<th>Mental Disorders</th>
<th>Number of Patients</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Psychotic Reaction</td>
<td>41</td>
<td>40.2</td>
</tr>
<tr>
<td>b. Neurotic Reaction</td>
<td>10</td>
<td>9.8</td>
</tr>
<tr>
<td>c. Personality Disorders</td>
<td>44</td>
<td>43.1</td>
</tr>
<tr>
<td>d. Brain Disorders</td>
<td>5</td>
<td>4.9</td>
</tr>
<tr>
<td>e. Mental Deficiency</td>
<td>2</td>
<td>2.0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>102</strong></td>
<td><strong>100.0</strong></td>
</tr>
</tbody>
</table>

Table 1b  Psychiatric Diagnoses of 44 Adolescents in the Present Study. (Group c in Table 1a)

<table>
<thead>
<tr>
<th>Psychiatric Diagnosis</th>
<th>Number of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adjustment Reaction of Adolescence</td>
<td>19</td>
</tr>
<tr>
<td>Emotionally Unstable Personality</td>
<td>8</td>
</tr>
<tr>
<td>Schizoid Personality</td>
<td>6</td>
</tr>
<tr>
<td>Inadequate Personality</td>
<td>4</td>
</tr>
<tr>
<td>Antisocial Reaction</td>
<td>4</td>
</tr>
<tr>
<td>Dyssocial Reaction</td>
<td>2</td>
</tr>
<tr>
<td>Immature Personality</td>
<td>2</td>
</tr>
<tr>
<td>Behaviour Disorder associated with Chronic Brain Syndrome</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>44</strong></td>
</tr>
</tbody>
</table>
mental conditions which bring adolescents to the Clinic.

In addition to this diagnostic selection, the patients chosen for the study were limited according to age and period of admission. All were from thirteen to nineteen years of age at the time of their admission; all came to Crease Clinic in the period from September 1, 1956, to February 28, 1958. Within this eighteen month period, 103 patients of the above age-group were admitted to Crease Clinic; of this total, 44 were diagnosed as having a personality disorder. It is this total which forms the "sample group", unless otherwise indicated.

Information about these adolescents was gained through study of their files; the data on Crease Clinic services, through interviews with the staff and through the writer's own experience as a social worker in the institution.
CHAPTER II

THE SURVEY GROUP: SYMPTOMS AND BACKGROUNDS

It will be evident from the material in this chapter that almost all the (44) adolescents studied were seriously disturbed youngsters who showed a multiplicity of problems and symptoms. Because many had two to three year histories of "problem behaviour", it might be expected that their hospitalizations occurred as a result of these accumulated difficulties rather than as a result of any one incident. This proved to be only partly true when the patients' records were examined, for over half of them (24), were admitted to hospital following a specific act of aggression. Nineteen had made gestures or actual attempts towards suicide directly prior to admission; five had made attacks upon others. While all twenty-four had other symptoms and problems, these aggressive outbursts and suicidal attempts constituted the precipitating factors in their admissions.

Since, by definition, youngsters with behaviour disorders are said to have little internalized conflict, the prevalence of suicide bids poses something of a question. Suicide is generally regarded as the ultimate in inward-turned hostility; yet this type of adolescent patient traditionally turns his aggressive impulses outward against his environment. At least two explanations of the apparent paradox are possible. For a number of the patients, their "suicide" attempts were little more than attention-getting devices. The swallowing of five
or six aspirins, followed by an immediate and histrionic announce-
ment to the family of the act was a pathetic, but often successful
way of gaining parental interest. This type of gesture was often
impulsive in nature and in keeping with the tendency of these
patients to act without much forethought. In other cases these
self-destructive attempts seemed to occur when normal avenues
of aggressive expression were cut off. Occasionally, in an
attempt to win approval, an adolescent of this type will try to
curb his "acting-out" behaviour. However, unless he has some
healthy outlet for his abnormally powerful aggressive drive, he
may turn his hostility against himself, becoming depressed and
suicidal. It is not unusual for the "acting-out" adolescent to
have such periods of depression while in treatment, as he
attempts to inhibit his usual expressions of hostility, and often
this may prove to be the beginning of his therapeutic progress.

The precipitating events in the remaining twenty cases
are less clear-cut and seem related to cumulative dissatisfac-
tion on the part of the patients themselves or their families
about their functioning. The most common admitting complaints
among the adolescents are clearly various types of aggressive
"acting-out", on the part of both males and females (Table 2).
None of the youngsters exhibited less than one of these types
of symptoms as primary problems; some showed many. It is
interesting to note that none of the girls had been in trouble
with the law, while almost half the boys had. The female
patients seem more likely to choose sexual delinquencies,
rather than theft or property damage, as a means of expressing anti-social attitudes.

Because of the gaps in history material, it is not possible to establish exactly when the youngsters first developed symptoms of emotional disturbance. From the information available, it appears as if the majority did not show "acting-out" behaviour prior to puberty. Earlier disturbance seemed to take the form of difficulties in socialization or in school-work, symptoms which are of dynamic significance, but which are not so demanding of attention as aggressive outbursts. However, because of the lack of data, these can be no more than unconfirmed impressions.

Table 2. **Primary Admitting Symptoms: Adolescent Patients with Behaviour Disorders, Crease Clinic, September, 1956 to February, 1958.**

<table>
<thead>
<tr>
<th>Primary Symptoms</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>Uncontrolled hostility, rebellion, or</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>incorrigibility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delinquent activity</td>
<td>7</td>
<td>46.7</td>
<td>0</td>
</tr>
<tr>
<td>Promiscuity or Sexual deviation</td>
<td>2</td>
<td>13.3</td>
<td>16</td>
</tr>
<tr>
<td>Social isolation</td>
<td>6</td>
<td>40.0</td>
<td>3</td>
</tr>
<tr>
<td>Immature, irresponsible behaviour</td>
<td>1</td>
<td>6.7</td>
<td>3</td>
</tr>
<tr>
<td>Total Patients</td>
<td>15</td>
<td></td>
<td>29</td>
</tr>
</tbody>
</table>
Eleven patients (all in their late adolescence) initiated admission themselves; the remainder came to hospital under the persuasion of their families or agencies who were active in their care. Six of the eleven patients who sought self-admission did so following a suicide attempt, while the remainder complained of difficulties in personal relationships, of inability to hold a job, or of uncontrollable temper outbursts.

Slightly less than half the patients had had contact with a social agency within one year of their admission to Crease Clinic; sixteen were active cases when they entered. The agencies involved are listed below. (Table 3).

Table 3. **Social Agencies having Contact with Adolescent Patients within One Year of their Admission to Crease Clinic.**

<table>
<thead>
<tr>
<th>Agency</th>
<th>Male Patients</th>
<th>Female Patients</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social Welfare Branch</td>
<td>2</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>Children's Aid Society</td>
<td>1</td>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>Child Guidance Clinic</td>
<td>2</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Probation Service</td>
<td>6</td>
<td>-</td>
<td>6</td>
</tr>
<tr>
<td>Y.W.C.A.</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Metropolitan Health</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>St. Paul's Hospital</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Social Service</td>
<td>-</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>11</strong></td>
<td><strong>17</strong></td>
<td><strong>28</strong></td>
</tr>
</tbody>
</table>

Eight patients were in contact with more than one community agency; thirteen had no listing with the Social Service Index.
for either themselves or their families. In eleven other cases the Index was not checked, but no agency contact was known. Since the majority of the adolescents had some history of disturbed behaviour, this lack of social work activity seems to indicate serious gaps in referral. It is a truism to point out that the youngsters would have been more amenable to treatment before their disturbances had a chance to become so serious, yet the plea for early diagnosis and treatment continues to be necessary.

Their Backgrounds and Families

Examination of the families and upbringing of these youngsters shows pathology and deprivation as the keynote. Twenty-three of them came from homes which were broken by death, divorce, or separation; two others, from homes where one parent had been absent much of the time. Those who had been raised by both parents had had to contend with various forms of rejection and deprivation as well as parental alcoholism, mental illness, and chronic marital conflicts. On the whole, the adolescents' parents appeared as disturbed and inadequate persons whose own problems were so consuming as to leave little energy or emotional sustenance for their offspring. With some exceptions, parental inadequacies were of a flagrant, rather than a subtle nature; overt rejection of the children by one or both parents was adjudged to have been present in thirty cases. Nine of the adolescents had a parent who was
alcoholic; seven, a parent who had been in mental hospital; four had had incestuous experience with a parent.

Of the youngsters from broken homes, twelve had had two or more disruptive moves in their histories, having gone from their natural parents to relatives, foster homes, or boarding schools; ten of this group had over four such moves. These frequent disruptions, besides contributing to the patients' general insecurity, also often presented highly conflicting value systems for them to adjust to. For example, one youngster spent the first twelve years of her life shuttling between a promiscuous, alcoholic mother and a rigid, rather puritanical pair of grandparents. The contrasting demands placed upon her by these two disparate environments, together with the lack of real affection obtainable in either, resulted in the girl's absorbing no definite standards, and becoming a very aggressive, hostile adolescent who "acted-out" her anger at her unjust, depriving environment.

<table>
<thead>
<tr>
<th>Parental Situation</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Parents alive and living together</td>
<td>5</td>
<td>14</td>
<td>19</td>
</tr>
<tr>
<td>b. One parent dead</td>
<td>5</td>
<td>6</td>
<td>11</td>
</tr>
<tr>
<td>c. Parents divorced or separated</td>
<td>5</td>
<td>9</td>
<td>14</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>29</td>
<td>44</td>
</tr>
</tbody>
</table>
Table 4b  Living Arrangements of 25 Adolescents from Broken Homes. (Groups b and c from Table 4a)

<table>
<thead>
<tr>
<th>Children raised by:</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>One parent</td>
<td>5</td>
<td>2</td>
<td>7</td>
</tr>
<tr>
<td>Natural parent and one step-parent</td>
<td>-</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Relatives</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Foster parents</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Boarding school</td>
<td>1</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Combination of two or more of the above</td>
<td>2</td>
<td>10</td>
<td>12</td>
</tr>
<tr>
<td>Total</td>
<td>10</td>
<td>15</td>
<td>25</td>
</tr>
</tbody>
</table>

The types of living arrangements which were made for the youngsters following the break-up of their families are depicted in Table 4b. The average age of the children at the time of family break-up was 6.9 years; the mean age, 8 years. It seems likely that many of the youngsters had already suffered a degree of deprivation prior to the actual division of the family. Fourteen of the 25 families were estranged by separation and divorce which was often merely the culminating act of a long period of rupture within family relationships, which, doubtless, was detrimental to the children involved.

It appears almost certain that the new living arrangements were unsuccessful in either correcting earlier deprivations or in meeting the children's needs for affection and security which were increased by the disruption. In the nine cases
where a step-parent was involved, the relationships with the youngsters were marked by rejection and hostility on both sides. The four children who had at some time been in foster home care had several placements each; one had been in five foster homes within one year.

Both the intact and broken homes offered little consistent love or standards to the children. The difficulties they provided ranged all the way from outright physical cruelty and economic hardships to more subtle psychological pressures and conflicts. Two composite histories might best serve to illustrate the damaging backgrounds from which the youngsters came. The first is drawn from the group who came from broken homes; the second, from the children who were raised by their own parents.

Nancy L.

Nancy was an only child, born to young parents during the early part of World War II. Mr. L. left to join the army shortly after she was born, whereupon Mrs. L. and the baby moved in with the maternal grandparents. The mother obtained employment when Nancy was a year old; and, for the next four years, the child was raised primarily by the grandmother. During her husband's absence, Mrs. L. went out with other men and had several affairs. Though her interest in Nancy was not great, there was, nevertheless, a great deal of conflict with the grandmother about the child's rearing, with resultant upset in discipline and authority within the home.
After a five year absence, Mr. L. returned to Canada and the couple established their own home again. However, marital conflict developed, and when Nancy was eight, the couple separated. For the following three years, the child moved back and forth between her parents, ultimately remaining with her mother who had by this time entered a common-law relationship. This also proved to be an unstable liaison, marked by frequent quarrels, occasional physical abusiveness on the part of the husband, and many brief periods of separation. Mrs. L. continued to be preoccupied with her own problems and exhibited inconsistency in her handling of Nancy. The "step-father" was an authoritarian type of man, whose attitude towards the child varied from indifference to active hostility.

Nancy displayed relatively few flagrant symptoms of disturbance until early adolescence, although she had had continuing difficulties in making friends and was thought to be "demanding and stubborn" by her teachers. From about age twelve, Nancy's behaviour became an ever-increasing problem. She was rebellious towards her mother, had attacks of uncontrolled hostility, became heavily involved with delinquent companions, and was promiscuous. This was the pattern upon her admission to Crease Clinic, which was precipitated by a bodily attack on another patient, while she was in the General Hospital for treatment of a minor physical complaint.

Keith T.

Seventeen when admitted to hospital, this youngster
already had a seven-year history of delinquencies, in the form
of theft, and more recently, of fire-setting. Just prior to
admission he had served six months in a correctional institu-
tion on a breaking and entering charge, and was still on
probation. The second of four children, Keith was raised in
a family which had long been known to the local social agency.
Mr. T. was a chronic alcoholic who had been in and out of jail
many times for drunkeness. During his absences the family
received Social Assistance; when he was home, his inability
to retain employment made their economic position even more
tenuous. Mrs. T. occasionally turned her husband out of the
home, but always accepted him back when he promised future
abstinence. Their quarrels were frequent and Keith was the
particular butt of his father's anger, receiving both verbal
and physical abuse from him. A youngster of above average
intelligence, Keith had shown disturbed behaviour at least
since school age. He had had periods of running away from
home, of stealing from classmates, of temper outbursts, and
of acts of violence. Open in stating his hatred of his father,
he seemed to retain a feeling of closeness for his mother, an
ineffectual woman with an air of permanent dejection. Both
the Probation Service and Public Welfare Agency had, at various
times, made attempts to "reach" this multi-problem family, but
with very limited success.

As illustrated in these composite histories, these adoles-
cents' backgrounds presented several common problems and inade-
quacies. The significant adults in their lives, whether parents
or parent surrogates, were generally immature, rejecting, or hostile persons who themselves had failed to incorporate acceptable standards of social conduct or controls. The prevalence of broken homes meant both an emotional loss to the children of one or both parents, and a disruption of the way of life to which they had become accustomed. The arrangements made as an alternative to being raised by natural parents often aggravated, rather than ameliorated, the problems already developed. When a child is removed from the security, (however minimal it may seem), of his own home, there is almost inevitably an increase in his need for affection and reassurance to counteract the disruption and feelings of loss he suffers. When these exacerbated needs are not met, his sense of rejection, insecurity, and fearfulness are likely to grow rather than diminish, with the consequence of furthering any emotional damage he has already suffered. That one in three of these youngsters underwent frequent changes of parental figures is of considerable significance when examining the causative factors in their disturbances.

Their Environment upon Admission

For many of the youngsters, their living circumstances at the time of admission were in the nature of temporary, transient arrangements. Sixteen of them had altered their circumstances within the year prior to admission; some had just returned to their parents after periods in foster homes or
institutions, several had recently left home to be on their own, one had married shortly before, and one was in the process of getting a divorce. Of the twenty-five adolescents who were with a family member (Table 5) six had at one time been on their own, while nine were under sixteen years of age. As might be expected, the family ties seemed to be looser within the older age group.

Table 5  Living Arrangements at the Time of Admission

<table>
<thead>
<tr>
<th>Living Arrangements</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>No.</td>
<td>%</td>
<td>No.</td>
</tr>
<tr>
<td>With one or both parents</td>
<td>8</td>
<td>53.3</td>
<td>15</td>
</tr>
<tr>
<td>On their own</td>
<td>6</td>
<td>40.0</td>
<td>9</td>
</tr>
<tr>
<td>In foster homes</td>
<td>0</td>
<td>-</td>
<td>2</td>
</tr>
<tr>
<td>With husband</td>
<td>0</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>In boarding school</td>
<td>1</td>
<td>6.7</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>15</td>
<td>100.0</td>
<td>29</td>
</tr>
</tbody>
</table>

Thirty-one patients entered the Clinic from some part of the Lower Mainland area; the remainder were from other parts of the Province. While this distribution might largely be explained by the greater population concentration of the former area, it is likely that the geographical accessibility of the Crease Clinic to Lower Mainland residents may also have contributed to their greater numbers.

The occupational groupings of the adolescents are shown in Table 6. Fifteen patients were still students at the time of
Table 6  *Ages and Occupations upon Admission to Crease Clinic*

<table>
<thead>
<tr>
<th>Occupation</th>
<th>Age in Years</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>13 - 16</td>
<td>17 - 19</td>
<td>Total</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
<td></td>
</tr>
<tr>
<td>Students</td>
<td>4</td>
<td>7</td>
<td>3</td>
<td>1</td>
<td>7</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Unskilled or manual</td>
<td>1</td>
<td>2</td>
<td>5</td>
<td>10</td>
<td>6</td>
<td>12</td>
<td></td>
</tr>
<tr>
<td>workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled or clerical</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>6</td>
<td>2</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>workers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housewives</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>3</td>
<td>-</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>5</td>
<td>9</td>
<td>10</td>
<td>20</td>
<td>15</td>
<td>29</td>
<td></td>
</tr>
</tbody>
</table>

admission; three were non-employed housewives; the remainder, (59.1%) were in the labour market. However, 76% of these employable patients were not working directly prior to entering hospital. Some of the youngsters had joined the labour market very recently, but seventeen had been in it over one year. These adolescents, the only ones who had had an opportunity to compile any sort of "employment record", showed great instability in their work, moving from job to job, having difficulties with their superiors and co-workers alike, and terminating in the face of any conflict. Only two of the seventeen had remained in one job over ten months.

Few of the patients had had any specific training for employment; three of the girls had taken a business course during or following high school, and one was a telephone
operator (Table 5). The mean school-leaving attainment for the boys was Grade eight; for the girls, Grade nine. Thus, their limited education and training, together with their personality instability, limited the choice of work open to them.

The academic achievement of the fifteen youngsters still in school showed some variation. Three of them were apparently able to contain their disturbances in the classroom and were thought to be above average students. Indeed, it would appear from their histories that their major source of satisfaction was in their accomplishments in academic areas. These same youngsters were often hostile and rebellious within their families, which might be indicative of the source of their greatest frustrations. Five were considered average students; seven, unsatisfactory to very poor.

By definition adolescents with behaviour disorders "act out" their conflicts within a social context. It would therefore be expected that these youngsters would have difficulties in social relations with both peers and adults. In the thirty-one cases which have detailed information about the patients' social adjustments, this proves to be so. Their tendency to impulsive acts, their basically egocentric orientation, and their

1That these children were able to restrict their "acting-out in some measure, is indicative of the presence of greater personality strengths than were shown by the majority; so, also, was their ability for positive achievement in the academic field.
easily aroused hostility militated against successful social contacts. None seemed capable of forming any permanent relationships on the basis of mutual interests, friendship, or heterosexual attraction. Only three belonged to any formal organizations and these liaisons were not successful. Eight were known to be in delinquent groups, but here again they showed few strong loyalties. Two general patterns seemed to be evident in the youngsters' social relations: either their history of failure in dealing with others was so great as to cause them to withdraw into hostile, sullen isolation, or they continued to plummet into a series of short-term, but highly emotional relationships, perhaps in an effort to achieve some sense of belonging, or to gratify their unmet needs for affection. These two types of reaction were not absolutely clear-cut, but rather appeared as different tendencies, as gleaned from the available history material and the descriptions of their behaviour in the Clinic.

Using this general method of classification, eleven patients showed the trend toward isolation; twenty, the trend toward explosive, transient relationships. All demonstrated difficulties in relating to adults; however, the degree of overtness in their expressions of hostility and resentment varied. Because of their lack of controls, the majority were open in demonstrating negative feeling, both verbally and in "acting-out". Some showed passive-aggressive behaviour; others, the sullen withdrawal described above.
Length of Stay

It can quickly be seen (Table 7), that few of the adolescents remained in the Clinic for the four month maximum period. The average length of stay was 8.5 weeks for this group of adolescents; the average for all patients within the same period was approximately six weeks. The shortest hospitalization was two days in length, occurring when a nineteen year old voluntary patient signed herself out. The longest was twenty-three weeks which resulted because of difficulty in finding resources for a thirteen year old, disturbed child. The seven youngsters who remained over the four month period all did so because of a lack of immediate rehabilitation resources, and not because of a conscious plan to prolong treatment. In six of these cases, plans had to be worked out for follow-up service from community social agencies; in three cases, foster homes had to be found. This problem is not an uncommon one with adolescent patients, particularly those whose "acting-out" symptoms continue to the point of discharge. Such youngsters are not usually suitable candidates for a foster home; yet few other resources are available. The implications of the short lengths of stay in attempting to treat adolescents with behaviour disorders, are, of course, manifold. In treatment available in Crease Clinic, (dealt with in the next chapter), the four month maximum period of hospitalization looms large, for all the therapy is posited upon a short-term approach.
Table 7  **Lengths of Stay**

<table>
<thead>
<tr>
<th>Number of Weeks in Crease Clinic</th>
<th>Number of Patients</th>
<th>Percentage of Patients</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 2</td>
<td>5</td>
<td>11.5</td>
</tr>
<tr>
<td>2 - 4</td>
<td>11</td>
<td>25.0</td>
</tr>
<tr>
<td>5 - 8</td>
<td>9</td>
<td>20.4</td>
</tr>
<tr>
<td>9 -12</td>
<td>6</td>
<td>13.6</td>
</tr>
<tr>
<td>13 -16</td>
<td>6</td>
<td>13.6</td>
</tr>
<tr>
<td>Over 16</td>
<td>7</td>
<td>15.9</td>
</tr>
<tr>
<td>Total</td>
<td>44</td>
<td>100.0</td>
</tr>
</tbody>
</table>

In this chapter, it has been noted that the majority of youngsters in the present study displayed signs of deep-rooted personality problems, with many of the areas of impairment described earlier in the study, i.e., weakened egos, faulty identifications, impaired super-ego functioning, and uncertainty about social roles. In the face of these facts, two questions must be asked. Is it realistic to attempt treatment of such patients within an abbreviated period of time? If it is not, should treatment of them be undertaken by Crease Clinic? These questions take on great significance in the material which follows.
CHAPTER III

TREATMENT SERVICES IN A CLINICAL PROGRAM

In a recent professional report it has been suggested that an in-patient treatment programme for children should comprise six principal elements. With some modifications, these might also be applied to an adolescent programme. The components described were: (1) participation of parents (or surrogate parents), (2) the therapeutic atmosphere, (3) individual psychotherapy, (4) somatic therapies, (5) education, and (6) medical services. With one omission and one modification, it is proposed to discuss these treatment elements as they exist in Crease Clinic, and to attempt to evaluate their effectiveness.

Medical services per se are not discussed here since there is little doubt that the Clinic offers a sound programme in this area, and in any case, it is technically outside the scope of the present study. With regard to education, two factors tend to lessen its importance to the teen-aged Clinic patient. First, many of the older adolescents have been out of school for some time; second, most of them stay in the Clinic only a short time. As noted in the last chapter, the average length of stay is about eight weeks. Consequently, the educational benefits to be

achieved within this brief period are perhaps not great, particularly when a non-productive period of adjustment to the new classroom is allowed for. Classes are available within the hospital, but are more often used by patients in the longer-term units. In practice, few Clinic patients attend them. This chapter, accordingly, will deal only with the other elements of treatment mentioned, and will attempt to show their particular relation to the subjects of study.

The Milieu

Over the last twenty years, there has been increasing realization of the importance of the institutional setting and atmosphere in bringing about improvement of an emotionally disturbed person. The term "milieu therapy" can be said to embrace all the elements, other than the somatic therapies and psychotherapy, that have an impact upon the patient within the institution. Among these would be the daily programme of activities, the interaction of staff with patients, and of patients with each other.

In treatment of the adolescent with a behaviour disorder, the milieu is of particular importance. Since his hostile and aggressive drives are directed outward against his environment, one of the main therapeutic goals is to help him learn inner

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Two comments should be made to qualify this statement. First, there are, of course, educational elements in the recreation and occupational therapy programmes provided. Second, perhaps greater use could be made of the classroom as an aid to the total therapeutic experience besides furthering the limited formal education that most of these youngsters possess.
controls and more adequate ways of living within a social organization. As seen in the last chapter, most of these patients have suffered strongly from disrupted, disorganized backgrounds in which inconsistency and vacillation on the part of key figures was the rule rather than the exception. Aside from the deprivation of affection which resulted in impaired motivation for learning and incorporating society's values, the sheer confusion of their world offered most of them scant opportunity to discover what these values were. If, from early childhood, the same type of behaviour was evoked from various people at various times, approbation, indulgence, annoyance, and physical punishment, it is small wonder the youngster's relations with his world are confused.

The need for some degree of environmental stability, is, of course, basic for the development and happiness of any human being, but for the "acting-out" adolescent, it is particularly essential. Both because of the inconsistencies of his previous experiences, and because of the inner turmoil which adolescence itself brings, stability of environment is a sine qua non in the treatment of these patients. Concerning adolescents, Ackerman points out:

Their complex adaptation is the product of two sets of forces: physical changes associated with rapid growth and sexual development and group pressure, familial and cultural.3

In attempting to correct the experiences of "familial and cultural pressures" which have been irrational and conflicting, an

3Ackerman, pp. 208-209.
institution has not an easy task. The standards and values of
the therapeutic milieu should bear some relationship to the
culture from which the youngster comes, and to which he is
likely to return, yet it should also reflect the values accept­
able to the society at large. A very simple example may serve
to point up this problem. The matter of smoking is frequently
the source of conflict within institutions dealing with adoles­
cents. On the whole, it might be said that North American
society finds smoking an undesirable activity for youngsters
under the age of fourteen. Yet the sub-culture from which the
child comes may deem it harmless, and the youngster may have
pursued the activity for a number of years prior to his hospitali­
zation. What position shall the institution then take? Shall it
set standards totally out of keeping with the child's normal
environment, or shall it accept the "undesirable" activity which
may produce disapproval among both staff members and other
patients? Although the example of smoking is an essentially
simple one, the ramifications of such minor problems of conflict­
ing cultural mores can be important therapeutically.

Beyond this, an institution must also be able to handle
the aggressive outbursts so common to the "acting-out" youngster,
without resorting to retributive punishment. Of this type of
adolescent, D.H. Miller notes:

...it is helpful for such patients to know that
their self-destructive actions will be controlled
and that behavioural limits will be set for them.4

It is important that these limits be fair and reasonable; it is also important that they be applied in a calm, kindly way so that the youngster may accept them as evidence of the staff's interest in him.

One of the values which almost all institutions offer is a non-demanding, structured setting. Temporarily, at least, the patient is removed from the maelstrom of his family and community life, and is placed in a protected environment where food and shelter are unquestioningly provided, where the rules are few and consistent, and where the routine is almost unvarying. While these intrinsic qualities of institutional life are beneficial to most patients, for the adolescent behaviour problem, they are not in themselves enough. Conscious efforts should also be made towards further structuring of experiences to meet the adolescent patient's specific needs at his particular level of development. If carefully employed, this can be one of the most cogent therapeutic techniques available to an institution.

Crease Clinic has six wards; three for male, and three for female patients. At the time the group discussed in Chapter II were in residence, both sides had an admitting ward, a treatment ward, and an "open" or pre-discharge ward. Each of these has three dormitories, a few single rooms, a day room, kitchen, and nurses' office. With a few exceptions, most patients take their meals off the ward in a cafeteria. The "open" ward

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5In the fall of 1958, what were formerly admitting wards also became "open".
signifies that its doors are not locked and that, consequently, the patients are able to have a considerable amount of freedom in their comings and goings. Also, on the "open" ward there is a greater degree of patient self-government; weekly meetings are held with patients as officers to discuss plans for social activities, to air grievances, and to talk about any problems which have arisen on the ward.

The distribution of the adolescents among the wards seems to be a matter of difficulty in most adult psychiatric units; certainly it has been so in Crease Clinic. The tendency of adolescents to "gang together" can be quite disruptive when the youngsters are all of the "acting-out" type, so the attempt has been to avoid having too many of them on a ward at one time. It must be re-stated that not all the adolescents who come to the Clinic are those suffering from behaviour disorders and it can be beneficial for patients with diverse emotional problems to have contact with one another on the wards. For example, the neurotic adolescent who may display over-conscientiousness can at times help his "acting-out" peers to curb their impulses.

The inter-action of adolescents with other patients is so complex that at the present stage of knowledge, no absolute ratios can be given to provide an "ideal" composition of a ward. One study suggests that the optimum number is four or five per

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ward, but the ability to maintain this or any other number also varies with the admission rate of the younger patients.

The Activity Programmes.

The Clinic maintains many activities for the patients, most of which are planned and supervised by the Occupational and Recreational Therapies' departments. Occupational Therapy activities include sewing, weaving, leather and copper work, ceramics, painting, woodwork, and carpentry; interest groups are also undertaken as part of the afternoon programme. As can be seen, there is little vocational orientation in the activities, but attempts are made to work out suitable therapies for each patient based to some degree upon his interest, skills, and treatment needs. Unfortunately, the pressure of work upon the staff often precludes a really careful working out of such plans for each individual patient.

The Recreational Department supervises programmes of bowling, swimming, baseball, gymnastics, and weekly dances and movies. Perhaps the best picture of these activities can be achieved by viewing the daily programme as it might apply to the adolescents with behaviour disorders: After breakfast the youngster might do some ward chores and then attend Occupational Therapy until noon. In the afternoon he could either return to "O.T." or he could bowl, swim, or see visitors. If he has grounds privileges, he might go to one of the two coffee shops with another patient, his "grounds partner." In the evening,
activities similar to those already mentioned are available throughout most of the week, with the addition of a weekly dance for all Clinic patients, and frequent inter-ward parties planned by the patients themselves.

It is interesting to compare this programme with that of a Borstal institution, wherein the main accent is upon retraining and vocational learning. It would seem that the latter type of programme attempts to provide a balance between work and recreation which is in some measure representative of normal community life. Since one of the main needs of the adolescents with behaviour problems is to learn the role expectations of their society, and since work is one of the most important socially approved norms, perhaps more attention needs to be paid to it as a part of the Clinical programme of activities.

There are at present no activities planned specifically for the adolescent patients, but they take part in all adult activities, an arrangement which causes several problems. Both sexes share the same social facilities and the same Occupational Therapy rooms, so that liaisons may spring up between male and female patients which are not always desirable, or easy of control. While most activities are supervised, for those patients on the "open" ward, constant supervision is not feasible.

7 From February, 1953 to June, 1955, there was an Adolescent Treatment Group for both mental hospital and Clinic patients. Directed by a psychiatrist and a groupworker, it met thrice weekly, and offered both group psychotherapy and groupwork, with diverse activity programmes being planned and carried out. Considered a very valuable form of treatment for the youngsters, it was disbanded when the original leaders left the staff. So far, unfortunately, it has not been resumed.
and certainly meetings between patients can and do occur on the grounds and in the coffee shops. The question arises whether this concourse with adult patients, coupled with the freedom available on the open wards, serves to place upon the adolescents more demands for inner controls than they are able to meet.

As noted earlier, many of these young people feel so much at the mercy of their own impulses that they need and desire external limits. To offer such adolescents freedom in the form of open wards and grounds privileges may well only add to their fears. It is not unusual for a youngster to adjust well to a locked ward, only to "blow up" when moved precipitously to an open ward. Occasionally the adolescent is able to express this himself, evidencing relief when returned to the more controlled setting where he is not expected to assume all the responsibility for his own behaviour. A more constructive way of using privileges is to structure them so that they can be earned by the youngster as he demonstrates ability to accept responsibility for his actions. The demand that he earn freedom by degrees is an aid in helping him build inner controls, and as these develop, he has less and less need to rely on limits imposed by others. While some attempt is made towards this type of structuring, it is not consistently applied at present within the Clinic.

Another problem often encountered by the nursing staff is the impact the adolescents' "acting-out" has upon the adult
patients. Their outbursts are often of a dramatic, even lurid nature, which many of the other patients find distressing and unacceptable. This conflict is augmented by the fact that the nursing management of the younger age-group is often quite time-consuming, and is thus inclined to detract from the time available for the adults. This is frequently resented by both staff and patients, and it raises both practical and moral issues when considering treatment of the adolescent within an adult psychiatric unit.

In summary, it can be said that the Clinic offers a substantially developed programme of activities to its patients, but perhaps does not make as much conscious therapeutic use of the milieu as would be desirable for the "acting-out" type of adolescent. The fact that there is no specific programme for the younger patients can be a detriment, for the following reasons:

1. Under the present system there is little opportunity for the adolescent to vent his exuberance or to sublimate his aggressive drives. Nor is there a chance for him to experience supervised contact with his peers wherein he might gain support, companionship, and perspective.

2. The administration of consistent controls to the "acting-out" youngster requires much staff time and reduces the amount of attention available to adult patients.

3. The type of aggressive and sexual "acting-out" the adolescent patient is prone to, is often upsetting to the disturbed adult, who is threatened by his own drives in these areas.

4. Without adequate supervision, the freedom offered to the youngsters seems often to be more
than they can cope with, and the contact with adult patients at times can be over-stimulating to them.

It is well recognized that the provision of a guided experience in group living requires a large number of personnel whose time is free to devote to dealing with the youngsters and their needs. Such a programme also demands time for frequent communication among staff members so that each is aware of the patients' recent behaviour, its probable meaning, and the decisions made about the handling of it.

Although the Clinic's staff-patient ratio of about one-to-one is generally regarded as very high, several considerations tend to modify its apparent adequacy. First, it includes all types of staff, many of whom are engaged in office, administrative, and maintenance work, and who thus have no direct contact with patients. Second, this number must be divided into three shifts, since care is maintained twenty-four hours a day. Third, all staff operate on a forty or forty-four hour work week, which means that relief staff must also be maintained. (Taking the last two points together, it means that, in theory, about five persons are required to fill one position). Four, much of the medical and nursing time is spent in carrying out the somatic therapies and administrative functions, both of which diminish the time available for personal contact with the patients. In the light of these considerations, there is still doubt as to whether enough staff exists in Crease Clinic at present to ensure that an intensive treatment programme can be effected for adolescent
patients in the behaviour disorder class.

**Psychotherapy and the Somatic Therapies**

Somatic therapies are, of course, available to the adolescents with behavioural problems, as they are to all patients in the Clinic. However, for this type of youngster, they are rarely considered to be a treatment of choice. In the group studied, a minority received tranquillizers during some portion of their hospitalization, while only one received any form of shock therapy.

With regard to psychotherapy, it is difficult to tell from the medical recording how many of the youngsters were seen in regularly scheduled therapeutic interviews. While the vagaries of their ward behaviour often necessitate the doctors' devoting much attention to them, such contacts are most frequently of brief duration and concerned with immediate problems in their management. The general tendency is not to regard the behaviour disorder as a top candidate for psychotherapy, with the result that they are inclined to have low priority for this limited service. Since the doctors' time for psychotherapy is restricted, it is generally offered only to those who seem able to use and to respond to it within the limited period of hospitalization. Thus, the youngster with a long history of severe deprivation, and social maladjustment, who is evidencing only limited anxiety and motivation would be unlikely to fulfill these standards.
The Participation of Parents

The involvement of parents in all phases of the in-patient treatment of their offspring has long been a goal of social workers in children's treatment centres. Two considerations make parental involvement desirable: (a) the in-patient period of care is but one episode in the continuum of the youngster's life; and (b) institutional treatment is designed to return the child to family and community life. While these propositions are quite evident for the young child, they might seem questionable for the adolescent, who is likely to be engaged in a struggle for independence from his family. For the teen-ager, should not the goal be to strengthen his desire for independence, and, if the family is inadequate, to help him be on his own? Occasionally this plan is effected, but it requires both that the parents are willing to "give up" the youngster and that he is sufficiently mature as not to need them—a two-fold combination rarely encountered.

While parents of disturbed adolescents are often profoundly inadequate in meeting their children's needs, they, nonetheless, remain the principal figures in the youngsters' lives. However much hostility the adolescents may express towards their parents, few are ready to face separation from them, and fewer still, to establish themselves independently in the community. As disturbed, unhappy people, the parents also have a need for service, in their own right, around difficulties in the parent-child relationship. It is becoming
increasingly clear that, because of the unitary nature of the family, successful treatment of any individual must also take into account the functioning of all the members in his family. Consequently, parental participation is desirable, often essential, for the successful treatment of these adolescents. In many treatment centres which have a selective intake, parental involvement is a condition of the child's admission. In public institutions with little control of admissions, this cannot be insisted upon.

Working with the family is part of the role of the Social Service Department in Crease Clinic, as it is in most psychiatric institutions. For the sake of convenience, parental participation can be viewed in three stages of the youngster's hospitalization: at the time of admission, during treatment, and when planning rehabilitation. Ideally, it should commence prior to admission; however, this is not possible at the Clinic where there is no provision for contact until the patient is actually within the institution. Often preparation for admission is offered by other community social agencies if they are involved; otherwise, it may be given by the referring physician. Pre-admission discussion with the patient and family is useful in clarifying with them the purposes and goals of in-patient care and in helping to allay their fear and anxiety about admission. Separation of a child and his parents is very anxiety-producing to both. For the youngster who has already suffered from rejection, the hospitalization may be regarded as the ultimate in repudiation, or as punishment for his misdemeanours. He may
feel the stigma that is attached to psychiatric institutions, and, indeed, may be extremely fearful of what he will encounter therein. Parents often undergo exacerbation of anxiety and guilt at the prospect of their youngster's admission to hospital, feeling that it reflects their failure as parents. This is particularly likely if they themselves have not initiated admission, or if they are not in full agreement with it. When these conditions prevail, they also may respond with hostility and projection, both of which need to be dealt with through support and clarification.

Since the handling of all these feelings is rarely accomplished prior to the youngsters' admission to Crease Clinic, it frequently becomes the social worker's task to deal with them at admission.

In the present sample group of adolescents, only four out of ten families were interviewed by a social worker at any time during hospitalization, usually at intake. Of the 19 families interviewed, close contact was maintained with 12 throughout the patient's stay in the Clinic. The foci of these contacts were variously, to let the family know of the patients' progress, to help them with their own attitudes to their offspring, and to assist in planning for rehabilitation. However, since the records do not indicate the actual number of contacts per family, it is difficult to know how regular they were. Certainly, much more study could be devoted to this aspect of the subject.

Of the twenty-five adolescents whose families had no
social service contact, seven were in some way under supervision of social agencies. In these cases, liaison was maintained with the agencies, either in loco parentis, or with the request that they, rather than the Crease Social Service, work with the parents. In nine cases, lack of relevant family ties or very brief hospitalization militated against family contact, while in the remaining nine cases, no specific reason for lack of service seemed apparent.

As mentioned before (Chapter II), the majority of the adolescents' families appeared to be disturbed and were deemed unsatisfactory from the youngsters' point of view. Yet, while 23 of the patients returned to their families at discharge, only 12 of these families were seen by the Social Service Department. It can be said, then, that at least half of this group returned to home situations which were known to be unsatisfactory, with no attempt being made to modify these conditions. The significance of this can hardly be minimized.

The Role of Social Service

The role of the Social Service Department within the Crease Clinic team has been discussed in earlier theses written by Social Work students from the University of British Columbia. For the purposes of this study, it is useful to summarize the social worker's responsibilities as stated by Ernest Schlesinger.

According to this listing, there are six distinguishable areas of function, as follows:

1. **Admission Services.** Recognizing that entering hospital may be both fearful and anxiety-provoking to the patient, the social worker can offer the new arrival reassurance, assist him in adjusting to the hospital and help him to cooperate with treatment.

2. **Diagnostic Services.** The obtaining of a social history from the patient's relatives or through the Social Welfare Branch is of help to the staff in arriving at a comprehensive diagnosis and an adequate treatment plan. This service of the social worker is deemed to have top priority by the clinical director of the team.

3. **Treatment Services.** Through the techniques of support and clarification, the social worker can help the patient strengthen his hold on reality, and, perhaps, arrive at a better understanding of his problems. Also, environmental modification can help lessen the stresses which may have acted as precipitants to his mental illness or which may deter his treatment and recovery.

4. **Pre-convalescence Services.** At this stage of the patient's hospitalization, the social worker has the responsibility of examining all existing resources in the community to assess which will be most helpful upon the patient's return to the community. Continued support and encouragement may be necessary to combat the patient's anxiety about discharge, and discussion with him about referrals to employment or social agencies, or continued out-patient service from his hospital social worker are instigated at this time.

5. **Convalescent Services.** Since the period when the patient first leaves hospital is often very stressful to him, it is frequently a time when help is needed most. Although there is no provision in the legislation for extension of service beyond the patient's discharge, the Crease Clinic social workers do offer post-discharge casework to selected patients. Those patients living outside the Greater Vancouver area may receive post-discharge visits from the Social Welfare Branch worker in his area; in such instances, progress reports are often received
from these offices, and both the patient's physician and hospital social worker are available for consultation to the field office.

6. **Family Services.** Help to the family throughout the patient's stay in clinic is a primary service of the social worker. This would include information-giving, support to counteract the relatives' fears and anxieties, clarification concerning their attitudes which might be damaging to themselves or the patient, and environmental help around finances or child-care when the patient is either the bread-winner or mother of the family.

These six categories apply to the adolescents with behaviour disorders just as to other types of patients. An additional element worth noting is the tendency to use casework as a treatment of choice more frequently for these young patients than for others. The rationale is that the caseworker can offer the adolescents both the non-threatening relationship and source of identification which he needs, and is also able to use his knowledge of community resources to mobilize help upon discharge, since the youngster is rarely capable of moving back into the community without environmental and supportive assistance.

In examining the social services offered to the adolescents in the study, it would have been helpful to use the classifications employed by Schlesinger. However, this detailed sort of information is not available in the social service recording; nor could a questionnaire be sent to the social workers since those who had dealt with the youngsters were no longer on staff. Consequently, the information (Table 8), is
Table 8 Social Services to 44 Adolescent Patients and Their Families

<table>
<thead>
<tr>
<th>Period of Hospitalization</th>
<th>Type of Service</th>
<th>Patients Receiving Service</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Number</td>
</tr>
<tr>
<td>Admission</td>
<td>Social History obtained from relatives</td>
<td>17</td>
</tr>
<tr>
<td></td>
<td>obtained from collateral source</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>not obtained</td>
<td>16</td>
</tr>
<tr>
<td>Treatment</td>
<td>Casework with patient</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>Casework with family</td>
<td>12</td>
</tr>
<tr>
<td></td>
<td>Collateral contact (liaison or referral)</td>
<td>23</td>
</tr>
<tr>
<td>Post-Discharge</td>
<td>Casework with patient</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td>Casework with family</td>
<td>2</td>
</tr>
</tbody>
</table>

No service offered during hospitalization 11 (25.0)

shown by periods of treatment, rather than by the explicit type of service rendered.

Social history information was obtained for 28 of the adolescents, either by direct interviews with relatives, by use of community agency material, or by a combination of both. When the patient was from a distant area of the province, the local Social Welfare Branch was often requested to interview the family for information; when he had had previous contact with a social agency, data were requested from that source. Of the 16 patients on whom no information was obtained, lack of service was due to shortness of hospitalization, lack of a source from
which to obtain data, or the patient's physician indicating no need for it. Since history-getting is considered a priority function of the Social Service, and since all new admissions receive some screening at ward rounds, it is rare that this service is foregone inadvertently. Rather, the above-mentioned deterrents together with inadequate numbers of social workers account for the lacks in this service.

The casework service rendered to the 24 adolescents while they were in hospital was, for the majority, intensive in nature. For 19 of the patients, the goal proposed was towards modification of their attitudes through the techniques of support, clarification, and limit-setting; for the remaining 5 youngsters, however, the contact was brief and could not be concerned with more than immediate discharge arrangements.

Collateral contact was of two types: the maintenance of liaison with social agencies who had been working with the youngsters prior to their admission, and who would be continuing their service after discharge; and pre-discharge referrals, requesting that community agencies provide service during the youngsters' convalescence. Several of the patients were involved with more than one agency. For example, Sally came to the Clinic from a northern town where she had been seeing a Social Welfare Branch worker. Pregnant upon admission, she remained in Vancouver to have her baby, was helped by the Children's Aid Society to arrange for its adoption, and continued post-discharge contact with her hospital social worker. Upon discharge she first went
to "Vista", the mental hospital rehabilitation residence, then to a home for unmarried mothers. After her baby was born, contact was arranged with the Special Placements section of the National Employment Service to help her find a job; ultimately, she returned to her home town where she continued her original contact with the field worker.

As might be expected, the youngsters who were given casework service while in hospital were also those who received the greatest number of collateral services. Conversely, the patients who had been active cases with community agencies upon their admission to the Clinic, also received the greatest amount of casework help while they were in-patients.

In the area of post-discharge service, follow-up visits were offered to 5 patients by the hospital social workers, while 16 were referred to community agencies for continuing help. Once again, these 21 adolescents who received post-discharge service were mainly those who had been receiving casework while in the Clinic.

Of the 11 youngsters who had no Social Service contact, 5 were in hospital for very short periods of time. For the other 6, no clear reason for lack of service is apparent.

In summary, it can be stated that, although the Social Service Department at the Clinic recognizes its responsibility in providing service to this group of patients, there are still large gaps in the quantity and type of coverage it can extend. The most severely neglected areas appear to be in work with the adolescents'
families, and in the provision of after-care. Some of the main reasons for this limited service have been mentioned: geographical distance of the family from the hospital, refusal of the family to involve themselves, shortness of the patient's stay in hospital, and chronic shortage of staff within the Social Service Department. Nevertheless, if the treatment of these adolescents is to be effective, provision must be made for adequate service from this department, for its role is a vital one.
CHAPTER IV

EVALUATION AND CONCLUSIONS

To judge accurately the success or failure of the treatment offered to the adolescents surveyed, a follow-up project would be necessary. In the face of the lack of post-discharge information, it is necessary to look to the patients' hospital records for impressions about their movement, but here the data are sketchy, and seem inadequate as a basis for judging therapeutic progress. From the information that is available from the medical, social service, and occupational therapy recording and from the ward notes, it would appear that many of the adolescents showed a tendency to more settled behaviour after being in the Clinic for a time. However, whether this reflected any stable or permanent progress is equivocal. It is perhaps only to be expected that the transition from an often highly stimulating, emotionally-charged family and community situation to the orderly routine of the Clinic would cause some abatement of "acting-out" symptoms. At least one medical observer has cautioned against correlating this sort of phenomenon with "real" improvement in the patients' personalities, and notes: "It is very important to be sure that in the calm regularity of an ordered institutional life there is real progress in emotional relationships and in forging emotional security."\(^1\)

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As an aid to further research, it would be of immense value to include more detailed information within the patients' records, concerning such matters as their reactions while in treatment, the work done with the family and community, and an evaluative statement about their progress in regard to the original treatment goals established at the time of diagnosis.

While no adequate assessment of progress can be undertaken on the basis of the data available, several comments might be made about the treatment offered in Crease Clinic relative to its meeting the needs of this type of youngster. Recognizing the difficulties of attempting treatment of these patients within a primarily adult setting, one basic shortcoming, nevertheless, seems evident. This is the lack of a conscious attempt to work out a treatment programme which is related to the dynamic structure of the adolescents with behaviour disorders. The pressures upon the staff which arise out of a heavy number of admissions, a large patient turn-over, and the demand for brief, intensive types of therapy, all, undoubtedly, militate against the establishment of an admittedly time-consuming programme for these adolescents. However, it seems doubtful if anything less is adequate to effect permanent improvement of these very disturbed youngsters. Thus far, there seems to be no known "quick cure" for the adolescent who demonstrates a deep-seated personality problem, and the most effective treatment has been posited upon a thorough assessment of the personality and needs of each. Some of the primary areas of personality impairment of this type of patient were described in
Chapter I, i.e., weakened ego structures, poor or inadequate identifications, faulty development of super-ego, and confusion about social roles and values. In considering these as their basic problems, the following might be regarded as some of the most important provisions in the treatment of the youngsters:

1. **An Opportunity for Long-Term Residential Care.** It has been brought out both in the theoretical discussion of the dynamics of the behaviour disorders and in the study of the adolescents, that this type of disturbance is the result of early and deep-seated maladjustment. While the patients themselves may be young, their disturbances are not recently acquired. Because of the depth and duration of their problems, it seems reasonable that their treatment would necessarily be lengthy, a supposition which must be planned for when therapy is undertaken. It is interesting to note that the new Treatment Centre for Emotionally Disturbed Children now being established by the Children's Foundation has planned on the period of in-patient care being from six months to two years in duration. The children to be treated within this residence are from six to twelve years of age, would be presumably more flexible than adolescents; yet it is believed this long a stay will be necessary if deep and permanent improvement is to be effected.

2. **A Well-structured, Coordinated Programme.** As a way of helping the adolescents to strengthen their egos, to develop inner controls, and to learn social roles and values, a carefully structured programme is essential. Consistent limits and controls may at first produce increased hostility in the patients, and
almost certainly, will give rise to a period of limit-testing. However, since such controls and restrictions act as a reassurance to the patients that their intense destructive impulses will not be allowed to overwhelm either the staff or themselves, they will eventually bring about a welcome reduction in the youngsters' anxiety and will be accepted because of this.

Similarly, a programme utilizing a clear-cut system of graduated demands and rewards can help give a consistency to the confusion of the youngsters' worlds. Expectations should be clearly defined, in keeping with the patient's ability to perform at his particular stage in treatment; privileges should be granted as he demonstrates developing ability to meet demands and to curb impulsive actions. This type of structuring can be carried through all the activities in the institution. For example, in Occupational Therapy, the patient can begin with a very simple task of short duration, and as his ability to remain at an occupation increases, he can be assigned increasingly demanding work. For the child with high impulsivity and poor controls, the achievement of even a short period of concentration at one task can be a step towards a more ordered existence and a source of considerable satisfaction to him.

As he learns to understand, and to function within this ordered system, so does he grow in his comprehension of the values and expectations of his wider society, for these must be reflected by the institutional programme. Thus, while developing inner controls, the youngster is also accomplishing the learning
of social roles through his contact with both staff and fellow patients.

3. **An Opportunity to Form Positive Relationships.**

As noted previously, many of the patients' problems evolved out of poor early relationships and the consequent inadequate or faulty identifications thus formed. Because of this, a treatment programme must provide an opportunity for the youngster to relate in a more constructive way to both parental figures and their peers. Within the framework of a new "parental" relationship, an opportunity is provided for him to work through conflicts about dependency and aggression which were not resolved with his own parents. Here again the value of a thorough diagnostic assessment must be stressed so that the meaning of the patient's behaviour can be understood in the light of his early experiences and relationships.

The relationship of the adolescent with his peers has long been considered important. It is through liaisons with youngsters of his own age that he is able to test his own attitudes, values, and social skills against those of his contemporaries, and thus achieve some perspective on his position in society. The goals and prohibitions of the teen-ager's peers are very significant to him, and he can often accept greater criticism from them than would be acceptable from an adult. This fact is of importance in using adolescent groups as a method of therapy.

In order to approximate in some measure the normal family and community life of the adolescent, it is desirable that both
wards and activity groups be kept fairly small in size. The use of small groups facilitates the formation of identifications, and enables meaningful relationships to take place without the dilution that occurs when the patient is exposed to many, constantly changing staff members and other patients. On the larger wards of many mental hospitals, it is possible for the patients to have daily contact with from one to two hundred fellow patients and staff members, a type of living situation which is neither representative of normal life in the community or of therapeutic benefit.

5. Adequacy of Staff. The necessity of having adequate numbers of trained personnel to enable individualized attention to the young patients is self-evident. The type of programme that has been outlined depends for its success upon personal contact between staff and patients, since this is the primary instrument of treatment. Besides maintaining an active programme schedule, and providing individual attention to the patients, the personnel must also have time for both formal and informal conferencing so that all the members of the treatment team may be clear as to the changing needs of each patient and the immediate goals in his treatment. Since the adolescent is particularly fluctuating in his behaviour, and since his management may pose daily problems, it is essential that all disciplines on all shifts be agreed upon and consistent in their handling of him.

It is, perhaps, obvious to state that the quality of the staff is of great importance; this is a truism in all types
of psychiatric therapy. However, the destructiveness, impulsiveness, and continuous "testing" of these young patients constitute particularly arduous stresses for all who deal with them. For this reason, it is imperative that the staff be stable, tolerant, and understanding, and that they be well-trained in the field of child behaviour.

6. *Involvement of Parents.* The rationale for considering the participation of parents in treatment as essential, has been discussed in Chapter III. While the Crease Clinic Social Service Department accepts the assessment and treatment of the family as one of their major responsibilities, several factors limit the service which they can offer, i.e., lack of staff, refusal of the parents to involve themselves, and inaccessibility of the family because of geographical distance from the Clinic. While it is not always possible to insist upon participation of the family as a condition of treatment, its importance should certainly be made clear when admission is being considered. It should be very evident from the study of the youngsters' backgrounds that, for many of them, a return to their unmodified home situations would spell death to continued progress.

Under its present structure, Crease Clinic cannot meet all the above-outlined treatment needs of the adolescent with a behaviour problem. To do so would require greater numbers of personnel and a longer period of patient-residence than is now available. If the Clinic is to continue to be used as a resource for this type of patient, the community should be aware of the limitations in
the services it can offer the youngsters, and in the restricted goals it can be expected to achieve with them. Some of the services it is equipped to bring to the adolescents might be envisaged as follows:

1. **Diagnostic Assessment.** For the youngsters who require either emergency assessment or a period of in-patient observation, Crease Clinic can offer a thorough diagnostic service through the combined skills of psychiatrists, neurologists, psychologists, and social workers. While diagnostic service for this age group is generally available through the Child Guidance Clinic, occasionally a youngster's "acting-out" may have reached such proportions that emergency assessment within the protection of an institution seems advisable. For the adolescent who presents unusual symptomatology, or difficulties in diagnosis, a period of in-patient observation may prove of help, and here the Clinic can offer a specialized service.

2. **Emergency Service for the Suicidal or Assaultive Adolescent.** As indicated above, Crease Clinic can provide a "holding" service to the youngster who is in need of emergency custody because of possible risk to himself or others. This presumes that the Clinic will act as a "stop-gap" in order to provide the community with sufficient time to make other, more permanent arrangements for the youngsters. The weakness of such a service is, of course, that there are very often no resources with which to make other plans, with the result that the child remains in the Clinic for a lengthy period of custody, or else the Clinic is requested to undertake a treatment service which it is not equipped to
provides.

3. **Limited Treatment of the Minimally Disturbed Adolescent.** For the adolescent whose "acting-out" appears to stem from immediate situational pressures and whose symptoms seem transient in nature, the Clinic can provide a supportive, organized environment within which the youngster can gain respite from external stresses, and a period in which to reintegrate. Short-term psychotherapy would also likely be available. It is obvious, however, that if any permanent gains are to be made for such patients, work must be undertaken with the family and community to insure that the stresses which precipitated admission will not be re-encountered upon discharge.

**Need for an In-patient Service for Adolescents**

The most obvious conclusion arising from the present study is that there is great need for an adequate in-patient treatment service for the adolescent with a behaviour problem. At present there is no resource within British Columbia for psychiatric residential/treatment of any type of emotionally disturbed child or adolescent; however, by the end of 1959, it is hoped that the Children's Foundation will have their pilot project in operation for those between 6 and 12 years of age. That children enter Crease Clinic or the Provincial Mental Hospital at all, is more often than not because of the lack of alternative resources for them. Unless they are delinquent and committable to one of the juvenile correctional institutions, there is,
very simply, no place for them but the adult psychiatric units. It has been seen that Crease Clinic is severely limited under present conditions in the services it can offer this group of youngsters. The same limitations apply equally to the Provincial Mental Hospital, with the one exception that there is no limit on the length of stay within that institution.

The question arises as to which type of centre would best meet the needs of the adolescents—a totally new unit within the community similar to the residence being planned by the Children's Foundation, or an additional unit within the already established mental hospital services. Points exist for both types of service. The community treatment unit has the advantage of being able to more nearly approximate the patients' normal life in that it can draw on nearby resources, more easily engage the interest and participation of volunteers, and facilitate a gradual move back into the community as the youngster progresses towards discharge. If the adolescent is able, he can attend a neighbourhood school in place of the rather more artificial institutional classes; he can enjoy contact with contemporaries who are not patients. In general, he can retain his ties with community life more easily in this type of unit than he can in the relatively isolated hospital.

On the other hand, the mental hospital can also offer some advantages, by way of providing easily accessible diagnostic services, a pool of trained personnel who could be easily drawn
into the new programme, and the stability of a firmly established hospital programme. The mental hospital has long recognized the need for more adequate facilities for its adolescent patients, and at one stage had tentative plans for a treatment wing designed especially for them. Many of its personnel are interested in work with younger patients, a fact which would undoubtedly facilitate the recruitment of staff for an adolescent programme.

These represent only a very few of the considerations that need to be taken into account in the planning of a treatment unit. Certainly, a full study of the merits of each type of unit would be essential before any plans were implemented. Fortunately, there is a growing body of literature about both residential centres and hospital units upon which to draw, and the American Psychiatric Association anticipate publishing a report on the whole field of adolescent in-patient care.

Need for Adjunctive Services: "After-Care"

In considering the establishment of either form of in-patient service, recognition must be maintained that residential care is only one phase of the total treatment. Equally important, if the youngster is to bridge the gap from institution to community and to continue the progress gained in residence, is the provision of after-care services to both the patient and

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2Unfortunately, these plans have not yet been realized, and, indeed, seem to have been post-poned indefinitely.

3American Psychiatric Association, p. ix.
his family. These services might take the form of continued outpatient interviews, or help with the obtaining of accommodation, employment, or social activities. At present there are many gaps in the resources of both hospital and community for the provision of such services. Traditionally, after-care in all its aspects has been the responsibility of the social worker. Yet, neither the Clinic social services or the community social agencies have adequate numbers of trained personnel to offer service to all discharged adolescent patients. Equally as restricting have been the lack of resources with which to provide the youngsters with basic needs of shelter and employment. For the adolescents without families, there are few foster homes, and fewer residences in the community which accept teen-agers. The very few residences which exist in the Lower Mainland for young people, are not, on the while, prepared to deal with adolescents who have any residual of problem behaviour, since they can easily fill their vacancies with more normal youngsters. The two rehabilitation residences operated by the mental hospital as half-way houses for patients leaving the institution, can provide accommodation to only a limited number of patients for a limited period of time (three weeks is considered an optimum length of stay).

The locating of employment can often be another source of difficulty for the youngsters, particularly in times of a poor labour market. Because of lack of training and skills, many of these adolescents are marginal workers, and in times of general
unemployment are among the first to lose their jobs. However, work is an often crucial aspect of the youngsters' rehabilitation; if unemployment continues for a long period following discharge, it can be a very demoralizing force, disrupting of treatment gains. The Special Placements Bureau of the National Employment Service can be of great assistance in finding jobs for the youngsters, but here again, their lack of personnel often limits the numbers of patients they can help.

The present picture of the after-care and the resources available for rehabilitative assistance is one of gaps and inadequacies. Yet this aspect of the total treatment programme is often a crucial one for the youngsters, representing as it does, their first attempts to return to the community as a contributing member. After-care service is, perhaps, neither more nor less important for adolescents with behaviour problems than it is for other types of mentally ill persons; all patients suffer from the inadequacies in this service as it now exists in British Columbia. However, if a programme is to be established for adolescents of this type, there might be a renewed opportunity to stress the importance of post-discharge care, and to include it as a vital part of the total programme.

Implications for Social Work

Within the area of treatment of the adolescent with a behaviour problem, the role of the social worker is two-fold. First, because social workers, possibly more than any other professor come into contact with these disturbed adolescents, they have a
responsibility to see that adequate resources are made available for their care. Most social workers are quite aware of the woeful inadequacies of the present treatment of these youngsters, but a concerted effort is needed in the fields of community organization and social planning if a treatment unit is to be realized. The work of the members of the Children's Foundation demonstrates what can be accomplished; the fact that they have instigated the development of a residential treatment centre within the province may help pave the way for future services to young people.

The second area in which social workers have a distinct role to play is, of course, as members of the treatment team within an adolescent unit. Although the whole development of adolescent in-patient services is a new one, from the beginning, social workers have been involved in the establishment and operation of them. Gradually, a body of professional literature on the subject is growing up and contributing greatly to the knowledge about residential treatment; however, much further research is needed. The position of the social worker within these units has not been a fixed one, historically. She has functioned as a recreation worker, child care worker, administrator, and psychotherapist. In general, the social worker's primary function within the treatment unit might be regarded as that of bettering "the adjustment of the child to his environment and of the environment to the child, through the utilization of community resources and the conscious adaptive capacities of the child and others concerned". Specifically, the following responsibilities fall

\footnote{Ibid., p. 65.}
within the realm of the profession: with the family, to give help to parents concerning their problems with the youngster, to obtain from them significant psycho-social history material, and to continue work with them through the periods of discharge and after-care; with the adolescent, to participate in the total diagnosis, to offer him direct casework treatment, to help prepare him for trial visits and discharge, and to bring to bear any community resources which may be beneficial to his treatment.

These are some of the specific implications the adolescent with a behaviour disorder has for the profession of social work. If a basic justification is needed to engage professional or lay interest in these children, it could be found, simply, in their suffering. For persons "involved in mankind", this is reason enough to act.
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