

# REHABILITATION OF CHILDREN DISCHARGED FROM A PSYCHIATRIC HOSPITAL\*

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*The problem of assisting the community to understand a patient discharged from a psychiatric hospital and help a child with his integration back into community life is considered. The importance of working with the particular community facility most critical in the life of the child is stressed. This paper is based on clinical experience with 23 children and focuses on three cases in which community participation has been crucial.*

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RESIDENTIAL TREATMENT centers for the psychiatric treatment of severely disturbed children have come more and more into prominence during the past few years. One such unit is the Children's Psychiatric Hospital of the University of Michigan Medical Center. One of the crucial problems in residential treatment is that of rehabilitating the child back into the community after discharge. Several articles in the literature deal with the rehabilitation of adult patients through the use of outpatient follow-up, vocational rehabilitation, day or night hospitals, halfway houses, and drug therapy.<sup>1-7</sup> While with adult patients efforts are mainly directed at helping the patient adjust to the community, in the case of the child patient in many instances, this is not enough. The adult patient can be rela-

tively self-sufficient, or at least lead a rather sheltered life within the home, while the child still has to be dependent on the community. In most cases, the child is forced to interact much more with the community because of the necessity of his attending a public school.

The local community often views the return of these children with alarm or disgust. The child frequently returns to the community viewed as a disturbing element. His having been in a psychiatric hospital brands him in the eyes of many of the local people as "crazy." People's perception of what happened to the child while he was away may not be that he was in a hospital receiving treatment. They may think he was locked up in an "insane asylum" and often they do not believe that he could have improved. They may also attach moral

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significance to the child's hospitalization and see it as being a punishment or at least as ostracism for bad behavior.

Communities vary in the way the negative response is manifested. For example, where one child may be challenged immediately to prove his sanity and is accepted only after having done so, another child may be indulged for a period of time and receive his negative attention later. To add to this, the child, even though he has improved generally, may still manifest some of the negative traits which helped bring him into the hospital.

This paper is based on the writers' experience with twenty-three cases. In all of these cases, work was done with the community, usually with the school. The interventions in the community which are discussed in this paper were deemed crucial to the reintegration of the child.

*Ronald.* Ronald was referred by a visiting teacher in a metropolitan school district primarily because of his inability to adapt and learn in school, because of stealing and aggressive behavior and because he was being a management problem at home. Ronald's mother was fourteen years old when he was born out of wedlock. His maternal grandmother took care of him while his mother worked to support them. His mother married when he was five years of age, and a half sister, Cindy, was born two years later.

Ronald's mother was quite a passive, immature person with limited intellectual ability, who alternately depended on her own mother and on her husband. There were numerous fights followed by separations between the parents.

Ronald's stepfather had a history of frequently changing jobs. He had been committed to a state hospital for alcoholism and had been on probation for forgery. Ronald's family often moved suddenly during the middle of the night because of nonpayment of rent.

Ronald was made a temporary ward of the Court before admission to protect him from being taken out of the hospital by his par-

ents against medical advice. This made it possible for us to plan with the Court for Ronald's future on a long-term basis. Ronald was at Children's Psychiatric Hospital for eighteen months. Casework efforts were concentrated on helping the parents see the importance of Ronald's having growing up experiences in either a foster home or suitable institution. The parents gradually diminished contacts with the hospital.

#### ADJUSTMENT IN NEW HOME

Ronald was discharged to a foster home under the supervision of the State Child Welfare Agency. The foster father was a salesman. The foster mother did not work outside the home. Although the family previously cared for an adolescent foster boy and now had an adolescent foster girl, Ronald was the first child they had who had been hospitalized at a psychiatric hospital. They also had four children of their own.

Ronald's initial adjustment in his new home was fair. He returned to the hospital once a week for out-patient treatment with the psychiatrist. The contact with the foster mother was kept at a minimum at this time. We felt that it was the function of the agency worker, not the hospital, to help the family with Ronald's adjustment problems in the foster home since Ronald was under the jurisdiction of the agency.

As Ronald began to feel accepted by the family, he started to test the relationship by stealing money and candy. The foster mother was extremely concerned about this because she saw this as "bad" and feared that Ronald's stealing would bring dishonor to the family.

At the request of the foster mother, the psychiatrist and social worker met with her. They helped her to see that Ronald's behavior indicated that he was beginning to feel a part of the family and that he feared this, since no previous relationship had been lasting. He wanted to see if the family really would accept him and/or control him instead of tossing him out as retribution for his actions. Because the foster parents liked Ronald very much and had a great desire to help him, they were able to reassure and control him.

A few months after Ronald was placed in the home, there was a change in agency worker, and the foster parents heard for the first time from the new agency worker that Ronald was only a temporary ward of the Court and could be removed from the home at the discretion of the Court. This informa-

tion was very upsetting to the foster parents. The foster mother said that she could not really invest in Ronald emotionally and try to work out this difficult initial adjustment period without definitely knowing that Ronald would be staying with them for a long time.

The psychiatrist and the social worker both strongly believed that Ronald's only opportunity to continue his recovery was to have this foster home as the permanent one. It was felt that in order for Ronald to form a solid, positive identity, he would need to have a stable home life where he could form appropriate identifications and develop an adequate system of values. This was especially pertinent as Ronald had not had a stable home in the past. Certainly, had he returned to his natural mother, the improvement that he had made would have been placed in jeopardy. To insure family stability and also to give assurance to the foster parents, a request was put forth by the hospital staff to the judge of the Probate Court that Ronald be made a permanent ward of the Court. Permanent wardship was refused on legal grounds. Unfortunately, the situation was that even though Ronald, the agency, the foster family and the hospital wanted to establish this home as a permanent one, the Court could not give us legal coverage. In spite of this, it was possible to engage the foster parents' commitment to helping this child.

#### **ESTABLISHING COMMUNICATIONS**

The critical aspect of this case was the collaboration between the hospital and the child care agency worker. This was the first experience for psychiatrist, social worker and agency worker to work very closely with each other on reintegration of a hospitalized child into the community. The definition of roles and an understanding of the focus of the interest of all three had to evolve. The interest of the hospital staff was primarily in Ronald. Ronald was the hospital's patient, yet he was also a ward of the agency. It seemed to us that the worker's primary interest was in the welfare of the foster parents and the other foster child who was in the home. Communications had to be clearly established. First, the three of us met monthly to discuss

our opinions about Ronald's adjustment in the foster family, ways of supporting the foster parents, interpretation of some of Ronald's behavior, the question of whether Ronald should have any contact with his natural mother at this time, and future plans. Soon we added the foster parents to these monthly meetings. The definition of roles began to emerge out of these discussions. After each meeting, the psychiatrist summarized the high points of the meeting in the form of a letter to the agency worker, thus keeping clear focus on where we had been and where we were headed. The team members felt themselves a part of a group with common operational goals relating to how best to help Ronald become established in the community.

*Jim.* Jim came to Children's Psychiatric Hospital at age thirteen. For at least one and a half years prior to admission, he had been withdrawing more and more from people. Jim's withdrawal became so severe that for the greater part of the day he would lock himself in his room, smoking cigarettes and reading science fiction magazines. Prior to this Jim had been considered a very "mature" and intellectual boy. At the psychiatric evaluation it was apparent that he was quite a disturbed child. His affect was flat, his associations were loose, he seemed quite paranoid and had already formed a delusional system.

Jim was seen by the psychiatrist for regular psychotherapy sessions while the family was seen in casework by the social worker, both during and after Jim's stay in the hospital. During his hospital stay, Jim began to drop his delusional system and to relate to people more effectively. It became apparent during treatment that neither Jim nor his parents were capable of acquiring much insight into their problems or their feelings. Therapy with both Jim and his parents was, therefore, geared at giving them directions as to how to manage the problems of living without the therapists getting too involved in their unique logical systems. It was felt probable that Jim eventually would need long-term hospitalization, but that a try should be made to keep him in the community at this time.

It seemed that the most crucial area in Jim's readjustment was going to be the school area. It was here that he had begun withdrawing from others. It was here where his omnipotence was most severely challenged. A routine school visit is made prior to the discharge of each child from Children's Psychiatric Hospital. In Jim's case, the visit was made by the hospital psychiatrist and teacher. The school counselor and principal were informed of the severity of Jim's illness and the great importance for him to be able to "make it" in the local community. The hospital teacher told them of how Jim had, in a structured school environment, achieved quite well scholastically. The school people were told that it might be a difficult situation and that the hospital staff would follow the child and family, and would be available for help at any time. It was noted at this time, that though the school people were somewhat unsure as to how to handle Jim, they were eager to help in any way that they could within their means.

### SCHOOL PROBLEMS

As expected, Jim made a relatively good adjustment to his family and neighborhood, although he began having difficulties in school. These difficulties manifested themselves in refusal to go to school and in an inability to get along with certain teachers. At first, this was handled by having Jim call the psychiatrist on mornings that he felt like staying home from school. The psychiatrist would tell him to go to school and he would go. Soon, however, this became ineffective and it was decided that a more radical approach was needed. At this time the psychiatrist went to the school and met with the principal, the counselor and all of Jim's teachers. The teachers were told, without being given a diagnosis, about Jim's difficulties in perceiving reality. Once this was done, people understood Jim's behavior much more than when they saw him as just "a naughty boy." The problems of the school staff members varied from person to person. One teacher who intuitively understood Jim's difficulty seemed to need encouragement in what she was doing. Another teacher with a strong psychology background needed to be discouraged from doing therapy with Jim and de-emphasizing academics. Another teacher seemed primarily concerned with the fact that special consideration given to Jim in assigning grades might lower the standards of his class. The school counselor was somewhat concerned as to what his role should be in

the case. All were unified by one goal, however: the desire to help Jim get through school.

At this meeting, several principles to be applied in working with Jim were set down. It was felt that while it might be unrealistic to expect Jim to do even average work, some achievement in each subject should be required. Jim's attendance at school should be considered mandatory. All absences from class would be reported by the teacher to the school counselor, who would speak to Jim and report the absence to his parents. In addition to this, the teachers, who had been very supportive of Jim, were encouraged to continue their support. Thus, an operational goal was formulated. For several months Jim's work and attendance improved. He was able to produce above the average in several subjects. On a subsequent visit by the psychiatrist and social worker the school staff were noted to be proud of their work and quite allied with the Children's Psychiatric Hospital personnel. It seemed that they had, to some extent, become a milieu therapy team. They began speaking of other mental health needs in the community and asking how they might be met.

The above work required a great expenditure of energy on the part of both school personnel and hospital staff. After several months it became difficult to maintain this intensity of effort and Jim's work began to slip. With a renewal of effort, however, his work began improving again.

*Henry.* Henry's course of treatment at the hospital was a particularly stormy one. He called forth more negative "counter-transference" from the staff and disfavor among his peers than any child in the hospital. When he entered the hospital a few weeks after his eighth birthday, Henry was diagnosed borderline psychotic because of reported hallucinatory experiences and his difficulty at times in distinguishing reality from fantasy. He had recently been excluded from school because of the difficulties which his symptom of encopresis and his unmanageable behavior caused the teacher.

During Henry's stay in the hospital, his prognosis for a long period appeared to be quite guarded. However, Henry's school performance had always been adequate in the hospital where there were only four children

in his class and he could receive much individual attention. As therapy progressed, his borderline psychotic symptoms decreased, and he began to show more interest in peers, joining clubs and athletic activities. With greater internalization of his conflicts, Henry appeared more depressed for a time, but gradually this dissipated and his major attitude seemed to be one of boredom. At this point those working with Henry began to question the advisability of keeping him in the hospital. The consensus was that after two and a half years Henry had progressed as far as he could in this setting and that from here on he would need the stimulation of a usual home and school environment in order to make more progress.

### RE-INTRODUCTION INTO COMMUNITY

Two months before the date set for Henry's discharge, the social worker contacted the school where Henry had originally been enrolled. The visiting teacher of the school questioned the advisability of discharging Henry. She said the school had large classes and that she didn't think Henry could function in this setting. The visiting teacher then insisted that before staff from the hospital visit the school, she and the superintendent be allowed to visit the hospital. This was arranged.

During the visit by the superintendent and the visiting teacher the superintendent's beginning attitude was that it would not be possible for them to accept an encopretic child, since they had just recently excluded another such child after the teacher threatened to resign. When the point was made that Henry still would have to be discharged and that from that point on, the community was responsible, the superintendent stated that it looked as though Henry would be a pupil in his school system. The staff assured him that the hospital would work with the school in whatever ways he felt most advantageous.

Anxiety on the part of the hospital staff was manifested in the unusually great care with which they planned the details of Henry's re-introduction into the community. For example, it was decided to let Henry wear airtight rubber pants to school. As a result, the encopretic problem was no longer outwardly an issue of concern at the school.

Shortly before Henry's return to school, a visit was made by several members of the hospital staff closely associated with his treatment—the psychiatrist, co-therapist, social worker, teacher, ward nurse and principal of the hospital school. An approximately equal

number of school personnel were present, including Henry's new teacher, the principal, school psychologist, visiting teacher, school nurse and janitor. It was clear that Henry had both friends and foes before he had even made an appearance. The anxiety felt by his teacher was apparent. She seemed to be a tense, compulsive person who was very troubled by Henry's encopretic difficulties. She couldn't discuss these fears and so focused on the question of his academic preparedness. The principal openly expressed his skepticism about the effectiveness of psychiatric treatment. The school diagnostician was obviously bored and wishing she were somewhere else. The two who impressed the hospital team as most free from conflict over accepting Henry and most capable of giving him some support were the school nurse and the janitor. Both were quite active in suggesting ways of handling Henry's soiling in school. The hospital staff members left this meeting with a realization that reintegrating Henry into this school setting was going to be even more difficult than they had anticipated.

When the psychiatrist phoned the teacher at the end of Henry's first day of school to see how things had gone, he met with many strong accusations from an incensed teacher. The complaints centered mostly around Henry's handwriting being very poor. The teacher took this as an indication that Henry's academic ability had been grossly misrepresented to her. The teacher sounded extremely agitated and expressed her opinion that Henry simply would not make it in this fourth grade class.

Henry was less anxious than anyone else concerned, including his therapist. He was making a better adjustment at home than had been anticipated. When asked about school, Henry would say unconcernedly, "Oh, it's half good and half bad."

### AN AMBIVALENT RESPONSE

The visiting teacher continued to report the school's being upset over Henry, so a conference was held at the school two weeks after Henry's return. The teacher insisted that it was impossible for Henry to meet academic requirements because of his handwriting. Despite her protest about Henry, she was giving him considerable personal attention. She was, in effect, quite ambivalent in her response to Henry. Most of her negativism, it finally was clear, came from her intense anxiety lest she fail with the child. For years her image of herself as a successful teacher had been of utmost importance to her.

The next contact and the subsequent contacts with the school were made by the co-therapist. The co-therapist observed Henry in the classroom for the greater part of the day on this and subsequent occasions. On this occasion, the teacher continued to vent her angry feelings, even though Henry was present. The co-therapist, in talking with her later, tried to impress upon her how successful she actually was being with Henry, which was a fact. During a discussion in the teachers' lounge, it became evident that the teacher, who originally excluded Henry, was actively discouraging the efforts of his new teacher and was obviously threatened by the possibility that the new teacher might succeed where she had failed. The co-therapist later gently cautioned the new teacher about this disparagement of her success by the other teacher. The teacher offered to write weekly reports for the co-therapist. The co-therapist offered to phone the teacher each week instead. The teacher readily admitted that this would be to her liking.

The weekly phone calls to the teacher consisted chiefly of the co-therapist listening for forty-five minutes to the teacher's complaints about Henry, many of which were justified. With this amount of catharsis the teacher was able to teach Henry for another week. His work improved much more than his teacher would give herself credit for. At one point, the co-therapist felt compelled to advise the teacher not to spend so much extra time on Henry because it wasn't fair to herself and the other children. The teacher then verbalized her recognition that spending so much time only made her more angry at Henry.

Henry was promoted to the fifth grade and it was evident that both the teacher and the principal felt much satisfaction over their success in helping Henry "make the grade." Close contact will be continued with his new teacher. For a compulsive, rigid woman, such as his teacher was, Henry's symptom no doubt aroused floods of anxiety over unconscious conflicts of her own. When her anxiety could be alleviated by fairly heavy support, she was able to experience some quite positive feelings for Henry. In time, she showed some excellent therapeutic judgment.

In all three cases, much time was spent both by the staff of Children's Psy-

chiatric Hospital and the personnel representing the community agencies. The hospital staff was not simply available to the community agencies, but often took the initiative in making repeated visits to the local schools. It is the writers' belief that the work done with a child patient can be severely jeopardized if reintegration into the community meets with too much difficulty for the patient. Certainly, we would not have been able to work with the community agencies without their willingness to spend many hours working with the hospital staff. It was our impression that everyone involved, both hospital and community personnel, came to know a great deal more about each other's disciplines and how to work together in utilizing respective skills.

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