

THE PERSONAL LIFE HISTORY BOOK METHOD

A MANUAL FOR PREVENTIVE PSYCHOTHERAPY WITH FOSTER CHILDREN

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CHAPTER I

INTRODUCTION

This is a "how to do it" book. It can help prepare the reader to perform a preventive psychotherapy with foster children. So far, the method described has been used mainly by caseworkers and therapists. Collaborating with those professional therapists, foster families have been helped to stop the dangerous patterns of rejection called "bouncing" or unplanned transfers among foster homes. We are encouraged by the outcome studies under those circumstances, and have summarized them in the next chapter. Several projects under the author's direction have succeeded in reducing transfers among foster homes, and are described. Those projects ultimately led to the current version of The Personal Life History Book and this Manual.

We ultimately plan to evaluate our belief that the Personal Life History Book can be used by foster parents themselves, as part of therapeutic foster care. It can already be used by regular foster parents as a guided activity workbook for mentally healthy foster children. However, we recommend that if therapy as well as good parenting is needed, therapeutic work using The Personal Life History Book Method should be done by foster parents only with supervision by a caseworker or mental health practitioner.

This Manual is also a text book concerning the mental health problems of foster children. Studies which illuminate the psychiatric problems among foster children are reviewed and evaluated. Data are summarized indicating the reasons for placement of foster children and the adversities which precede the event. Evidence shows that rather than being harmful, foster care may be rehabilitative to children's cognitive and behavioral processes. Psychopathology found among foster children appears mainly due to their prior adversities and genetic loading, and is comparable to that of children from similarly adverse backgrounds. Some preventive projects which further improved the outcome of foster children's psychiatric status are summarized. The role of numerous placements and transfers among foster homes is especially pernicious and may be especially preventable.

We hope you will give us feedback on your use and results with this method.

CHAPTER II

MENTAL HEALTH OF FOSTER CHILDREN

It is hard for most persons who raise their own children to appreciate the scope of the foster care system. Currently in the United States there are millions of children in and out of short-term and long-term, official and unofficial foster care placements of various kinds (Schaeffer, 1981). The official foster care population is roughly equivalent to that of the city of Cincinnati, Ohio. Most of these children, perhaps 75%, are in the care of private foster families, a trend which has been increasing since the early 1930's (Maas, 1959).

Although the number of children in foster care may appear shockingly high, there has in fact been a recent shift away from foster placement, especially in areas where the population is very large. For example, in New York City a total of 19,177 children, or 11 out of every 10,000, were in foster care in 1984--but that number represented a decrease of 25% from the 1979 level of 25,535 (The Foster Care Monitoring Committee, 1984). The average duration of foster placements has also been reduced. New York City foster children now stay in care an average of four years, rather than five years.(Ibid, p. ii).

HISTORICAL BACKGROUND

The United States has had English-based laws concerning the care of indigent and homeless children since its colonial days (Brenner, 1971). In 1601, an English Poor Law gave justification for public actions regarding orphaned children. In the 17th and 18th Centuries most dependent children who were removed from their homes were placed in almshouses along with criminal, mentally ill and elderly adults. Others were placed as apprentices or servants, as part of the indenturing system then prevalent (Ibid.). By 1875 these conditions were regarded as oppressive to children, and New York State and others passed laws requiring removal of children from almshouses. Gradually, private facilities and religious associations took over the task of supervision. In 1868, The State of Massachusetts became the first to provide governmental support of private family care for foster children (Brenner, p.323). It was not until the middle of the 20th Century, however, that Federal legislation created a unified basis for supporting the physical and psychiatric

well-being of foster children.

As the numbers of publicly supported foster children grew so did the scope of governmental responsibility for their physical and mental well-being. By the mid-20th Century, most foster children in the United States had become eligible for medical care under Medicaid. By fiscal year 1973-1974, Medicaid funds expended by federal, state, and local governments for health services for these children exceeded \$200 million (DHEW, 1974). Overall costs were proportionately increasing. A New York State estimate (Jones, 1976) showed statewide foster care expenditures totaling \$178.5 million in 1969 and 212.9 million in 1972. As for the U.S. overall costs, by 1984 the total of residential, administrative, health and other service expenditures involved in foster care nationwide was estimated as 4.75 billion dollars annually (Kliman and Schaeffer, 1984).

FOSTER CARE IN CANADA

Steinhauer (1984) reports that children now coming into foster care in Ontario are generally older and more seriously disturbed than in previous years. This is said to be due in part to increased numbers of young, single-parent mothers, in part to social and cultural changes (such as increasing alienation of minority groups), in part to economic deterioration of subgroups within the general population, and in part to the consequences of de-institutionalization of children and a planned decrease in both the training school population and the number of long-term residential beds available for child psychiatric patients. Steinhauer urges a reduction of emergency placements, an increase in the energy of casework, and a focus on the prevention of drift. He proposes the use of an instrument for assessment of parenting capacity among biological parents if a child must be separated from them. Steinhauer also advises that caseworkers focus on assisting the child to mourn for his or her lost family life.

One problem in the Canadian as well as U.S. foster care systems is the rate of burn-out, documented as 25% per year in terms of the number of Ontario foster homes closed each year. The total number of foster homes declined 40% in the period between 1966 and 1978, Steinhauer notes.

Another documented problem is an overly rapid rate of placement. One agency, despite an official policy favoring planned placements, made 65 % of its placements

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within 48 hours of the request for placement. Non-urgent requests were ignored due to overloading of personnel.

Byles (1980) reported that adolescent girls removed from parental care were having particular difficulties with their foster care givers. Entering at an average age of 14, a sample of 120 adolescent girls had 760 different agency-planned placements by age 16. The mean was 6.3 agency planned placements per child in two years.

Forty nine of the parents of these girls had histories of admission to psychiatric hospitals. The multiplicity of adverse factors in the lives of these 120 Canadian adolescents is indicated by the presence of each of the following factors in at least half the families:

- ☐ alcohol abuse
- ☐ high mobility
- ☐ conflict with law

FOSTER CARE IN ENGLAND

As of 1973, Wolkind and Rutter reported there were 70,000 children in foster care, defined as "local authority residential care," throughout England and Wales. Primarily young children were involved; Mapstone (1969) found that 2 % of all 7 year old children in the National Survey had been in care. At the same time, of the 50,000 admissions to such care each year, more than half were due to the mother being in jail or hospital. Studies of English children in long stay care describe a high prevalence of psychiatric disturbances (Pringle and Bossio, 1958; Wolkind, 1972; Yule and Raynes, 1972).

Little is known about the outcome for children originally admitted to care because their mothers are confined to jail. One previous report (Mapstone, 1969) indicates that such children included in the National Child Development Study showed "a high rate of poor reading ability and poor social adjustment in the classroom."

Wolkind and Rutter note that since most studies have focused on children in care for long periods, even less is known about the outcome of short term care. An epidemiologic investigation of psychiatric disorder in two communities gave an opportunity to compare short-term care children with other groups of children. The investigation occurred in the Isle of Wight in 1969 and an inner London

borough a year later, when all children ages 10 and 11 were screened by means of teachers' questionnaires. (Rutter, 1967) regarding classroom behavior problems. An over 99 % response rate occurred in both communities. The teacher based study was followed by interviews of selected parents in both groups. A rating of the parental marriage was made. Details of prior separations of child from parents were ascertained, including any placement in local authority care, such as with foster parents or a children's home. At the same time, systematic information was obtained about the children's behavior and social functioning. Three groups were compared: a random control group, a group deviant on the teachers' questionnaire, and a group deviant on the questionnaire for whom a psychiatric diagnosis was made following a detailed parental interview. (For another important British study, see the section below on Psychopathology Following Brief Placement.)

Foster Care in other Cultures: See below (Longterm Followups of Foster Children) for an important Swedish study involving comparisons of adopted, biologically raised, and fostered children.

PSYCHOPATHOLOGY CORRELATED WITH EVEN A BRIEF PLACEMENT EXPERIENCE

Of the Isle of Wight children deviant on teacher's questionnaire, 13 percent had some experience of being in care, versus only 2 percent in the control group (Rutter, 1987). The London data were 10 percent versus 1 percent. Of the 27 deviant children with a history of being in care, 23 showed antisocial disorders and only 4 had neurotic disorders. Most of the deviant children who had been in care were male.

It is thought that many of the placements were not only brief but had occurred at an early age, so that the teachers' filled in their questionnaires with no knowledge of many of the placements. Using the more systematic and detailed information from parents a smaller group of psychiatrically disordered children was found. Seventeen percent of psychiatric disorder children in the Isle of Wight sample and 20 percent of the London psychiatric disorder sample had been in care, versus 2 and 3 percent of the respective control groups.

Since this is a very important and very high yield of distinction between the ever in care and never in care groups, the question was also asked "the other way round" concerning proportion of ever-in-care children who later show deviant behavior. An estimate concerning this figure was obtained by calculating an estimated total of 10 to 11 year old psychiatrically disordered children in the two communities who

had been in local authority care for at least a week. It was estimated that 78 children had been in care and of them 51 showed deviant behavior. Most of the deviant children, as already shown, were boys although there should be an equal sex ratio as almost half of children in care are girls.

An important aspect of this work is the high risk of antisocial disorder for boys even in even a brief placement, with a low risk for girls. It is acknowledged that previous studies have shown the children admitted into care are from already disturbed families (Schaeffer and Schaeffer, 1968), Mapstone, 1969). They also come from families with four or more children in 67 percent of cases, versus only 39 percent of the control group. It is known from other studies that large family size correlates with juvenile delinquency (West, 1967).

Most of the children who had been in care had parents with a "fair to poor" or worse marriage as rated by the interviewers on a 6 point scale. The control group had only a third of parents with a fair-poor or worse marriage. Again, this factor has been correlated in other studies with male antisocial behavior (Rutter, 1971).

When considering the etiologic role of the period "in care", one must ask whether it leads to the disorder and why boys but not girls are adversely influenced during their childhoods. Maternal deprivation seems an inadequate explanation when only short periods are involved, and seems too weak a factor to account for the boys' antisocial disorders. This is especially true since the care was mostly for only a few weeks and in only half the cases occurred under age five years when separation sensitivity would be greatest.

With long term separation, girls have been found equally or even more susceptible to bad effects (Yule and Raynes, 1972, Wolkind, 1972). In looking further for an etiologic clue, it appears there is not much information on the family circumstances before care, and more about the circumstances after such placement is over. At the study point, when the children were already 10-11 years old, two thirds were from four-plus child families (versus two fifths of the control children). Less than a quarter had families with parents living harmoniously, versus two thirds of the control children. So that even after coming home, the children were exposed to factors known to lead to antisocial conduct (Rutter, 1971, 1972). Even if the stay is a long one, Wolkind (1972) has found that coming from a large family and having adverse parental relationships prior to entering the stay is correlated with antisocial behavior in both sexes equally.

Why boys are more susceptible to the short term stay is still mysterious. Certainly there may be greater male general vulnerability, to many or all forms of early life physical stress (Rutter, 1970) but it need not be true for all forms of psychological stress. Since antisocial disorder and overt delinquency are male disorders predominantly, the present study suggests that etiology may also be different. There is no question, even in this study, that a few of the girls who had long stays were also disturbed psychiatrically, especially those whose stays started early in life. Three of the four girls who were disturbed had started their stays before age one year, versus 5 of 27 boys. The institutional way of life and relationship may be severely damaging to girls as well as boys, but the short stay does not appear to damage girls after age one year so far as vulnerability to antisocial conduct at age 10-11. Perhaps the problems will appear in adolescence, when female behavior is under new stresses different from those of the male.

A conclusion is drawn that the antisocial problems which arise among formerly placed boys should not be attributed to poor care in foster placements. Instead, the causes should be sought among the family of origin, and in the child himself. Since antisocial disorder is very difficult to treat, there is need for trials of preventive interventions, especially focussing upon boys admitted to short term placements.

PSYCHOPATHOLOGY OF BIOLOGICAL PARENT/ PSYCHOPATHOLOGY OF FOSTER CHILD

Placement in foster care is an unintended experiment which can illuminate questions of transmissibility of psychiatric illness despite a currently nonpathologic environment. A good example of longitudinal research in this area, focusing in part on foster children placed by schizophrenic mothers, is the Waterloo High Risk Project (Steffy, 1984). From a set of 900 mothers whose children had been removed to foster homes, 28 satisfied the criterion of agreement of two project psychiatrists that there was a diagnosis of schizophrenia. They had 33 children in foster care. The final number of children actually available for testing was only nine, producing a likely bias. A "Low-Risk Foster Children" group was chosen to control for many life stresses unique to fostered children. Ten foster children were in this control group, and 10 community control children were also studied. The foster children were generally separated from their parents at about nine years of age. Psychological tests comprised an "attention battery", including a set of measures demanding various types of attentional functioning. The decision to emphasize measurement in this

area was based on the central position of attentional functioning deficits in many contemporary theories of schizophrenic disorder and the exceptional sensitivity of attentional tasks in discriminating schizophrenics from normals (Steffy, 1978)

REASONS FOR PLACEMENT

Foster children and their biological families (Olmstead, 1981) are mostly recidivists. Less than one third of the cases are without a prior record of some child welfare service. Forty percent have already been in out-of-home placements prior to entering the current placement. Similar experience of recidivism is found in New York State (Fanshel, 1977; Kliman, 1982) and Canada (Steinhauer, 1984).

The primary reasons for placement in Washington State are neglect and/or abuse (32%), alcohol abuse by adult (34%), mental health problem of adult (23%) abandonment (13%), and sexual abuse of the child (13%). These are overlapping categories as two or more may occur in the same family. Some of the primary reasons are likely to be part of pathologic behavior within the child himself -- running away (12%), child delinquency (8%), child "rejects parents" (22%). These categories and proportions of reasons are similar to those reported by Fanshel (1977) in New York City, Kliman (1982) in Westchester County, and Steinhauer (1984) in Ontario. A comparison of U.S. and Canadian studies with Rutter's (1984) studies of English foster children indicates that although racial and ethnic differences are great, psychiatric factors in the family backgrounds and reasons for placement of English foster children are comparable in that there is high incidence of parental mental illness, sociopathy, and substance abuse.

BARRIERS TO RESTORATION OF BIOLOGICAL FAMILY CARE

Olmstead (1980, 1981), Fanshel (1977) and Kliman (1982) have similar findings. The most extensive data are those of Olmstead, from the State of Washington, showing that at time of placement the parent is out of state in 38% of cases, refuses or breaks appointments in 24%, is incarcerated in 6% of cases. To this 68% of cases of practically unavailable families must be added a different segment -- that overlapping one third who are suffering substance abuse, alcoholism, or psychiatric disorders sufficient to make the parent emotionally unavailable (Kliman, 1982).

PSYCHOPATHOLOGY AMONG FOSTER CHILDREN

Foster children utilize publicly provided mental health services to an extraordinary extent compared to other children from low socio-economic groups. An examination of Medi-Cal (the California version of Medicaid) claims was undertaken and showed that children in foster care account for 53% of all Medi-Cal supported psychologist visits, 47% of all Medi-Cal psychiatry visits and 43% of inpatient hospitalizations with public funds (Halfon, 1992). Halfon's findings were that the most common diagnosis among foster children was adjustment disorders, followed closely by conduct disorders and anxiety disorders. Halfon (1987) also found that of 14 counties investigated, none could document the rate at which Early Periodic Screening Diagnostic and Treatment Services were used on behalf of foster children, although such use is a federal requirement. In another report, they note one of 14 counties had regular mental health screening of foster children and in most counties only a third of foster children received such evaluations.

Psychiatric and Psychological Examinations of Children entering Foster Care are certainly not routine, even though required by law throughout the United States. Therefore, two uncommon studies in which psychiatric examinations were performed on large samples or universes of foster children are reported on here -- one of over 100 consecutive new foster children entering care (Kliman, 1982, 1984), and one study of children at various stages of care (Kavaler, 1983).

Only one study has been found in which a psychiatric examination was given to a total population of foster children at the time of entry. Kliman (1982, 1984), working with a population of 104 recently placed "new" foster children who had never previously been in care, provided clinical interviewing of 59 families, psychiatric examination and psychological testing of 93 of the 104 foster children, and then a random assignment to two quantities of preventive psychotherapy (see below).

Twenty eight percent of the children examined psychiatrically had a DSM III disorder other than an adjustment reaction. Less than five children had mental retardation or psychoses.

This study of psychiatric diagnoses allowed a prediction that children with the relatively benign diagnosis of adjustment reaction disorders would be transferred among foster homes less often than children with the relatively more serious other diagnoses. It was postulated that adjustment reaction disorder was a

situational disorder and therefore less likely to be carried within the child to a new situation. Indeed, it was found that transfer rates were lowest in the adjustment reaction disorder group of diagnoses. Among adjustment reaction children, 46/68 had no transfers versus 11/27 among other diagnostic group children, showing a rather opposite kind of experience -- likelihood of stable placement for the least disturbed versus likelihood of unstable placement for the most disturbed children.

Initial degree of disability or impairment was also rated by the psychiatrist at intake, using a four point scale with four indicating the most severe pathology, and one indicating the least. Low degree of pathology correlated with adjustment reaction, and in turn with greatest stability of placement experience.

At seventeen month follow up, there was no difference found in the total length of time in care, according to diagnosis, only in the total number of homes. Children with high degrees of pathology and with diagnoses other than adjustment reaction tended to stay in care at the same frequency as other children, at seventeen month followup. Seventeen of the 27 (63%) with other than adjustment reaction disorder were still in care at that time, while 44 of 68 (65%) adjustment reaction children were still in care.

PSYCHIATRIC AND PSYCHOLOGICAL EXAMINATIONS OF CHILDREN ALREADY IN FOSTER CARE

Kavaler (1983) conducted comprehensive reviews of the physical and mental health status of 668 of 795 eligible New York City foster family children. Included in the review process was psychiatric evaluation of a randomly selected subsample of 179 children six years of age and older. This was performed by means of a standardized protocol, including a screening questionnaire developed by Langner (Langner, 1970). The recruitment, initial training and ongoing supervision of a team of psychiatrists was done with the assistance of two members of the original Langner team, Edward Greene and Joseph Herson, M.D. The evaluation required about an hour, and included inquiry concerning the child's school functioning, home functioning, peer relationships, dreams, fantasies and a brief neurological examination. In addition, the Peabody Picture Vocabulary Test and the Bender-Gestalt Test were administered. After each interview, the child was assigned a general rating of impairment and ratings in 10 areas of function, each on a five-point scale (well-to-minimal, mild, moderate, marked, and severe-to-incapacitated). A caseness rating, estimating confidence that there should be some form of therapeutic intervention, was made in addition to a diagnostic impression.

Of the 179 children who were examined, 33 percent had marked to severe impairment, and 61 percent had mild to moderate impairment according to psychiatrists' ratings. Intelligence ratings on the Peabody Picture Vocabulary Test showed a mean score of 87, compared to the Nashville white group used to standardize the test -- which of course received a mean score of 100. The Puerto Rican children studied by Kavalier received a mean I.Q. score of 77.4, much lower than a group of Spanish-speaking Mexican children reported by Corwin -- who received 95.8 (Corwin,1962). The other races of children are contrasted by Kavalier using data from other studies with Wechsler Intelligence Scales for Children Scores, which have been shown to correlate well with the PPVT. (Lindstrom, 1961) The black children had a PPVT mean of 88, contrasting with a WISC national sample of black children with a mean of 90. The white children had a 10 point differential from the national sample -- 93 versus 103.

The intelligence test results of Kavalier's study are in marked contrast to Kliman's study of newly placed Westchester black and white foster children. Kliman's black children had no significant differences of intelligence quotients from white children and both groups were at national norm levels. Not only were Kavalier's children in placement for much longer periods than Kliman's subjects. Kliman's testing was by means of the Stanford-Binet rather than the Peabody Picture Vocabulary Test.

A comparison of Fanshel's, Kliman's and Kavalier's studies of I.Q. among foster children is summarized in the following table:

	Mean	White	Black	P.R.
	I.Q.	I.Q.	I.Q.	I.Q.
WISC	100	103	90	
Fanshel: Cattell Infant Scale	92			
Fanshel: Preschool (Minnesota Preschool Scale)	88	91	86	87
Kavalier PPVT	87	93	88	77
Kliman Stanford-Binet	95	97	95	85
Kliman Cattell Infant Scale	97			

CHANGES IN PSYCHIATRIC AND PSYCHOLOGICAL FINDINGS OVER TIME IN FOSTER CARE

Both Fanshel and Kavalier find little correlation between length of stay and psychiatric status at the time of study. A possibly related variable is far more significant, Fanshel's findings concerning visiting by parents as a correlate of psychopathology in the children. The absence of visiting may affect psychological time from a child's point of view. Given the psychological effects of loneliness and frustrated attachments and yearnings, the length of time between infrequent visits may be intolerable. Absence of parental contacts and even a low frequency of such contacts correlates with more behavioral pathology than among those children who are visited often (Fanshel, 1977).

Fanshel found mean I.Q.'s were stable over a five year period. Kavalier also found no correlation between I.Q. and time in care. Kliman's study was limited to a 17 month followup during which I.Q. scores were stable. However, Wide Range Achievement scores rose for those children remaining in foster care compared to those who returned to their biological families. This was particularly true in the Arithmetic Achievement scores. Kliman's 17 month followup thus showed a benefit in academic dimensions for those children remaining in care. The benefit was most striking in the arithmetic scores. Similarly, Kliman's sample, like that of Fanshel and the earlier study of Freeman (1924) showed an I.Q. advantage for children living with "intellectually stimulating" foster parents. There was also a WRAT advantage for such children.

FOSTER CARE AS A CORRELATE OF RUNAWAY BEHAVIOR

Shaffer and Caton (1984) report on a sample of New York City homeless youth using official shelters. The study is of preventive importance for a number of reasons, including that among psychiatric patients who had been runaways, sociopathic behavior in adulthood is more common (Robins and O'Neal, 1959). The authors estimate there are 4,550 admissions to youth shelters in New York City. A sample of 118 admissions to a shelter were studied, from among 175 non-overlapping presentations of children and adolescents aged 17 and under. The children ranged in age from 12 to 17. Most had run away before. Over 18 percent had run away from a foster family or foster group home. Half of the runaway shelter users had previously lived in a foster family, or foster group home. This group of foster children and former foster children presented the most severely disturbed behavior of all the runaways. They had significantly more changes in

their living arrangements in the year prior to the present episode, had run away more often, had used shelters more often than other runaways, showed more deviant behavior in general. Three times as many as other runaways had received psychotropic medication, and five times as many had been hospitalized. They had significantly higher scores on the Achenbach Child Behavior Checklist, more had been arrested, more had committed serious crimes, had used a variety of street drugs and were sexually experienced. They had started to run away younger than other children (39% before age 13, versus 17% of the group not ever in foster care) and their parents were significantly different. Their mothers were three times as likely to abuse substances, and were more likely to have run away themselves (cf. discussion of the repetition compulsion and identification with the aggressor, below).

ADVERSE EXPERIENCES WHICH REGULARLY OCCUR WITHIN FOSTER CARE

Loss of contact with parents occurs to about half of foster children within a five period placement (Fanshel, 1977). Disruption of schooling is a concomitant of multiple placements. In Washington State, among those foster children attending school, 22% had changed school at least once during the past year. Two thirds of these children had changed schools because of a change in foster care placement, thus experiencing a major cognitive adaptive task simultaneous with a social and emotional stress (Olmstead, 1980)

POSITIVE EFFECTS OF FOSTER CARE --

Prevention of delinquency is suggested by Leitenberg's (1981) Vermont sample of neglected and unmanageable children. This study improved on McCord's (1960) also relevant Massachusetts study. McCord had failed to make a baseline match, but found that his previously delinquent cohort of foster children was much more antisocial than an unmatched control group at time of followup in adult life. McCord also had no random assignment to foster homes versus retention in natural homes. He found 15 of 19 former foster children exhibited adult criminal behavior whereas only 8 of 19 controls exhibited such behavior.

Leitenberg's somewhat more refined study selected 187 children in the care of the state rehabilitation service because of an original adjudication of either neglect or unmanageability. Random assignment was not possible. However, the sample was demographically representative of the larger pool of children of similar age in the active files, of which they comprised over 50%.

School attendance over three years studied was substantially lower for children who had been allowed to remain with their biological parents than for children who had been placed in either group homes or foster family homes.

Contact with police was substantially more for children who had been allowed to remain with their biological parents, over a three year period. This was most true for children originally in the 11-13 year range.

Leitenberg contributes information on other points, such as the transfer rates of these children. The older the child the more transfers experienced. In the older age range the mean move rates were over one per year. Females committed between ages 14 and 16 moved more than two times a year. This Vermont group of adolescent girls resembles the Ontario adolescent girls in respect to transfers within foster care (Byles, 1980).

The less urban quality of the Vermont sample makes it striking in that it is quite similar to data concerning populations of foster children reported upon in Detroit (Ambinder, 1965) and Maryland (Maas and Engler, 1959). Fewer than 10% of the children returned to their parents prior to age 16. The supposedly temporary custody was mostly permanent. Yet the time spent in any one placement was short.

ANTISOCIAL BEHAVIOR BY FOSTER CHILDREN

We report on the incidence of runaway behavior elsewhere. Foster child-caused property damage within the home was reported by foster parents in 25% of cases, each year (Olmstead, 1980). In half the families, the cost was between \$100 and \$500. It ranged between \$500 and \$3000 in 10% of reported cases. We are not so informed by the Olmstead report, but believe this antisocial form of child-induced financial stress is part of the foster system's high breakdown problem, and induces many transfers among foster homes. Whether adult crime rates are greater among former foster children than demographically comparable adults is a different question, one which is addressed by longitudinal studies below. And even before the end of their childhood, it would also be important to study the types of crimes committed by former foster children, as they may be harsher crimes in cases of harsh childhood experiences.

LONG-TERM FOLLOW-UPS OF FOSTER CHILDREN

Festinger (1983), Zimmerman (1982) and Ferguson (1966) have reviewed and conducted studies of former foster children who are now grown. Each of the studies had major flaws, readily admitted by their authors. Festinger, for example, had a population of former foster children with an extraordinary (40%) rate of childhood bereavement -- a condition less likely to be associated with psychopathology than the antisocial behavior, neglect, and parental mental illness which characterizes most foster children's families. Festinger also had to exclude (for ethical reasons) severely physically and mentally handicapped former foster children. The bereaved children were not only over-represented in the original population, they were later excessively represented in the followup-accepters. It is therefore not surprising that Festinger has documented a rather benign long-term outcome of foster placements.

Zimmerman (1982) did a followup study of 319 former New Orleans foster children born between 1951 and 1961. They had entered foster care between 1951 and 1969. The sample was obtained from closed case records still on file in Orleans Parish. One child who met the age and length of placement criteria was chosen from each family, and birth order of the child chosen was rotated. Since the primary focus was on youngsters in foster home care, children who were placed for adoption or were solely in institutional placements were not studied, nor were children in foster homes for less than one year. Additionally, three children who died in care, and thirteen youngsters who were discharged to relatives in distant states were eliminated from the study.

Remaining in this clearly selective followup were 170 youngsters eligible for followup. Sixty percent were male, 65% were black and 35% white. A disproportionately large number of white males and black females were in the adopted group not studied. Of the 170 former foster children eligible, 109 or 65% were located.

An unstated number of white males (at least seven) refused to be interviewed, several being "quite angry about being contacted." The most frequent reason for refusal was that "childhood experiences were too painful to deal with." One young woman denied having been in foster care and another refused interview because of a seizure disorder which was considered by her family to be "possibly aggravated by the stress of an interview." Seven institutionalized persons were not interviewed: one in prison out of state, four severely retarded and/or physically

handicapped, and two hospitalized for mental illness. Of two deceased males, one had died as the result of a traffic accident, and the other of a gunshot wound in a barroom fight. In all, the number not interviewed or not located constituted a highly disordered group. The fact of being available or agreeable to interview, thus appears likely to be associated with greater health in a substantial way, as in Festinger's followup study.

Seventy-five percent of the interviewed former foster children were found to be self-supporting. But their incomes were low. Among those with full-time employment, one third were at federally defined poverty levels. Sixty percent of the employed were earning under \$9,000 per year. Twenty-five percent of the entire group were receiving support by some public means, including 15% from public welfare sources. The latter rate is essentially the same as the 12% rate of Orleans Parish in 1970. Educational achievement levels were "low by any standard." The median educational level was between tenth and eleventh grades, for which comparison figures in Orleans Parish were not given. The high school dropout rate was 56%. (Five percent in special education classes only were not included, and so the non-graduating rate is understated.) The overall dropout rate in Louisiana in 1976 was 40%. About 20% of blacks nationally drop out of high school between ages 14 and 24 (U.S. Bureau of Census, 1980), but this does not include blacks who did not make it to high school, which was true of 15 percent of the Zimmerman sample. Thirty-eight percent of the interviewed group had married, and 30 percent of these marriages had ended in divorce or separation, a rate comparable with the national average for the age group. While 46 percent of the former foster children had become parents, only 36 percent were rearing those children within legally married, two parent families. An additional 14 percent of the subjects were in two-parent non-legal unions, in which the present male was not necessarily the father of the child(ren). "For all intents and purposes, 50 percent are single-parent households which are female-headed," a figure higher than the 1978 estimate of 41% of black families nationally which are female-headed (U.S. Bureau of Census, 1980). Only two children were being reared by non-parents, and none of the children were in foster care or adoptive status, so far as the interviewers could ascertain. Again, Parish control or comparison figures were not used.

An interesting feature of the Zimmerman study was its effort to assess the general social and behavioral adjustment of the 61 interviewed former foster children. Using the young adults' self reports of adjustment, Zimmerman judged the reports according to "minimally expected behaviors" such as "adherence to the law, self-support, being in the process of preparing for self-support, and caring for one's own children, especially in the case of women. Using these criteria, ratings of

the former foster children's adjustment were good in 27% of cases, adequate in 39%, major dysfunction in one area 23%, and major dysfunction in most or all areas 10%. Again, the lack of a comparison group makes these high dysfunction figures difficult to evaluate, alarming as they are.

A way of using Zimmerman's data to understand the impacts of foster care is to look at a set of variables directly associated with the experience of care, and to study the correlation of those variables with adult outcome. Zimmerman notes that youngsters who returned to biological families were significantly over-represented ($P = .0001$) in the "inadequate current functioning group". As in the short-term study by Kliman (1982) there was clearly an advantage to staying in foster care. In fact, Zimmerman's data show that the longer the child was in foster care, the more likely he was to be better functioning. Those in foster care one to six years were all returned home to a biological parent or relative. These youngsters comprise 14 of the 20 inadequately functioning adults on follow up. Those in foster care from seven to twelve years included children who returned to biological family and those who were released on their own recognizance. These latter among long term foster children are more often in the inadequately functioning group than other long-term care youngsters. Those who stayed in care thirteen or more years are almost all better off than those who stayed in care for shorter periods.

The variable of parental visiting (see Fanshel, 1977) is a complex one. Those children who were most visited were also those who mostly returned to the custody of the natural parents. This fact, rather than the visiting itself, is the most plausible explanation of the poor outcome for those children most visited. When length of time in placement is controlled, those in longterm placement who were visited are more frequently represented in the adequately functioning group than those not visited at all.

The antecedents of adult antisocial behavior among Zimmerman's followed former foster children are also of interest. Eighteen percent ($n = 11$) of the 61 interviewed adults reported having been convicted of crimes and having served at least six months in prison for those crimes. This was primarily a male phenomenon.

Only two percent of the female adults had this history. Of the 11, six individuals were incarcerated at the time of interview. Their current incarcerations were for armed robbery in two cases, drug offenses in two cases, and one each for aggravated burglary and murder. Five others not in jail at the time of interview had been convicted for various thefts and assaults, some combined with drug charges. The harshness of the crimes is impressive, as if the youngsters were

wreaking vengeance, although Zimmerman does not suggest this.

Among these criminal former foster children, significantly associated variables accounting for most of the variation between them and the non-criminal group were the following:

Placement pattern short term or unstable, discharged to biological relative rather than parent, large number of homes lived in, lack of high school completion, young age of discharge from foster care. By their own reports, these criminal adults were already delinquent in early adolescents, and were in early and severe academic and behavioral difficulties which resulted in their dropping out of high school.

Most impressive of the relevant long term studies is a Scandinavian one. Bohman and Sigvardsson (1980) conducted a prospective, longitudinal study of Swedish children who were registered for adoption at birth and followed until age 23. This is a study of importance for study of nature/nurture questions in general. Of particular interest is the author's report concerning 329 such male children. The authors ask, "does the early placement of children from families of antisocial or otherwise socially insufficient families protect them from developing juvenile delinquency and/or social maladjustment?"

The study originated with a cohort of 624 children born 1956-1957, after unwanted pregnancies, and all had mothers who reported to a Swedish adoption agency that they wished the child adopted. Of the original cohort, 93 boys were placed in adoptive homes before age year -- constituting "Group I". Group II consists of 118 boys who returned to their biological mothers, mostly right after birth, and were brought up by their biological mothers. Group III is of greatest interest in this review as it comprised 118 boys who were placed in foster care, mostly before one year of age. Usually there was no clear permanency of the legal status of the children and yet almost all of the children were raised by their foster parents and more than half were legally adopted by them at some point.

The biological parents of all three Groups were heavily represented in Swedish registers of criminality and alcohol abuse. About one third of biological fathers were listed in the criminal register -- against an expected ten percent for a representative group of Swedish men of the same age. There were no significant differences among the three Groups, regarding paternal criminal listing, but it was highest in Group III (40%) and lowest in Group I (27%), with Group II having an

intermediate position (34%).

Alcoholism history was noted by the register of offenses under the Swedish Temperance Act. A representative population of men of the same age would have an 18% registration, while the subjects had respectively -- Group I, 26%, Group II, 39%, and Group III, 48%. These differences, unlike those for criminality, were significant at the $p < .01$ level.

Biological mothers also had high prevalence of registrations for crime and alcohol abuse, compared to a random group of women. Therefore, it is clear that the biological parents were an aberrant group, which Bohman and Sigvardsson rightly point out could be expected to produce antisocial children, if there is either a genetic or environmental transmission. The question is of great scientific and social importance, as to whether adoption and/or foster care of such parents' offspring would lead to a lower than expected rate of antisocial behavior. The question might to some extent be answered by a comparison of the adopted and fostered groups with those raised by their biological mothers. In effect, the three groups comprised a "post-facto experiment", beginning during pregnancy and extending up to age 23 years.

Study information included the following: at 11 years -- teachers' interviews, school marks; at 15 years -- teachers' questionnaire, school marks; at 18 years -- military enlistment data and health processing; at 22-23 years -- registration of criminality and alcohol abuse.

At eleven years the adopted boys (Group I) had a high rate of behavioral and nervous disturbances compared to classroom controls. Twenty two percent versus 12 percent were considered "problem children", but very few were severely maladjusted.

The eleven year old mother-raised (Group II) and foster family boys (Group III) showed the same rates of disturbances as the adopted boys, an unexpected finding which contradicted original hypotheses that fewer disturbances would be found among the adoptee. After all, the adoptee had been brought up in higher socio-economic circumstances than the Group II and III children. And, indeed, when the severity rather than incidence of disturbances was examined, that factor was more pronounced in Group II and III children.

At age fifteen, in the eighth year of nine years of Swedish children's schooling, the teachers were sent questionnaires. These contained rating scales with seven-point measures, for both adjustment and behavior. Adopted children had little difference from class mates. But the boys in the two other groups had even stronger tendencies of maladjustment than at age 11. Compared to their control classmates, the II and III boys had two to three times as much social maladjustment. In Group II 14% of the boys were social maladjusted, compared to 5% among the controls. Group III boys were 12% maladjusted compared to 4% among controls. Here the term "social maladjustment" includes repeated criminality, abuse of alcohol, or drug abuse.

By age fifteen, academic achievement was significantly less among Group II and III children than their control classmates. But again, adopted children (Group I) had only small differences from their controls.

At age eighteen, when 90 percent of Swedish males undergo a two day medical, psychological and social examination, there was a major experimental opportunity. Every subject from the original cohort was identified. Intellectual measures were obtained on four different tests, including logic-inductive, linguistic, and technical abilities.

Group I showed almost the same achievements intellectually as age-related controls. By contrast, Group II and III had greater than control frequencies of exemption for socio-psychiatric reasons compared to controls, and their intellectual and cognitive achievements were not as high as either their controls or the Group I subjects.

By age 22-23 years, all subjects in the cohort of boys and their controls were sought among entires in the Swedish Excise Board Register (for alcohol abuse) and the Criminal Register. The Excise Board register included data about fines for intemperance, supervision by temperance boards, and time in alcoholism receiving facilities. The criminality definition used was a criminal sentence of more than 60 "day-fines". The control groups showed no differences amongst each other.

There is good agreement between the collapsed control groups and the Group I (adoptee). The same is true for Group II, biologically raised boys. However, the Group III boys, now grown, had an almost double the control rate of registrations, 29.2% versus 15.5%. Alcohol abuse -- either on its own or combined with criminality -- is particularly characteristic of this group. This is more the case than for biologically parented (Group II) boys who had only a 16.5% rate, barely and not

significantly higher than the controls.

It is clear from this study that the adoptee fared well socially, intellectually, and behaviorally. The poor outcome for foster children now grown was unexpected by the authors. They review their data and point out that "socio-economic status of the biological parents of these boys was significantly lower than that of the other two groups, which may to some extent explain the low school achievement. Other negative factors include a higher than other group incidence of perinatal complications, alcohol abuse by parents, and criminality among parents. One explanation proffered for the poor outcome of fostered children is thus a genetic and perinatal risk load greater than that of the adopted children and greater than that of the biological parent-reared children who were originally placed for adoption. Another explanation offered is that unlike adoptive parents, foster parents "were seldom prepared for placements...and there was also legal and psychological insecurity connected with the placement, as there was no guarantee that the child could not some day be moved back again to the biological mother."

A conclusion reached through this unusually systematic study is that early preventive work is necessary. The child's legal status should be decided as early as possible, and prolongation of psychological and social insecurity among foster parents and foster children should be avoided. The alternative of adoption seems clearly preferable to that of foster care along the dimensions studied, although the results may be accounted for by other variables.

PSYCHIATRIC CORRELATES OF TRANSFERS AMONG FOSTER HOMES

A Stanford University study (Wald et al, 1985) concluded that "the most common criticism of the foster care system focuses on its instability. The majority of children, especially those who remain in foster care for longer than six months, are subjected to multiple placements (Knitzer and Allen, 1978; National Commission on Children in Need of Parents, 1979). It is common for a child to be in three or more placements in a one to two year period."

Zimmerman (1981) clearly finds that youngsters who transferred among homes had a high rate of dysfunction. In his longterm follow up of 61 former foster children, nearly half of the frequently moved youngsters had inadequate function, as opposed to only 14% of the stably placed longterm care youngsters. The number of homes in which a child lived had an orderly association with adult functioning. Over 50% of the inadequately functioning adults had lived in five or more homes. Only

one-sixth of those in the adequately functioning group had lived in that many homes.

Pardeck (1983) analyzed data provided by the United States Children's Bureau, consisting of extensive information on a sample of 4,288 children in foster care throughout the U.S. Reasons for placement in care were sorted in 14 categories, and the number of times the child had been re-placed was available, as well as the length of time in care. The basic demographic characteristics of the sample were similar to other recent foster care studies. Three quarters of the children were between six and seventeen years of age. Half were male. Most of the children were from single parent families and had been in care under three years. Nearly 25% of the children experienced at least three foster home placements.

A positive correlation was found between number of placements and the reason for original placement being behavioral or emotional problems. This finding is comparable to that of Kliman (1982, 1984) in a prospective study of 104 children entering foster care (see above).

Unfortunately, it is clear from the Pardeck and Kliman studies that those children who need stability of placement most are the least likely to receive it.

In general, abused foster children commit fewer crimes than comparison cohorts of abused children living in their family homes. A study of 114 abused children placed in foster care showed they committed 0.05 crimes per person/year after age 11 (Runyan, 1985), versus 0.059 among the 106 abused children left at home, who comprised a comparison cohort. But if the children "bounced" among foster homes, the crime rate went up. Thus, the social cost of transfers among abused children in foster homes is a matter of concern in terms of both administrative costs and danger to community safety. Runyan's study found increased number of foster home placements had an orderly correlation with increased number of delinquency convictions.

TREATMENT OF FOSTER CHILDREN: QUANTITY OF HUMAN INPUT AS A FACTOR IN OUTCOMES

Several foster care intervention studies of a carefully constructed nature lead to similar conclusions about quantity of treatment being correlated with quality of outcome. Stone and Stone (1983) report that the amount of caseworker "energy", operationally detected as amount of contact with any and all members of the client

system by the caseworker, is positively correlated with stability of placement. High Caseworker "Energy" input correlates more highly with stability of placement than any of 63 other items studied, and accounts for more of the variance than all the other significant items combined, including child traits of antisocial behavior. Jones (1976) has massive data establishing a higher versus lower quantity of caseworker input as a correlate of successful preventive efforts, reducing placements among at-risk families, reducing days of placement among already placed children, and reducing behavior problems among placed children.

The phenomenon of quantity of treatment influencing quality of outcome is not confined to therapeutic interventions in foster care. Howard (1986) made a meta-analysis of 15 separate psychotherapy projects, none particularly focusing on foster children or even on children. Two thirds of the studies showed a significant positive association between length of therapy and favorable outcome. The meta-analysis covered 2,400 patients and over 30 years of research. It displayed an orderly and significant relationship between treatment outcome and number of treatment sessions.

Kliman (1984) has shown that a pilot study in which almost anything clinically necessary was done to help 31 foster children resulted in a zero rate of unplanned transfers in a one year time frame. This contrasts with an expected 25% rate.

Using more constrained methods, Kliman, Schaeffer, and Friedman (1982) have shown that a systematic delivery of therapeutic services to consecutively referred foster children was possible. But of the 104 children served, only those who received a 40 session mode of treatment appeared to benefit. The lesser quantity of input -- a 10 session mode -- appeared to do no good.

Similarly, the high cognitive "inputting" or "intellectually stimulating" trait among foster parents has a positive effect on I.Q. change. First noted by Freeman in 1928, the phenomenon of I.Q. rise among foster children has been confirmed by Fanshel (1977) and again by Kliman, Schaeffer and Friedman (1982). I.Q. rise appears confined to foster children placed with foster parents who are "intellectually stimulating."

All of the above facts may be explained by using a broad view of behavior based upon psychoanalytic views of narcissistic lines of development. Children, and indeed adults, families and social systems, require substantial support and various forms of interpersonal and cognitive inputs for their best functioning. To deal with human object relationship loss, as foster children must, they must have object

relationship replacement or even object relationship gain. Much of this needed human relationship input must come in the form of emotionally supportive and/or cognitive auxiliary functions of caregiving persons.

Energetic caseworkers certainly can support parents and foster parents to tolerate the provocations of an impulsive and rejection-seeking child. Foster parents in turn support the frustration tolerance and attention span of a child doing his homework, as well as supporting the child's social and emotional processes. The necessary processes for successful foster care placement all have a component of constructive applications of narcissistically nourishing functions.

The I.Q. gains of children parented by intellectually stimulating foster parents, the higher Wide Range Achievement Test Scores of children who remain in foster care rather than returning to their probably more chaotic and often less intellectually stimulating biological families have similar explanations. What must be done for foster children must be done well, with a rich expenditure of energy.

The academic impoverishment of our society's most vulnerable children appears to be partly preventable. Selection and recruitment of foster parents for intellectually stimulating qualities would be a low-cost means of enhancing children's academic functions. Behavioral impairments the children suffer are sufficiently related to family practices, such as lack of parental visits, that family-based approaches to prevention are in order. Psychotherapy directed to the children as well as the family also appears useful and worth further trial with efforts to focus upon the child's experiences of discontinuities. The more psychiatrically impaired the child, the more likely such discontinuities will be experienced, and the more desirable it is to provide a psychotherapy in order to reduce the likelihood and damage of multiple transfers among foster homes.

REVIEW OF PREVENTIVE TREATMENT PROJECTS

I succeeded in delivering several systematic preventive projects to populations of foster children. A pilot study showed rates of "bouncing" among foster homes could be reduced by a variety of treatments from a 25% per year level to a zero per year level in a population of 30 treated children (Kliman, 1982). Since the pilot treatments were costly, it was decided to next use measures which could be widely disseminated. An intermediate level of cost and intensity of treatment was then tried with 104 consecutive children entering foster care. The treatment was preventive, applied to all children, randomly assigned to differing durations of

intervention. One duration was 40 sessions and the other was 15 sessions, both durations having the same methodology despite differing lengths. The methodology was to have an inexperienced therapist work under the supervision of an experienced child psychiatrist, and to focus on helping the foster child mourn for his lost relationships and lost environments. There was no specific treatment focus on a history book or on prevention of transfers. Neither the 15 or 40 session modality reduced transfers. The 40 session modality (but not the 15 session modality) was effective in reducing indicators of behavioral pathology (Kliman, Schaeffer, Friedman and Pasquariella, 1982).

Subsequently a clearly transfer-prevention focused treatment was developed, building on experiences with life story books. This would become a project focus. The use of life story books had been particularly well developed by Aust (1981) and Wheeler (1978) independently and earlier than the current project. Aust reports her casework unit has a collection of twenty Life Books, and that they are used in the weekly psychotherapy each child in the program receives. Aust provided information concerning placement stability or other replicable measures of outcome. The method had not been manualized as a replicable form of psychotherapy and had not been studied in a controlled assessment of outcome. Transfer rate was not a treatment-specific target.

CONTROLLED ASSESSMENT OF PSYCHOANALYTICALLY DERIVED PREVENTIVE PSYCHOTHERAPY

This section describes a preventive project based on a psychoanalytic hypothesis. My purpose was to determine the social system impact of providing preventive mental health services to children newly entering foster care in New York City. The project was designed to assess the efficacy of a distinct form of preventive intervention called "The Personal Life History Book Method", which is a psychoanalytically informed, highly structured, focussed, cognitively oriented

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therapy. From the experience of the project a manual has been created so the particular method can be replicated in most communities.

I have long been interested in applications of psychoanalytic theory and technique to preventive interventions with children (Kliman, 1968, 1975, 1980, 1982, 1983, 1990) and especially in connection with preventing the effects of severe traumas by enhancing the personal narrative and related sublimative activities of young children (Aust, 1981; Klagsbrun and Kliman, 1989; Kliman, 1975; Kliman and Rosenfeld, 1980; Lopez and Kliman, 1975, 1980; Stein and Kliman, 1974; Kliman, Oklan and Wolfe, 1989). Systematic preventive interventions with foster children have increasingly been my focus (Kliman, 1982, 1990). In designing the study and the method of intervention, I hypothesized that the adversities preceding being placed in foster care involved a frequently traumatic set of stresses whose pathologic social consequences would be the target of the preventive intervention. These prior adversities are mainly relationship deficiency, relationship toxicity, and relationship discontinuity stresses: neglect, abuse, rejection, and ultimately the loss of family relationships. A blanket hypothesis to cover all those adversities was formulated as follows, so as to focus an operationally measurable social consequence of the hypothesis:

"Traumas preceding foster care placement lead foster children to behave in a way characterized by the repetition compulsion, a detectible tendency to re-experience the prior traumas, including rejections and losses. The child's repetition compulsion behavior powerfully evokes rejections and abandonments, detectible as the operationally measurable phenomenon of transfers among foster homes."

One theory is that the repetition compulsion is a maladaptive effort to become the master of the passively traumatized inner life (Littner, 1960; Kliman, 1980). Whatever the underlying theory, this hypothesized tendency to evoke repetition of trauma can be measured in a foster child population by counting the number of times a child transfers among homes. If all other factors are controlled, the effects of a preventive intervention could also be detected in a population of foster children simply by the change in number of transfers. Few populations of children or adults are so widely available, readily found, greatly in need, and amenable to the measurement of a preventive service's effectiveness.

A rare opportunity in psychotherapy research was then provided by this investigator gaining access to a large number of children to screen and a sufficient number in treatment and control status who had a number of characteristics in common. They had all been through a single experience: placement in a new family. All of the treated and children were in their first round of foster care, and had not yet been returned to their biological families. These homogeneities being a basis, we went further and made the most careful analysis of the outcome of our clinical interventions through study of a matched subset of 8 treated and 8 untreated (control) children. By using the matching method, we had even more reasonable assurance that we were making a meaningful experiment, through further reducing many of the conditions of human variability. We matched by weighted criteria comprised of age, score on the Achenbach Child Behavior Checklist, and sex.

The therapeutic method used is designed to help the children reduce their transfer rates. They are helped to channel their distress into creating a personal record book, a sublimation-promoting process. This is expected to enhance the sense of internal continuity, and particularly enhance conscious access to mental rather than behavioral representations of past relationships. Through encouraging sublimated expressions of recall, primitive behavioral enactments, and defenses of avoidance and denial of past traumas could be somewhat reduced, transformed into manageable verbal and artistic representations. The child could, through developing more adaptive means of dealing with its past, be less likely to coerce the new care givers into repeating the history of abandonments and abuse, could be more likely to stay put and have measurably fewer transfers among foster homes.

To select our subjects, 648 foster children were screened, using data from four referring agencies. Inclusion in the study was based on being between ages 3 and 12 years, being placed in foster family care for the first time, and living in a foster family home within 45 minutes of the research unit as measured by public transportation travel time. Children who had been in family foster care earlier in their lives and had previously returned to biological family were excluded.

Of the 648 children screened, 52 met all the study eligibility criteria and became participants in the study. Some characteristics of the adversities faced by the 648 foster children screened can be grossly (but not precisely) discerned. One agency (DAFCS) gave us statistics on all placements in the screening year (1986), revealing that 20% of the children were placed because of abuse, 21% because of neglect, 23% because of drug use by a parent, and 36% were abandoned. These

figures are generally but not precisely relevant to our 648 screened children, as our 648 come from a larger group of 962 placed in the reporting agency and are only presumably representative of that group.

All foster families were paid for their travel and participation time at a rate of \$7 per hour, whether treated or simply studied. Fees were paid to the foster parents for time spent filling out behavioral checklists. Upon completion of all tasks, an additional \$7 per hour was paid.

Twenty four treatment cases were recruited before their 28 nontreatment counterparts, to allow for completion of the 30 session treatment protocol. Among the 8 matched treated children, the range of time it took to administer 30 sessions was from 7 months (2 subjects) to 12 months (1 subject). Two subjects required 9 months for completion, two required 10 months, and one required 11 months.

DEMOGRAPHIC DATA FOR 8 MATCHED PAIRS OF TREATMENT AND
CONTROL CHILDREN ARE THE FOLLOWING

	Treatment	Matched Control
Total	8	8
Male	4	5
Female	4	3
Black	3	4
Caucasian	2	0
Hispanic	3	2
Ages 2-5	4	5
Ages 5-12	4	3

Matched pairing was done with priority for ages 3-6. If we opened the pairing widely to the younger and older children this would be less precise clinically. And in social service systems, infants and very young children entering foster families tend to have stable placements (Fanshel, 1977). Ultimately the age and sex distribution was as follows:

	Matched Treatment	Matched Control	Overall Treatment Group	Overall Control Group
<i>Males 2-3</i>	0	0	0	2
<i>Females 2-3</i>	0	0	1	1
<i>Males 4-5</i>	1	3	3	5
<i>Females 4-5</i>	3	2	6	5
<i>Males 6-11</i>	3	1	10	6
<i>Females 6-11</i>	1	1	3	6
<i>Males 12+</i>	0	1	1	2
TOTALS	8.00	8.00	24.00	27.00

*Age data on 1 control case is missing at this writing.

BEHAVIORAL SCORE INFORMATION

We obtained baseline Achenbach Behavioral Checklist scores for the total sample of 52 children who reached the entry stage of the Foster Care Study Unit program. The scores at T1 (Baseline) had a mean of 32.9 S.D. 25.56. The range was from 1 to 104, a range so wide that the few extreme scores skew the mean as a measure of central tendency. The median was 24.5. The majority, 69.2% of the subjects were below the 90th percentile, that is, below the clinically significant range for psychopathology. A minority, 30.8% were in the clinically significant range. However, with this wide range, we could not be optimistic about matching the children by Achenbach scores, or about interpreting the Achenbach outcome data. The main outcome measure would have to be what was our main target anyway: number of moves among homes. There were some sex difference in regard to behavior ratings on the Achenbach scores. Of the females, 5/19 (26%) were above the 90th percentile, and 11/33 (33%) of the males were above the 90th percentile.

In regard to the social competency characteristics of the sample, the mean Achenbach social competency scale was 11.81 with an S.D. of 4.95. The sample range was between 2.0 and 25.0, with a median and mode both of 11.0 Compared to the Achenbach norming sample, 51.9% were within the normal range. On the other hand, 48.1% were within the clinically significant range. Sex differences in this regard were: 20/35 (57%) of the males were within clinically significant problem range on the social competency scale. This is almost identical to the 10/17 (59%) of the females who were within clinically significant range of social competency.

ACHENBACH SCORES:					
		Time One		Time Three	
		Mean	S.D.	Mean	S.D.
Matched Treatment Group	N=8	47.5	27.25	39.71	33.3152
Matched Controls	N=8	57.375	33.483	41.75	39.949
Total Treatment Group Including Siblings (Collaterals)	N=22 at T1, 15 at T3	30.54	23.30	24.066	26.974

Total Control Group Including Siblings (Collaterals)	N=28 at T1, 27 at T3	34.75	27.47	25.37	25.413
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Statistical analyses show treatment did not have significant effects on Achenbach scores. Differences between the groups at Time one have an F Ratio of .4446, an F Probability of .5118 The Time three differences between groups have an F Ratio of .4064, and Probability of .5307.

ANALYSIS OF ACHENBACH BEHAVIORAL SCORE DATA: DIFFERENCES BETWEEN TREATED AND CONTROL GROUPS			
		F RATIO	F PROBABILITY
Time 1	Treatment N=22 Cont = 28	.3289	.5690
Time 1 Matched	Treatment N=8 Cont = 7	.4186	.5281
Time 3	Treatment N=15 Contr = 27	.0243	.8769
Time 3 Matched	Treatment N=8 Cont = 7	.0113	.9170

DATA ABOUT MOVES:				
	Matched Treated	Matched Control	All Treated	All Controls
No Moves	7	3	19	18
One Moves	1	4	3	8
Two or More	0	1	2	2
TOTALS	8	8	24	28

Both the matched and unmatched treatment groups showed advantage over controls in regard to transfer rate reduction, but this was significant only with the matched pairs. Using a chi square analysis, $P=.01$ in favor of the treatment members of matched pairs. Using an analysis of odds, a probability of .01 also emerges. A social system perspective on this data can also be stated quantitatively. The odds of a stable foster home placement are markedly in favor of the treated children. The treated children in matched pairs have eleven times greater than control odds of a stable placement, measured as not being transferred among foster homes.

SUMMARY OF STATISTICAL ANALYSES

PLHB treated children had more stable placements than controls, measured by not having moves, when matched pairs of children are studied. Comparison of the matched treatment and control subjects (total $n=16$) using odds ratio analysis showed the odds of not having a move are 11 times greater in the matched treated children than the controls. The odds ratio analysis gives $P= .01$ for the matched treated versus control group, the same as the Chi-Square probability. From this analysis we conclude that the PLHB method reduces bouncing, as measured by numbers of transfers among foster homes.

CONCLUSIONS

It appears that a crucial preventive goal in a social service system can be achieved by psychoanalytically based means. The method is manualized and can be replicated. Children's transfer rates among foster homes can be significantly reduced by a simple form of psychoanalytically derived, structured, focussed psychotherapy. The matched treatment versus control subset shows this difference significantly.

DISCUSSION

It is rare in psychoanalytic psychotherapy research to succeed in conducting a project with the four characteristics of 1) a well-controlled design, 2) application to a reasonably homogenous population, 3) use of an easily detected outcome measure such as numbers of transfers among homes, and 4) use of a replicable method. This project has accomplished all of those aims. Further, the preventive treatment can be given at modest cost by minimally trained and moderately intensively supervised personnel.

This is the first controlled preventive psychotherapy to show an effect on transfer rates of foster children.

While the results are encouraging, we do not yet know anything about the long term effects, or the durability of this reduction, or its applicability in cultures and systems elsewhere. Although we tried to study the possibility of a post-therapy rebound effect, we could not get sufficient data to report upon. Confounding variables need to be further considered, such as differing reasons for transfers, and the pre-treatment number of transfers.

Larger numbers of subjects will cancel confounding variability, even without the difficulties of a matched-pair design. In order to show the reduced bouncing effect in unmatched, randomly controlled studies a power analysis indicates we would need a total of only 275 subjects and controls, not an excessive number for a simple psychotherapy.

Much more could be extracted from the existing data. Our psychiatric examinations are very rich and not yet analyzed. For example, we have data on DSM III-R Axes I to V from before-and-after psychiatric examinations of each treated and control child. This would be good to correlate with transfer history, as

indicated by our prior study of Axis I diagnosis as a correlate of transfers (Kliman and Schaeffer, 1990). Similarly, we cannot yet report on our before-and-after treatment Beck Depression Inventory and SCL90 data concerning the foster parents. These are tasks for which we await further funding. Meanwhile, we urge others with responsibility for the health of foster children to also try the method preventively and systematically do follow up studies of transfer experiences among treated and control children.

Foster children are recipients of often quite belated and costly treatment for deeply ingrained mental disorders that are greatly aggravated by multiple transfers among foster homes. Ultimately, foster children are excessively represented among older children who populate special education classes, homeless shelters, jails and mental health facilities. As adolescents, many foster children soon begin making new generations of foster children. It makes good clinical, social and economic sense to immediately prevent the aggravating influence of unstable placements in this pathology-prone population. The nation's half million foster children are the responsibility of all and a worry to all who care about the upcoming generation. A replicable theory-based technique with an operationally detectable outcome is worth wider testing.

CHAPTER III

THE PERSONAL LIFE HISTORY BOOK METHOD: BASIC ASPECTS

The Personal Life History Book Method, in its basic aspects, is a brief focused preventive psychotherapy. It can be used by inexperienced therapists and by foster parents if they have supervision from a licensed mental health practitioner. It is time-limited, requiring up to 30 hours with the child. Another 8 to 10 hours should be spent with collateral adults who can help fill in sections of the book.

The method is for use with children ages four and older.

The focus of the therapy is on enhancing the child's sense of personal history. It can help him or her to mourn for human and environmental losses. An expected result is to reduce current behavior problems and prevent behavioral pathology which may arise when future discontinuities occur in the child's care.

The basic aspects instructions are to be used with any foster child within the specified age range. With presumably healthy foster children they can be used as a the sole form of intervention. Such a purely preventive measure can be carried out by foster parents. Rather than being a treatment for existing troubles, the task of the basic aspects is to prevent mental health troubles.

Although simple, the method should be carried out only with supervision available on request from a responsible clinician. If the child's Achenbach score is over 40, or if the child's behavior is dangerous or deteriorating, a psychiatric examination is needed.

A later chapter (IV.) is for caseworkers and other mental health workers who are already experienced with psychotherapy. Experienced psychotherapists can use the PLHB as the framework for other, more complicated forms of psychotherapy. In such hands the method may help provide treatment of an emotional disturbance which already exists, or it may be a purely preventive task.

INTRODUCING THE PLHB TO YOUR FOSTER CHILD

The way you introduce the task is in itself part of the preventive mental health effort. The introductory attitude you convey can be in itself a corrective mental health experience. It can help prevent the child from experiencing distrust, disillusionment, rage and bitterness toward all adults.

What needs correction includes that your foster child probably had a rather disorganized or rapidly changeable life before he came to you. Possibly many abrupt changes occurred and were seldom announced. Perhaps changes and adaptive tasks were forced upon the child. Often the child may have felt things which affected his life were hidden from him until the last possible moment and he was expected not to think about or remember them.

To create a corrective experience for the distrust-provoking, disorganized, abruptly changing, forced, and often concealed experiences in a child's life, the following four rules of introduction will be helpful:

FIVE BASIC RULES

1. STRUCTURE

Introduce the PLHB in a structured way. Say it is a planned activity which you and the child will do together. It is an important job, and you will be spending an hour or more a week on that job together with the child for at most 30 hours. Emphasize the time will be up to 30 hours no matter how long he stays. (You should give more than 30 hours of mutual time to the book only in an exceptional case if the child and you agree to, later on.)

2. GRADUALNESS

Introduce the PLHB gradually with a simple levels of explanation, going to deeper explanations in later weeks. A suggested simple first level is in the "Getting Started" section.

3. FIRMNESS

Introduce the PLHB firmly but not forcefully.

4. PROMPTNESS

Introduce the PLHB early rather than late, so the child knows you were not hiding the plan.

5. CONFIDENTIALITY

Explain that you will not put anything in the PLHB the child or you feel will make trouble for the child later on, such as an item that would get him or her punished by a parent who read it later. You will keep such pages separately.

MORE ABOUT GETTING STARTED

Start with structure, gradually, firmly and early. If you are a foster parent, when your new foster child has been in your home long enough to put his or her clothes in a drawer, and knows where his bed and bathroom are, then introduce the Personal Life History Book matter-of-factly. The following introduction is at the easiest level of explanation. It is simple and yet can be used with children of kindergarten age through adolescence:

"You and I have lots of things to do together. One of the things we'll will do together is make a book about your life. It's a job I am supposed to do for you and with you. When it's done you will have something to show for it. It will belong to you. You will own the book in this loose-leaf cover after we finish it. (Show the child the cover and the blank insides.)

"I want you to work on it with me as hard as you can. I will give you at least an hour a week of my time for us to work on that job. We can work on it for up to thirty hours or until you go to your birth family, whichever happens sooner. You can take it back to your own home. You might keep the book all your life. It's important for you and I'll explain more as we get into it."

At that point, look through the blank book together, get the child's name, birth date, and a few facts onto the first page. Tell the child that a camera you have or a camera you can borrow will help fill in some of with some of the later photo

pages.

AFTER YOU INTRODUCE THE PLHB

The PLHB is made together as part of a relationship. As in any human relationship the child's stage of life, his and your personalities, earlier experiences, and many other things make the next steps very different for different people. Children of different ages and abilities work at very different paces and different levels of ability to remember and express their history.

One thing that should not change is trying to spend regularly scheduled time every week for a total of thirty hours with the child personally helping him make his Personal Life History Book. A four year old child might work best 30 minutes at a time, twice a week. A teenager might work best having 90 minutes with you for 15 weeks. If the time is spent alone, it can be more valuable to some children. However, you must share the work with all the child's biological siblings who live in the home.

If there are two or more children from the same biological family living with you, you will need more than thirty hours for this task. Add at least a quarter of an hour a week for each additional child. Try to get the help of the oldest child in getting history for the youngest children. Each child will have a somewhat different Personal Life History Book, even though you can photocopy some pages and use much of the same wording and use duplicates of family photos for siblings. Ask your agency for reimbursement for film processing costs and duplication of photos.

Your explanation to the child of the importance of the book should soon be deeper than in the introduction. At first you only stated simple and concrete importance, such as that the book is a shared task and that you would spend time on it, and that it would belong to the child.

Now we suggest saying the book is a way of "showing respect for the importance of the family, friends and places you came from." The importance is there no matter what the people's behavior has been. The parent could have done some very helpful or very harmful things, but the parent will be very important to the child regardless. Even if the parent was never around, that absence was very important to the child.

EXAMPLE

Foster Parent: "Your birth family is important in your life. I want to be sure you do some thinking about your birth family while you live with me. This Personal Life History Book will help you keep your thinking very strong."

The child should choose which parts of the book to work on first. Let him or her browse to choose where to start. If the child can't or won't choose, then take the initiative. Settle into a section that will probably not be highly distressing in content.

EXAMPLE: WHEN A CHILD CAN'T GET STARTED

Foster Parent: "Here's a way to work in your book today. Let's go to page _____ and write in the names of people who lived with you just before you came here, maybe starting with your mother. Then, later on we can work on harder things."

Once there has been a listing of a few family members' names, you might use the opportunity to show respect for the importance of remembering and understanding the reasons for placement away from those family members:

EXAMPLE: WHEN NAMES OF A FEW FAMILY MEMBERS HAVE BEEN LISTED

Foster Parent: "I know you and your family wouldn't live away from each other unless there were reasons. One of these days, it doesn't have to be today, let's both of us try to be strong and think together about the reasons why you came to live with me.... We should sometime put that in your own private book, here. It's like making your muscles strong with exercise....

"A child's mind has to be strong to help you with your feelings. Your mind will get really strong like from exercise by remembering and writing."

Later on you can say, "Your mind gets even stronger each time you do the work of remembering and talking with me."

EXAMPLE: SHOWING RESPECT FOR THE IMPORTANCE OF A BIOLOGICAL FAMILY MEMBER WHO HAS BEEN NEGLIGENT, ABSENT OR UNKNOWN

Foster Parent: "I'm glad you told me you don't know who your father is. That was brave of you to tell me. It's important to you that you don't know who your father is. Some children aren't brave enough to think of important things they have feelings about."

EXAMPLE: SHOWING RESPECT FOR THE FORMER ENVIRONMENT

Human beings aren't the only things important to your foster child. Surroundings and possessions are important emotionally.

In that spirit, a Foster Parent can say, "Jane, I never visited you before you came to me. I think about you a lot. And I'd like to have a drawing in this book, showing me where you used to live. That will be good for you, so you can have a strong memory of your life when you get older.

"Was it a big building? An apartment? What floor did you live on?.....And did you have a bed of your own....or a bunk bed?.....Lets draw a picture of the room where you slept.

PERSONALIZING THE BOOK WITH PHOTOS

In the first few days of foster care, take a picture of the child by himself. When it is ready, paste his own photo on the front page of the PLHB. Take pictures of all the people in your home. Paste those on the correct page.

Have the child take your picture. Paste it in with him. For younger children, you will be doing all the writing of names in the PLHB. For many older children, you will have to help with the spelling and writing.

Try to arrange the same time each week to do this. Pick a time when you won't be having a lot of interruptions. If that's impossible, let your foster child know you are trying.

If you can obtain photographs of his birth family and friends, do that. The PLHB is usually a loose-leaf. Add pages for as many friends and relatives as you can. Get an extra loose-leaf binder if necessary.

If child talks about some things that happened around the time a birth family photo was taken, urge the child to let you write that story down. If necessary use a separate page right after the photo.

GIVING SOME STRUCTURE TO MEMORIES

Often an older child or the child's caseworker can help you write a chronologic list of all the places he lived or all the schools he attended. Ask a biological parent or the child herself for a few names of teachers the child especially liked at each school. These should be recorded, as well as names of one or two the child disliked. Names of other children who went to each school should be listed, with as much identifying information as possible so that contact might be made later. Explain the purpose of this historical exercise, especially the hope that the child may keep a memory of his life history inside himself with the book's help, no matter whether he moves.

Other items likely to be at a low level of original distress, but important to record in every child's book are names, addresses and phone numbers of four or five old friends as well as four or five relatives.

This can be a hard job. What that may show, is just how disconnected and lost the foster child's personal history can be.

Your case worker may advise you not to contact the biological family. That might be for safety reasons. But otherwise, you will usually find that at least some telephone contact with his biological family is helpful to your foster child. A lot of research shows that once a child is three or four years of age and placed in foster care, he does much better if there is frequent visiting and telephone contact with his biological family. Your work on the PLHB might help your foster child to have contact with a number of relatives.

You might get contact information with the assistance of current and former caseworkers, older siblings, neighbors, former school personnel, or family friends. Get this information while it is still fresh. Use it in subsequent weeks to help the child write letters and make telephone contacts. Keep carbon or photocopies of the letters (and any replies) in the PLHB.

Unfortunately, many foster children cannot even have the advantage of more than two or three names and addresses of close family and friends to contact. So the adult helper must be careful not to express disappointment in the results of this section. New opportunities from the outside world as well as from the child's memory may come up from time to time.

When visits and phone calls from biological mother or father are lacking, come back to this section. Gently ask the child to think if there are names and addresses to add. Urge the child to think of who else could help add names and addresses. Be the child's assistant. Make calls and write letters for him at first, if he gives permission. Develop this section with all the help you can get from the caseworker's files.

ENDING THE PLHB TASK

The blank outline of the PLHB is largely self-instructing regarding how to fill it in. But ending it may not be simple. And the importance of a planned ending can be greater than any other aspect of the PLHB. Since you are only human, this will not be totally under your control and the child will usually have no power over timing either. Nevertheless, if you are a foster parent try your best to emphasize to the agency, caseworkers and biological family that if the child has stayed more than two months you will need at least a week to wind up your preventive work with him. Fortunately, you have been planning the ending since the first session. After all, you have been telling the child the treatment is time-limited.

If you have a couple of weeks warning of an ending, there is great opportunity for another corrective experience. The child may have had many losses of human relationship before, but probably never had a chance to anticipate the ending of one. That way he can mourn a little in advance. His advance mourning will probably reduce unhealthy forms of reaction later on--such as denial of feelings, forgetting of cherished memories, and shallowing of future relationships.

Give the child a calendar to mark the days you have left to work on the PLHB together. Pay special attention to filling in photo pages and written accounts about the stay in foster care. Provide the best log you can of names, addresses and phone numbers--including your own--of important people the child has met in foster care.

Since you are going to be apart in the near future, encourage appropriate sadness or other emotions on the child's part by being a model to him. Admit that you are sad, if you are. Admit it was a hard job taking care of him, if it was. Tell him you want to stay in touch if you mean it, and offer to write him if you are willing. Include your name, address and phone number in his PLHB if you are willing.

Be tolerant of regressions in the child's behavior at this time. If you are a foster parent turn to the Achenbach check list and your own list of the child's problems, behavior and symptoms if you made such a list with clinical guidance. Re-do these lists. See how they have changed. If the Achenbach score is lower, or if your own list of the child's problem behavior is lower, compliment the foster child on how much you and he have done together to help him grow emotionally strong. If the problems are worse, ask the foster care agency to arrange mental health services.

If you have personal contact, give the child's new caregiver an introduction to the child's PLHB. Point out the name and address of the doctors who last saw the child. It is important to prevent discontinuities of medical care, and to avoid omitting or duplicating vaccinations and x-rays. Offer to have a copy of school medical and dental records sent. Get the caregiver's address at least for this purpose.

CASE EXAMPLE

Beryl, a seven year old girl was placed with a family of four biological children belonging to the foster mother and father. Little was known except that the child's mother was on cocaine and had abandoned her without notice.

Although diagnosed as having a "Parent-child problem", and a mild developmental disorder of language and motor functioning, Beryl was generally functioning well in the view of her examining psychiatrist. Despite stressors rated as 6 on a scale of 7, the psychiatrist rated her functioning in the past year as 2 on a scale of 7, a good rating.

The treatment was conducted by a professional psychotherapist (a social worker), for preventive reasons. It could have been conducted by a foster parent with a small amount of supervision by a professional psychotherapist.

Working on her Personal Life History Book came easily to Beryl. The time-frame of work and the general plan of making the book were explained in a structured way (rule one) and promptly (rule four). In the opening session she counted that there would be thirty sessions and "this was number one", and was quite reluctant to end the session. She brought forth memories of another time her mother had left her, describing a private placement the mother had made with a woman who gave her "clothes, toys, magic markers.." Although it was seven months till Christmas, she related a dream of a Santa Claus who had given her many toys and had a store, about which Beryl said, "Wow!"

Beryl dictated numerous realistic sounding episodes of history regarding her mother and former surrogate mother, adding many details of games she played with children in the two places. Many of these items were entered in the PLHB.

At first, Beryl had an overly cheerful attitude. But she was able to express some sadness even in the first session by slowing down in speech. The therapist mentioned that in a way Beryl really felt sad, not cheerful about these memories. Occasionally verbalizing the child's emotions in this fashion, the therapist thus helped the child do some appropriate mourning for the lost environment and human relationships. She helped the child over-come her defensive reversal of sadness into cheerfulness.

In keeping with the rule (number two) of gradualness, the child was not urged or introduced into discussion of any painful topic she did not raise herself. This gradualness apparently helped her tolerate and become de-sensitized to the painful emotions involved. By the third session the child was speaking with more detail and depth of emotion about her biological mother:

"I don't like her. She uses drugs. Marijuana."

This was placed on a loose-leaf page of the PLHB, but was kept by the therapist--who explained she would keep it to protect Beryl (see next section).

The child denied being sad about her mother's drug troubles, when asked, and said "No, I am angry." But she drew "a sad flower", thus acknowledging a greater range of affect than moments earlier. We considered this an evidence of increasing strength, a product of some de-sensitizing even in the first three sessions.

During later sessions, Beryl often asked to record history in her book. She particularly liked to write about "sad memories" connected with leaving her former mother-surrogate, Henrietta. She now feared her biological mother would take her out of foster care, and do so in anger.

"I remember I wanted to be with Henrietta. Mommy lived with Henrietta and me, for a while, but then Mommy had a fight. I wanted to stay with Henrietta, but Mommy wouldn't let me. She used to be mean..hit us with a belt, real hard, all, all the time."

Beryl was now bravely confiding and was rewarded verbally for having the courage to talk about such unhappy times. She expressed fear that the mother would find out she talked about the beatings. Beryl knew that she had considerable control over her own PLHB, and it was agreed not to place the history of the beatings in the child's copy of the PLHB.

At that point she and the therapist worked on a family tree. They discussed Beryl's longings to see her baby brother, who is with Henrietta in another country now. She spoke of James, Henrietta's husband, who bought her toys.

During the final five sessions Beryl showed an interesting use of the method by discussing and recording her future goals. She wanted to learn how to read and write better, because she felt babyish. At a deeper level, she showed great strength in facing her own emotions:

"I get confused because I like foster care. I never want to leave here, with Mrs. N. I know she loves me...I don't like to say goodbye to you, either...That's why I feel sad. I also want to live with you (the therapist)."

The child was showing direct self-confrontation with sad emotion, and awareness of a tie to the therapist. A working through was occurring in that the patient repeatedly dared to share derivatives of her prior losses through the in-session sadness and sense of tie to the therapist. She expressed awareness of the link to the past within the treatment:

"Good-byes remind me of when I had to say good-bye to Henrietta."

The child had not been visited by a parent in the entire time of treatment. In the very last session the child once more expressed hope that she would be protected from her biological mother, complained more about the mother's drug use, and stated she would like to be adopted by her foster mother.

Beryl seemed to thrive, according to her therapist. The foster mother's ratings were in strong agreement, showing a marked improvement over the period of treatment:

INDIVIDUALIZED LIST OF PROBLEMS AND SYMPTOMS NOTED AND RATED BY FOSTER PARENT ON A SCALE FROM 1 TO 7		
	INITIALLY	AT TERMINATION OF PLHB TREATMENT
Sibling rivalry/fighting	5	2
School problems with peers	7	5
Hyperactive	6	4
Anxious	6	5
Lies	5	4
Easily distracted	7	5
TOTALS	36	25
ACHENBACH SCORES	97	46

PLHB AND CRIMINAL ACTIVITIES OF PARENTS

An important technical point was raised by Beryl's case. In order to protect the child, even if she had not requested, we removed and kept in our own files any PLHB pages which referred to criminal activities by her parents. In Beryl's case, we wanted to be sure that if the mother regained custody, she would have no stimulus to punish the child for the revelations. The child was assured that by our knowing what she had gone through (beatings and her mother's drug-related general irritability) she had some protection.

However, the mother made no efforts to re-establish the relationship. She made no contact at all. Therefore we recommended that if a lack of parental contact continued through the rest of the first year of placement, the child should be adopted by the foster mother--who wanted this to happen.

Another child who had been criminally and very badly burned -- third degree burns over forty percent of her body -- also used the PLHB method. We learned much from the then four-year-old's dictation of history. Her stepmother had inflicted the burns by scalding her in a bathtub after a bowel accident. The child was increasingly able to verbalize historical events using the PLHB and was also willing to tape record her account of the scalding episode. Parental rights were terminated and the stepmother was successfully prosecuted in this case. It was the district attorney's opinion that the successful prosecution resulted largely from the child's account in the PLHB method.

CHAPTER IV:

MORE ADVANCED ASPECTS FOR EXPERIENCED PSYCHOTHERAPISTS

A specific psychotherapy can be focused by or organized around the PLHB. Therapists using a psychoanalytically oriented, or a supportive-expressive therapy, or a cognitive treatment to modify behavior can utilize the PLHB as a structural organizer. Within any of the above psychotherapies, examples of three highly specific psychotherapeutic procedures which can be carried out with the PLHB as an organizer are:

1. Desensitizing to historical adversities and stresses.
2. Facilitation of mourning
3. Psychological immunization against future adversities and stresses.

DESENSITIZING TO HISTORICAL ADVERSITIES AND STRESSES

Use of the PLHB gives opportunities for de-sensitizing the child to prior adversities and stresses he has suffered. Discussion around the PLHB can be used to promote a form of emotional graduation to higher degrees of "strength." By strength is meant the child's ability to communicate to you in words and art regarding memories (including emotions) of stressful experiences which would distress any child of her age, and yet not have any lasting regression of adaptation. The stressful experiences could include sexual abuse, abandonment, neglect, illness or the death of a caregiver.

It is prudent to assume the child's mental mechanisms of adaptation are not very strong at first. At first, topics not introduced by the child herself should be chosen with low level of distress likely in their content. Occasionally tell the child you know there might be even harder things she has gone through in her life, "but we don't have to talk and write about them all at once."

Here is a series of examples, with increasing levels of emotional distress likely to have occurred in the original experiences, so that increasing ego strength is expected of the child as she goes through the series:

1. "Jane, let's draw and write the story of your last birthday."
2. "Jane, let's draw and write the story of something else that you did with your Mommy."
3. "Jane, let's draw and write the story of something sad that happened, or something that made you angry."
4. A few days later, having found the child cooperative in the above example, the therapist says, "Jane, if you are able, let's do some harder work. Let's write the story of what you were doing when the case worker came and told you that you were going to live with another family."
5. Having found Jane able to deal with the above work without regression of habits or ego functions, therapist says, " Jane, I know you are stronger now than when I first met you. Now I think you can do a harder part of your book. If you agree, let's make you even stronger. Let's write and draw the story of what you happened the day your brother died..."

Indicators of increasing strength of mental health, in addition to a lack of back-sliding in achievements of habit-training and executive skills, may include progress in numerous ego functions. The increasing use of advanced mental mechanisms such as sublimative skills (creative use of art and construction, for example), improved reality testing, increased intellectual curiosity, and improved social adaptation, show the child is growing stronger.

Indicators of decreasing strength of mental health common among foster children include back-sliding in habit-training, loss of speech or academic skills, increased antisocial behavior (such as fire-setting, stealing, lying), or the presence of new behavior problems such as day-dreaming, inattentiveness, phobias, clinging, overactivity, or sexual misconduct.

FOLLOWING A CHILD'S PROGRESS

A simple way of following a child's behavioral progress is available and has been found practical in the foster care situation. It involves assisting the foster parent in filling out the Achenbach Child Behavior Inventory when the child enters care and then on one or two later occasions for comparison. Many foster parents can do the inventory on their own. It is designed to be self-instructing.

Achenbach Child Behavior Checklist Inventory forms are currently available at modest cost (\$25.00 per hundred) from University Associates in Psychiatry, 1 South Prospect St., Burlington, VT 05401.

Ask a foster parent to fill in the initial Inventory when the child has been in the home for a few weeks.

"RAW" BASELINE SCORING: Add up the scores on pages two, three and four. If they equal more than 40, a clinical psychologist or psychiatrist should be consulted. Achenbach provides a better scoring method of considerable sophistication and low cost (\$4.00 at the same address), but this "raw" method is useful in our experience.

Foster parents should contact the child's caseworker regarding the Achenbach score if above 40, and request consultation for the child. Usually this can be done with Medicaid support by a clinic or licensed private mental health practitioner. In most communities, a private psychologist or psychiatrist will accept Medicaid. The local Psychiatric Society can usually provide a list of Medicaid-accepting practitioners. A foster child will usually have at least a temporary Medicaid number when he or she arrives.

FOLLOW UP: The Achenbach Inventory should be filled out again 120 days later, or upon learning the child will go to another home, whichever is earlier. If the score is lower, the child is showing improvement. The opposite shows deterioration. Achenbach scores should definitely lead to mental health consultation if the scores on pages on two three and four are greater than 60, in our experience.

FACILITATION OF MOURNING FOR LOST ENVIRONMENTS AND HUMAN RELATIONSHIPS

Mourning is healthy. It is a way of dealing with loss of human relationships. Many foster children have trouble dealing with their losses.

Mourning is hard work. People who mourn get stronger by doing that work. Mourning is a process of working over memories and related feelings. As the work is done, energy becomes available for current life. The more detail of idea and emotion the child can go into about his memories of "lost" persons without long-term regressions, usually the more he may become free and able to invest energy in his current life. The more thorough mourning is, the more love and healthy assertiveness is available to go on with life's new tasks and new relationships.

The PLHB method stimulates memories and allows the feelings connected to those memories to be worked on within a new relationship. The more emotionally "charged" details of memory are worked on, and the more often they are worked on, the more thorough mourning will be. Emotional charge includes happy as well as sad memories, loving as well as angry emotions. It includes emotional charge within abstract and attitudinal processes -- such as loyalties and disillusionments. Use the PLHB to encourage mild but not overwhelming degree of remembering with sadness.

Listen to the child's resentments of you and other adults.

Understand and accept but do not stimulate the child's resentment and disillusionments with his birth family.

In cases where the child remembers being abused or neglected, reward him verbally for being strong and able to talk about such hard memories.

Point out whatever positive feelings the child also has, without exaggerating.

Sometimes the number or emotional magnitude of losses is more than a child can bear without psychotherapy. Occasionally you will find an overwhelmed child who has lost two parents at once by death, sometimes by murder. Generally (but not always) a foster child over age three who never cries about his losses is using too much energy to control his sadness. At the other extreme, a child who is

constantly remembering and is sad or increasingly withdrawn, or cries all day long is not being helped by the mourning. He is being overwhelmed.

If you are in doubt about in which direction a mourning child is going (strength or weakness), re-do the Achenbach Child Behavior Checklist. If the score is going up, the child may be unable to handle his mourning and should have a more specific psychotherapy than the PLHB alone will provide. Another important indicator of a child's mental health is his school adaptation, including his behavior and marks. Some children show big gains in school work when they face their past. If a child becomes more curious about historical facts, that curiosity can spread to school work.

See the assessment section regarding how to create a foster parent's own list of child's problems and symptoms. If these are improving, as well as the Achenbach inventory, it is even more likely that the child is benefiting from your help.

PSYCHOLOGICAL IMMUNIZATION REGARDING EXPECTED STRESSES

Of course, scientists studying human behavior have never found a vaccine to immunize people against the effects of stress. But for a long time they have suspected that one reason for events being "traumatic" is that some events catch the mind unprepared, lacking any immunity. Had there been some warning, the defenses of the mind could have gone to work like the immune defenses of the body facing an intruding micro-organism.

This theory has merit. A caseworker and/or foster parent can help prepare children for future, expectable stresses. It is now too late to prepare children for the event of placement itself; but children can be prepared for visits by biological parents, and they can be helped to face returns to their biological families. The child should be assisted in treatment by experiencing small doses of feelings during discussions about the anticipated visits. This process can be structured by helping the child anticipate and then record the events in the PLHB.

The PLHB includes a line on just when the first visit is expected by the child. That line should be filled in the first week of placement. Emphasize that the child's expectation is only a guess. "We know that visits don't always come when you expect them. Often they can't happen just then because something gets in the way like bad weather or job troubles." The child will thus have a chance to anticipate disappointment, but in a low dose and in an intellectually structured way.

The next lines will be used to record when the visits actually occurred, and a few lines about what happened on the visits. The therapist should encourage the child to express pleasure or disappointment about changes in the expected schedule of visits.

If at all possible, the expected return to biological family or change to other home should be written about, with some calendar entries and some lines about preparations the child made for the return.

Urge planning on the child's part as soon as an official decision has been made for a change. The child's "locus of control" will be enhanced if he or she plans what clothes, books, toys, supplies and other belongings to take to the new home. A record of names, addresses and phone numbers of the foster family and neighborhood friends acquired during foster care could be a help to the child so that he can stay in touch. Usually the foster parent will have to provide a good deal of help in creating such a record.

Emotional aspects of immunization will be promoted by being a model of strength for the child. That means the therapist admitting (if it is true) that he or she is sad about the child leaving and will miss the child. The child will thus be encouraged to identify with the lost therapist and allow his own sad feelings to emerge and be faced rather than buried once more with the new loss.

CHAPTER V

ILLUSTRATIONS OF CASE PROCESS AND TECHNIQUE: CASE EXCERPTS FOR STUDY BY EXPERIENCED PSYCHOTHERAPISTS

The cases presented here and the one in Chapter V are reasonably representative of the author's experience with thirteen experimental treatment cases using the existing PLHB method at The Foster Care Study Unit, Columbia University. The illustrations resemble eight other psychotherapy cases of foster children the author has supervised at St. Mary's Hospital in San Francisco, where the PLHB method is now also in use. They also illuminate what went on in an earlier generally similar treatment project involving diagnosis and random assignments of treatment with 104 foster children at The Center for Preventive Psychiatry in White Plains, New York (Kliman, Schaeffer and Friedman, 1982). Two thirds of those Center for Preventive Psychiatry foster children were assigned to a 40 session mode which resembled the PLHB in content (but without the use of a structured written product). The other one third were assigned to a similar 10 to 15 session mode. The results of the 40 session mode were superior to those of the briefer mode (Ibid., 1982).

The four cases which follow are examples of supportive-expressive treatment use of the PLHB with a focus on object-loss experience. They were carried out by experienced psychotherapists who used the PLHB as a tightly structured organizer of the supportive-expressive treatment. The PLHB method fit readily with the need of the patients to mourn for lost objects. By its strict emphasis on time-limits, it enabled the children to anticipatorily mourn for the loss of the therapist. Clinical effects as judged by the direct observations of therapists as well as through problem and symptom lists, rated by foster parents, were generally very good.

CASE 1:

Topics:

- Five year old female
- Maternally bereaved
- Revelation of a murder
- Cooperation with district attorney
- Developmental progress (speech and cognitive skills)
- Facilitation of mourning

- Self-concept
- Self-esteem
- Use of interpretation: of link between therapeutic situation and prior loss counter-transference - therapist's recall of losses

A developmentally moderately delayed and speech-slurring Hispanic-Jamaican five year old girl, Lakisha had witnessed the apparent murder of her mother by her uncle. Not only was the child having to assimilate this extraordinarily painful history, her capacity to do so was being undermined by the same uncle. In visits with him, the uncle maintained to Lakisha that mother was still alive.

The initial psychiatric diagnoses were "Parent-child problem", and "developmental disorder of language skills and basic reading skills". Stressors were considered "severe", rated 5 on a scale of 7. Overall functioning of the child in the year prior to diagnosis was considered fair, 3 on a scale of 7.

In a series of visits with the therapist, Lakisha's uncle, the sole surviving caregiver, was actively delusional. The child's caseworker accepted a recommendation that the uncle should be psychiatrically examined and treated before the child and he had further visits. The uncle did not accept this recommendation but enhanced its credibility by informing the child's caseworker that his sister was following him around with video cameras.

The PLHB treatment method was like a sea anchor in heavy storms for Lakisha. She could ignore it much of the time, but it kept her safe and oriented. After fifteen sessions she was clearly reactive to a vacation break. She then pretended not to remember the therapist, but immediately recalled her book. She had by now started kindergarten and was doing increasingly well in language and cognition, and teased the therapist in an acerbic lancing fashion rather than being vague and unrelated as at first. By the end of the post-vacation session she verbalized:

"I missed you. Where were you? I'm mad."

Swiftly after this confession of yearning, Lakisha was able to discuss her uncle and mother with keen articulation of hatred and mourning:

"Uncle Simon is a lazy old junkie. He does a lot of cocaine He don't get no work, don't want to do no work, just drugs. "

Drawing Simon's pipe she added, "I miss my mother" and looked very sad. Previously, for fifteen sessions, she had looked retarded and obtunded whenever her mother was mentioned. Warned now that only ten minutes were left in this session, Lakisha responded forthrightly:

"I don't want to go. I want to see you. I want to come tomorrow."

In the final 15 sessions of her treatment Lakisha demonstrated marked developmental, cognitive and speech progress. She seemed stimulated by the challenge of dealing with a termination known for weeks in advance and discussed openly with the departing person. In the combined 16th and 17th sessions, the therapist found Lakisha expressing memory of the murder scene with lucidity "I didn't expect." At first Lakisha used an introductory story of "dumplings they make in Jamaica." Then she switched to castigating her uncle:

"Simon was once so mean he ate all the dumplings..."

Then Lakisha had a dumpling become an immense ball, a rock on a hill that could kill a person by "crushing, smushing, blood all over, pieces sticking out."

The therapist interpreted this fantasy as related to a real memory of mother's smashed body. To this, Lakisha responded:

"I don't ever want to see Simon again..He's so mean...He hurt Mom so bad...He hit her, so hard, she was bleeding all over..blood came out of her..He hit her...I'm so scared. He's crazy in the head. He made my Mommy go away. I miss her.."(crying, limp like a rag-doll, Lakisha was held by the therapist at this point.)

In the combined 18th and 19th sessions, Lakisha reached hair-raising intensity of emotion, as her therapist perceived the child. Looking through her PLHB, Lakisha seemed to be in a reverie, and reported an episode from two years earlier:

"(It was when) we used to live in Jamaica, me and Mom and Kitty and Simon. They all started arguing because I peed on myself. Simon said 'She can't sleep in my bed anymore because she wets the bed.' I was ashamed. Simon yelled at Mom and she hung her head and went to the barn. Then Simon slept in my bed and I wet it anyway."

After being given some perspective on this poignant bit of her life history ("Children aren't really responsible for their family arguing.") Lakisha became hyperactive briefly. She wiggled, crammed her head under the therapist's chair and put her head on the therapist's lap. Pretending to be asleep, Lakisha's hyperactivity ceased and she became flaccid. She wouldn't "wake up", occasionally opening an eye to look up, staying in the therapist's lap for about half an hour in what seemed a nurturance-seeking, psychologically and physically relaxed state until the session ended.

This seemed to be a regression in the service of the ego, and it was accepted and interpreted as a form of mourning:

"You would like to be mother cuddled, if only your mother could do that for you."

Lakisha spent a large portion of the final sessions drawing details of the treatment room, using levels of artistic ability, (including geometric perspective) never evident earlier. She seemed to be memorializing the setting.

When only four sessions remained, the therapist made a chart with calendar boxes on which the patient and therapist checked off the impending sessions -- a count-down.

Lakisha colored in the boxes and gave some unsolicited details of her self-concept, apparently spurred on to ask for help in the setting of an impending and carefully anticipated loss:

"I talk funny... A boy in my class talks like this and everyone laughs at him..."

As the count-down proceeded session-by-session, Lakisha grew more silent and copied details of the room with increasing care, scanning back and forth from the actual room to her drawing. Her silence and visual taking in of the room were clearly a preparation for her loss.

With increasingly more frequent moments of highly intelligible speech, she spoke of her uncle, and his murder of her mother:

"You know, Simon smokes drugs...He's gonna be a robber...He had a gun under the other end of my bed. Soon as the cops come, he hide it under the bed. He shoot her and then he hides the gun. He tells me not to say, not to tell."

[Technical note: The above and earlier material about the uncle's alleged homicidal activity was reported to the appropriate district attorney. Although it was used during treatment, the page was not put into the child's PLHB lest the uncle ever have custody of the child and be punitive to her.]

As material about her mother's murder emerged, there was a positive change in Lakisha's quality of speech and a parallel change in the quality of her drawings. When treatment began, Lakisha's pictures were unrecognizable squiggles without apparent sequence or meaning. Lakisha now drew competently and admired her own expressed artistic products.

She reproduced the room around her in further detail, showing the wall switches, a desk and chair, a ventilation shaft and intake duct. The therapist found herself silently reacting to this product as "a phenomenal piece of work...indicative of a higher level of visual-motor functioning than one would expect of her." In a healthy counter-transference resonance, the therapist silently remembered a major bereavement of her own.

The therapist commented to the child about what "a clever way this is to remember the room and the good times we had together in it after we stop working together." This insistence on the termination-relevance of her work led to new recall of memories of her dead mother. The child completed the previously incomplete section on her mother in the PLHB, volunteering new descriptions of domestic events:

"Mommy used to iron my clothes....always woke up happy, singing in the morning."

Lakisha and the therapist sang a song together which the child and mother had also sung:

Lucy had a baby,
She named him Tiny Tim
She put him in the bathtub
To see if he could swim...

She drew a picture of both her mother and uncle for the PLHB, and after a long silence asked the therapist for help in spelling,

"I LOVE YOU, MOMMY."

The therapist linked the child's sadness and missing Mommy with the feelings of sadness "that we feel because we won't see each other any more." The therapy ended with mutual sadness and a sense that both the therapist and Lakisha had grown.

Lakisha was referred for further assistance with her speech pathology and surveillance of her developmental progress.

Here are some quantitative ways of viewing Lakisha's progress since starting treatment:

CHILD'S PROBLEMS AND SYMPTOMS AS STATED AND RATED BY FOSTER PARENT ON A SCALE FROM 1-7		
	At Intake	At Termination
Touching other people's things	4	2
Crying about mother	3	1
Talking about everything	6	1
Wanting food immediately	3	2
TOTAL ABOVE ITEM RATINGS	16.00	6.00

CASE 2:

TOPICS:

- Five year old boy with 8 and 11 year old brothers
- Role of sibling collaterals
- Use of 90 minute sessions
- Resistance to a suggested task
- Interpretation of resistance as anger related to impending termination
- Loyalty conflict over preference for foster care over biological family

The initial psychiatric evaluation led to a diagnosis of "Parent-child problem" and "Developmental disorder involving language and speech articulation." No medical problems were evident. Stressors were rated 4 to 5 on a scale of 7, and the child's functioning during the year prior to diagnosis was rated as 4 on a scale of 7.

Five year old David was seen with his eight year old brother as a collateral during most of his 30 session individual treatment. If David's treatment had been done by a foster parent in her own home, it probably would have included all the siblings in all the sessions as separating them would have been difficult in an apartment setting.

Transportation was such a problem that sessions were doubled-up to 90 minutes rather than the traditional 45 minute child therapy session. Fifteen such double sessions were held instead of 30 single sessions.

At the beginning of treatment, David sat rigidly and silently in whatever position he first assumed. He refused eye contact and met all overtures with stony indifference. He appeared electively mute. On the rare occasions he did speak in the first sessions, David was generally monosyllabic and unspontaneous. He became much more assertive, loquacious and spontaneous when his siblings were present. Usually his spontaneity was in the form of corrections of their history-giving.

During the twenty first and twenty second sessions (which were combined into a 90 minute session) both of David's brothers were present. Because David was calm, the therapist (Mary Courtney) felt she could suggest working on an emotionally difficult chapter. That was the still unworked-on chapter concerning Mother. Resistance to this suggestion was strong. Brother Ulrich was evidently furious at the mother and said he would not talk about her. Ulrich also consistently refuted statements his siblings tried to make about mother, and even tried to silence them for being disloyal.

The therapist only slightly changed the subject, to where the children used to live. In response David became quite intensely engaged in drawing a house, showing round windows and bars. Terry insisted the windows were square. An argument ensued over colors and other details.

This irritable, angry squabble was interpreted from a loss-related view. "You boys are getting upset because you know we have only a few sessions left to work together."

Noteworthy responses occurred to this interpretation. The first was that David became busy in contributing to his PLHB with increasing detail. He began making a drawing which he described as bunkbeds which broke when Ulrich was on top. Mom bought a new bed, he reported. The older sibs discussed this contribution in depth. Ulrich had the opinion that mother had fixed the bed that time. It was another time that she had bought a new one, not the time Ulrich broke it. The discussion was amiable.

The next and more important and sudden breakthrough of communication in apparent response to the interpretation above was in the form of a lengthy account of events leading to placement. David recalled being in the bed with Ulrich on top when a knock came at the door. Robert answered the door, which made David blame Robert. "If Robert hadn't answered the door (and Mom told us not to answer the door) the police wouldn't have come in. They said 'Where is your mother?' and David and Terry told them, 'At work'. Ulrich, however, maintained that mother always was at school.

All the boys agreed there was an uncle who took care of them months earlier but stopped coming because he stole mother's money and was afraid to come back.

In their final session, more personal history poured out, despite continued resistance by the oldest child. The boys all agreed the police were nice. David now stated he liked being in foster care "better than home", and this led Ulrich to become furious. He tried to stop the younger boys from talking to the therapist. His interference was irritating and not accepted by either the therapist or the other boys. Nevertheless, Ulrich's attitude was respected by the therapist as resulting from an understandable loyalty conflict. It was one which she firmly said should not be allowed to spoil this good-bye moment. This resulted in the children all continuing to complete David's PLHB energetically.

The foster-mother's view of David's problems and progress is expressed in her intake and termination lists and ratings:

CHILD'S PROBLEMS AND SYMPTOMS AS STATED AND RATED BY FOSTER PARENT ON A SCALE FROM 1-7		
	INITIAL	FINAL
Bedwetting	6	2
Uncommunicative	5	1
Fighting with brother	2	2
Wary of adults	4	1
Nightmares	2	1
Total ==>	19	7
ACHENBACH RAW SCORES		
Initial	Interim	Final
44	29	Not Available

CASE 3

TOPICS:

- Eleven year old male
- Multiple prior transfers in foster care
- Neglect and abuse by biological parent
- Attachment to PLHB
- Use of interpretation of a fantasy
- Increasing realism of history
- Account of abuse
- Dream
- Reversal of roles with mother
- Forthright confirmation of an interpretation
- Genogram as a stimulator of history-production
- Taming sad affect
- Realistically based bitterness
- Interest in the therapist's person
- Fantasy of misbehavior as a cause of reunion with mother
- Focal therapy with focus on object loss
- Interpretation of misbehavior as loss-related
- Anticipated separation from therapist
- Termination is vigorously used in treatment

- Behavioral improvement
- Cessation of prior multiple transfer pattern

Eleven year old Michael had an unfortunate but not rare "systems" adaptation problem. Multiple transfers occurred among foster homes before we could even start his treatment. He was initially anxious, overactive, and enuretic. Disruptive at school as well as in foster homes, he was shifted about to four different foster homes in one week!

Michael was very attached to the PLHB. He made a written product in each session, usually involving an affect-laden memory (i.e.: "It made me sad"). At first he idealized his mother, who had neglected and abused him for years prior to his placement in foster care. But in the fifth session he wrote a story in which his mother seemed negligent and unable to help him.

"I'm at the beach, and my mother lets me go way out. I start to drown. She can't swim."

The therapist made an interpretative comment concerning the above fantasy:

"Mother wasn't able when you really needed help."

Michael reacted to this interpretation by giving a realistic account of his mother having bruised him, spontaneously giving up his previous account that the substantial bruises with which he had entered foster care were self-inflicted.

In the next session, he brought in a dream which was of:

"Mom committing suicide...shooting herself in the head...she was so sad the kids aren't with her."

The dream was not interpreted, and the patient simply gave his associations that he felt both "sad and glad about the dream...glad because mother wouldn't have to suffer any more because it hurts her to have me be away."

This confiding of a dream seemed a remarkable product of Michael's growing trust in the therapist, who had been making a persistent emphasis on the child's inner life and helping him to deal continuously with the theme of object loss. But it shows a marked reversal of roles, in that the child feels sorry for the mother, rather than angry or lonely or feeling sorry for his neglected and abandoned self.

Michael soon made a startling correction of his perspective on mother. It occurred when stimulated by an anticipation of absence from the therapist due to her imminent vacation. He expressed curiosity about the therapist's activities outside of the clinic, and whether she has other patients. The therapist interpreted this curiosity as part of the child's hope that he would not have to share the therapist with anyone, and that "Maybe this is how you would like your mother to feel about you." The patient confirmed the interpretation with a surprisingly forthright, "Yes" and stated:

"You know, I don't think my mother likes me."

Michael expressed increasing sadness as he made a genogram, which showed his concept of his history was that he had "five fathers", none of whom he could name except for one who is an alcoholic athlete. As his sadness became somewhat tamed through persistent work on the genogram, he brought up two people of whom we knew nothing before -- a three year old little sister living with a maternal aunt and a two year old little brother living with his maternal grandmother. By the seventh session, Michael was straightforwardly discussing his recent historical situation and realistically explaining reasons for his placement:

"The trouble is my mother's boyfriend. I'm not going to be able to go home until he stops spending money on cigarettes, movies and drinking. Mom's not going to have enough money to take me home."

By the fifteenth session Michael was filling his PLHB with very charged material. He was bitter because his mother had not yet visited him in three months of placement, although his grandmother had told him on the phone that his mother misses him:

"Yeah, sure. She never wanted me to be born. She wanted an abortion. My grandmother talked her out of it...I am afraid I will be in foster care all my life."

Reacting to his growing interest in her person, Michael noticed the therapist was pregnant, and expressed concern that she would give up her baby. This question was interpreted:

"It's a way you have of showing me how worried that your mother didn't want you and doesn't want you."

Michael confirmed that his grandmother has made him very worried about this, and that whenever grandmother and mother fight -- which is often -- they bring this up.

"Even though I want my mother to take care of me, I don't think she can ever do it any more."

He also revealed a contrary concern, by telling a fantasy of great relevance: "I sometimes think that if I am bad, my mother will come and take me back."

Using the principle of focus on object loss, the therapist worked vigorously with this loss-related fantasy. She interpreted his actual misbehavior as understandable in light of this fantasy but likely to produce an undesired result.

"Instead of getting what you really want, what you get is trouble. You might get yourself moved again, but I don't think you can really get your mother to take you back this way."

By the end of his thirty session treatment, Michael continued to show straightforwardness rather than defensive distortions and denial regarding his mother's abuse and neglect of him. He reduced his aggressive behavior in school, and his enuresis in foster care.

By the last session the court had taken custody of Michael and this was discussed in his PLHB. His mother had called Michael to report finding a four room apartment, and had not even mentioned the possibility of him coming to live with her. He was able to see that his mother's lack of active involvement with him was pathologic behavior, not his fault or his responsibility. He recalled being threatened with foster placement if he disobeyed household rules about going outside or spending money.

As part of the last two sessions, Michael spoke of good mothers and bad mothers, hoping the therapist would be a good one and not abandon her baby. He thought about having children himself, and that he would like to keep them out of foster care. He made a connection to saying goodbye to the therapist with having to say goodbye to his grandmother when he left for foster care. Then Michael was able to be angry in a modulated, expressive rather than action-prone way:

"I'm angry at you. I don't like saying good-bye. I always have to say good-bye. Foster care is rough. You never know when things are going to end."

Michael then reviewed his four brief placements prior to this one. He created a story in which the protagonist asks for freedom -- a tale of Oscar the Grouch, Big Bird and Cookie Monster in which Big Bird asks to be released: "Let me go!" In this fashion he turned passive abandonment into an active quest for freedom.

In the final session, Michael was appropriately quiet and sad, but also withdrawn. He said, "This is the final page to my life story book" and pretended to be dying, saying "this is the final page of my life." The direness of the situation could not have been made more clear. He then expressed frank wishes to be a baby again so his mother would take him. He expressed continuing but realistic uncertainty about what life in foster care would bring, the difficulty of predicting events.

In the final moments Michael remarked on the novelty of actually deliberately saying good-bye instead of just leaving without saying anything. "I'm not used to that."

The PLHB method appeared to be a corrective and fortifying experience to Michael. He accepted the therapist's model of courageously facing inner life. Calmly and without regression he told of his disappointments, bitterness and burdens. At the end, he used no façade or camouflage, and suspended his extravagant prior defenses of denial and avoidance. He ceased trying to provoke a rejection as a compulsive way of taking charge of loss. He accepted his losses, accepted the associated affects, bound them up and continued his sublimative activity of making a book with the therapist up to the final moment.

He experienced no further transfers among foster homes during our 30-week time frame of study.

CHILD'S PROBLEMS AND SYMPTOMS AS STATED AND RATED BY FOSTER PARENT ON A SCALE FROM 1-7		
	INITIALLY	AT TERMINATION
Nervous	7	3
Bad manners	7	5
Hyperactive	7	6
Bad temper	7	6
Easily distracted	5	4
Poor discipline	7	5
No structure	7	6
Depressed	7	3
Poor behavior	7	6
Selfish	4	3
TOTAL	65	47
The initial Achenbach score and final Achenbach scores were not available as we went to press.		

CASE 4:

TOPICS:

- Eleven year old male
- Attachment to PLHB
- Confusion and misunderstanding about his genogram
- Assistance from biological mother regarding genogram
- "Discovery" of a father
- Fantasy of future discovery of PLHB
- Emergence of aesthetic sensitivity
- Emergence of high academic ability
- Attachment to foster family
- Loss-connected use of toy
- Verbalization of painful current episode
- Enhanced self-esteem
- Interpretation and angry response

- Distancing and derogation of PLHB at termination

Victor entered foster care when his mother voluntarily placed him because of inability to provide a home. She lived with a violent man-friend. Victor had a recently married seventeen year-old brother, whom he claimed had married Victor's former girl-friend.

His psychiatric diagnoses were "Adjustment disorder with academic inhibition and mixed emotional features, as well as "Atypical anxiety disorder". In addition he was noted tentatively to have a developmental reading disorder. Stressors were rated as 5 on a scale of 7, and functioning in the year prior to diagnosis was rated as 6 on a scale of 7 (highly impaired).

The child elicited a disconcerted reaction from the therapist, who found Victor to be a prematurely adult person, very self-possessed. While he seemed friendly at first, and amenable to treatment, he was resistant to discussing any emotionally charged topic. In contrast to this appearance of maturity, he talked of "soft fuzzies" and other babyish things, in a high sing-song voice.

Victor had little interest in school. His grades were mostly on the edge of failure or fully failing. He was constantly serving time in school detention.

The PLHB was seized on avidly by Victor, who populated it at first with magazine photos of wrestling heroes. His mother and he, it soon became clear, shared an interest in this sport. The emphasis on wrestling was interpreted as a way of feeling close to his absent mother, as well as an identification with powerful persons. However, he had little understanding of his placement or of his family structure, and denied some facts known to the caseworker -- that Victor had been beaten and choked by his grandmother, who dislikes and does not want the child.

Victor avowed that when it came to "sad things, I just throw them away. I don't pay no attention to them. I just try to stay happy all the time." The therapist acknowledged this might work a lot of the time, but is hard to keep doing when "the sad builds up inside."

Victor responded to this interpretation of his defensive dilemma with an acknowledgment that he needs physical care (for sunburn, for example) and that his mother just tells him to be tough.

By the tenth and eleventh sessions (which were doubled up because of transportation difficulties, as were all his sessions) Victor was articulating many details of his daily life. He managed to obtain numerous photos, including some of his last birthday party, which was at his foster home. This led to many domestic details being shared, including some of an embarrassing nature such as his blushing in one picture. He dictated an extensive story about the party, on a very positive theme. The therapist (Mary Courtney) at times found herself irritated by the child's incessantly Poly-Anna view of life, and pointed out how much else there was to his emotional life beside these happy thoughts.

Victor responded to this explorative remark with articulation of his other pleasant interests -- drawing and writing about his jogging route, his go-cart hobby, his interest in the Yankees...

There was no acknowledgment of sadness or resentment concerning his situation in these early sessions.

Victor used the PLHB avidly. He filled in almost every available chapter and line. However, there were notable defensive avoidant operations, such as filling in grandmother's telephone number but not mother's.

Victor focused more on siblings than on mature adults in his kinship. His most intense conscious conflicts were over his brother's marriage, and some questions as to whether he was actually invited. He inserted many extra pages into his PLHB, filled with photos and anecdotes of the wedding.

His biological father was a particular source of confusion for Victor and he lamented "I don't know what his address is. I don't know where he's at. I don't care."

The simple task of trying to list his family members' whereabouts led to an immense constructive turmoil and revelation not only for Victor, but also for his biological mother. Victor expressed the conviction that his father was living in a veteran's facility for mentally disabled veterans. The therapist, trying to enlist the biological mother's participation in the PLHB method, was finally able to get her to have a long telephone session. It was then learned there was indeed a man friend who met the description of the disabled veteran. But Victor's father was an entirely different person. Victor was deeply confused on the issue. She could not understand how Victor had such a misunderstanding, and after much urging from the therapist, took particular trouble to discuss and correct the misunderstanding

by phone and a personal visit with her son.

The PLHB method thus stimulated mother to make an effort she might otherwise never have made, or made with less timeliness. During the course of her efforts, she learned more about Victor's misunderstandings, which included confusion as to which children were his biological siblings. Two children who were not at all biologically related to him were in his conceptual sibship, and mother tried to help him comprehend the true relationships.

Victor's response to these endeavors and the "discovery" of his father was an important one. He began taking his PLHB book home, with the therapist's permission, so he could call his older brothers for information on some points. He also had an increased curiosity about many academic matters a few weeks later. It appeared that his specific genealogic confusions and inhibition of family curiosity had been lifted. The effect was one of giving him generalized permission to correct other intellectual confusions and inhibitions. His grades began to improve markedly. This is an important, regularly occurring intellectual recovery phenomenon among stressed, treated children the author and colleagues have known at The Center for Preventive Psychiatry. Therapeutic positive effect on I.Q. occurs in a wide variety of "traumatic" experiences and early childhood disorders. (See Zelman, et al, 1985.)

In the twelfth and thirteenth session, Victor discussed his biological father and several half siblings. He expressed scorn and sarcastically described the father's stinginess and tendency to waste money on gambling. From his disappointing father Victor went on to discuss his relationship to the school principal, in whose office he was spending a good deal of time. It appeared that other children enjoyed seeing Victor become agitated, and get in trouble. Victor had no insight into his role in seeking the discipline of the head of the school, and no effort was made to provide the insight.

The session ended with Victor taking Polaroid pictures of a male security guard he has befriended outside the treatment room while waiting with the therapist for transportation.

Sessions fourteen and fifteen included a revelation by Victor that he had a tender relationship with a girlfriend now, and that he was gaining a favorable perspective on his biological family in comparison with his foster family:

"One trouble with my (biological) family is that we don't do nothing together. We don't even go anywhere together."

In the next sessions he brought up sadness as well as mild reproach toward his mother, who was regularly missing visits with him. He expressed worry about his school average having been dragged down by earlier poor work, and was clearly becoming academically ambitious.

Victor's PLHB was now a catalytic agent for well-articulated memories of his extended family. He reported amusing tricks by a disabled uncle, his "favorite uncle". He filled in details of the genogram, including the divorce of his mother from biological father and her marriage to a man he recalled having seemed to be his father even though mother hadn't yet met him when Victor was born. Memories of this man emerged with sadness, and were associated with profound sadness concerning another deceased relative who appeared to be both an angry and a generous person.

As the sixteenth session was ending, Victor spun a poignant fantasy, indicating his hope for a permanent attachment to the treatment product:

"Let's practice like when I was older." He pantomimed blowing dust off the PLHB book, opening it and flipping through the pages as an adult. The therapist found her role "heart-wrenching" as she watched this discovery in an imaginary future attic, fulfilling her own desire to give the child a continuity of self through time.

In his final sessions, Victor reported on his accelerated attachments to his foster parents. He was able to enjoy a summer vacation in a small cabin with them, and developed the ability to enjoy mountain scenes silently for an hour at a time. This was an unprecedented aesthetic sensitivity for Victor, paralleled by increasingly constructive involvement with school work. His grades soared from D's and F's to A's and B's, and his frequent detentions and disciplinary comments on report cards ended. He no longer seemed learning disabled, in sharp contrast to an intake psychiatric evaluation which had concluded he had a reading disability as well as an adjustment reaction disorder.

CHILD'S PROBLEMS AND SYMPTOMS AS STATED AND RATED BY FOSTER PARENT ON A SCALE FROM 1-7			
	INITIALLY		AT TERMINATION
Whines and cries a lot	6		1
Clinging to adults	6		6
Refuses to defend self/victim	5		1
Poor academic performance	7		2
Few friends/too smothering	6		2
Holds everything inside	3		6
TOTALS	33		18
	INITIAL	INTERIM	FINAL
ACHENBACH SCORES	54	37	31

So far, we have only one possible case of worsening in treatments using the PLHB. That case was of a child who improved markedly with PLHB treatment at first but then deteriorated when transferred to another foster home. The transfer was against the foster parents' wishes and against our clinical advice. Since the deterioration appeared so closely correlated with a new and specifically contra-indicated stressor, we regard it as "despite" rather than "due to" the treatment.

CHAPTER VI:

ASSESSING OUTCOMES

HOW TO OPERATIONALIZE THE EVIDENCE FOR SUCCESSFUL TREATMENT

If the basic method described in previous chapters is carried out by foster parents or case workers, measurable benefits are predicted. These benefits will help the social system as well as the individual child. The two most important measurable benefits are probably reduction of transfers among foster homes (bouncing) and reduction of unsuccessful transfers back to biological families. The following is a menu of assessment suggestions, which even if carried out in a limited way, can aid an agency in objectively and persuasively measuring cost-effectiveness as well as the value for an individual child. So far as we know, the only systematic assessment studies of the PLHB method completed to date have been confirmed to criteria in A1, below.

A. A MENU OF SUGGESTED ITEMS FOR MEASUREMENT OF GROUP OUTCOMES, SOCIAL SYSTEMS GOALS AND COST BENEFITS

ITEM A1. REGARDING UNPLANNED TRANSFERS AMONG FOSTER FAMILY HOMES

We should strive for zero transfers of children among foster homes. Comparison can be made to untreated (control group) rates of such transfers. An expectable transfer rate in untreated foster children is 0.25/365 days. Transfer rates should be expressed in child-day units -- such as "1 transfer per 365 days".

Local cost benefit figures can be derived from informal estimates offered by local department of social services administrators. These estimates need only be "ball-park" in order to compare treated and untreated children. Knowing the local ball-park administrative cost of an unplanned transfer, the cost of treated compared to control group transfers can be calculated. The difference, minus the cost of treatment, is net cost benefit.

ITEM A2. REGARDING "BURNOUT" (TOTAL CESSATION) OF FOSTER PARENTING

We should strive for a reduction of foster parenting cessations, to half the level of control groups.

Cost figures for recruiting/replacing a foster parent can be estimated by local social services administrators. The cost of treated group burnouts compared to control groups is the gross cost benefit for this item. Subtract the cost of treatment to get the net cost benefit.

ITEM A3. REGARDING REDUCTION OF VANDALISM

Property destruction by the subject and control children can be compared using dollar damage reports provided by the foster parents. (See Olmstead, 1982 for Washington State figures on foster children's property destruction costs, which were about \$500 per child-year.)

ITEM A4. REGARDING SCHOOL ATTENDANCE

Numbers of school days attended and absent can be recorded and a subcategory for truancy days. The ball-park cost of a lost school day, as estimated by local school administrators, can be used as a unit for calculating cost-benefit of treatment versus control status.

ITEM A5. REGARDING RUNAWAY BEHAVIOR

A local administrative estimate can be obtained for the cost of a single day in an official local runaway shelter. A local police official should be asked to estimate the cost of a police search for one day for a missing child. These costs and the number of shelter days and search-days involved by the treatment versus control groups can be compared.

ITEM A6. REGARDING INCREASED EFFICIENCY OF JUDICIAL PROCESS

We should strive to ease the tasks of judges concerning continuation and termination of parental rights. Reports should be sufficiently well documented so that judges can reach decisions more quickly than in control cases.

This goal's measurement should be based on a local administrative judge's estimate of the cost for an additional month of carrying a case on a court calendar. The total number of court case-months in the control and treated groups can be compared, to determine cost-benefits of the treatment. There may be more cases in the treatment group as a result of the PLHB's uncovering of abusive acts. Therefore case duration is the critical measure.

B. SUGGESTED INDIVIDUAL BEHAVIOR GOALS

ITEM B1: Reduction of problems and symptoms which are listed by the foster parents. After two weeks in care, the foster parent is asked to create a list of what he/she considers the child's most serious problems and symptoms. She is asked to use her own language. She is asked to list up to ten items. Then each item is rated by the foster parent on a severity scaled of 1 - 7, seven being the most extreme possible for a child of that age. A score of zero is reserved for follow up, in case the problem disappears. A score of one or two indicates a mild problem, three or four a moderate problem, five or six a severe problem, and seven is extreme.

The rating is repeated at the end of the treatment. A reasonable goal is a reduction of 25% in the total score. Comparisons with untreated control groups are inexpensive.

ITEM B2: REDUCTION OF PROBLEMS AND SYMPTOMS ON THE ACHENBACH CHILD BEHAVIOR CHECKLIST

The foster parent is asked to complete the Achenbach form at the end of two weeks and again at the end of treatment. A lower score shows improvement. A higher score (especially if the total is greater than 40 points initially and then goes higher) indicates need for psychiatric consultation about the child.

A reasonable goal is a reduction of 25% in the total score. Comparisons with untreated control groups are inexpensive. An Achenbach form costs only .25 cents per child!

C. FACILITATION OF MOURNING

These suggested intrapsychic goals are included for instructional and experimental purposes. They are secondary to the Social Systems Goals and Individual Behavior Goals (categories "A" and "B").

It is considered desirable to facilitate a moderate but not overwhelming amount of mourning for the previous environment and previous human relationships and losses of trust in safety and care givers.

Many children will not require treatment to achieve this goal, but a comparison can be made of the frequency of achievement in treated versus control groups.

In order to permit untreated control children to be studied, the evidence can not come from treatment observations or therapist's evaluations alone. Therefore, evidence for the achievement of this goal will be family members' accounts of the child's range of affective and verbal expressions in regard to remembering lost environs and relationships. The presence or absence of such affective and verbal expressions will be noted. For example, note will be made of presence or absence of memory-associated emotions of grief, sadness, and longing.

In some cases realistically based sense of relief from danger will be evidence of good adaptation to loss.

Operationalization of the assessment will include use of the following checklist:

ITEM C1: On at least two occasions in thirty weeks the child over age three cried for a minute when speaking of lost environs, lost persons, or realistically based loss of trust in former care givers. If over age 12, the child cried for more than a minute on at least two occasions. Twenty or more such brief occasions, or ten episodes of crying for more than an hour would be considered excessive sadness if they occur during the last half of a 30 week span.

ITEM C2: The child verbalized sad feelings about lost environs or personal relationships, on at least two occasions in a 30 week period. Children over age 12 will be expected to verbalize such feelings on at least three occasions in 30 weeks. Forty or more occasions would be considered excessive frequency and intensity of mourning work in a thirty week span.

ITEM C3: The child reports at least two dreams in which the lost environs or persons appear. Obtain this information directly from the child.

ITEM C4: The child spontaneously seeks out mementos or information or possessions connected to the lost environs or absent biological family

on at least two occasions in a thirty week period. Forty or more occasions would be considered excessive mourning.

ITEM C5: Resolution of mourning. After having expressed sadness, the child eventually becomes attached to new care givers over a 30 week period. (An immediate attachment which increases over time does qualify, but an unintensified immediate attachment does not.)

Attachment will be operationally indicated by increase of any of the following since onset of placement:

- a. confiding behavior
- b. seeking the companionship of the caregiver
- c. distress on separation from the caregiver
- d. requests by the child for assistance from the caregiver in regard to age-appropriate needs, such as dressing if under age seven, homework if over age 6, recreational activities at any age.

Means for collecting psychometric evidence for achievement of mourning have not yet become systematic (see Greenberg, W. for an example of such an approach to assessment of presence of mourning in projective materials).

D. RE THE SENSE OF PERSONAL HISTORY:ASSESSMENT OF TREATED CHILDREN

A goal is to exercise and strengthen a section of the self-concept, particularly the sense of personal historical continuity and the associated bank of detailed data concerning personal historical events, including loss-related and other potentially traumatic experiences.

Evidence for the achievement of this goal will be concrete production of a personal life story book to which the child has substantially contributed. The therapist will record which items of the book were requested by and/or contributed by the child. None of the items need be spontaneously contributed, and the child may simply acquiesce to the therapists's suggestions.

Minimum items for achievement of the goal vary according to age:

Children ages 3-5 should achieve three of the items below. Children 6-10 should achieve four items, and children ages 10 and up should achieve five items.

- ITEM D1: Child makes request for or himself makes a contribution of photos, drawings or memorabilia concerning at least one biological family member and one other person who previously lived with the child, or concerning a major psychological trauma.
- ITEM D2: There is dictation or writing of an episode about the previous neighborhood, or the geographic site of a major psychological trauma. This story must be at least 20 words long for children up to age five, and at least 40 words long for older children.
- ITEM D3: There is dictation or writing of an episode about the biological family, or a non-geographic aspect of a major psychological trauma. Length as in the previous item.
- ITEM D4: There should be a clear and contextually embedded account by the child of the reasons he believes account for his placement in foster care. Dictated or written, the account should be of the lengths in the previous items.
- ITEM D5: There should be creation of a log of names, addresses and/or phone numbers of at least two people from the previous environs, beside a primary caregiver, and for children over age five the list should be at least five persons long. There are no limits to the amount of assistance the foster and biological parents may provide in producing this log.
- ITEM D6: There was objectively noted effort to telephone or correspond with two of the above logged persons, with or without the assistance of the therapist or other adult.

E. RE THE CHILD'S PERSONAL LOCUS OF CONTROL

Our intention is to increase the child's executive skills and data bank related to the personal locus of constructive control over interpersonal experiences of separation and loss.

This goal's achievement will be judged by recording direct clinical observations and family members' accounts. These may give evidence that the child was active on at least 3 occasions in 30 weeks in gathering data or getting help about how to contact, or is actually contacting or encouraging arrangements for communications

and visits. These contacts may include not only family but also friends and neighbors.

It is unlikely that a control group will be observed sufficiently to yield comparative data.

F. REGARDING INTERPRETIVE PROCESSES

This item will be of value mainly to psychoanalytically oriented therapists, including those performing supportive-expressive therapy (Luborsky, 1984).

Re "Unlinking" (G. Caplan, 19__): Unlinking efforts are defined as any interpretation by the therapist concerning any tendency on the part of the child to confuse current foster family relationships with previous pathologic relationships. Also included are interpretation of transference reactions in which the child confuses the therapist with a previous caregiver or a perpetrator of a crime who behaved traumatically.

For example, a sexually abused child may seek sexual contact with foster family members or the therapist. Interpretation by the therapist may be along lines of the child being helped to understand he is trying to re-create and master a passively experienced upset, but that the people in his life are different from the ones who used to do these sexual things with him.

The therapist should record all interpretations made, in a post-session note.

Verbal and behavioral responses to interpretations should also be recorded in post-session notes.

In a thorough project recordings of all or randomly sampled sessions can be kept, dated and numbered so that objective judges can review sessions in which interpretations are made. The judges can decide for themselves what the child's response was, if any. No control group would be feasible.

Examples of confirmatory responses:

ITEM F1: Child elaborates on previous history of an abusive relationship, or a negligent relationship, providing new details or expanded affective repertoire of affects accompanying the account.

ITEM F2: Child plays a related story.

ITEM F3: Child reports a related dream content.

ITEM F4: Child's provocative behavior at home is reduced.

G. FOCUS THE CHILD'S LOSS-RELATED PATHOLOGIC BEHAVIOR WITHIN THE TREATMENT RATHER THAN OUTSIDE THE TREATMENT SITUATION

We believe a prognostically favorable phenomenon is noted when the rejection-seeking behavior is increasingly focused within the treatment setting.

The achievement of this treatment phenomenon is a goal which is noted if the foster and/or biological family reports the child is generally getting along without provoking rejection or abandonment, yet that behavior is evident in and around the treatment situation. It may be particularly manifest around vacations and at the time of termination. Manifestations may be:

ITEM G1: Separation anxiety in connection with the therapist.

ITEM G2: Anxiety or misconduct clusters in connection with weekends and vacations from therapy.

ITEM G3: Outbreaks of unprecedented symptoms occur when treatment is underway. The clustering of the symptoms is in and around the treatment situation (i.e. phobic or somatic upsets en route to the session, toilet accidents, tantrums, speech regression or pilfering en route to the session or in the clinic but not otherwise).

H. REGARDING THE REPETITION COMPULSION

The goal is to overcome a process called the repetition compulsion. This process is operationally defined as an observable tendency to unreasonably, compulsively and precisely re-create prior real experiences of a painful nature, such as rejection, abandonment, abuse or neglect.

Achievement of this goal may be judged only if there is evidence that there is a repetition compulsion at work--this requires data that the child has ever tried to re-create some precise situational details of prior traumatic events such as molestation, rejection, abandonment, abuse or neglect. The effort might be

observed by a teacher or at the foster home or right in the treatment situation.

ITEM H1: Operational Confirmation would come from reduction of repetition-compulsion behavior. This might occur when the repetition is interpreted to the child. The interpretation should include that the behavior is an effort to actively take charge of what happened in the past by making it happen over again in the relationship to the therapist. There should be at least one such effort in order to qualify the treatment as having met this effort goal. Even without interpretation, the supportive-expressive treatment may reduce the repetition compulsion. The child must then respond in a way that the foster parents or therapist recognize as less provocative of rejection or more evocative of their acceptance. Items A1, A3 and A5 are also confirmatory.

CHAPTER VII

REFERENCES

- Aust, P. (1981) Using the Life Story Book in treatment of children in placement. Child Welfare. LX: September/October 1981.
- Bohman, M. and Sigvardsson, S. (1980) Adoption and fostering as preventive measures: A prospective and longitudinal study of boys of negative social heritage London, Association of British Adoption and Fostering Agencies 101:3, p. 25-36
- Bondy, D., Davis, D, Hagen, S., et al (1990) Brief, Focused Preventive Group Psychotherapy: Use of the Personal Life History Book Method with Groups of Foster Children. J. of Preventive Psychiatry 4:1.
- Brockhaus, J. P., Brockhaus, R. (1982) Foster care, adoption and the grief process. Journal Psychiatric Nursing and Mental Health Service. 20:9-16
- Carbino, Rosemarie (1980) Foster Parenting. Child Welfare League of America, NYC.
- David, Janet (1984) The effects of placement in foster family homes on selected aspects of school adjustment and academic achievement. J. of Preventive Psychiat. 2:1 113-114.
- Derdeyn, Andre P. (1980) Adoption. in Schetky, Diane H. and Benedek, Elissa P. (Eds) Child Psychiatry and the Law, Brunner/Mazel, Inc., New York, 1980.
- Derdeyn, Andre P. (1977) A case for permanent foster placement of dependent, neglected, and abused children. Am. J. Orthopsychiat. 47:4. 604-617
- Derdyn, Andre P., Rogoff, Andrew R., Williams, Scott W. (1978) Alternatives to absolute termination of parental rights after long-term foster care. Vanderbilt Law Review 31:5, 1165- 1184.
- Eisenberg, Leon (1965) Deprivation and Foster Care: Journal of the American Academy of Child Psychiatry. 4:243-248.

Fanshel, David (1981) Decision-making under uncertainty: Foster care for abused or neglected children? Am. J. Pub. H. 71:7, 685-687

Fanshel, David and Shinn, E. (1978) Children in foster care: A longitudinal Investigation. New York, Columbia University Press.

Ferguson, T. (1966) Children in care and after. London, Oxford University Press.

Festinger, T. (1983) No one ever asked us ...A postscript to foster care. New York, Columbia University Press.

Fitzgerald, Joseph M. (1995) Intersecting Meanings of Reminiscence in Autobiographical Memory.

Fraiberg, Selma (1962) A therapeutic approach to reactive go disturbances in children in placement. Amer. J. Orthopsychiat. 32:1, 18-31

Gurak, D. (1977) Foster care experiences among incarcerated adults. Unpublished Manuscript. New York Center for Policy Research.

Halfon, N., Berkowitz, G., Klee, L (1992) Mental health service utilization by children in foster care in California. Pediatrics 89:2

Halfon, N. and Klee, L. (1987) Health services for California's foster children: Current practices and policy recommendations. Pediatrics 80:2.

Halfon, N. and Klee, L. (1987) Mental health care for foster children in California. Child Abuse and Neglect. 11:1

Harvey, John.H. and Uematsu, Mika A. (1995) Why We Must Develop and Tell Our Accounts of Loss , Presented at Society for Applied Research in Memory and Cognition First Biennial Conference, U British Columbia, Vancouver. Authors are at University of Iowa.

Howard, H., et al (1986) The psychological interior of psychotherapy: Exploration with the therapy session report. In L. S. Greenberg and W. M. Pinsof (Eds), The Psychotherapeutic Process: A Research Handbook (pages 477-501), New York: Guilford Press.

- Jones, M.A., Neuman, R., Shyne A.W. (1976) A second chance for families: Evaluation of a program to reduce foster care. Research Center, Child Welfare League of America, Inc., N.Y.
- Klagsbrun, S. and Kliman, G. (1989) Preventive Psychiatry: Early Intervention and Situational Crisis Management, co-editor, with S.C. Klagsbrun, M.D., E.J. Clark, Ph.D., others. The Charles Press, Philadelphia.
- Kliman, G. (1975) "Analyst in the Nursery: Application of Child Analytic Techniques in a Therapeutic Nursery," The Psychoanalytic Study of the Child, Volume 30, New York Times Publishing Company.
- Kliman, G. (1977) "Preventive Measures in Childhood Bereavement," in Linzer, N. Understanding Bereavement and Grief, Yeshiva University Press, New York.
- Kliman, G. (1979) "Facilitation of Mourning During Childhood," in Gerber, I., Wiener, A., Kutscher, A., et al., Perspectives on Bereavement, MSS Information Corporation, New York.
- Kliman, G. and Rosenfeld, A. (1980) Responsible Parenthood: The Child's Psyche Through the Six-Year Pregnancy, Holt, Rinehart, and Winston, New York.
- Kliman, G., Oklan, E. and Wolfe, H. (1989) My Earthquake Story: A Guided Workbook for Children, Parents and Teachers, Family Development Press, Kentfield, CA.
- Kliman, G., Schaeffer, M., Friedman, M. and Pasquariella, B. (1981) "Children in Foster Care: A Preventive Service and Research Program for a High Risk Population". The Journal of Preventive Psychiatry, Volume I:1.
- Kliman, G., Schaeffer, M., and Friedman, M. (1982) Preventive Mental Health Services for Children Entering Foster Family Care: An Assessment (with M. Harris Schaeffer, and M. Friedman). Monograph of The Center for Preventive Psychiatry, White Plains, New York.
- Kliman, G. and Schaeffer, M. (1983) "Summary of Two Psychoanalytically Based Service and Research Projects: Preventive Treatments for Foster Children" with M. Harris Schaeffer, Ph.D. J. of Preventive Psychiatry, Vol. II, No. 1

- Kliman, G. and Schaeffer, M. (1990). "A Breakthrough in Prediction and Prevention: Diagnoses as Social Predictors for Foster Children." J. Preventive Psychiatry and Allied Disciplines 4:1.
- Knitzer, J. and Allen, M.D. (1978) *Children without homes*. Washington, D.C.: Children's Defense Fund.
- Krugman, Dorothy (1968) A new home for Liz: Behavioral changes in a deviant child. Amer. Acad. Child Psychiat. 7:3 398-419.
- Leitenberg, H., Burchard, J.D., Healy, D., and Fuller, E.J. (1981) Nondelinquent children in state custody: Does type of placement matter? Am. J. Commun. Psychol. 9:2 347-360.
- Littner, N. (1960) The child's need to repeat his past: some implications for placement. Social Service Rev. 34(2):128-48
- Lopez, T and Kliman, G. (1979) "Mourning, Memory, and Reconstruction: The Analysis of a Four-Year-Old Maternally Bereaved Girl at Age Sixteen Months" (With Thomas Lopez, Ph.D.), in *The Psychoanalytic Study of the Child*, Volume 34, The New York Times Press, New York.
- Lopez, T. and Kliman, G. (1980) "The Cornerstone Treatment of a Preschool Boy from an Extremely Impoverished Environment" (with Thomas Lopez, Ph.D.), *The Psychoanalytic Study of the Child*, Vol. 35, The New York Times Press, New York.
- McCord, J., McCord, W., and Thurber, E. (1960) The effects of foster home placements on the prevention of adult antisocial behavior. Social Services Review 34: 414-420.
- Malluccio, Anthony, et al (1980) Beyond permanence planning. Child Welfare 59:9, 515-530.
- Miller, Frank B.; Mackey, William; and Maginn, Vincent J. (1981) The modern displaced person: The repetitive foster child. J. of Clin. Ch. Psychol. Winter, 1981 21-26.
- Murphy, H.B.M. (1964) Natural family pointers to foster care outcome. Mental Hygiene 48:3 380-394

- National Commission on Children in Need of Parents (1979) Who know? Who cares? Forgotten children in foster care. New York: National Commission on Children in Need of Parents.
- New York State Department of Social Services (1976) Annual Report on Delivery of Child Welfare Services in New York State. Albany, N.Y.
- New York State Department of Social Services (1972) Foster care children in New York State. Program Analysis Report No. 54, pages 18 and 19. Albany, N.Y.
- Nowicki, S. and Strickland, B.R. (1973) A locus of control scale for children. Journal of Consulting and Clinical Psychology 40:148.
- Olmstead, J. (1980) Children's service needs assessment: Family foster care survey. Office of Research, Analysis and Information Services Division, Dept. of Social and Health Services, Olympia, WA.
- Pardeck, John T. (1983) An empirical analysis of behavioral and emotional problems of foster children as related to re-placement in care. Child Abuse and Neglect 7:75-83.
- Quinton, D. and Rutter, M. (1984) Parents with children in care -I. Current circumstances and parenting. J. Child Psychol. Psychiat. 25:2 211-229.
- Quinton, D. and Rutter, M. (1984) Parents with children in care - II. Intergenerational continuities. J. Child Psychol. Psychiat. 25:2, 231-250.
- Rabinovitch, Ralph. Dubo, Sara, and Juracsek, Valeria (19) Psychiatric considerations in foster home placement and adoption. Unpublished. University of Michigan Neuropsychiatric Institute.
- Runyan, Desmond K.; Gould, Carolyn L.; Trost, Donald C. and Loda, Frank A. (1981) Determinants of foster care placement for the maltreated child. A. J. P. H. 71:7 706-709
- Shaffer, D. and Caton, C. (1984) Runaway and homeless youth in New York City. A report to the Ittleson Foundation. New York City. Columbia University, Div. of Child Psychiatry.

- Stevvy, R.A. (1978) An early cue sometimes impairs process schizophrenic performance. Journal of Psychiatric Research, 14,47-57.
- Steffy, R.A., Asarnow, R.F. , Asarnow, J.R., MacCrimmon, D. J., and Cleghorn, J.M. (1984) The McMaster-Waterloo High-Risk Project: multifaceted strategy for high-risk research. In Watt, et al, Eds. *Children at Risk for Schizophrenia*, Cambridge University Press, Cambridge, England.
- Stein, S. (1974) The Open Family Series (Kliman, G., Consultant Editor). A series of five books entitled About Dying, Making Babies, That New Baby, A Hospital Story, and About Handicaps, Walker Publishing Co., New York.
- Stein, Jonathan M. and Derdeyn, Andre P. (1980) The child in group foster care: Issues of separation and loss. J. Am. Acad. Ch. Psychiat. 19:90 - 100.
- Steinhauer, P.D. (1984) The management of children admitted to child welfare services in Ontario: A review and discussion of current problems and practices. Can. J. Psychiatry 29:473-484.
- Stone, N. and Stone, S. (1983) The prediction of successful foster placement. Social Casework 64:1.
- Swire, Margaret R. and Kavalier, Florence. (1977) The health status of foster children Child Welfare 56:10 635 - 653.
- U.S. Bureau of the Census (1980) Statistical Abstracts of the U.S. 101st ed. Washington, D.C. p.163 U.S. Bureau of the Census, Social Indicators III. p. 293.
- Walker, C. William (1971) Persistence of mourning in the foster child as related to the foster mother's level of maturity. Smith College Studies in Social Work, 41:3 173-245
- Wald, M. Carlsmith, J., Leiderman, P., French, R., and Smith, C. (1985) Protecting abused/neglected children: A comparison of home and foster placement. Stanford University. Stanford Center for the Study of Youth Development.
- Weintraub, Sheldon, Neale, John M. Liebert, Diane E. (1975) Teacher ratings of children vulnerable to psychopathology. Amer. J. Orthopsychiat. 45:5 838-845.

Wheeler, C. (1978) Where am I going? Making a Life Story Book. Juneau, AK. Winking Owl Press.

Witmer, Helen L. National facts and figures about children without families. J. Amer. Acad. Ch. Psychiat. 4:2, 1965

Wolkind, Stephen and Rutter, Michael (1973) Children who have been "in care" -- an epidemiological study. J. Child Psychol. Psychiat. 4. 97-105.

Zimmerman, R.B. (1982) Foster care in retrospect. Tulane Studies in Social Welfare Volume 14 New Orleans, Tulane University (School of Social Work)