Part One
Introduction

1 General introduction: basic concepts

Summary

The main object of the research project described in this book was to find ways of developing mental health services in the community, particularly in ordinary schools, in an attempt to counteract the modern society's high incidence of psychological problems. Essentially, we were concerned with finding ways of identifying maladjusted children in ordinary schools and, more important, evaluating the effectiveness on them of different types of treatment, administered from within the school.

Because the developmental stage of the child is relevant to the type and nature of the problem experienced, two age groups of children were selected for study – seven-year-old juniors (265) and eleven-year-old seniors (309), ranged over six junior and six senior schools. We tested four treatment approaches – behaviour modification, nurture work, parent counselling–teacher consultation, and group therapy. Our research necessitated the development of techniques for the detection of disturbance at both early and late stages, for assessment of the results of treatment, and for evaluation of different approaches.

In this chapter we start by setting our work in the context of current discussions about types of treatment. We consider that effective results may depend on where the therapy takes place and the qualities of the therapist. Also of great importance is the type of problem in evidence. Common childhood psychiatric disorders can be classified as either neurotic or conduct disorders, both of which differ from normal patterns of behaviour in a quantitative rather than a qualitative sense. Both these disorders are defined in this chapter,

and their high prevalence in the community is stressed. We also examine some studies that maintain that psychotherapy is ineffective. The differences between therapy in the clinic and in the community are discussed, together with the advantages and disadvantages of the latter. The concept of 'cure' is also considered in this context. The reasons for using ordinary schools as a frame of reference are discussed in detail, and the potential of the school to influence child development is stressed throughout.

We go on to discuss the classification and our choice of therapies. Approaches may be classified in a number of ways, such as direct or indirect – according to whether the therapist sees the child face-to-face or not; or as psychodynamic or behavioural – according to whether the therapist works with inner thoughts and feelings or confines him- or herself to observable behaviour.

The background to our research project

Alarming research findings over the 1960s and 1970s have forced mental health clinicians to review their approach to their work. In various parts of the UK, for example, between 7 and 25 per cent of schoolchildren are handicapped by frank psychiatric problems (Rutter, Tizard, and Whitmore 1970; Rutter *et al.* 1975; Kolvin *et al.* 1977; Macmillan *et al.* 1980). Many have educational difficulties that may be related to their own and their families' adverse attitudes to, and experience of, the educational system. In these circumstances, approaches to mental health that advocate prolonged, highly specialized treatment of a few children have become impossible to defend – but what is to take their place? Faced with what is a major public health problem with implications for so many aspects of human effectiveness, what can be achieved by a 'treatment' service? Do we, in fact, have to sit back and wait for broad changes in social policy? Or can we adapt our services to meet real, immediate needs?

Many clinicians have responded to these concerns by moving into the community. They have started meeting teachers and children in schools and visiting homes. In doing so they have encountered those who are involved in the bringing up of children with whom they themselves only have brief contact. They have had to ask again how clinical skills can fit into the long-term projects of care, parenting, and education. What adaptations are needed? How can brief yet relevant interventions be carried through with the same rigour and attention to detail that has characterized the best of traditional therapy approaches? How can the 'dilution' of skill, which many clinicians fear, be avoided?

In the early 1970s, in Newcastle upon Tyne, UK, we started to study these questions, as have others on both sides of the Atlantic (e.g. Bower 1969). We were attached to a clinical base, reputable both in terms of paediatric and of psychiatric services, in a city with an excellent educational and school psychological service. Not only were we looking for complementary ways of extending services into the community but, most important, we were attempting to *evaluate the effectiveness* of the services we set up.

An important aspect of our approach, and one that we will emphasize repeatedly, is that we were approaching the child within the context of the school. This was because, right from the outset of our research, we recognized the important socializing influence of the school (Power *et al.* 1967; Rutter *et al.* 1979) and the unique opportunities that school provides as a background for therapeutic intervention. In the British educational system the compulsory age of school entry is five years, although many local education authorities admit children who are approaching their fifth birthday. The common pattern is for the child to move at seven years from infant to junior school, where the curriculum is more academic and formal. At this stage the child will usually have made a start at basic school subjects. Next, at the age of eleven years, the child usually moves from a smaller, neighbourhood, junior school, to a larger, secondary school, which is able to provide a much broader curriculum for all ability groups. At this stage the child will be expected to have a firm grasp of the basic subjects of writing, reading, and arithmetic. There are variations of the above, for instance certain local education authorities favour a middle school pattern, but none applied to our schools.

It seemed to us that we could make maximum use of the school background if we started working with the children at an early point in their long, settled period in the school. For this reason, we selected our younger children at the age of seven years, after they had settled in the junior school, and the older children when they were eleven years old and had settled in the secondary school. We thought that younger children were in a plastic, undifferentiated stage of development, including development of their problems. For this reason we sought to identify a spectrum among them – from those who showed early signs of difficulties to those with quite severe disorders. Among the eleven-year-olds we identified those with more established disorders. In this way we sought to help the younger children with a wide spectrum of severity of problems, whereas with the older children we found we were only concerned with the treatment of established disorders.

In both age groups we tried to develop a range of treatment approaches that complemented each other in their theoretical bases and the levels of training of the staff involved.

During this research work we pioneered many techniques and expanded, developed, or modified others in order to detect disturbance both in its early and in its more deeply developed stages. We also developed techniques for the evaluation of improvement and outcome (which are not necessarily the same – see Chapter 3) and for assessing the effectiveness of the different approaches from as many points of view as possible: these are described more fully in subsequent chapters.

The fields both of mental health and of education abound with contrasting theories, some of which were useful to us and require careful elaboration, while others were of less service. It was our hope that the research project would enable us to test out the various theories as applied in practice.

The traditional approach to treatment and its current status

Since the start of our research project a widespread and often impassioned debate has developed over the organization of mental health services. The 'Aunt Sally' of these discussions has often been the so-called 'traditional child guidance approach'. Considering that the whole child guidance movement is only about seventy years old, it seems unlikely that there has ever been a clearly identifiable traditional approach. Nevertheless, characteristics that are generally associated with the term may include: a team of psychiatrist, psychologist, and social worker who work together on all cases; prolonged treatment with intensive psychoanalysis as the only 'real treatment', other approaches being considered to be inferior and makeshift; long waiting lists, which restrict admission; finally, the ivory tower image created by restricted community involvement for all except the educational psychologist in his or her capacity in the school psychological service.

These characteristics are now generally associated with outmoded practice. Reports from both the USA (Long, Morse, and Newman 1971) and the UK (Rehin 1972), for example, suggest increasing disenchantment. In the UK a series of professional reorganizations (Seebohm Committee 1968; NHS Reorganization Act 1973; DES 1974) together with further proposals for change (Court Report 1976; Warnock Report 1978) have led to a great deal of experimentation and intermingling of roles. In addition, the emergence of new concepts

and techniques of treatment, and of stronger individual professional identities, has added to the ferment.

A difficulty is that, too often, new work patterns have been moulded by strongly held opinion, fashion, and interprofessional rivalry, rather than by well-considered ways of providing services of proven effectiveness for children. Very seldom have heuristic questions been asked; too often, answers have been prematurely provided. In connection with this Garside *et al.* (1973) have posed a series of crucial questions. For instance, is the team approach the most effective and sensibly economic use of the highly skilled members of such a psychiatric clinic? For what types of cases does it work best? Do all cases merit the triple-team assessment? These questions highlight the need to examine what type of treatment works best for what type of disorder, under what conditions, and with what type of therapist (Strupp and Bergin 1969). Organizational relationships should stem from such knowledge rather than from competing whims and fashions in treatment.

The effectiveness of treatment as a whole has been considered by various reviewers (Eisenberg 1969; Robins 1970, 1973; Levitt 1971). The major conclusion has been that results of psychotherapy, and in particular one-to-one psychotherapy, are unimpressive. For instance, in his early review, Levitt claimed that treated patients and untreated controls improve at the same rate (Levitt 1957). Eisenberg (1969) also came to the conclusion that traditional psychotherapy has not been proved to be effective. The most quoted study in this area is that of Shepherd, Oppenheim, and Mitchell (1971). They compared fifty emotionally disordered children, who were neither delinquent nor psychotic, with an untreated control group matched for type and severity of disorder. Two-thirds of each group improved markedly, so that treatment appeared to make little different to outcome. The issue of spontaneous improvement is a major one and we will return to it in Chapters 2 and 10, together with a more detailed review of previous studies that have cast a somewhat more optimistic light on psychotherapy.

Why community intervention?

This question is particularly relevant in view of the strictures of the previous sections: if we are so unsure of treatments given by the clinic, why complicate the issue still further by giving services on a community basis? The answer is that community interventions and therapies are in many ways quite different from clinic therapy, and thus cannot be evaluated by extrapolation from clinic-based studies

(Hulbert, Wolstenholme, and Kolvin 1977; Wolstenholme, Hulbert, and Kolvin 1976; Nicol 1979).

The first difference is that many of the community-based therapies have an educational component. Children with educational problems frequently have overlapping problems, both at home and at school, consisting of psychiatric disorders, minor physical problems, visuo-motor difficulties, antisocial behaviour, and 'deprivation'. Robins (1973) pointed out that, in these circumstances, educational therapies make sense, whether the educational problems are considered to be primary or secondary to such handicaps. Robins saw such therapies, based on 'traditional educational techniques or behaviour modification techniques, which are educational methods more precisely designed and more self-consciously related to learning theory' (1973:111), as constituting a major movement in child psychiatry in the USA in recent years.

The second point is that the community base allows the therapist to gauge the general social climate that is impinging on the child. Hobbs (1966) has pointed out that most concepts of child disturbance demand an understanding of the way the wider systems of family, neighbourhood, and school support have been broken down. This is where notions of 'cure' can be seen to be inapproriate – a more realistic aim is to assist the wider support systems to 'cure sometimes, relieve often and comfort always' (Garside *et al.* 1973:149). The clinician is likely to find that the child is part of a destructive web of social interactions in which his or her own difficulties in social relationships are complicated by understandable but less than helpful responses from the wider systems of family and school.

A third, and most important, difference is that the school base (for example) is a familiar environment for the child, where the established pastoral system of the school may help in familiarizing the child with therapeutic procedures; this particularly influences the tendency of clients to continue therapy (Holmes and Urie 1975).

As well as giving help to children within their familiar setting, school-based therapy may help teachers to be involved more actively in treatment. This is its fourth difference from clinic-based treatment and it is particularly relevant to so-called 'indirect' treatment approaches (see p. 14). Despite contact with colleagues in the staff room, teachers can become very professionally isolated and the presence of a mental health worker who can talk to them about classroom difficulties can be a great support. The professional isolation of teachers is reported by Knoblock and Goldstein (1971).

A fifth difference is that, in working in the community, one is able to contact children in need of help who, through poor motivation or

family disorganization, would never appear at a clinic. Related to this is the controversial issue of whether one should 'treat' children who have not specifically come for help. We will return to this theme in Chapter 10, where we discuss ethical issues.

A sixth difference is that community intervention allows us to reach *large* numbers of children in need.

Despite these advantageous factors, we were aware of several possible disadvantages of community-based work. For instance, the first was the potential lack of confidentiality when away from the formal clinic with its 'medical' component. Also, community institutions, such as the school, are powerful social systems with established hierarchies demanding conformity to norms. The community worker is always in danger of serving institutional needs that perhaps conflict with a child's needs or, alternatively, of siding with a child against community demands. The implications of these possibilities are discussed in Chapters 6 and 7, where we talk of the importance of the clinic base in community mental health work.

The ordinary school as a frame of reference

Throughout this book, the term 'ordinary' school covers all state schools that are not 'special' schools for the physically, emotionally, or mentally handicapped. We have already touched on several of the reasons that influenced our decision to make the school our frame of reference: the recent diversification of treatments; the fact that the prevalence of disturbed children is so high; the advantages of community intervention. Much more important is the fact that the school is second only to the home in its potential for influencing child development. This has recently been demonstrated persuasively in studies that show different schools produce different results, as measured by school behaviour, achievement, attendance, and delinquency (Power *et al.* 1967; Finlayson and Loughran 1975; Reynolds, Jones, and St Leger 1976; Rutter *et al.* 1979). In addition, there are suggestions that these results are associated with different aspects of the atmosphere and curriculum of the schools (Rutter *et al.* 1979). Thus, there are trends in the school that may be working for or against any treatment efforts. We will return to this theme in Chapter 10 and Appendix 4.

A second factor making a move into the school particularly relevant at present is a shift in emphasis in educational philosophy. This shift is well illustrated in the UK by the findings of a recent committee of inquiry into the educational needs of handicapped children (Warnock 1978). This report recommended that the concept of

handicap be replaced by one of special educational need. Traditional thinking has seen children either as handicapped or non-handicapped. Special educational need is a more positive concept, one in which children are not seen in the light of their particular handicap, but rather in terms of everything about them, their abilities as well as their disabilities. This change of emphasis has profound implications, both for bringing more flexibility into the school curriculum, and also for introducing therapeutic techniques where indicated.

While some believe that teachers have an important role in managing social and behavioural problems of children, there are many who would see this neither as part of their task, nor one for which they have been equipped. Thus, despite the fact that some of their most crucial tasks involve handling difficult, unsettled, and disruptive children, student teachers are usually given very little training in coping with such problems, but are, instead, left to 'sink or swim'. There is thus a great diversity of attitudes, and of ability to cope with behavioural problems (Kounin 1970). While the central theme of our research was to test specific techniques, we were acutely aware that, among teachers, there were often very polarized opinions about whether they could, or should, make any contribution towards solving the behavioural or emotional problems of children.

In addition, we were often aware of a deep-seated suspicion between home and school. Often, in their formative years, parents have had unfortunate experiences at school which they carry over into adult- and parenthood without appreciating that the climate within schools has changed, and is generally more permissive and humane than in the old days. Teachers nowadays are often receptive to the idea that parents should have some kind of link with the school. Unfortunately, ways of developing these links have yet to be adequately developed.

The role of the ordinary and the special school in helping disturbed children

Although our aim in this project was to help disturbed children in ordinary schools this should not be construed as a denigration of the important role of the special school.

We have already stressed that teachers in ordinary schools do not necessarily see coping with the problems of disturbed children as part of their job. The management of emotional problems in school demands a high degree of skill and, as Gropper *et al.* (1968) pointed out, there should be programmes to train teachers to recognize social and emotional problems. This is being actively developed at the

present time (Jeffery *et al.* 1979). The enhanced skills and awareness of the teachers must be a necessary background to the more specific treatment efforts embodied in intervention programmes.

Some of the concepts deriving from work carried out in the USA have, so far, been ill-digested in the UK. For example, Redl (1949, 1966) has suggested that if the disturbed child is retained in an ordinary class the other children may, by a form of contagion (germophobia), become disturbed. Empirical research by Kounin, Friesen, and Norton (1966) has led to the conclusion that teachers who are successful as classroom managers are also likely to be successful in coping with the behaviour of emotionally disturbed children in the classroom. In addition, they reported that those teachers who proved successful at coping with disturbed behaviour also produced a climate that prevented such disturbance from disrupting the behaviour of other children. Such conclusions have been supported by subsequent research. For instance, in an American study, Saunders (1971) reported that elementary schoolchildren who were exposed to an emotionally disturbed child for a period of three months did not appear to be affected by the experience. However, he agreed that the length of the exposure may not have been long enough to provide conclusive results and, further, he only studied the effects of disturbance of an acting-out variety and not of the withdrawn, neurotic type. The implication of this research is that the disturbed behaviour of one or two distressed children in the classroom does not necessarily give rise to generalized disruption. In conclusion, the policy of retaining emotionally disturbed children in ordinary classes is an important one but, at the same time, it has yet to be properly evaluated.

As we were introducing treatments of as yet unknown effectiveness we thought it essential on ethical grounds that we did not influence the normal processes of referral among the children and schools who were in our study. On occasions we fully anticipated that this might mean that children in the study would be referred to child guidance or child psychiatry units for further assessment, treatment and, if appropriate, placement in a special school.

The problems of troubled children

Our concept of psychiatric disorder is based upon that outlined by Rutter, Tizard, and Whitmore (1970) who defined it as marked and prolonged abnormalities of behaviour, emotions, or relationships sufficient to give rise to handicap which might affect the family, community, or child. For instance, the problem could manifest itself

as a handicap in the areas of emotional or social adjustment and educational progress.

One of the many facets of work with children is that they are developing organisms: behaviour that is quite common at one age may give rise to great concern at another. For example, enuresis is so common at the age of four years that it is not usually regarded as worth treating, whereas this would not be the case with a fifteen-year-old. Conversely, preoccupation with sexual matters may be quite appropriate in a fifteen-year-old, but would be regarded with concern in a seven-year-old. For this reason, it is important to be sure of the developmental stage of the child when assessing his or her symptoms.

What types of psychological disorders do children suffer from, and how long do they last? These questions about natural history must be answered before one can begin to discuss treatment sensibly.

There are a variety of types of childhood disorder that differ in their clinical features and outlook. Some of these are rare, such as infantile autism and adolescent schizophrenia, in which the children show behaviour that is quite different from that of normal children. In this community-based study we did not come across any cases of this degree of disturbance. Much more common were neurotic and conduct disorders, which represent less extreme degrees of departure from normal and in which the exaggerated feelings and types of behaviour involved represent basically a *quantitative* rather than a *qualitative* deviation from normal (Kolvin *et al.* 1975a).

NEUROTIC AND CONDUCT DISORDERS

Population and follow-up studies of the common handicapping disorders of childhood have confirmed the clinical impression that there are good grounds for distinguishing between those disorders that are characterized mainly by neurotic problems and those that are characterized by problems of conduct. Many disturbed children, of course, show varying mixtures of neurotic and conduct problems but we found it convenient to use a simple dichotomy based on the predominant type of problem.

A *neurotic* disorder is one in which there is an abnormality of the emotions but no loss of reality sense. Neurotic disorders in this category include states of disproportionate anxiety or feelings of depression, obsessions, compulsions, phobias, and hypochondriasis. These disorders can be extremely incapacitating and, while many of them appear to improve with time and not progress to disorders in adult life, it seems that some of the earlier estimates of 'spontaneous remission' were unduly optimistic. The theme of spontaneous re-

mission is discussed in Chapters 2 and 10.

A *conduct* disorder can be contrasted with an emotional disorder in that it gives rise to disapproval and distress in *other people*. It overlaps legally defined delinquency, but also includes non-delinquent disorders of conduct, such as bullying and disruptive classroom behaviour. The main point is that the behaviour is abnormal in its sociocultural context and its association with other symptoms, such as abnormal social relationships. Behaviour typical of an individual with conduct disorder would be truancy and stealing. Conduct disorders usually become manifest in middle childhood and the outlook is generally much worse than that for neurotic disorders (Robins 1966; Robins, West, and Herjanic 1975); they may precede life-long behaviour and personality disorders and, in addition, may be associated with deviance in subsequent generations.

The distinction into these two major types of behaviour has not only been of clinical value but has regularly emerged from multivariate statistical studies of child behaviour, irrespective of whether the samples studied were younger or older children, or of whether they were a random sample of the population, a delinquent sample, or a child psychiatric clinic sample (Kolvin *et al.* 1975a). There is evidence to support this distinction, from studies of aetiology, sex ratios, responses to treatment, long-term prognoses, and educational progress (Rutter 1965, 1970).

We should emphasize that these are merely the major crude groupings of disorders, which may vary and overlap from case to case. A full assessment of a disturbed child would include not only a description of the disorder but also a comprehensive assessment both of the child's functioning and the pressures to which he or she might be subjected within the family and other settings. Specific assessments would also be needed to explore the applicability of the various treatment approaches (Graham 1974).

We were aware that there are fundamentally different ways of approaching children's emotional problems to the one we adopted. One might, for example, have contrasted sociological approaches (Rock 1973; Hargreaves, Hester, and Mellor 1975), the approach of practical educationalists (Clegg and Megson 1968), or psychoanalytic approaches (Freud 1922). We regarded each of these as important in their own context but chose our approach as being the most useful for our purpose.

Different types of therapy – those chosen for our project

The treatment approaches currently available are most easily differentiated by consideration of the theory on which they are based, and it is usually at this level that protagonists of different therapies argue most passionately. How do the theoretical differences of the various schools of therapy, whether psychoanalytical, existential, behavioural, or transactional, influence what actually happens between therapist and patient? This is a question that may be investigated at many levels, right down to a fine-grain analysis of interaction within the session – a task of the utmost complexity and sophistication (Kiesler 1973).

DIRECT AND INDIRECT THERAPIES

We were seeking a crude classification of therapies that would, none the less, reflect fundamental differences in approach and we therefore selected two dichotomies. First, as did Robins (1973), we drew a distinction between direct and indirect therapies. Direct therapies are ones in which work takes place face-to-face with the child; with the indirect therapies, the work is with significant figures in the child's environment who, in turn, undertake some intervention or modify their behaviour towards the child. In trying to sample a wide spectrum of therapies, therefore, it seemed sensible to include both direct and indirect methods for comparison.

In choosing a direct therapy we had the problem of limited skilled treatment resources. For this reason group therapy approaches seemed to be most useful. On reviewing the literature (Ginott 1961; Ohlsen 1973) we concluded that for the seven-year-old children a playgroup approach would be most appropriate, whereas for the eleven- to twelve-year-old children a talking group would be most in line with current practice. We review these techniques more fully in Chapter 8.

Indirect therapies have the potential advantage that mental health expertise can be channelled through other professionals who have an ongoing relationship with the child, or through parents who can work directly with the child (Becker *et al.* 1967; Patterson 1972); these persons are not necessarily mental health experts (Caplan, 1964). Such an approach was incorporated into our research as parent counselling-teacher consultation (see Chapter 7).

For some of our therapy programmes the direct-indirect classification was less appropriate. For example, we used a behaviour modification programme with the eleven- to twelve-year-old children that involved special training for teachers, and a nurture work

programme with the seven- to eight-year-olds that involved a group of specially trained teacher-aides.

In Chapter 10 we discuss further the theme of directness in the light of our own findings.

PSYCHODYNAMIC AND BEHAVIOURAL APPROACHES

In distinguishing between consultation and behaviour modification approaches we come to the second major dichotomy in our classification of therapies. This was according to whether the emphasis was on psychodynamic or behavioural approaches. In psychodynamic approaches, of which mental health consultation and group counselling are examples, the therapist is concerned with internal events and nuances of feeling within his or her client, whereas, in behavioural approaches, the therapist concentrates on observable behaviour as his or her focus of intervention. We sought to employ a behavioural emphasis in both the behaviour modification and the nurture work regimes.

Another, and overlapping, way of distinguishing types of therapy is by the skills and experience of the professional therapists. Many authorities have recently realized the important part that may be played in mental health programmes by people who are not traditionally associated with the mental health services, such as parents (Patterson 1972), teacher-aides (Hulbert, Wolstenholme, and Kolvin 1977), and teachers (Becker *et al.* 1967; Macmillan and Kolvin 1977b). This is in addition to a wide range of mental health professionals with diverse patterns of training.

The identification of disturbed children

From our discussion of the variety of problems, circumstances, and treatments available, it will be clear that uncovering problems of maladjusted children is a very complex process. In our research project we had to develop rapid and effective ways of identifying children in need (see Chapter 3). We should emphasize that our screen was a research enterprise that may not always be best for ordinary practice. Part of putting our research into context will be a discussion of how children should be identified in the normal day-to-day work of the school. In complex cases of multiple psychological handicap the combined expertise of many professionals may be needed to assess the child and decide what will be, for him or her, the most appropriate programme of management and the most helpful type of placement.