10 Summary and conclusions

Summary

In the first part of this chapter we summarize the main findings of our research and discuss them with regard to the seven hypotheses stated in Chapter 3. The positive results of our work were as follows: (a) some regimes were better than others; (b) every one of the regimes showed some improvement on some measures but there were major differences in the effectiveness of the different treatments. Broadly speaking, at the final follow-up the best junior results were in the playgroup regime and, to a lesser extent, in the nurture work programme, while the seniors responded best to behaviour modification and group therapy; (c) there was evidence that some regimes were more effective in relieving the neurotic symptoms and others in relieving the antisocial symptoms in any one child; it was found that for the junior children the nurture work and playgroup regimes, were the most successful in reducing antisocial symptoms; (d) irrespective of regime, children with conduct disorders differed from those with neurotic disorders in outcome and improvement, with neurotic-disordered children improving more than conduct-disordered children on certain measures; (e) irrespective of regime, boys differed from girls, in that girls improved more on some measures.

Other important findings were that effectiveness of treatment on behavioural measures seemed to increase with time; some treatments showed situation-specific improvements in children (for example, improvements were limited to classroom-related behaviour) whereas others had more widespread effects; associated antisocial behaviour in neurotic children seemed to be less deeply ingrained than in antisocial children, and the same seemed true of neurotic behaviour in

antisocial children; senior children with neurotic disorders did better than seniors with antisocial disorders on cognitive measures; and neurotic behaviour responded better to treatment in boys than in girls, the reverse being the case with conduct behaviour.

Turning to the theoretical implications of these findings, we discuss the nature of the at-risk and maladjusted control groups and the rate of spontaneous remission, and emphasize that, because it was far from certain that these control groups did not receive any form of help, the differences reported in our research were likely to have underestimated the true effect of the intervention.

We consider four main components of psychotherapy in relation to our findings. For example, with regard to time it was particularly interesting to find that outcome and improvement continued to gain ground in effective therapies even when treatment had finished. Concerning the therapist and his or her techniques, we have suggested that direct therapy may be more effective than indirect. Also, the shorter-term treatments (group therapy, playgroups, and behaviour modification) were seen to have had the best outcome: *our results suggested that it is type rather than amount of treatment that is a critical factor in intervention.*

We discuss various aspects of the design of our programme to see whether or not they influenced our results, and we also comment on the ethical issues involved in our research.

Finally, we discuss the practical implications of our findings, and consider how they may be useful to educationalists, mental health professionals, and planners. In particular, we analyse the cost effectiveness of the various regimes, and show that *those therapies* (group therapy, playgroups, and behaviour modification) *that have given the most promising results have done so in the shortest possible time, at the least expense.*

Introduction

In this chapter we bring together the main conclusions of our research project and offer some interpretations which will set them in the context of the wider theoretical issues discussed in the opening chapters. Most important, we need to discuss the practical aspects of our findings which have implications for educational and mental health planning. Our interpretations of the data and their implications will, we hope, be seen as the first rather than the last words on the subject. We feel that our findings were important enough to warrant widespread debate and analysis, and have, therefore, provided extended

technical and statistical appendices at the end of this book so that other workers can examine the data and draw their own conclusions.

The findings

The object of our research was to explore ways of helping maladjusted children in the setting of ordinary schools. This included the development and evaluation of treatment models reaching beyond the traditional child guidance approach. Early in Chapter 3 we listed seven linked hypotheses on which our research was based. In brief, these postulated that there would be differences in the amelioration of maladjustment between four comparable groups of children who had received different types of treatment or no treatment at all. In addition, the outcome would be different for two diagnostic groups and for boys and girls.

The study was carried out with two different age groups – seven- and eleven-year-olds. Initial screening was undertaken for approximately 4300 children in six senior and six junior schools (Kolvin *et al.* 1977; Macmillan *et al.* 1980). Additional information was obtained on 574 children selected for study: this was gathered from parental interviews, parent and teacher completions of behaviour checklists, individual and group tests of children, and observation of children in certain programmes. All data were reviewed by a psychiatrist who produced a global clinical assessment of the type and severity of disorder.

The children selected were randomly allocated by school class to various treatment regimes or to at-risk (junior level) and maladjusted (senior level) control regimes. In order to overcome difficulties arising from differences between schools we ensured that all regimes were undertaken in each school. The number of subjects in each group ranged from sixty to ninety. We studied three types of treatment in both junior and senior schools: in the juniors these were parent counselling-teacher consultation, nurture work, and playgroups; in the seniors they were parent counselling-teacher consultation, behaviour modification, and group therapy. Detailed accounts of these treatments can be found in Chapters 5 to 8. The major follow-ups were undertaken at eighteen and three years after the baseline assessments. We looked at patterns of change in two ways, both of which allowed for variations in initial severity of disturbance. First, an outcome measure was derived, based on clinical ratings at three points in time – baseline, midline follow-up, and final follow-up. These ratings were made by clinicians who did not know to which regime the children belonged (see Appendix 2). Second, improve-

ment on individual measures was evaluated by comparing baseline and follow-up data.

WERE THE HYPOTHESES CONFIRMED?

The first hypothesis was that the four regimes (which included the control regime) differ in effectiveness in reducing maladjustment; in other words, some regimes are better than others. This hypothesis was confirmed by our research, and we can say with confidence that certain of our treatment efforts had tapped some important forces for change. Furthermore, there were substantial differences in effectiveness of the different treatments.

Narrowing the focus, hypothesis 2 stated that one or more of the three treatment regimes would prove more effective in reducing maladjustment than the no-treatment regime (the controls), that is, any treatment is better than no treatment at all. Some complex and interesting results emerged. The overall picture was that relative to controls, every one of the regimes showed *some* improvement on *some* measures. *In the remainder of this chapter improvement should be taken to mean significant improvement of treated children in comparison with their respective controls. Similarly, outcome means significantly better outcome for treated children than for the comparable controls.*

At the junior level (seven- to eight-year-olds) the playgroups were effective over the widest range of measures and most successful on the aggregate measures, both clinical and statistical. At the senior level (eleven- to twelve-year-olds) the group therapy and behaviour modification regimes were both effective over a wide range of measures, but with different combinations of measures. They were also both effective on aggregate measures.

Looking at the results in more detail, a very complex picture emerged. First, various time patterns became apparent: in some treatments, and on certain measures, improvement appeared to be immediate, but then washed out; on other treatments and measures improvement occurred slowly but surely, so that the gap between treated children and their respective controls increased over time; with yet other treatments and measures there appeared to be a latent effect, with improvement appearing only after a delay.

To examine the results in terms of hypotheses 1 and 2 still more closely and specifically it is best to present the major positive results of each regime separately, bearing in mind throughout whether the data came from the child, his or her peers, parents, or teachers.

Parent counselling-teacher consultation programme in junior schools
On outcome measures there were no significant differences between the at-risk controls and the treated children. On improvement there were significant differences but these were on classroom-related behaviour measures only, both at the eighteen-month follow-up and three-year follow-up (about eighteen months after the end of treatment).

Parent counselling-teacher consultation programme in senior schools
There was positive change compared with the maladjusted controls on one outcome measure – antisocial behaviour at the three-year follow-up (that is, again, eighteen months after the end of treatment). At the same point in time the treated children made two positive changes on improvement measures.

The nurturing approach (a junior school programme)
In this regime, while treated children seemed to have had better results than the at-risk controls on all three outcome measures, it was only on overall severity at the final follow-up that changes were significant. In relation to improvement, there were several classroom-related changes at both midline and final follow-ups, and, in addition, there were improvements on home-based measures of behaviour (i.e. antisocial behaviour) at both follow-ups.

Group therapy in senior and junior schools
To some extent the junior and senior group therapy programmes can be considered together as they were based upon the same Rogerian principles (Axline 1947a; Rogers 1952). However, they differed in detail in that the junior programmes were playgroups and the senior programmes discussion groups.

When studying data based on clinical assessment it was evident that group therapy gave rise to good outcome at both the junior and senior levels. At the junior level there was encouraging outcome in relation to neurotic behaviour at the midline and at the final follow-up; at the senior level there was good outcome in terms of all three measures (neurotic, antisocial, and global severity).

The various main measures that were employed provided a view of precisely where improvement occurred. In the case of the junior playgroups there was improved classroom functioning and general behaviour (as viewed by teachers at the midline follow-up) and also improvement on a wider variety of measures at the final follow-up. This was true, too, on a large number of measures as viewed by parents. As far as the seniors were concerned there was again

improvement on a wide range of measures derived from different sources. At the midline, there was improvement both in achievement and adjustment. At the final follow-up there was again widespread improvement in adjustment, both in the home and the school. The improvement in achievement did not seem to have been maintained.

Behaviour modification (a senior school programme)
There was significantly better outcome on all three measures at the final follow-up, and on neurotic behaviour at the midline. In terms of improvement, at the end of treatment the children had become less isolated and had also showed improvement on some aspects of school behaviour (Devereux) and attitude to school (Barker-Lunn), but these washed out. On the other hand, at the end of treatment and at the midline follow-up, parents' reports of the treated children's behaviour at home (based on the Rutter parent scale A) revealed an increase in disturbance – fortunately this did not persist. At the midline follow-up there was improvement in terms of both verbal and non-verbal intelligence and also a decline in neuroticism.

At the final follow-up there was improvement in behaviour in the classroom as viewed by the teachers, (particularly of neurotic behaviour – Rutter teacher scale B2), and there was a reduction in the amount of antisocial behaviour as viewed by the parents.

We have examined these results in detail in Chapters 5–8, and the numerous differences between treatments are reported in Chapter 9. We will now consider the remaining five hypotheses.

Hypothesis 3 stated that some regimes are more effective in helping children with neurotic disorders than those with conduct disorders, and vice versa. Our results showed little evidence that this was the case. Similarly, hypothesis 4 postulated that some regimes are more effective in helping boys and some in helping girls, but, again, we found little evidence that this was true.

Whereas hypotheses 3 and 4 related to categories of children, hypothesis 5 referred to dimensions of behaviour, that is, different aspects of behaviour occurring in any one child. It stated that some regimes are more effective in reducing the neurotic component of a child's behaviour and others in reducing the antisocial component of his or her behaviour. Here there was some evidence that playgroup and nurture work regimes (junior children) were more effective in relieving antisocial than neurotic behaviour. In the senior programme there was little or no evidence of any such differences.

The final hypotheses were that, irrespective of regime, children with conduct disorders differ from those with neurotic disorders in outcome and improvement and that, again irrespective of regime,

boys differ from girls. Both these hypotheses were confirmed, particularly in the junior programmes. On certain measures, neurotic-disordered children showed more improvement than conduct-disordered children, and girls fared better than boys.

Further important findings

Most striking, and quite unexpected, was the evidence that treatment effectiveness seemed to increase with time (see *Tables A3(2)* and *A3(3)*): the follow-up at three years from baseline showed, overall, more and greater positive results than did the intermediate eighteen-month follow-up.

A second point was that some treatments seemed to show situation-specific improvements (for example in the junior parent counselling-teacher consultation regime improvement was confined to classroom-related behaviour) whereas others seemed to result in more widespread improvement.

Third, when the diagnostic and sex groups were analysed in more detail, some further important findings emerged. For example, children with neurotic disorders tended to lose associated antisocial behaviour and those with antisocial disorders soon lost any associated neurotic behaviour. This suggested that associated antisocial behaviour in neurotic children is less deeply ingrained than in antisocial children and that the same is true of neurotic behaviour in antisocial children as compared with neurotic children.

Fourth, senior children with neurotic disorders did better than those with antisocial disorders on measures of cognitive development.

Fifth, further analysis of sex differences suggested that neurotic behaviour was more easily modified in boys than in girls, whereas antisocial behaviour responded better to treatment in girls than in boys.

Some further findings merit a brief mention. The first concerned the measures of educational progress. At the junior level there was evidence of some improvement on some measures in nurture work and playgroup regimes at the eighteen-month follow-up. At the senior level, at the midline assessment, there was improvement on cognitive measures generally in the group therapy and behaviour modification regimes, though these were not maintained at the final follow-up.

Finally, there were some interesting findings concerning the effective qualities of the therapist and these are reported in Chapter 9 and Appendix 4. Surprisingly, good outcome was associated with therapeutic assertiveness, extroversion, and openness.

In the remainder of this chapter we discuss the theoretical and practical implications of the findings summarized above.

Some theoretical issues

IS TREATMENT EFFECTIVE?

In Chapter 2 we briefly reviewed the debate that has been taking place since the early 1950s. The most crucial question to be asked by Eysenck (1952) for adult and by Levitt (1957) for child psychotherapy was 'Is psychotherapy effective?'. Having established that the answer to this question is 'Yes, it is', we can examine the nature of the control groups, discuss rates of outcome and patterns of improvement, and use new techniques to compare the effectiveness of different forms of treatment.

NATURE OF THE CONTROL GROUPS – CONTAMINATION

In our programme there were obviously opportunities for the controls (i.e. at-risk and maladjusted) to be exposed to some treatment. A handful received treatment from other sources anyway, but of far greater consequence was the possible influence of the ethos of the school: as receptivity to new and more humane approaches grew the opportunities for controls to receive help were likely to have also increased. In other words, contamination was unavoidable. In such circumstances the results of some of the treatment programmes are even more impressive than earlier outlined, for they reveal differences, not between true, control groups and treated children, but between the latter and control groups that may, in fact, have received help. In these circumstances the differences between the parent counselling-teacher consultation programme and the controls may have been minimized, and our results may not have constituted a true index of the effectiveness of this programme. Furthermore, it will be remembered that our control families were subject to interviews and specific testing – Lambert (1976) has pointed to evidence that indicated that a testing session or even one interview may have a therapeutic effect on the patient, with particular weight being given to the initial interview. Unfortunately, we have no idea of how much help may have been obtained, nor of the extent to which the behaviour of the controls may have been influenced by any such help. We cannot even hazard a guess as to what would have resulted were there really no contamination. In the next section we discuss the issue of spontaneous improvement in more detail, and in relation to other studies.

RATES OF OUTCOME AND PATTERNS OF IMPROVEMENT – OUR RESULTS IN CONTEXT

Related to the issue of control groups is the considerable controversy about rates of spontaneous remission, i.e. the rates of improvement in neurotic disorders in the absence of systematic treatment. These rates are important because they are viewed as 'baseline figures' in untreated neurotic patients. Eysenck (1952), after reviewing the literature, concluded that two-thirds of such patients showed a spontaneous remission. Bergin (1971) re-examined the evidence and cited a median remission rate of 30 per cent: he, in turn, was criticized by Rachman (1973), who supported Eysenck's original figures. Lambert (1976) and Bergin and Lambert (1978) again reviewed the evidence and reported a median spontaneous remission rate of 43 per cent, adding the warning that 'this is an average figure which obscures considerable variation' (Bergin and Lambert 1978:147). Hence, it is essential to draw comparison groups from the total population under study.

The controversy about the extent of spontaneous remission and base rates in adult patients was taken up by Levitt (1957) in relation to child patients. He used the study by Lehrman *et al.* (1949) which included 110 untreated controls, to provide a base rate. Lehrman's study showed a success rate of 32 per cent and a partial success rate of 38 per cent, i.e. a base rate of about 70 per cent. This has been considered by some (Barrett, Hampe, and Miller 1978) an excellent study for the provision of such a base rate: however, as it was undertaken in the 1940s, it is not possible to say what kinds of other help were available at the time, to judge the impact of the evaluation and diagnostic interviews, nor are details of the ratings available. Unfortunately, Levitt's base rate was dependent on Lehrman's and one other study, which is also questionable by modern standards. In our senior and junior programmes we had 144 controls, and calculated a base rate of good plus moderate outcome, after three years, of only 41 per cent, which is closer to the Bergin and Lambert (1978) base rate with adults than to those of Eysenck (1952) and Rachman (1973).

Despite the shortcomings of Levitt's review, written in 1957, of outcome in child guidance cases receiving treatment, his conclusion that one-third improved, one-third partly improved and one-third did not improve has become the hallmark against which other therapies are compared. His rate consisted of 67 per cent improved at the end of treatment and 78 per cent (40.5 per cent greatly and 37.6 per cent partly) improved at follow-up. However, it needs to be noted that Levitt included a number of 'slightly improved' cases in his 'improved' category. Levitt has not been alone in this. A more

stringent test is, therefore, to see what percentage of cases fall into the 'much improved' category. Our examination of Levitt's later data (Levitt 1963) indicated a further problem. This was that these early studies were overloaded with cases with known high rates of spontaneous improvement: these patients were classified as having 'special symptoms' which, in addition to 'school phobia', included enuresis and tics. In this category, the 'much improved' rate was 54 per cent, whereas in neurosis (similar to adult neurosis) it was 15 per cent, in the mixed disorders 20 per cent, and in acting-out (antisocial disorders) it was 31 per cent. If allowance is made for these rapidly improving disorders then the 'much improved' rate falls to 25–26 per cent, i.e. one in four cases.

In evaluating outcome, our position was different and very much stronger than Levitt's. We had untreated control regimes drawn from the same populations as the treated children with random allocation. Moreover, we provided information on rates of improvement in all these groups. As *Table 10(1)* shows, the controls had a 'much improved' rate of 19 and 29 per cent for the seniors and juniors respectively at the midline follow-up, and 24 and 33 per cent respectively at the final follow-up. Our treatment regimes usually did better than this.

As already indicated, these findings probably constituted a conservative estimate of the effect of our treatment programmes, because of the unavoidable 'contamination' of the controls. Further, our data appeared to support the suggestion by Bergin and Lambert (1978) that spontaneous recovery rates may be far lower than has been assumed, not only because of the possible contamination described

Table 10(1) *Percentage of children classed as having a good outcome in the Newcastle upon Tyne study*

age group and treatment regime	*midpoint (18-month follow-up)*	*final follow-up (3-year follow-up)*
juniors	%	%
controls (ARC)	29	33
parent counselling-teacher consultation (JPC)	20	32
nurture work (NW)	27	52
playgroups (PG)	35	56
seniors		
controls (MC)	19	24
parent counselling-teacher consultation (PC)	23	33
behaviour modification (BM)	18	54
group therapy (SG)	37	53

above but also because a handful of controls may have been provided with help elsewhere, and certain diagnostic groups with high spontaneous remission rates, such as developmental disorders, may have been included. Thus, some may argue that even our control groups were not true control groups in the experimental sense: while this may be true, it simply serves to emphasize that the differences reported in our research are likely to *underestimate* the true effect of the intervention. On the other hand, controls based in a different set of schools in which we had not undertaken intervention would have been less subject to contamination. Had we used this technique, though, there would have been no guarantee that some controls would not have sought treatment elsewhere: furthermore, studying controls in a different set of schools would have been inappropriate because there are such considerable differences between schools (Rutter *et al.* 1979).

In some respects our findings were not what we expected (cf. Levitt 1957, 1963). It is therefore essential to now examine the results of more recent studies. The one most comparable to ours in terms of techniques used was that of Miller *et al.* (1972) who evaluated the treatment of phobic children. The salient features of that study are mentioned in Chapter 2. The treatments examined were psychotherapy and systematic desensitization. At a two-year follow-up the rates of improvement were more impressive for younger than older children but, overall, at the final follow-up, 73 per cent of the treated groups were successful as opposed to only 34 per cent of the untreated groups. When, in our study, we combined good and moderate outcome, we obtained a rather similar picture (*Table 10(2)*). Hence, our findings suggested a base rate for untreated cases, and outcome rates for treated cases, more consistent with those suggested by Miller *et al.* (1972) and Bergin and Lambert (1978) than with those proposed by Eysenck (1952) and Levitt (1957, 1963). It must be emphasized that the outcome rates on overall severity were less

Table 10(2) *Percentage of children with good and moderate outcome in the Newcastle upon Tyne study*

juniors				*seniors*			
ARC	JPC	NW	PG	MC	PC	BM	SG
44	53	67	78	39	52	73	75

Note: ARC = at-risk controls; JPC = parent counselling-teacher consultation in the junior schools; NW = nurture work; PG = playgroups; MC = maladjusted controls; PC = parent counselling-teacher consultation in the senior schools; BM = behaviour modification; SG = group therapy.

impressive than the rates on the more discrete dimensions of neurotic and antisocial behaviour. The difference, though, probably just reflected the greater specificity of these latter dimensions.

COMPARING EFFECTIVENESS OF DIFFERENT FORMS OF TREATMENT – NEW RESEARCH TECHNIQUES

Newer research has indicated that the previous suggestion that psychotherapy has no demonstrable effect was based on inadequate surveys or techniques, or both. For instance, Glass and Smith (1976) and Smith and Glass (1977) developed a method of comparing the results of different therapy regimes by standard scores. In their survey of 375 controlled studies they calculated outcome measures by dividing the mean difference on outcome measures between the control and treatment regimes by the standard deviation. While their work was statistically complex, their conclusions were simple – they demonstrated that the 'average study' showed a two-thirds standard deviation superiority of the treated group over the control group. Thus, the average client receiving therapy 'was better off than seventy-five per cent of the untreated controls' (Glass and Smith 1976:10). Though there has been some criticism of their procedures, it has been pointed out that their method was a considerable advance over merely counting positive and negative studies. Similarly, in our study we calculated the superiority in standard deviations of each of our treatment regimes over the control regime (*Table 10(3)*). These

Table 10(3) *Comparisons of the effectiveness of the different treatment regimes in the Newcastle upon Tyne study*

treatment	*standardized outcome scores at follow-up*		*average treated child better off than the untreated controls*	
	sum neurotic and conduct	*total severity*	*sum neurotic and conduct*	*total severity*
			%	%
juniors				
junior parent counselling-teacher consultation (JPC)	0.21	0.14	58	56
nurture work (NW)	0.57	0.46	72	68
playgroups (PG)	0.70	0.74	76	77
seniors				
parent counselling-teacher consultation (PC)	0.26	0.20	60	58
behaviour modification (BM)	0.81	0.75	79	77
group therapy (SG)	0.91	0.76	82	78

standard outcome scores were based on psychiatric ratings of overall severity, irrespective of the type of disorder the child showed, with a consequent loss of degree of sensitivity on these measures. We recalculated the measures separately for children with conduct and neurotic disorders and then summated the standard scores; the relevant differences are given in *Table 10(3)*. These averaged standard outcomes were usually marginally better than when using only a single measure of outcome.

It is of considerable interest that the standard outcome score of behaviour modification was 0.81 while the average standard amelioration of behaviour therapies as reported by Glass and Smith was 0.80; in addition, the average of our group therapies was 0.80, while an average standard amelioration of 0.63 for client-centred studies was reported by Glass and Smith. As our group programmes were based on client-centred principles this was an interesting contrast. We believe that the difference was due to the greater uniformity in technique, measures, and therapists employed in our study than the composite and uneven group of studies analysed by Glass and Smith.

The crucial ingredients of psychotherapy

Having examined our two basic questions 'Is psychotherapy effective?' and 'Are some treatment approaches more effective than others?', we can now turn to a more fine-grain analysis.

In Chapter 2 we described the three main components of psychotherapy identified by Kiesler (1971). These were (a) the patient and his or her problems; (b) the therapist, his or her personality, style, and techniques; and (c) the dimension of time. To Kiesler's triad we added a fourth ingredient – the psychosocial context in which psychotherapy occurs (in our case the school). We now discuss these key ingredients in the light of our research.

THE PATIENT AND HIS OR HER PROBLEMS

The characteristics of the children and their problems have largely been described already. We discovered that sex and diagnostic categories, while important predictors of improvement in themselves, had little bearing on the children's differential response to treatment. This finding was contrary to a strong tide of opinion in psychotherapy that stated treatment needs to be tailored to the specific patient and his or her problems (Goldstein and Stein 1976). However, in one of the best studies of child psychotherapy to date (Miller *et al.* 1972) it was reported that neither sex, intelligence,

socioeconomic status, nor chronicity, influenced the effectiveness of treatment. Our findings therefore supported other well-controlled studies.

THE THERAPISTS AND THEIR TECHNIQUES

In the introduction to this book we presented our rationale for selecting the therapy techniques. We aimed to choose a variety of treatments that would reflect fundamental differences in approach. Thus we compared direct with indirect therapies and psychodynamic with behavioural approaches. We now examine whether or not these contrasts have any relevance to the patterns of outcome and improvement. We will also comment on the two other closely allied topics, therapeutic skill and the intensity of therapeutic contact, to see whether our study can throw any light on the importance of these.

Direct versus indirect therapy

First we considered direct versus indirect therapy. Many services provided for children are indirect, such as education, prevention, and consultation services, i.e., they are not with children but rather with adults who, in turn, have direct contact with children (Adams 1975). Thus, children are what Adams calls 'parapeople', who are usually reached indirectly through 'paraprofessionals', such as parents and teachers.

Our service cannot easily be classified as either direct or indirect in this way, as it covered a spectrum of therapies. The most highly direct was group therapy, but even this contained a degree of indirectness because the group therapists were supervised and directed by another set of professionals. Behaviour modification was moderately direct in that it was applied by teachers who were given some initial training, then continuous support and supervision. Nurturing could be seen as being fairly direct, involving the least professional of the therapists, who were supervised and supported by a professional team. The parent counselling-teacher consultation programme was the least direct in terms of the above definition, because there was guidance but no specific training for teachers. It is tempting to suggest that the greater the directness of contact of trained professionals with disturbed children the better the outcome. Admittedly, this is a rather crude analysis as there are many factors that need to be disentangled.

Psychodynamic versus behavioural therapy

The second dichotomy we considered is psychodynamic versus behavioural types of therapy. The best method of comparison was to

contrast the group therapy (psychodynamic) with the behaviour modification (behavioural) treatment at the senior level. These were strikingly similar in that both brought to bear a high degree of skill, stuck rigorously to the treatment model they were designed to represent, and took place over the same brief time span. The overall results were compared by using standard scores (see *Table 10(3)* and Chapters 5 and 8), and it can be seen that at the final follow-up they were almost identical for the two treatments: in the group therapy regime the average treated child had a better outcome than 78 per cent of the controls, whereas the comparable figure for behaviour modification was 77 per cent.

We might have expected that although the overall outcome was the same for the two treatments, the mechanisms by which they operated would have been different. Some light was thrown on this by examining the pattern of improvement scores for differences between the two treatments. There were, in fact, quite a number of differences in their scores, both at the end of treatment (the point at which we were first able to get an early look at the process) and at the eighteen-month and three-year follow-ups. At the end of treatment the two measures that favoured behaviour modification were sociometric isolation and a classroom measure, creative initiative, where behaviour modification had a marked but early gain, the advantage with isolation being sustained at the eighteen-month follow-up. With regard to maladjustment as seen by parents (Rutter A scale and antisocial behaviour) the group therapy children showed significantly greater improvement than the children in the behaviour modification regime at the end of treatment and at the eighteen-month follow-up. By the final follow-up all the significant differences in results between these two treatments had disappeared. In general, behaviour modification seemed to result in a number of early changes in children that then washed out, but there were positive changes at the midline follow-up and a larger number of changes on important measures at the final follow-up.

These differences were the total reverse of what was expected. Group therapies have commonly been thought to be particularly appropriate for isolated children – so much so that, as we saw in Chapter 8, isolation has been a common outcome measure in such studies. In a similar way, behaviour modification has been seen as the most suitable treatment for antisocial behaviour, and as showing effects specific to the period of treatment. The only finding that was in line with expectations was that therapy directly focused on changes in demonstrable behaviour gave rise to immediate change.

Therapeutic qualities and techniques

The third dichotomy we are able to comment on is between therapeutic qualities and techniques. There is a division of opinion in the literature, one school of thought claiming psychotherapy can usefully be viewed as a set of technologies that can be applied to psychological problems, the alternative stating that it is the meeting and communication between people that is important, with therapeutic technique playing a relatively small part in determining the outcome. When we looked for the evidence to resolve this controversy, we found that, so far, it has not been possible to show one approach to be clearly superior to another under reasonably controlled conditions, in research either with adult patients (Luborsky, Singer, and Luborsky 1975; Sloane *et al.* 1975) or with child patients (Miller *et al.* 1972).

This is not to deny, however, that certain qualities of the therapist may be of major importance. Like patients, therapists differ on a wide variety of factors, such as age, sex, cultural background, professional experience, sophistication, empathy, etc. Many of these factors may have a significant bearing on the therapist's theoretical orientation, techniques, and influence (Strupp 1978). The most radical view, advanced by Franks (1973), claimed that psychotherapeutic change is a result of therapist factors common to all therapeutic techniques and based on the relationship between the patient and the healer. On the other hand, Rogers (1952) and Truax and Carkhuff (1967) described a more discrete set of factors (accurate empathy, genuineness, and unconditional positive regard) as necessary and sufficient conditions for beneficial therapeutic change. Both of these authorities demote the effectiveness on the therapeutic techniques and promote the relationship factor to a position of importance.

One important practical implication of these findings is that non-professionals may be just as effective as highly trained professionals (Cowen *et al.* 1975b). Our non-professionals (nurture workers) had only moderate success when compared with professionals working as group therapists, but had greater success than the same set of professionals working as social workers in schools. This set of findings led us to conclude that the critical factor in treatment is the technique used.

Our findings concerning therapeutic qualities were really quite dramatically different from those of Truax and other workers, who found empathy and non-possessive warmth to be the therapist characteristics that correlated with outcome. Indeed, we found that extroversion, therapeutic assertiveness, and openness in the therapist seemed to correlate with good results. One possibility for this is that

extroversion and assertiveness are characteristics particularly appropriate to the ordinary school situation, where effectiveness may depend on negotiating with large numbers of people and making an impact in a large institution as well as with the individual children. This may be an easier task for a more outgoing and assertive personality than for a quieter person. In relation to this conclusion, it is interesting to note that Strupp (1978) considered the therapist should take a much more active stance, take greater responsibility for becoming a moving force in the therapeutic encounter, actively plan the intervention, and actively resist the temptation to broaden the therapeutic objectives once limited goals have been achieved.

Duration and intensity of therapy

There are practical aspects of the therapist's technique, such as duration and intensity of the therapeutic contact, where our results can perhaps give some guidance.

In terms of patients' expectations and motivations, educational or health service resources, and many other practical considerations, it is essential to identify psychotherapies that give rise to a successful outcome in the shortest possible time with the least expense (Strupp 1978). We have been able to demonstrate that *the shorter-term treatments* (group therapy and behaviour modification) *had the best outcome*. While in no sense could parent counselling-teacher consultation and nurture work programmes be considered long-term, they were substantially longer in duration than group therapy and behaviour modification. Thus, although we did not specifically study length of treatment it was noted that our two shorter-term treatments had the best outcome and, like Luborsky and Spence (1978), we concluded that certain time-limited psychotherapies are effective.

Another important point is whether or not frequent contact with the therapist is more effective than less frequent contact over the same period. We indicated in Chapter 2 that some recent work suggested that the more intensive or the more frequent contact in psychoanalytic-type therapy the more impressive the results.

In nurture work, contact was daily over many months; in teacher consultation and behaviour modification we could only speculate that contact was reasonably frequent; in group therapy, contact was probably the least frequent. Our results therefore suggested that is is *type rather than intensity of treatment that is a critical factor in intervention.*

THE DIMENSION OF TIME IN TREATMENT PROGRAMMES

We found that, overall, however brief, treatment effects seemed somehow to remain active for eighteen months or more. This was

extraordinary considering the many experiences the children must have had in their normal lives during this time, which one would think were as, or more, important than the therapy. Why, then, did outcome and improvement continue to gain ground in effective therapies, even when treatment had finished?

First, we should note that this finding has a bearing on the question of whether psychotherapy merely brings forward improvement rather than produces change that would not have occurred without therapy. If the former was true we would have expected the controls to catch up but, as they did not, it is clear that by intervening we produced change that would not have occurred otherwise.

The next point to make is that this was not a unique finding. We mentioned in Chapter 8 that in those two studies of group therapy which had long-term follow-ups there appeared to be a similar trend towards further improvement after active therapy had finished. Levitt (1971), in the light of uncontrolled studies, concluded that further improvement at follow-up was merely an expression of 'spontaneous improvement'. However, Wright, Moelis, and Pollack (1976) analysed six reasonably well-controlled studies of child psychotherapy, with particular reference to continued improvement after active therapy had finished. At the end of treatment only one of the six studies showed significant gains compared with the control group. At follow-up four of the studies showed significant improvement and only one showed a deterioration compared with the control group.

To summarize, there seems quite good evidence, which our study heavily reinforced, that improvement continues and may, indeed, become demonstrable for the first time long after active therapy has finished. The mechanism behind this process is not known but several explanations could be examined in further studies. The first possibility is that the early changes that must occur are of too subtle a nature to be detected by our current, rather crude, techniques of measurement and analysis. In particular, our criterion of 'statistical significance' must be examined because between-group variation may be quite irrelevant to subtle within-subject changes.

Wright, Moelis, and Pollack (1976) suggested that their findings supported the view that psychotherapy affects underlying central or structural aspects of personality functioning rather than overt behaviour. This is certainly another possibility, but subtle shifts in behaviour and social functioning during therapy could, equally, be undetected and could lead to adjustments in the individual's interactions with others: these alterations, through subsequent positive feedback mechanisms, could eventually result in demonstrable changes.

THE PSYCHOSOCIAL CONTEXT OF THERAPY

This is the final component of psychotherapy that we have delineated. Taking treatment techniques into the school, rather than taking the child out of school to a clinic setting, has enormous advantages in that it allows study of the effect of therapy in its social context. It also has the advantage of avoiding labelling the child as a psychiatric patient. It was clear from the results reported earlier in this chapter that the characteristics of the schools had a major impact on the children's progress. At a more detailed level, it was difficult to disentangle the effects on progress of the type of therapy, the therapeutic qualities, and the school social context; some further results on school differences are reported elsewhere (Mullin 1979).

SPECIFICITY OF TREATMENT

One of the crucial questions in psychotherapy research is whether or not different kinds of treatment are effective with children with particular types of disorders. We found no consistent evidence of such specificity, neither in the junior nor senior school programmes. Such attractive concepts of specificity, which are important in adult disorders, do not seem to have held up over the range of treatments we used in relation to the types of children we studied. It seems logical that there may be good reasons for the use of different treatments in the school setting, but until these can be demonstrated we have to accept that the case for specific treatment for neurotic and conduct disorders has not been proved. We have mentioned this important matter in relation to the children's problems in Chapter 2.

Some comments on our research design

We believe that our findings pointed strongly to the effectiveness of our interventions, particularly in the cases of the group therapy and behaviour modification regimes. However, we need to report some of the ways in which we ensured that artefacts had not crept into and influenced our research.

The first issue concerns the possibility of biased reporting at follow-up. This problem really needs to be examined at two levels of data collection: the initial point at which questionnaires or interview schedules were completed and the subsequent points where assessments and analyses were made on this data base.

Although we were not dealing with a 'double-blind' situation, it seemed unlikely that there were biases in data collection. First, parent counselling-teacher consultation, the regime that had the greatest contact with parents and teachers and hence may have been expected

to be the one most influenced by report bias, proved to be the least effective treatment.

Second, apart from in the parent counselling-teacher consultation regime, the reported improvements were spread across several of the different reporters simultaneously, some of whom would have had minimal knowledge of the treatment. For example, while parents were fully informed of the group therapy they were minimally involved in it, yet there were significant improvements on the parent measures. A third point was that the interviewers and testers were also quite ignorant of the main hypotheses of the research and of the groups from which the children came. For these reasons bias at the point of data collection seemed very unlikely.

The subsequent assessments were, as we explained in Chapters 3 and 9, carried out in two ways: clinical ratings were made on the basis of examination of all the data and, independently, change was measured on mathematically derived main measures and aggregate measures. The clinical ratings were made by psychiatrists who were completely unaware of the regime from which the cases came. These clinically derived ratings were, in addition, largely supportive of the mathematical ratings, which were handled entirely by machine from data collection onwards and hence could not have been subject to bias at this stage.

A second design consideration that merits discussion is that the research took place over two years, with the group therapy, behaviour modification, and nurture work regimes taking place in the second year, and showing better results than the first year parent counselling-teacher consultation regime. There are various ways in which the better results of these three therapies might have been due to the fact that they all occurred in the second year. Two possible explanations are fluctuations in the levels of disturbance in the schools and the sensitization of the teachers, as a result of the first-year experience, leading to biased reporting. Fluctuations could have been due either to treatment in the previous year or to other extraneous factors.

Looking more closely at our data it appeared that comparison of initial levels of disturbance for the two years might throw light on whether either of these artefacts was operating. If the initial levels were markedly different then perhaps either fluctuation of levels of disturbance between the years was important or exposure to the first year had seriously biased teacher reports (or both). In fact, on examination, the initial levels were much the same for both years: it seemed unlikely, therefore, that either of these processes was operating. In addition, it seemed unlikely that reporter bias could have

affected parents' or children's reports. The consistency of behaviour over time within schools was in line with other research results (Rutter *et al.* 1979).

An allied argument might be that as a result of the first-year programme the schools became generally more 'therapeutic' environments, so that the second-year children had added non-specific help that was unrelated to the particular regimes in which they took part. It seemed to us that there were two reasons why it was unlikely that this process contributed to the results. First, there was continuing greater positive change in outcome and improvement in the second-year children over the three-year follow-up period than there was in the first-year children. Over this time the school environment would have been acting on all the treatment and control regimes, first- and second-year, to the same extent, so that one might expect, if non-specific therapeutic factors were at work, that positive change would be equal in both year cohorts.

A second point is that the first-year treatment was the least impressive when applied directly to the families. Again, therefore, it seemed unlikely that its indirect effect on subsequent years was of very major importance. One additional point should be mentioned: both first- and second-year cohorts were relatively new to their schools at the start of treatments, so that they could not have been much exposed to 'treatment' indirectly before the specific programmes started.

A further point also merits comment at this stage. The most successful regime at the junior level was the only one where children were withdrawn from the class (i.e. playgroups). We cannot therefore rule out the possibility that withdrawal from class was important in itself. Maybe the psychological effect of the special treatment under such conspicuous circumstances is therapeutic in itself. This goes against sociological ideas about 'labelling' being important in the perpetuation of behavioural deviance.

Finally, we must discuss why there were apparent discrepancies between outcome measures (based on clinical judgement) and improvement measures (based on mathematical analyses). In actual fact, the overall trends for these very different types of analyses were remarkably similar. Perhaps the biggest discrepancy was between the results at final follow-up in the junior regimes. Here the outcome measures showed rather modest (in fact statistically non-significant) changes on the antisocial behaviour measure whereas on the improvement measures there were quite impressive changes on the aggregate antisocial score.

It is important to realize that there were quite fundamental dif-

ferences in approach between the two types of measure. First, the clinical outcome measures were most heavily influenced by data collected at home. This was because we considered parents to be the most sensitive source of information about children. A second, and equally important, difference is that the clinician can judge and give clinical meaning to the symptoms shown and his or her judgment is not simply summation of results. It seemed likely that it was this second difference that gave rise mainly to the above-mentioned discrepancies in the findings in the junior programme. Finally, of course, outcome is not simply a measure of change but takes into account both change and final state (see Appendix 2).

Ethical issues in research and practice

The research worker always has to ask him- or herself 'Is what I am doing ethical?' We were confronted with two ethical questions: first, was it ethical not to treat those children who were maladjusted and who were allocated to the control groups? When we started our research, our evaluation programme would have been morally, socially, and psychologically indefensible had two conditions been met: (a) if we had known that treatment worked (we did not); and, (b) if there had been enough treatment for all (there was not). As neither condition existed, our strategy allowed a moral and permissible allocation of varieties of psychotherapeutic help in order to enable us to learn the true value of the intervention we provided. However, we were careful never to stand in the way of any referral that a family or school felt appropriate.

The second ethical question that arose was whether we were justified in offering to help people who had not specifically asked for it. This was an extremely delicate question – no less so in those of our interventions that proved to be most effective. It was absolutely essential in the application of these techniques that clients maintained the right of refusal and that they were not subjected to coercion that might serve a social system or be administratively convenient. A particularly difficult ethical issue arises when interventions have a partly educational component, because education is compulsory up to the age of sixteen years. The crucial distinction seemed to us to be that therapeutic interventions involved an element of the child's private life. For this reason, we felt that children and their families should be fully informed of all investigations and treatment carried out and that they should have the right to refuse to participate. We pursued this policy and the number of refusals was negligible.

Practical issues: practical guidance for educationalists, mental health professionals, and planners

The whole thrust of our research project was a practical one. We are sure that our findings have implications in the academic debate, but consider that our most important audience comprises practical planners and workers in the field. What lessons does our research have for them? Again, we can discuss the issues under a variety of headings.

THE FEASIBILITY OF INTRODUCING SPECIAL HELP

We suspect that most efforts to introduce new services get no further than this preliminary question of feasibility. For us it was just a starting point though, nevertheless, it raised important issues.

All the treatments that we introduced into the schools were carried through to their conclusion. We must point out, however, the hard work that was undertaken by the project team and the sympathy and understanding that was forthcoming from the education authorities and schools, all of which contributed greatly to the project's success. First of all, it was necessary for us to convince hard-headed administrators of the local authority that the project was worthwhile. The positive results of our study should help further projects a great deal in this respect; nevertheless, funding for mental health projects in schools still has to compete with other major priorities in local authority or health service budgets. One view is that mental health projects would be more favourably received if the results of research were more widely disseminated. It would then be for local education authorities, working with health authorities either *ad hoc* or through established consultative machinery, to decide which measures, if any, to introduce in their respective areas. Such new services do not need official sanction.

The next set of problems we faced was in convincing an equally hard-headed and often sceptical group of Headteachers and staffs that, among the new and 'trendy' ideas in education, our proposals were worth taking seriously. The crucial ingredient in our being able to do this was that we were able to offer special help to some of the children about whom they were most worried, and with whom they felt they needed assistance. We found universally that both the Headteachers and their staff were acutely aware of the emotional and social problems of their pupils and that the schools had potential far beyond that of learning in the narrow sense. In some cases the teachers had moved quite consciously into a strongly pastoral role and we came to realize that our more specialized efforts were extend-

ing and enlarging on work that was already being done, rather than adding a whole new facet to the curriculum.

TREATMENTS THAT APPEARED INEFFECTIVE

When a treatment does not work, the investigator naturally looks for explanations for its failure. We have already discussed one possible explanation for the rather limited success of the parent counselling-teacher consultation regime, which was that it coincided with the introduction of something new into the school.

There are potentially a multitude of other explanations for the apparent failure: perhaps more personnel were needed, with smaller case loads; perhaps we looked at the wrong factors in our evaluation; perhaps the evaluation was too crude. We could presumably explain away failure in any one of these ways. However, there are three explanations in particular that merit further scrutiny and that should be taken into account by anyone who attempts to replicate or extend our research.

The first of these centres on the fact that, as we have seen in Chapter 7, in the parent counselling-teacher consultation groups the families had severe and widespread problems. It may be that these were so deeply ingrained in the fabric of the family behaviour patterns that they were not modifiable. In other words, the social workers' efforts could possibly have been dissipated in a welter of family difficulties, so that the impact of their work on the children was hopelessly attenuated. If this was the mechanism in operation, it can be taken as a clear indication for jettisoning the indirect approaches of the project and concentrating resources on the more direct professional interventions of behaviour modification and group therapy.

The second possibility, and one with quite different implications, hinges on the fact that the social workers were 'uninvited guests' of their clients. This had a far-reaching impact on the type of work they undertook in that they had to keep a rather low profile and act mainly as a support and helper to the family, being only secondarily an active agent of change in family functioning. It may be that this type of intervention is less appropriate for the school and more appropriate for the clinic.

A third possibility is that work with parents and teachers was a potent but insufficient intervention. In normal practice such work would often be accompanied by time spent with the child and it may be that work on all three fronts together, and perhaps over a more limited time span, could have more success than the sum of any partial interventions.

Whether or not any of these explanations and suggestions are valid, we feel it would be premature to condemn indirect work on the basis of our findings alone.

COST EFFECTIVENESS (*Tables 10(4) and 10(5)*)

The costs of the different treatment programmes can be only roughly estimated. They can be divided into overt costs and hidden costs.

The group therapy programme would seem to be the least expensive as it consisted of thirty-four groups of ten sessions each, undertaken by a total of six social workers over a period of three months (one school term). However, the hidden costs in training and supervising the social workers were extensive and had to cover some months spent gaining prior experience of working part-time in schools; a period of sensitivity training (see Chapter 8) (provided by two trained therapists); training and experience in group therapy (provided by a consultant psychiatrist and psychotherapist, and covering about three months); and continuous supervisory discussions with other trainee group therapists and the consultant. As all six social workers were already fully trained when they joined the project we conclude that in costing terms, we were using three full-time trained workers who needed a year's further training before they could be employed as group therapists.

The behaviour modification programme's hidden costs consisted of providing a generalized practical and theoretical training to improve the psychologists' skills in relation to behaviour modification. We estimated that this would normally require training for about six to

Table 10(4) *Comparative staff costs of treating 60–70 children by various methods, in the initial and subsequent programmes*

		number of workers and time required	
treatment	*programme(s)*	*fieldworkers (full-time equiv.)*	*back-up*
GT*	initial	3 for 15 months	at least 1 for 15 months
	subsequent	3 for 3 months	½ for three months
BM	initial	1¼ for 12–15 months	possibly 1 for 6 months
	subsequent	1 for 6 months (includes further courses for teachers)	nil
JPC/PC	initial	3 for 15 months	1½ for 15 months
	subsequent	3 for 12 months	nil
NW	initial	3½ for 18 months	at least 1 for 18 months
	subsequent	3½ for 18 months	at least ½ for 18 months

Note: * for details of abbreviations see p. 309.

Table 10(5) *Months of professional time to treat 60–70 cases*

	treatment			
programme	BM	GT	JPC/PC	NW
initial	25	60	72	45*
subsequent	6	10	36	36*

Note: the figures for nurture work have been adjusted to reflect the cost of professional time; * minimum.

nine months on a part-time basis. We followed this with the training of thirty-nine teachers over a period of three weeks prior to the start of the programme itself and supervised them over a twenty-week period. We estimated the cost of this programme to be at least half the cost of the group therapy approach.

Parent counselling-teacher consultation utilized the equivalent of six part-time social workers over an academic year (three school terms). The hidden costs were incurred by their additional training by the back-up university team and by supervisory sessions. It was therefore at least 100 per cent more expensive than the behaviour modification programme, but similar to that of group therapy. However, subsequently, group therapy would be substantially less expensive.

Finally, the nurture work programme was based on the use of seven part-time teacher-aides (three full-time equivalents) over five school terms. However, there were hidden costs of back-up support consisting of, at least, a social worker and a psychologist. While neither of these needed to be full-time, we estimated that they would have to be employed for at least eighteen months. Teacher-aides earned about half the salary of a trained professional and therefore the cost of the programme was about half that of the parent counselling-teacher consultation approach.

A *crude* comparison of staff costs for treating between sixty and seventy children is shown in *Table 10(4)*, while *Table 10(5)* shows the costs in terms of months of professional time and allowances needed to be made for the cost of such time. Thus, initially group therapy and parent counselling-teacher consultation were 100 per cent, and nurture work 200 per cent more expensive than behaviour modification. Subsequently, the amount of professional time needed for group therapy and behaviour modification was dramatically reduced, but that for parent counselling-teacher consultation was reduced by only 50 per cent, and that for nurture work not at all. We have already shown that, of the four treatments used, behaviour modification and

group therapy were of the shortest duration: it is therefore evident that *those therapies that gave rise to the most promising results did so in the shortest possible time with the least expense.* As group therapy and behaviour modification were not only relatively inexpensive to mount, but also gave rise to a successful outcome, they would appear to be treatments that should be looked on favourably by administrators. Both, of course, require a high degree of expertise and training.

PARENTAL INVOLVEMENT

One very topical theme is the relative importance of home and school factors in the perpetuation of psychological problems and poor academic progress. A number of influential reports have contributed to the notion that schools do not have an important influence. For instance, Coleman (1966) in the USA suggested that educational achievement was largely independent of the type of schooling the child received and Jensen (1969) concluded that compensatory education had failed in relation to attainment and ability. The pre-eminence of family factors and social class factors over ability in the case of educational achievement (Douglas 1964; Plowden Report 1967) led us to speculate about how far positive school influences can counteract the adverse effects of negative home influences. Wall (1973) argued for the primacy of the home over the school in determining academic success and adjustment, but concluded that schooling may serve to accentuate difficulties. Schools are presented either with the problem of trying to get children to adjust to their standards, thus possibly creating out-of-school difficulties for them, or with the problem of trying to get the teacher to tolerate different behavioural norms. More recent work has begun to indicate that when home factors are controlled some schools have a higher incidence of anti-social behaviour (Power *et al.* 1967; Power, Benn, and Morris 1972) and of poor educational progress (Rutter *et al.* 1979) than others. Many reviewers have been impressed by research evidence of effects of teachers' attitudes and expectations on children's behaviour. Perhaps attention should be focused on determining what part the home can contribute towards (Douglas 1964) and the school co-operate in (Plowden Report 1967) meeting the child's needs. This leads us on to the subject of parental contribution.

Clinical tradition, going back to the roots of child psychiatry, dictates that parental involvement is an important ingredient in the relief of symptoms (Freud 1911). This claim has received some empirical support in the case of maladjusted children (Love and Kaswan 1974) and, in the case of deprived children, Bronfenbrenner (1974) has argued that parental participation is essential. While aware of the

importance of the involvement of the mother and, indeed, of the father as well (Love and Kaswan 1974), for the practical reason that we had insufficient funds we were unable to involve parents to the extent we desired. Nevertheless, it was evident that some of the treatments were singularly effective despite complete lack of contact with parents. This led us to suggest that the *child's experiences in school are critical for psychological adaptation* and second only to their home experience. Often, treatment has been denied to children because of what are considered to be intransigent social and personal family problems and also poor motivation or lack of organization on the part of the family in getting to the clinic. The *consistency of our findings emphasizes the importance of treatment of the children themselves*, with parental contact taking a secondary but probably important place.

BEHAVIOURAL ADJUSTMENT AND ACADEMIC PROGRESS

Educators and mental health specialists are likely to see school adjustment from different perspectives (Cowen 1971a). The former are likely to emphasize academic progress and the latter, behavioural adjustment. It is usually argued that the two areas are not unrelated and that poor functioning in one may give rise to problems in the other. The fact that the two are interrelated was confirmed by our screen measures, where there was a positive correlation between educational and behavioural measures. There are, of course, many ways in which the two may be linked. Lack of encouragement and supervision at home may lead both to poor achievement (Douglas 1964) and poor adjustment (Craig and Glick 1963).

What is far less well-substantiated is whether improvement in one area can generalize to improvement in others (for example, can psychotherapy, via behavioural adjustment, lead to educational improvement?) We have not been able to demonstrate consistent academic improvement – despite considerable behavioural changes. Our efforts were, of course, mainly directed towards behaviour and the main changes witnessed were specific to this area, though, as in other studies (see Chapter 8) we did find some short-term educational gains in the group therapy cases. In this part of the study we have not concerned ourselves with the reverse aspect, i.e., whether specific help with educational problems gives rise to a secondary improvement of behaviour.

The Warnock Committee asserted that 'Educational failure is now recognized as a significant factor in maladjustment and the contribution of successful learning to adjustment is more widely recognized. . . . Areas of conflict between therapeutic and educational objectives are still evident, especially where the latter are charac-

terized as formal and academic' (Warnock Report 1978:222). The Committee went on to express the opinion that special education for maladjusted pupils 'is not complete unless it affords educational opportunities of quality' (Warnock Report 1978:222). Our findings led us to support strongly the view that direct treatment of maladjustment is unlikely to lead to substantial and permanent educational gains and needs to be complemented by the adaptation or development of special curricula to meet individual needs, applied, wherever possible, by teachers from the child's own school. The evidence for this conclusion was shown particularly clearly among the junior schoolchildren, who showed minimal educational improvement despite the fact that many were identified and included in the treatment groups on grounds of educational failure.

EDUCATING MALADJUSTED CHILDREN IN AN ORDINARY CLASSROOM

The concept of educating children with psychological problems in the ordinary classroom reverses the move towards labelling children as abnormal and then recommending special schools or classrooms for them. It makes psychological sense because the child will not perceive him- or herself as different nor be perceived as such by others; it makes educational sense because the child is kept in the ordinary stream of education where there are many more opportunities to take advantage of the full curriculum and to mix with a wide range of children; and it makes financial sense in that special educational facilities are rapidly becoming prohibitively costly. However, all this cannot be achieved unless there is special intervention either at home or at school, and unless teachers are provided with the skills and the back-up support to enable them to cope effectively with likely problems.

One of the main worries voiced by teachers and parents is the impact of maladjusted children on non-disturbed children. Saunders (1971) has studied the subject and his work seems to suggest that no disruptive influences were found, particularly if classroom management was effective.

CLINIC AND SCHOOL APPROACHES TO TREATMENT

Over the past two decades there have been some cogent criticisms of traditional forms of child psychotherapy, particularly of the child guidance approach. We have discussed these in Chapter 1. In addition, reviews have pointed out that there is little evidence to suggest that long-term psychotherapy is helpful – naïve counselling is often considered as useful as other forms of therapy: however,

there is better evidence in favour of the effectiveness of shorter-term psychotherapies (Tizard 1973). There is also the theoretical possibility that different forms of treatment may be more effective if correctly employed for the right type of patient – such a specific programme of psychotherapy, for phobic disorders in children, was mounted by Miller and colleagues (1972). Tizard concluded that, with certain important exceptions:

> 'individual treatment of maladjusted children is a pessimistic one. Psychotherapy, play therapy and other forms of individual therapy based on dynamic beliefs have not proved successful in practice. Changes in children's behaviour are consequences either of growth (as every wise GP and teacher knows) or, more immediately, they occur as a response on the part of the child to changes in his environment. Where there is no growth and no environmental changes occur, the counsellor is unable to cure.'
> (Tizard 1973:31)

He suggested that what the counsellor *could* do was undertake the very important support of listening and giving advice. He further stressed that there is only slight evidence that prompt remedial treatment in infancy or early childhood will prevent later psychiatric breakdown. It is only when there is a marked change of environmental circumstances that children tend to respond (Clark, Lachowicz, and Wolf 1968). Similarly, when these circumstances deteriorate, behavioural development also suffers. Tizard's solution was to look for ways of helping a large number of children, possibly at classroom level, rather than to seek an individual therapeutic solution.

While we thought that these were unduly pessimistic views, we noted that they were advanced at a time when apparently impressive research programmes, such as that of Shepherd, Oppenheim, and Mitchell (1971), were producing negative conclusions about traditional therapeutic approaches in child psychiatry. Such conclusions were unlikely to be fully supported by more recent research, but they were, nevertheless, views that strongly influenced us, especially as they seemed to have much in common with the newer, attractive, community approaches to identification, prevention, and treatment of psychiatric disorder advocated in the USA (Caplan 1964; Bower 1969; Cowen *et al.* 1971a). Our basic objective, therefore, became to explore the suggestion that schools could play a vital role in ameliorating psychiatric disorders in children, through their recognition, prevention, and treatment.

Our programme of redeploying mental health personnel within the schools was, in certain ways, more successful than we had ever anticipated: we have therefore had to consider what part such programmes should play in the range of services available for helping with children's problems. It is unlikely that new services would totally replace existing ones: rather, they would constitute one part of a network of services that would continue to incorporate psychiatric and psychological outpatient facilities and, of course, a small number of special settings, such as hospital or hostel units and special schools.

The question that now faces health service personnel is 'How much time should be devoted to conventional psychiatric work, and how much to developing the type of work explored in this project?' Our research findings, tempered by clinical experience with more serious forms of psychiatric disorder, have continued to lead us to advocate caution. While we can see how a child and adolescent psychiatrist, psychologist, or psychiatric social worker can effectively function in the community as a consultant to other professionals, we think that he or she still needs to accept full responsibility for the treatment of severely disturbed children and adolescents, and apply techniques that have clinical components. Another point is that recipients of consultation need to have a high degree of background skill and be given defined tasks. Whatever the different models of service eventually established, it is essential that these should provide a network of services, incorporating both the community and the health service, that will cater for a wide variety of acute and chronic disorders.

BACK-UP TEAMS

While there will certainly need to be modifications to the traditional child guidance approach, the concept of a core team of mental health professionals who work regularly together and who can deliver a high level of expertise in community settings is one that must be preserved if the findings of our study are to be applied effectively. The reason for this is that personnel in schools will need back-up teams both for training and for continued professional and emotional support.

The training needs of school mental health programmes are likely to be continuous, particularly for the more indirect approaches. This is because the background training of the teacher-aides in nurture work and the teachers in behaviour modification was less extensive than that in, for example, group therapy. The social workers had all undergone a thorough background training, so that in the case of the

two social work programmes we cannot point to a deficiency of skills, but we could suggest, rather, that these skills should be applied in a different way. There is a pressing need for further research into the components of effective casework.

In all programmes there will inevitably be some turnover of staff due to promotion and other changes. The issue of adequate professional and emotional support is, in our opinion, a far more important one than changes in staff. The school is a powerful social system with a very necessary well-defined structure, specified roles for staff, and often strongly underlined norms of behaviour. The responsibility for operating successfully as a therapist in this system must be firmly that of the mental health specialist, who will need special skills in managing the strong emotional forces that are generated, particularly in conflict situations. The mental health worker must, as it were, join the system, yet be able to operate also from a base outside the system and keep a somewhat separate identity. This may be particularly difficult for paraprofessionals, such as nurture workers, who have lower status in the school and are less equipped by training to manage the situation than are specialists. We found that they needed continuous close supervision from a trained professional. We also found that the teachers in behaviour modification needed constant reinforcement and stimulation if they were to maintain interest and apply the technique systematically. Treating a number of children involves the co-operation of many teachers and this is unlikely to be achieved without the help of a skilled supervisor – either a teacher counsellor or a psychologist.

The group therapists were, of course, far better equipped by training than the therapists in the above-mentioned two groups. The technique is, however, a particularly stressful one for the therapist, who has to cope not only with the school social system, the cultural basis of which may be very different from that of the therapy group, but also with the powerful interplay of emotional forces in the groups themselves. It may be that, with experienced therapists, support can be offered from a peer group.

It seems to us that the community mental health services (which may equally be staffed from child guidance clinics or hospital-based clinics) have a major role in the future in supporting school-based programmes, even though the work that might take place may be rather different from that done in the past. We should emphasize that there will, in addition, always be a need for a clinic service for the more seriously disturbed child.

CONTRIBUTION OF RESEARCH TO EDUCATIONAL POLICY

From a practical point of view the value of our research can be measured in terms of its contribution to decisions about educational policy. Such decisions may concern ways of using the budget, either by employing staff, developing facilities, or supporting one type of development rather than another. Carefully controlled studies should point to the 'best buy' in terms of developing services. The evidence that the administrator examines will include the cost and effectiveness of the programme, its ease of implementation, and the reaction of parents. The likely response of ratepayers, who will be looking for both helpfulness and cost-effectiveness will, of course, also be under consideration. We recognize, at the same time, that decisions concerning the allocation of resources are political ones and will, therefore, be influenced by the wider political and economic climate. This apart, we feel that our work has been in a field that is largely free of entrenched traditions and vested interests, one where innovation is accepted.

With these points in mind, we would recommend that mental health programmes in schools be extended, with a particular emphasis on psychodynamically based group therapy and behaviour modification. It is particularly important to maintain a high level of expertise and adequate training among professionals doing this work. This is not likely to be an easy task because the skills required for such training are not widely available, in the UK at any rate, at present. Of critical importance, also, will be the quality of back-up aid that can be offered from existing child psychiatry and child guidance settings: these will play a major role as centres of training and support for such new developments, as well as continuing their established role with more severely disturbed children and their families.

With regard to the other regimes, we advocate caution over dismissing them entirely. Nurture work may have a very valuable contribution to make in two situations: first, where only lower levels of expertise are available (although in the long run it may be more expensive and less effective than playgroup therapy); second, in the treatment of deprivation rather than psychiatric disturbance (the effects of deprivation were not specifically assessed and monitored in this study). A large question mark must remain over parent counselling-teacher consultation. In the form in which it was applied in our study it seemed to have had minimal effect; however, as we discussed above, it may be that in combination with direct contact with the child, or with some other change of procedure, this technique could become much more effective.

This study has shown that group therapy (both play and discussion

groups) and behaviour modification, applied with a high degree of expertise, are clearly effective. They should be additionally attractive to health and education administrators because of their short-term natures and relatively low costs.