Maladjusted Pupils in Ordinary Schools

Some programmes of management are described by Dr. I. Kolvin, reader in child psychiatry, Dr. R. F. Garside, senior lecturer in applied psychology, Dr. A. R. Nicol, consultant child psychiatrist, A. Macmillan, senior psychologist, and F. Wolstenholme, lecturer in applied sociology, all members of the Human Development Unit, Newcastle University

There is a vast pool of maladjustment or psychiatric disorder in the school community, for which current resources and methods of treatment are inadequate. Studies of school children in the United Kingdom have shown that the rate of psychiatric disorder runs at about 6-18 per cent (Garside *et al.*, 1973) and about two thirds of these are likely to need some form of help.

The aim of the Newcastle school-based action research project, which began in 1973, is to examine ways of preventing and treating such maladjustment in children in ordinary schools. We hope, in particular, to discover which forms of school-based intervention are most effective with which type of problem. The programme consists of a series of studies focussing on the identification and treatment of maladjusted children within the ordinary school. Aspects of this are described in greater detail elsewhere (Kolvin *et al.*, 1976).

Our concept of psychiatric disorder is based upon that outlined by Rutter and his colleagues (Rutter *et al.*, 1970). They 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 himself. For instance the problem could manifest itself as a handicap in the areas of emotional or social adjustment and educational progress.

We have found it useful to differentiate between *conduct* and *neurotic* disorders. The former denotes abnormal behaviour (such as aggressiveness, stealing or lying) which gives rise to social disapproval and which is repeated and habitual. To be classed as a conduct disorder, the behaviour must exceed that expected in the child's sociocultural environment. Neurotic disorder is diagnosed when there is an emotional abnormality, such as a state of anxiety or depression, which is enduring and which is disproportionate to the child's circumstances. In both cases, the behaviour observed is that found to some extent in normal children but, in the child with psychiatric disorder, it is present to an inordinate and handicapping degree.

Criticisms of traditional treatment

A central issue is whether treatment techniques used in child guidance or psychiatric settings are actually effective. A frequently quoted study, which comes to a negative conclusion, is that by Shepherd, Oppenheim and Mitchell (1971). They compared emotionally disordered children, treated at a child guidance clinic, with an untreated control group and found no difference in outcome. While aspects of the design of this study are open to question (Rutter, 1970), these major findings cannot be lightly ignored. In fact, there have been many criticisms in the UK (Garside *et al.*, 1973; Rehin, 1972) as well as in the USA (Levitt, 1971; Robins, 1970) of traditional child guidance treatment or traditional one to one psychotherapy as the single approach to management. In modern child guidance or psychiatry settings there has been a growing interest in the use of a diversity of treatment techniques (Scott *et al.*, 1975). Furthermore, a more flexible use of the team approach has been advocated, together with redeployment of trained psychiatric personnel within the community (Scott *et al.*, 1975). It has been argued that, as 98 per cent of emotionally disturbed children in the USA remain in ordinary schools, the primary support should be the class teacher (Long *et al.*, 1971). Similar arguments are applicable in the UK. Further the exclusive use of the clinic-based approach is subject to the danger of a breakdown of communication between the clinic and the school. This is likely to result in the teachers perceiving their role as being devalued and passive and their insights and concerns not being considered.

Emphasis on helping teachers

In the Newcastle project we have redeployed mental health specialists (including social workers, psychologists and psychiatrists) to work in schools, with the emphasis changed from treating individual children, to helping teachers themselves to help their pupils. The specialists also were used within the school system in such a way that help became available to many maladjusted children, rather than to a few.

The help thus provided constituted a supplementary service to the existing child guidance and psychiatric clinics. We have not interfered with the customary referral of very seriously disturbed children to such clinics; rather, our research has facilitated it by providing on-the-spot and immediate referral in serious cases, as with one suicidal child. Such a dramatic incident was rare but many of the children came from as seriously disturbed backgrounds as those attending child guidance clinics.

The research focussed upon two forms of action; we wanted to find out if certain *preventive* measures undertaken with children of seven to eight years, and certain *interventive* measures with children of 11 to 12, were effective in preventing or modifying the course of existing disturbed behaviour.

(a) AIMS

The aims of the research programme can be set out as three linked hypotheses which we wished to test:

(i) Treatment is more effective than no treatment in reducing psychiatric disorder in children.

(ii) The different types of treatment differ among themselves in their effectiveness.

(iii) Differences between the effectiveness of treatments are related to types of disorder; for example, some treatments may be more effective in neurotic disorders, and others in conduct disorders.

(b) METHODS

(1) Screening

As the frame of reference was the school, rather than the home or psychiatric clinic, it seemed sensible to gather the necessary information about the children from the teachers and children themselves, although inevitably this screening system would fail to identify those children who reveal their distur-

bance only in the homes. Children with organic cerebral disorders or psychoses were also excluded.

Table 1 shows the various screening tests applied to over 1,100 junior and 3,300 senior school children who constituted the total population in the first year of the selected schools. This

TABLE 1

NEWCASTLE ACTION RESEARCH		
Screen Test Used		
Source of Information	Junior School	Senior School
From Peers	Sociometry	Sociometry
From Teacher	Teacher Scale (Rutter, 1967) Absenteeism	Teacher Scale (Rutter, 1967)
From Child	Reading Assessment	Junior Eysenck Personality Inventory (JEPI)

research was conducted in 12 schools and in addition children in a number of other schools were studied for control and comparison purposes. *Preventive* measures were applied to those junior school children aged seven to eight years who were considered, on the basis of these tests, to be 'at risk' for subsequent psychiatric disturbance, or for social or learning problems. Such children were those who (1) had high maladjustment ratings on a behaviour check list filled in by the teacher (Rutter, 1967); (ii) on sociometric assessment appeared to be isolated or rejected; (iii) were failing educationally as measured on the Young Group Reading Test; (iv) had frequent, unexplained, absences from school. *Intervention* was applied to those senior school children aged 11 to 12 years who had adverse ratings from their teachers, their classmates, and also on a self-rating scale — the Junior Eysenck Personality Inventory.

(2) Additional data

The baseline data provided by the screening techniques were supplemented by information obtained from interviewing the parents (family, social and child behaviour), direct observation by psychologists, completion of more detailed classroom behaviour checklists (by the teacher), and some group and individual psychological testing (Table 2). All the data amassed on each child was studied by a psychiatrist in order to produce a global clinical assessment of the type and severity of the disorder.

(3) Allocation to treatment or control groups

The children who had been selected according to the criteria outlined above were allocated by school class, at random, to various treatment or control groups. The use of untreated controls for better evaluation of treatment effects may be justified where resources are inadequate to meet the very basic needs of the community, when it is ethical to allocate randomly rather than to allow systematic selection bias to determine which children are helped. Controls are certainly justified where there are doubts about treatment effectiveness; in fact it is from such controlled studies that we obtain evidence not only of ineffectiveness but also of the possible adverse effects of certain forms of psychotherapy (California Youth Authority, 1970).

There were two types of controls; first, control classes in the schools in which treatment programmes were being undertaken and, second, controls in schools where no treatment was being

TABLE 2

NEWCASTLE ACTION RESEARCH		
Additional Assessments		
Source of Information	JUNIOR	SENIOR
CHILD	Reading and Vocabulary Verbal/Non Verbal IQ	— An Ability Test School Attitudes Questionnaire
TEACHER	Classroom Behaviour Scale	Classroom Behaviour Scale
PARENT	Social Data Parent Attitudes Child Behaviour and Temperament	Social Data Parent Attitudes Child Behaviour and Temperament
CLINICAL STAFF	GLOBAL ASSESSMENT	GLOBAL ASSESSMENT

given. Within certain practical constraints we have tried to ensure that the schools used were reasonably representative of the state-run schools in the cities of Newcastle and Gateshead. These cities are fairly typical of the large industrialised conurbations in the north of England with their attendant economic and social problems. Indeed this area has traditionally been associated with severe economic problems, and the authors believe this is one of the major reasons for the relatively small scale influx of immigrants.

(c) TYPES OF TREATMENT

A variety of treatments has been introduced over the last 10 years, and can be classified as *direct* or *indirect* therapies (Robins, 1973). Direct therapies are implemented by experts in mental health, examples being group therapy or counselling. This type of approach has, in a few studies, rather surprisingly led to significant scholastic gains (Mezzano, 1968; Baymur and Patterson, 1960) and to improving the popularity of unpopular children, which is what might be expected (Hansen *et al.*, 1969). Other examples of direct therapy are play therapy (Axline, 1955; Shiffer, 1969) and conjoint family therapy (Beels and Ferber, 1969; Minuchin, 1974). In indirect therapies the mental health expert intervenes indirectly by consulting with other, more plentiful, professionals, who in turn work directly with the child. Alternatively, the expert may help parents to work therapeutically with their own children.

Finally the so called educational therapies merit comment. Children with educational problems frequently have overlapping problems both at home and at school, consisting of psychiatric disorder, minor physical problems (some of which can be included under the heading of minimal cerebral dysfunction), visuomotor difficulties, anti-social behaviour and 'deprivation'. Robins (1973) points out that in such circumstances educational therapies make sense, whether the educational problems are seen as primary or secondary to the above handicaps.

In the Newcastle project, four forms of treatment are being

evaluated: parent counselling in both senior and junior schools, combined with teacher consultation; group counselling of children in both senior and junior schools; nurture work with junior children; and behaviour modification with senior school children. Table 3 shows the numbers of children in each treatment and control group.

TABLE 3

NEWCASTLE ACTION RESEARCH				
Basic Design				
JUNIOR SCHOOL	Parent Counselling n = 69	Group Therapy n = 74	Nurture Work n = 60	At Risk Control n = 67
SENIOR SCHOOL	Parent Counselling n = 83	Group Therapy n = 73	Behaviour Modification n = 74	Maladjusted Control n = 92

(1) Parent counselling and teacher consultation

This combined social work intervention with the parents, and consultation with the teachers, of identified children. For one academic year, six trained social workers each were based for two days a week in both a junior and a senior school. Whilst the social workers were based in the schools they received back-up support in the form of regular consultations with a psychiatric team, which included a lecturer in social work and two consultant psychiatrists. This arrangement meant that the social workers were able to offer a service which whilst different in emphasis was as sophisticated as that offered in many child guidance centres.

First, they discussed with teachers methods to improve the school environment to help individual children. Any policy regarding a particular child would be the outcome of the interaction of the different but complementary skills of the teacher and social worker. A course of action might involve a different child-handling approach, a short period during which academic work was relaxed, or specialized extra-curricular activities (Harvey *et al* 1976). There was much to gain simply from the additional details the social worker was able to glean from her family visits. This assisted teacher awareness in even the shortest of teacher-pupil interactions.

Second, the social workers had the delicate task of linking home and school. Occasionally, this consisted initially of carrying the teacher's ideas to the parents, and helping to reduce any mutual distrust and prejudice. In these instances it was important to convey the feeling that each party was 'pulling in the same direction'.

Finally, the social workers devoted up to 10 sessions with the families in an attempt to concentrate on specific problem areas which might have been affecting the child's behaviour.

(2) Group counselling of children

This work was also undertaken by the six social workers after an introductory training programme. Small groups of four or five children were withdrawn for one lesson period a week, for a counselling session. Each group had 10 sessions during a single school term. During the session the children were invited to talk freely about whatever they chose, in a confidential atmosphere. The task of the therapist was to try to understand the way that the children related to each other and, by reflecting this understanding in a non-judgemental way, to help the children to know and understand themselves better. For the junior school children, toys were used to stimulate interaction, and group discussion was employed for the secondary school children (Nicol and Bell, 1975).

(3) Nurture work

The main objective of this approach is to provide, in ordinary school classrooms, compensatory nurturing for disturbed, disadvantaged and deprived younger children (Hulbert *et al.*, 1976). The concept of compensation is a familiar one to teachers and is similar to that underlying the enrichment programmes characteristic of the Head Start Programme in the USA.

In Newcastle we were more concerned — although not exclusively — with the emotional and behavioural aspects of the child's life, rather than with academic progress. The essence of a nurturing approach is to provide the type of interaction characteristic of a healthy mother-child relationship, which includes warmth, interest, acceptance, together with an ability to be firm when necessary. In our project this approach was directed at those selected children who demanded a disproportionate amount of the teacher's time.

Our scheme, which we have designated a 'Teacher aide programme in ordinary schools', involves a non-professional part time teacher aide working directly with the selected children, whilst under the supervision of the teacher. Initially the Rochester University group in the United States spearheaded the introduction of non-professional personnel into schools (Cowen and Zax, 1969; Cowen, 1971; Cowen *et al.*, 1971; Cowen *et al.*, 1971; Cowen, 1973). In the UK the nurturing component of this scheme was developed in the ILEA Woodberry Down Child Guidance Clinic (Boxall, 1973).

The role of the traditional classroom aide/auxiliary in British schools has been perceived mainly as that of a domestic helper. More recently, recommendations from the Plowden Report (1967) and the Scottish Education Department (Duthie, 1970) suggest the need for a classroom aide with a much wider role than previously envisaged. In the Newcastle scheme, the teacher aide has been involved more fully with the direct management and care of children, in addition to the usual domestic duties. As well as the strong nurturing emphasis, the aides were trained to use child handling techniques to promote in the child a greater ability to accept personal behaviour limits and to facilitate greater consistency in child handling. However, behavioural shaping did not predominate in the programme.

The aides were carefully selected and, though given some training, they were encouraged to retain their natural style of relating to the children (Hulbert *et al.*, 1976). Regular consultations between teachers, teacher aides, and mental health professionals, were the basis for the implementation of treatment objectives which were tailored to individual children.

(4) Behaviour modification

Behaviour modification techniques have now been used with conspicuous success with diverse populations, such as the mentally retarded (Staats, 1970), delinquents (Krasner, 1969; Phillips *et al.*, 1971), autistic children (Lovaas *et al.*, 1973), and emotionally disturbed children (Becker *et al.*, 1967; O'Leary, 1969) in a variety of settings, ranging from institutions to the

ordinary school and home. One of the most significant features of this approach is that it lends itself both to direct and indirect application. The techniques can readily be taught to, and applied by, para-professionals (Kolvin and Macmillan, 1976). The research emphasis in this area is now on crucial questions such as, first, whether or not changed behaviour can be maintained after the end of treatment; second, whether or not change in one class of behaviour generalises to others; and third, whether or not there is generalisation from one environment to another.

In the Newcastle project, behaviour modification treatment was designed and organised by a psychologist for implementation by teachers (Macmillan *et al.*, 1976). Teachers were trained by means of a carefully drafted document, supplemented by a series of seminars; the training was continued in the consultation process that was a continuous feature of the regime. Individual behavioural prescriptions were prepared for each child on the basis of the assessment data already described, from direct observational data for child and teacher, and from discussions with the teachers involved. The major emphasis was on techniques of social reinforcement. These comprised, for example, systematic use of teacher attention and approval in relation to specific types of appropriate behaviour, and ignoring or withdrawing attention from, inappropriate and undesirable behaviour. Concrete rewards were employed with a limited number of children.

(d) TRAINING

For each treatment regime the senior research staff, who comprised mainly the authors of this paper, organised training programmes for therapists and other personnel involved. Detailed training documents were also drawn up, where necessary.

(e) EVALUATION OF EFFECTS OF TREATMENT

A series of follow-up assessments is being undertaken at specified intervals, which included the end of the treatment and two further assessments, the final one being three years after the research had first begun. As well as the objective assessments shown in Tables 1 and 2, some more subjective views of improvement and change will be gathered from involved personnel. We have planned the intervals so that the time between assessments is brief enough to tap any change that occurs and yet, we hope, long enough to allow changes to occur. Because the different initial levels of severity of psychological disorder between the groups will have to be taken into account, the overall design and data analysis will be complex.

At this point we should perhaps consider what we mean by a cure. Most concepts of child disturbance incorporate what has been described as a breakdown in the wider systems of child, family, neighbourhood, school and community (Hobbs, 1966). Rather than attempt to cure, perhaps we should try to adjust and balance the demands that each component in the system makes of other components. Indeed, there are other normal socialising agencies in our society and hence mental health agencies should not be expected to take over these responsibilities indefinitely. This is relevant to our research, as our basic philosophy was to help one such socialising agency — the school — to cope more autonomously with disturbed child behaviour. A previously held optimistic hope was that if childhood disorders could be cured subsequent child and adult disorders could be prevented — or minimised. A more realistic therapeutic philosophy is to 'cure sometimes, relieve often, comfort always' (Garside *et al.*, 1973). However, even such concepts can make little contribution to progress unless supported by sound principles of evaluation.

We hope that this very simplified version of the total research strategy will not be misleading to the reader. A fuller account of how we dealt with theoretical and technical problems of classification, definition and measurement, and details of treatment, will be available in due course. Some aspects of these are already appearing in the literature (Garside *et al.*, 1973; Harvey *et al.*, 1975; Hulbert *et al.*, 1976; Kolvin *et al.*, 1975; Nicol and Bell, 1975) and we estimate the final report will be available in 1978.

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