# ACTION RESEARCH IN CHILD PSYCHIATRY

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## Introduction

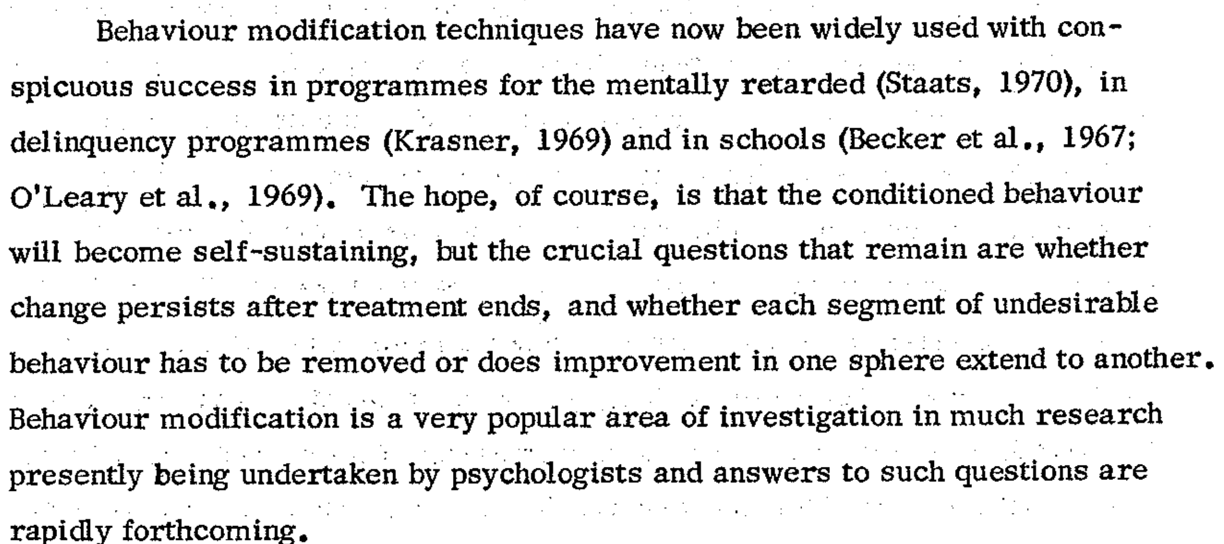
There is a vast pool of psychiatric disorder in the school community which methods of treatment and presently available resources can hardly hope to touch. Prevalence of psychiatric disorder in school children runs at about 6 to 18 per cent (Garside et al., 1973). Research Workers from the Isle of Wight Study (Rutter et al., 1970) estimate that about one third of the cases probably need treatment, one third possibly need treatment and the other third require guidance and advice only. Unfortunately, the facilities in the community at best can only cope with about one in ten to one in twenty of these. Similarly in the U.S.A., Eli Bower (1971) estimates that only about 2 per cent of the most seriously disturbed children are receiving help. Furthermore, the waiting lists are long and so there is the danger of developing ivory towers which can only serve a small proportion of the seriously psychiatrically ill child population and an even smaller proportion of the next level of severity.

Another central issue is whether the techniques which are currently in use are actually effective. This subject has now been tackled by various reviewers (Eisenberg, 1969; Levitt, 1971; Robins, 1970 and 1973). Traditional one to one psychotherapy has not come out particularly well. Levitt claims treated patients and untreated controls improve at the same rate, but this is a questionable conclusion as it is based on work where more acute cases come into therapy compared to the less acute cases which gravitate to waiting lists. However, Eisenberg's verdict of 'not proven' does not inspire confidence. The most quoted study is that of Shepherd, Oppenheim and Mitchell (1971) who compared fifty emotionally disordered, non-delinquent, non-psychotic children with an untreated control group matched for type and severity of disorder. Two thirds of each group improved markedly. The inference is obvious: treatment appears to make little difference to outcome. However, this negative conclusion is questioned by Rutter (1970) on three main counts: that the research assesses therapy of an unknown type and quality on a group of disorders of largely unknown diagnosis; that the groups were ill-matched as to severity of disorder; and that the follow-up period was too long to assess the effects of treatment on conditions with a high spontaneous improvement rate.

All such reviews and studies have led to an uneasy suspicion (Garside et al., 1973) 'that child psychiatric treatment with its cumbersome team, blanket-type approach with its aura of mystique has become a sacred cow'. Such criticism reaches its extreme form in Rehin's (1972) theoretical destructive attack on the child guidance approach. More recent work (Kolvin et al., 1974) attempts to meet and answer some of the questions posed about traditional child psychiatry and child guidance.

In the last ten years, the picture has changed in that there is now a diversity of new treatments (Robins, 1973). Robins addresses herself to the question of whether they work and, if so, for which disorders they are effective. Group therapy has led in some studies to significant scholastic gains (Mezzano, 1968; Baymur and Patterson, 1960), and to improving the popularity of unpopular children (Hansen et al., 1969). However, none of the studies tells us about cures, and in some there are even certain adverse sequelae (California Youth Authority, 1970).

Some therapies can be grouped together as 'indirect', as here the psychiatrist consults with other more plentiful professionals or trains parents to work as therapists with their own children. This has an obvious economic, but also philosophical, basis as it no longer regards child behaviour as only stemming from adverse maternal handling. Such theories have not as yet been adequately explored and evaluated, but the studies so far undertaken indicate variable outcomes from fair (Eisenberg, 1958) right through to poor (Schiff, 1970). They were more likely to fail when the therapist used a permissive approach, and to succeed when parents were taught specific techniques for addressing, encouraging and controlling children.



Behaviour modification techniques have now been widely used with conspicuous success in programmes for the mentally retarded (Staats, 1970), in delinquency programmes (Krasner, 1969) and in schools (Becker et al., 1967; O'Leary et al., 1969). The hope, of course, is that the conditioned behaviour will become self-sustaining, but the crucial questions that remain are whether change persists after treatment ends, and whether each segment of undesirable behaviour has to be removed or does improvement in one sphere extend to another. Behaviour modification is a very popular area of investigation in much research presently being undertaken by psychologists and answers to such questions are rapidly forthcoming.

The last major group that merits comment are the so-called educational

therapies. 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. Robins sees such techniques, which are based on traditional educational or behaviour modification techniques, 'educational methods more precisely defined and more self-consciously related to learning theory', as constituting a major movement in child psychiatry in the U.S. at the present time.

The next issue is how the community views the situation. Judging from reports in the U.S.A., there is an ever-increasing disenchantment with the classical child guidance approach as the single approach to treatment. Long et al. (1971) argue that, as 98 per cent of emotionally disturbed children in the U.S.A. remain in ordinary schools, the primary support should be the class teacher. They assert that the use of an individual therapist has led both to poor communication between the therapist and the teacher and to the teacher's role becoming devalued and relegated to a passive one where her insights and concerns are not considered.

This brings us to considering alternative ways of tackling maladjustment.

## The Aim of the Newcastle Action Research

The aim of our project is to explore both the prevention and the treatment of maladjustment in children in ordinary schools. The modus operandi is to re-deploy specialists to function within the educational system, with the emphasis being changed from treating individual children to helping teachers help themselves to help their pupils, and/or using these specialists within the school system so that help is available to many psychiatrically ill children rather than to a few.

The research will focus on two forms of action, i.e. whether certain preventive measures at younger age ranges and certain interventive measures at older age ranges are respectively effective in preventing or modifying the cause of existing disturbed behaviour.

a) Hypotheses

We have advanced three main null hypotheses which we will test:

i) All innovated treatment programmes (types of treatment) will be equally effective in relation to psychiatric disorder in children, and also in relation to the two main types of disorder, namely neurotic disorder and anti-social disorder.

ii) When children are rated along various dimensions of maladjustment, there will be no interaction between these and the effects of different treatments.

iii) There will be no interaction between the different categories of maladjustment (i.e. neurotic and conduct) and the effects of the different treatment regimes.

b) Method

We have changed our frame of reference from the psychiatric clinic to the schools in the community (Bower, 1971) and we have directed our attention to the non-organic, non-psychotic group of disorders. As the frame of reference of the therapy is to be the school, it appeared sensible to try to gather all our screen information about the children from the school - from the teachers, the children and their peers.

Preventive measures were or are being applied in the case of younger children (7-8 years) who are 'at risk' for later psychiatric disturbanc. The criteria for being at risk were operationally defined as (i) having high maladjustment ratings on behaviour check lists; (ii) rated by peers as being unpopular or being rejected; (iii) failing educationally; (iv) showing frequent school absences. Intervention has been applied to the older 'maladjusted' children (11-12 years) who had high or adverse ratings on (i) teachers' scales; (ii) sociometric instruments; and (iii) self-rating instruments.

The children selected as being at risk or maladjusted were allocated at random to various 'treatment' regimes. We will evaluate the effects of these therapies by comparing the treated groups of children with a control group who have not had the benefit of help. The use of untreated controls is only justified where resources are inadequate to meet the needs of the community, when it is ethical to allocate randomly rather than allow systematic selection bias to determine which children get help. Severely disturbed children who were referred will continue to be referred, as usual, to appropriate centres.

The concept of the use of the school as a frame of reference merits further description. Firstly, as already described, it appeared sensible (Bower

and Lambert, 1971) to try to gather all our information about the children from the school - from teachers, peers and from the children themselves. Secondly, we would innovate treatment programmes in the schools and evaluate them. This help in the schools would constitute a supplementary service rather than an alternative service to the existing child guidance and psychiatric clinics.

We have tried to ensure that the schools we are using are reasonably representative of the cities of Newcastle and Gateshead. There were some constraints which space precludes discussing. The children were then randomly allocated by class within schools to the treatment regimes, including the control groups. There were two types of controls - firstly, control classes which were located in the schools in which treatment programmes were being undertaken, and, secondly, controls in schools where no treatment was being given.

c) Types of Treatment

The following are the themes which have been implemented:

1. Direct Therapies These are therapies which are undertaken by non-teacher professional staff either with the child or the parents or both.

a) Group Therapy of Children This will be undertaken by social workers.

b) Social Work This is only partly a direct therapy, as it consists of a combination of case work with the parents and consultation with the teacher. The social worker would be school-based but receive back-up support in terms of regular consultation within a team which contains a lecturer in applied social work and consultant child psychiatrists.

2. Indirect Therapies These are therapies which are mediated through third parties and in essence consist of variations of behaviour modification techniques.

a) Nurture Work This was developed in the I.L.E.A. Woodbury Down Child Guidance Service (Boxall, 1973). Here underprivileged children are provided with compensatory stimulation in terms of domestic and material care which, it is thought, are not being provided in their home environments. For the purposes of this study, this has been reconceptualised as a kind, tender, loving care, combined with operant conditioning training, so that the child, while receiving enriching material, social and educational stimulation, is simultaneously trained to accept personal behaviour limits. For this purpose, teachers' aides have been employed to supplement teacher activities.

b) Behaviour Modification This consists of using positive reinforcement (social or tangible rewards) and, hopefully, seldom or never using negative reinforcers (punishment or deprivation of privileges) for building in desirable responses and eliminating undesirable behaviour. This treatment will be organised by psychologists and implemented by teachers.

3. Educational Regimes This will consist of remedial teaching undertaken by supernumerary teachers and given to those maladjusted children who are educationally retarded.

## Additional Data

Additional data will be obtained on some of the selected children. It will derive from direct interviewing of parents (family, social and child behaviour data), direct observation techniques by psychologists, completion of more detailed classroom behaviour inventories (by the teacher) and some group psychological testing.

## Evaluation of Effects of Treatment

A series of follow-up tests will be undertaken at specified intervals. Some of the assessments will be more subjective and others more objective (uncontaminated by fore-knowledge of the child). We have planned the intervals so that the time between assessments is brief enough to tap the change that occurs and yet, hopefully, long enough to allow changes to occur. The different initial levels of severity between the groups will have to be taken into account.

## Final Commentary

This paper constitutes an oversimplified version of the total research strategy. There is the possibility that such condensations can be misleading for the reader, as inevitably they give rise to minor distortions and hence to misinterpretations of detail. However, we feel this paper, in broad outline, gives an accurate account of our research. A fuller account of theoretical and technical problems and solutions about classification, definition, measurement and details of treatment, etc. will be available later.

## Acknowledgements

Finally, while the aims, initial design and strategy which we have described here were conceived and developed by the above named authors, a number of

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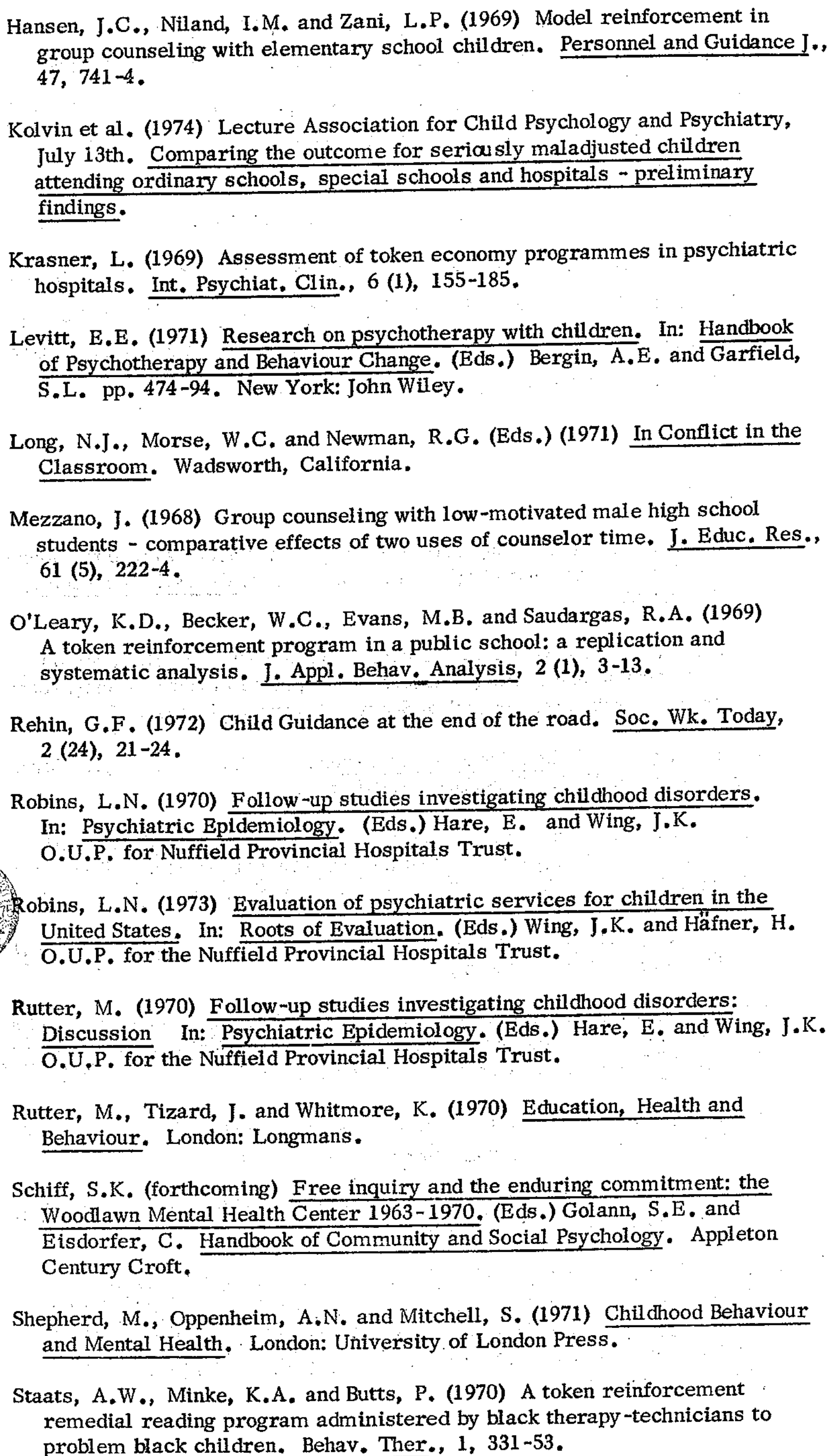

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