

# A RESEARCH EVALUATION OF AN ACTION APPROACH TO SCHOOL MENTAL HEALTH

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## 3. THE SCHOOL MENTAL HEALTH PROGRAM

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WHILE there exists a common core of principle that identifies our approach to school mental health, it is also true that no two such programs are ever exact replicas of one another. At the initiation of any program there is a predictable period of time during which we try to assess the kind, quality, and intensity of the mental health problems the school is confronted with; but once we are satisfied with our preliminary "diagnosis," we design a sequence of "treatment" which, more often than not, is a solution unique to the particular system. Such variety eliminates the possibility that a collection of anecdotes would do justice to the aims and goals that guide us in our work; hence I will plan to keep focused on general principles, and hope that the flavor of our activity will not be lost in the process.

A broad philosophy, which we call the Clinical Management of Education, has evolved slowly for us since the days when we became acutely aware that mental health talks to teachers were more entertaining than enlightening. Our search for a more effectual means of getting clinical skills into the repertoire of persons who work in educational settings with children soon began to resemble a frantic attempt to plug a very leaky dike. In addition to direct work with school systems on a consultation basis, we have attempted to expand our program and diversify it by presenting weekly workshops and seminars for teachers who can come to our campus in the evening when they finish work. These are credit courses that deal exclusively with their classroom problems. Using the University Laboratory School as an experimental and working model of what we believe ought to be the role of mental health workers in educational settings, we try, in other seminars, to teach the principles we feel are important to the clinical management of children in the school setting. Under the continued sponsorship of the Michigan Society for Mental Health we also conduct problem-solving sessions, on a regular basis, for working school psychologists in and around the Metropolitan area of Detroit. Finally, each summer at the University of Michigan Fresh Air Camp we spend two months operating an intensive program of clinical training for social workers, clinical psychologists, psychiatric nurses, and special education teachers. They number about 60 trainees in all and we try in this setting to conduct teaching, training and

supervision in the clinical management of children in an internship-apprenticeship arrangement. These internships are supported financially by a five-year grant from the United States Public Health Service, and they draw students from graduate programs in universities of a number of states.

All this activity we have engaged in issues, we feel, directly from what we call a philosophy of the Clinical Management of Education. An *idea* about the clinical management of education might be more appropriate; a "philosophy" is presumptuous. If we called it a clinical orientation to children or if we called it clinical training for teachers, the general notion would still be the same. It is a set of beliefs that implies that the principles of mental health have as much application to the average child in the classroom as they do to the exceptional child. It includes the assumption that the principles which define the way in which mental health workers relate to and deal with children require a great deal of translation if others are to use them without long and arduous training; that these are teachable principles even if a lecture is not an adequate technique for teaching them. It is an approach that puts a great deal of emphasis on the relationship each teacher has with each pupil as well as on the relationship she has to the group as a group. If we could really put our ideas to work as we would like to, their purpose would be to help everyone connected with education to understand the individual child, and not just children in general, so that educational decisions would allow the maximum learning and development of each child. Some current educational practices often rely on general rules that fit part of the pupils most of the time and most of the pupils part of the time. Those left over are the exceptions who not only disprove the rule but become our educational wreckage—those whose potential never gets achieved. While our aim is to change the teacher's role so that it encompasses the sort of understanding that characterizes a clinical approach to children, it does not redefine the teacher's job so that it becomes that of a classroom psychotherapist.

I must now cease describing a clinical orientation to the management of education in such general phrases, because these broad generalities are words that sound typical of campaign promises which promise a solution to all educational ills. This brief philosophical statement is enough time devoted to what things would be like if they were perfect. What is important is that we have found that we can accomplish a state of affairs that is something on a continuum between things as they are at their worst and utopia as it might be. Our continuing research program over the next two years is designed to measure where we will actually fall on this continuum. The specific kinds of things that we actually do in the school systems where this approach has been tried are more relevant at this point.

At any one time a variety of kinds of activity is taking place and the

kinds of approaches we use are limited only by our skills and the time we have available. At different times in a single school system we have had programs such as these:

*Executive development seminars for principals.* These are meetings focused on open discussions of the problems principals face in their relations with their teachers, the children, the parents, and each other. It is remarkable how little thought sometimes goes into delineating exactly what the role of this educational executive ought to be; it is even more startling to see the wild collection of role definitions which actually exist—often primarily by default. We have found that principals can be the gatekeepers of mental health in a school building. They can occupy key mental health roles which merge the needs of child, teacher, and community and they are responsible for setting the over-all tone of mental health in their school. The seminar is used to explore a new role for principals as vital contributors to the clinical management of education.

*Special services seminars.* A common delusion on the part of financially poverty-stricken school systems is that money and the ability to hire special service persons (school psychologists, visiting teachers, counselors, speech therapists, etc.) will be a solution to their mental health problems. We find, in rich systems, that money acts more like the discovery of gold in the Yukon. Special service people of all stripes converge on the system, stake out their claims, establish defenses against claim jumpers, acquire an overload of cases, cease to communicate with one another, and jealously guard the secret information in the gold mine of their files. Before serious inroads can be made into mental health problems in a school system, a device must be established to settle the jurisdictional disputes that always exist among the special services. Regular meetings to air the problems of jurisdiction and distribution of services and to encourage a redefinition of their mental health role in the schools have proved to be worth while in gaining maximum cooperation and efficiency among the various services. Without a truly functional team approach to the problems of mental health in the schools, the fragmentation by discipline and the inevitable overlap of effort soon produces gross inefficiency. Since the problems of mental health in the schools are too many and too great for any specialist to manage, a considerable part of the time spent in this special services seminar is devoted to discussion of the ways and means of converting teachers into willing members of the mental health team. Teachers in the classroom represent an almost totally unused resource and they almost always are seen as clients rather than colleagues in the mental health effort. Teachers have a limited clinical background and experience but they are persons who are highly trainable and eager to participate in resolving the problems of children.

*Direct work with teachers.* Although we work with the principals, the special

services persons, and, for that matter, with all the lines of forces that converge on the classroom relationship, our primary goal as mental health consultants is to reach the front lines where the day-by-day action is going on. We have found that consultation with teachers about classroom problems is not at all difficult to arrange; the problem, regularly, has been to hold back the flood of requests just long enough to choose the most strategic or productive problems with which to make a beginning.

The initial contact with teachers usually takes place in a lecture-and-discussion presentation which serves as a get-acquainted device. Starting with the topic of discipline in the classroom, for example, we outline something of the way in which we work and the philosophy we hold of teachers as mental health workers. We then help with the formation of groups interested in attacking various problems. Thus, typically, the sixth- and seventh-grade teachers might band together to study the problems peculiar to the transition from elementary to junior high school. After a few group meetings devoted to an analysis of the nature of the problems teachers face, subgroups form such that one group may tackle the problem of the transition and its impact on children while another focuses on studying the psychological make-up of preadolescents. Taking a quite different direction, some teachers agree to meet one evening a week to discuss their personal problems as teachers while others explore the problem of parent-teacher-child relationships. Regularly, a number of teachers agree that their greatest need exists in understanding individual children who are currently disrupting their classroom and contributing greatly to the difficulty of their job. As mental health consultants, we meet with each of the groups acting as resource persons, yet we take active roles in the exploration of the chosen problems. Finally, we set aside a regular schedule of individual consultation with teachers. It is in this facet of our work that we feel we have the greatest and most direct impact on the classroom situation. The personal supervision of teachers as they explore the process of understanding and relating to individual children is done with an eye to making each of them an in-service student of psychology for whom the learning takes place in practice on everyday problems.

Let's look now at the general principles that have guided us in our work with the classroom teachers. We aim at a series of goals to be accomplished. We want teachers to:

- Be sensitive to the existence of individual and group psychological problems in the classroom.

- Not only diagnose the individual and group learning situation accurately but along more dimensions than teachers usually consider.

- Then be able to manage the social, emotional, and intellectual learning situation of the classroom in a fashion consonant with the principles of good mental health.

- Acquire the know-how and skill to design a program of action that will translate psy-

chological theories into workable plans designed to bring about the changes necessary to facilitate the learning process.

Finally, we aim at having this experience of problem solving furnish insight that will generalize to other experiences and problems that will occur in the future. The teacher ought to be able to tackle the next and different problem without even being aware that she is using a recently acquired skill.

These aims and their accomplishment rest heavily on our fundamental belief in the ability of teachers. We start by trying to capitalize on their assets and we have been pleasantly rewarded by the amount of profitably refinable clinical creativity we have discovered over and over in our work with teachers. Starting with the knowledge that teachers actually can do a great deal more and are much more sensitive than most professionals give them credit for, there are general principles in the steps we take.

1. *We try to define the relationship we have to the teacher.* We make it clear that we are going to tackle the problem together, and in the process of solving the problem, learn something about how to go about solving problems of all sorts in the classroom. One of the difficulties of being labeled a specialist or being seen as an expert is that it encourages a passivity in others and a belief that if they present the problem clearly you will be able easily to solve it from the depths of your innate wisdom. There are other relationship-with-expert problems that must be met. The need for immediate solutions, the fear of criticism for being less knowledgeable than the expert, the inability to tolerate expert mistakes or ignorance are hazards that must be overcome. So we have been much concerned with assessing what it is that a teacher expects to get from a mental health consultant and in examining how her satisfaction fits with her perception of what he delivered.

2. *We probe for the teacher's problems and do a rough rank-ordering to find a beginning point.* This frequently takes some time. Teachers may know their problems but not assess which is the core problem that must be solved first. Most often, teachers are unaware of what the problem really is and they frequently do not know how much of the problem is of their own making. Almost always the problem turns out to be much more complicated than they first thought it to be—its roots run deep. Some problems are real but the solutions would take too long or would prove to be impossible for short-term work. The consultants' help in diagnosing the central problem is a vital step and one that regularly needs some confirmation from experimental work. Often, we arrange tests and experiments to ferret out the intensity and other dimensions of the problem. The exploration of the nature of the presenting problem regularly unearths many others and the teacher frequently drops one problem and begins work on another. If we continue with the original problem we must still diagnose it in all its dimensions, for it never remains as simple as it first appeared. This step amounts to a

diagnosis or analysis of the total situation—the child, the teacher, the setting, the milieu, the whole life space in which the problem is shaping up.

3. *We put psychological theory into practice by designing a plan that, at least, is a first step in an action program.* It seems vitally important to map out in detail something a teacher can do. General principles get vague and never are put into a workable form. This frequently amounts to a step-by-step outline of what to do the next time the problem comes up. Telling a teacher to be firm in the face of rebellion differs from translating this general statement into exact terms for her to rehearse and then try out. We labor over each step, its reasons, its probable effect, the step that ought to follow next, and how to bail out of a situation when it starts to deteriorate. We encourage invention and experimentation with new and unique methods of solving problems. Most of the teacher's previous experience with tests and measures on which to base a design for change has been mechanical and robotlike. Teachers have been taught devices which they barely understand, which they apply automatically and interpret blindly in a meaningless fashion. It is tragic to see a teacher making decisions based on tests that remain a mystery to her and the limits of which she barely comprehends. We want these designs to be her own invention or modification of traditional methods so that the mystery goes out of the techniques.

4. *Finally, we establish a routine expectation that there will be a follow-up and evaluation of the action program the teacher undertakes, and plan that this evaluation will serve as the basis for revision and adaptation of the plan.* This is a vitally important aspect of our method. All too frequently our society initiates changes in method, technique, or goal and then fails to get anything more substantial than testimonial evidence to determine if its continuation is worth while. Teachers, too, make new arrangements in education and never check to see if they brought about any significant change. We all know that something, once begun, is notoriously hard to stop or alter. Tradition slowly strangles initiative and inertia takes over. The fact that everybody thinks it is a good idea means, usually, that no one is interested enough to stop it. We try to teach the importance of knowing the validity of changes in order to slow down the inevitable swing of the pendulum from one philosophy to another and one technique to another.

This description of the variety of means we have used to work on the problems of mental health in the school tells something about the general philosophy of our efforts. It is apparent that the mental health consultant who goes into the school system is many things.

He is a person who stimulates the system to act, to study, and diagnose its problems, and bring them to the surface of awareness.

He is a resource person bearing mental health lore and the clinical point of view about the nature of children.

He is a teacher-trainer-supervisor who sees to the learning and application of clinical skills and techniques on both a group and individual basis.

He is, then, a working philosopher of mental health who tries by every means to sell a clinical orientation to the education of children. He teaches, he preaches, he demonstrates, and he uses all of his clinical skills actively to bring about a change in the fundamental relationship of teachers, parents, pupils, and education.

Over the years, it has become increasingly apparent (since we have made it a point to work together closely as a team) that there are a great many individual differences in the way in which this role of mental health consultant can be filled. There are some characteristic differences in emphasis which we can trace back to the discipline in which the consultant was trained. There are varying levels of skill and ability at this task, just as, for example, individuals will tend to show greater or lesser ability to give up the traditional role of an expert who makes pronouncements which are supposed to solve difficult situations. The most difficult part of the entire task turns out to be translating the clinical point of view into concrete, step-by-step plans of action for the teacher. While members of the team could always agree on abstract general principles, we did not always see eye to eye about the diagnosis and proper remedy of each specific problem. Probably the important observation here is that there is more than one way to skin the clinical cat and that disagreements among consultants about the proper clinical orientation to educational problems are of little importance to the teacher. Having someone spend time with her on her problems as a teacher, the fact that someone feels confident that something can be done to help her and teach her to solve her own problems in the future—these facts tend to make the teacher uncritical of the fine points about which professionals might agree or disagree.

In working together, we came to agree, finally, that if we could teach teachers to be alert to the existence of psychological problems, to respond to child behavior in terms of its depth as well as surface aspects, and to develop some confidence in their own ability to meet and solve these educational problems, then we would have imparted to them the best of the clinical point of view and we would have provided a base on which greater understanding of the child could develop. We believe that the greatest strength to be found in the dynamic psychological points of view about children lies in its use as a framework for making sense of and organizing and understanding the mass of otherwise unrelated fragments of observation and experience that every teacher tends to accumulate.