DOCUMENT RESUME

ED 084 330 UD 013 913

AUTHOR Wayne, Martin S.
TITLE New Mental Health Approaches to the School Failure (a Therapeutic-Educational Center for a Disadvantaged Population).
PUB DATE 31 May 73
NOTE 19p.; Paper presented at the American Orthopsychiatric Association annual meeting, w York, N.Y., May 31, 1973

EDRS PRICE MF-$0.65 HC-$3.29
DESCRIPTORS *Academic Failure; Counseling Programs; Disadvantaged Youth; Economically Disadvantaged; Educational Diagnosis; *Experimental Schools; *Junior High School Students; Low Achievers; *Mental Health; Negro Students; Program Evaluation; Psychiatric Services; Socially Disadvantaged; Spanish Speaking
IDENTIFIERS *New York; Yonkers

ABSTRACT

This is a report on one attempt to provide an educational setting designed to incorporate some psychiatric treatment modalities as a way of reaching disadvantaged school failures, called the Onna Maloney Center. The report focuses on the structure of the center and the results of the first school year. The center ran for two school years; unfortunately, following the trend elsewhere in the country, it did not re-open in September of 1972 due to drastic budget cuts. The staff consisted of one psychiatrist working half time; a full time social worker administrator; a psychologist half time; a remedial reading teacher half time; a full time case aide; a secretary and cook. Two teachers were supplied by the Board of Education, and during the second year a full time group worker joined the staff. A research psychologist acted as consultant to the staff in developing instruments to try and determine the program's effectiveness by evaluating change in the children. Our goal was to help school failures to reach a point of maturity and educational ability which would enable them to return to the regular school system and benefit from it. Small class size was essential. The school day ran the length of a regular school day and used the regular school calendar. The children accepted represented the population of the community of Yonkers, New York, proportionately. (Author/JM)

50th Annual Meeting
May 29-June 1, 1973

American Orthopsychiatric Association, New York, N.Y.

AUTHOR: Martin S. Wayne, M.D.
Instructor in Psychiatry
New York Medical College

TITLE OF PAPER: NEW MENTAL HEALTH APPROACHES TO THE SCHOOL FAILURE (A Therapeutic-Educational Center for a Disadvantaged Population)

PRESENTATION: Thursday, May 31, 1973
2-5 P.M., New York Hilton

ADDRESS OF AUTHOR: 17 N. Broadway
Tarrytown, N.Y. 10591

SUMMARY: Our schools are irrelevant to the lives of our children, especially the disadvantaged. New approaches are desperately needed. A therapeutic educational center in Yonkers, New York, that accepted junior high school failures and offered a school experience that was intellectually and emotionally rewarding is described. Objective instruments for evaluation were used.

I. INTRODUCTION

The conclusion reached by a significant number of educators, school administrators and mental health professionals is that our schools are not reaching a majority of the students they are set up to teach. This is especially true for the socially and economically disadvantaged youth who feel the educational system is irrelevant to their lives. Added to this group, the economically privileged and intellectually average and superior children are turned off on education because they too fail to see a connection between what they are taught in school and their future roles in our society. There is a distinct need for re-evaluation of what and how we are teaching as well as for change in a bureaucratically stagnant school system.

This is a report on one attempt to provide an educational setting designed to incorporate some psychiatric treatment modalities as a way of reaching disadvantaged school failures, called the Onna Maloney Center. The report will focus on the structure of the center and the results of the first school year. (The center ran for 2 school years; unfortunately, following the trend elsewhere in the country, it did not re-open in September of 1972 due to drastic budget cuts.)

Yonkers, New York is the 3rd largest city in New York State, with New York City its immediate southern neighbor. A junior high school district within Yonkers was identified by the Westchester Community Mental Health Board as being a high risk area. It houses 28% of the city's total population yet accounts for 77.4% of the city's non-white population. Indices of poverty and hardship show that it has 70.37% of the city's substandard housing, 50.23% of the city's fires, and 34.58% of the major crimes in the city. The juvenile delinquency records account for 51.4%

of juvenile crimes in the city.

In 1970, the principal of the junior high school asked for help in providing a program for over 100 children in his school who were not benefitting from the school system as it was then organized. The children he identified were failing but not because of lack of ability. They were the truants and the disrupters in the classroom, many of whom had performed with potential in the past. They had not been classified as emotionally disturbed or retarded. Of the 100 children referred by the principal, 35 were more closely evaluated out of which only 14 were selected because of the small size of our staff. It was hoped that with a demonstration of success with the 14 we would be able to enlarge the center to service the larger population at a later date.

II. DEVELOPMENT OF CENTER - GOALS

A therapeutically oriented school program was organized with the combined financial support of the County Community Mental Health Board, Catholic Charities Guidance Institute (a non-profit social agency) and the Yonkers Board of Education. The staff consisted of one psychiatrist (myself) working half time; a full time social worker administrator; a psychologist ½ time; a remedial reading teacher ½ time; a full time case aide; a secretary and cook. Two teachers were supplied by the Board of Education, and during the second year a full time group worker joined the staff. A research psychologist acted as consultant to the staff in developing instruments to try and determine the program's effectiveness by evaluating change in the children. Finding no adequate model to follow, we planned an innovative program based on our psychiatric knowledge of adolescent behavior. We wanted to find out what interfered with learning

before attempting solutions. Our goal was to help these school failures to reach a point of maturity and educational ability which would enable them to return to the regular school system and benefit from it. Small class size was essential (6-8 children). Our school day ran the length of a regular school day and used the regular school calendar. The children we accepted represented the community population proportionately: about half the children were black and the other half included a small percentage of Spanish speaking children of both Puerto Rican and Cuban extraction, with the remainder Roman Catholic and Protestant whites. The staff was white, except for the full time case aide who was black.

A composite picture of a typical child follows: He or she comes from a poor family on welfare and medicaid, has been found to have an I.Q. within the average range, with a higher performance I.Q. than verbal, reading three to four grades below his school placement, with severe problems of truancy and cutting out of classes in school and some experience with the Probation Department. Using the APA classification, he has been diagnosed by our clinical evaluation as having one of the Behavior Disorders of Adolescence, although has not been previously identified by the school system as requiring psychiatric help. The family make-up is usually of a mother with a number of children in school, who may or may not be working. The father is more often not living at home, or is so busy with his work in a blue collar job that he does not have the time to involve himself with the school system or take an interest in his children's school and recreation. Invariably, the children come from homes where education does not play an important part in the lives of the parents. Although many of the parents are upwardly mobile and verbalize their wish for

children to obtain an education, they do not have the skills nor the experience to be of value to the children with their homework or in encouraging them to develop adequate study skills. Many of the students belong to social groups who encourage truancy and delinquency during school hours. The children are self-willed, independent, very distrustful of adults, resistive to being identified as having a difficulty that is different from their peers.

Our first task was to evaluate the children and try to determine the reasons they were failing, truant and disruptive. Thirty five children were evaluated using a psychiatric interview, a social history obtained from a parent, a full battery of psychological tests and a reading evaluation. Teachers and guidance counsellors were interviewed and each child was discussed in terms of specific learning deficits and relationships and behavior manifestations in the classroom. Neurological consultations were obtained when considered necessary.

At meetings in which the entire staff participated, each child was carefully considered and an individual profile developed of his academic assets and deficiencies. His emotional needs were included in the profile as we felt these had to be in any effort to understand and help the child. We found that the most significant attitude of these children towards school was one of dread. There was no "joy of learning" because there was no learning. School was a place where one experienced almost constant frustration and humiliation. School was a place where, for 6 years or so, one went daily and was taught over and over and over again the rudimentaries of reading, the letters, the sounds, the same way, by different adults called "teachers", sometimes as many as 3 or 4 in one year, some of them kindly, some not, but in the end making no difference. One never

learned to string all those letters and sounds together well enough to go much beyond, "Oh look, Dick, see Jane run!" The way to avoid these feelings was to go to school as little as possible and to keep on the move once you got there, and fighting openly for a sense of dignity.

It became clear that they needed to experience some measure of success in school where they had never felt successful before if there was to be any hope of their return to a regular classroom setting. This meant relating to them initially in an accepting manner, no simple task, especially for our non-psychiatric personnel. Members of our staff who were trained therapists constantly had to interpret and help those of the staff who had had no previous experience with acting out children or with therapy. In general, as a team, we tried to foster ego development by identifying positive qualities in the children and making them aware of their own abilities and assets. Frequent verbal stress was placed on this point.

Because we were working with a junior high school age group (from 12-15) which is activity oriented and peer related, the program was set up to take advantage of these factors by offering them varied and frequent group activities.

III. STRUCTURE OF CENTER

The center was located outside the regular school building and some distance from it. It had a modern attractive appearance in contrast to the institutional architecture of the junior high school. The atmosphere was one of a very lenient and giving home. The largest area within the center was a playroom with ping pong table, pool table and hi fi. It was decorated by the children and maintained by them.

A cheerfully decorated and well stocked kitchen was available, as was a coke machine. The children were offered lunch every afternoon and prepared their own snacks throughout the day, with few limitations. Jobs of responsibility were rewarded with a small salary dependent upon the completion of a weekly contract.

The daily schedule consisted of classes of six or seven children in the morning and group activities including outside trips in the afternoon. It was not possible to run a morning schedule in a rigid routine. Keeping some of the children even in a small class group all the time resulted in a battling teacher-child relationship which served no educational goal but aided the child in avoiding the learning process. We quickly discovered that immediate removal of the child from this situation was a better means of dealing with whatever problem precipitated the child's wish to leave the learning situation. In those instances where it was not a situation provoked by a teacher, it was handled as a resistance maneuver and was dealt with individually by the child's assigned therapist. One very withdrawn youngster required the complete attention of our social worker for most of her first school year before she would sit with other children in a class. Each child in the center had such a therapist. When it was the teacher who consciously or unconsciously antagonized the child, this became a matter for team and staff examination at later meetings.

One afternoon a week, the children were dismissed after lunch in order to allow the staff to meet and review the childrens progress and the staff reactions to the children. In order to make up the school time, the other school days ended one hour after dismissal of their former school.

A parents meeting was held every other week in order to maintain the cooperation and offer counselling in a group therapy setting. These were attended only by mothers. Group meetings with fathers were offered in the

evening but never materialized because of lack of response. Fathers were seen occasionally individually or in family groups in crisis situations.

Meetings with the guidance department of the referring school were held on alternate weeks in order to keep the school involved with the children and help plan for their re-entry. Some children returned to their original school gradually and suggestions for their management were offered.

As an illustration of how one child was effected by the center, S.B. will be described: S.B. was over 14 in September 1970 when she was admitted to the center. She was repeating the 7th grade because the year before she had been officially absent a total of 100 days out of 180 and had been tardy 23 times. Actually, she had attended less than that because of her skipping out of school after attending homeroom in the morning. She was a large, heavy black girl who sometimes went with the same group outside the school building but mainly was a loner. She was found to be depressed and withdrawn in her general adaptation. She lived with an alcoholic, unstable mother and an older brother who was addicted to heroin. Two younger sisters were in a foster home in a community nearby. Her father was alive but separated many years from the family and preoccupied with his new family and unavailable to her. Her mother was on welfare and supplemented her income, at times, with odd jobs, but when money was available it went into clothes for her mother. One of her wishes for herself was a new winter coat. She was diagnosed as having a Withdrawal Reaction of Adolescence, but in addition was clearly reacting to almost constant changes at home with acute short-lived depressions.

A WAIS done on admission revealed that she had a Verbal I.Q. of 77, a Performance I.Q. of 93 and a Full Scale of 83. A reading evaluation indicated that she was reading at the end of 4th grade level.

Our main approach was to offer her a sense of belonging. Although a large girl, she was attractive, but was completely unaware of her attractiveness. When comfortable, she had an infectious laugh and big broad smile. Every adult in the center appreciated her and experienced her as a delight, because her sense of humor frequently broke up many a tense atmosphere during frequent stressful days. Through her relationships with the staff she developed a realization of her worth, as her positive qualities were frequently pointed out to her both verbally and by the staff's non-verbal recognition of the important role she played.

Our total approach included counselling her mother in the parent's group and individually during the frequent crises at home. We also attempted to concentrate on individual remedial reading.

Her attendance at the center was perfect. She became a respected member of the center peer group and leadership qualities were encouraged. At the end of her 1st year she was firmly involved with the center and joined our summer camp program. Her acute depressions continued and they were found to be directly related to changes in her home situation.

As with most of our children, she did not respond to a scheduled individual remedial reading program, but instead, did make use of informal sessions of scrabble and other word games. A repeat reading evaluation done in December 1971 indicated that she was reading oral paragraphs at the 7.3 grade level, an increase from September 1970 when she was at the 5.6 level. Her spelling, vocabulary and comprehension were at a lower level and showed about ½ grade increase over the time period.

S.R. attended the center in 1971-72 school year and was returned to the school system jumping a grade to the 10th and was placed in a special career program starting September 1972.

IV. RESULTS

The research psychologist designed a battery of evaluation instruments in order to make an objective evaluation of change in the children. These included a WAIS, TAT, Figure Drawings and two standardized questionnaires. One questionnaire "The Behavior Rating Scale" was given to the teachers to complete and the other "Pupil's Perception of Hope, Prognosis and Self Concept" was given to the students. All five instruments were given at the beginning of the school year and repeated at the end.

A group of children who did not attend the center, but were from the same referred group as the center children, were used as controls. "The Behavior Rating Scale" was completed by their Principal also at the beginning and end of the school year.

(See Tables 1 to 6 for details of results of these instruments. Note that most of the results were on less than the 14 children who attended the first year. Of the 14 children who attended the program, two withdrew before they were retested, one left the school district and in some cases (up to three) they were unavailable for retesting.)

There were no statistically significant results in comparing the Behavior Rating Scale of the controls and our students; however there were favorable trends for our students in the data and unfavorable trends for the controls.

Significant differences were noted in the average increase in the performance I.Q.'s of 10.9 and an average increase in the full scale I.Q.'s of 8.0. These differences on the WAIS were statistically significant at the .01 level of significance. The average increase of the verbal I.Q.'s was 4.7 and this was significant at the .05 level of significance. Even considering the learning factor in retaking the WAIS ten months apart, the

differences were impressive and significant.

An evaluation of their TAT responses showed an increase of trust in the children's perception of adults and this was statistically significant at the .05 level.

The results of the Behavior Rating Scale by teachers gave statistically significant results in the behavioral characteristics of cooperation and emotional level. The group as a whole has shown movement away from a point where "they volunteered nothing" to a position of being seen as "conservatively cooperative". As far as emotional level goes, the group showed movement from a point where they were "easily aroused" to a position where "emotions are slowly aroused".

During the first school year, the center admitted 14 children. Of these, two children withdrew and one child left the school district. Two children graduated from junior high school and went on to the high school. Three children were returned to the parent school and three children were referred for residential treatment at the end of the school year, but subsequently returned to the parent school.

Attendance of all the children was remarkably excellent. Some of our children had attended much less than half the school days the year before. During the school year at the center, not only were they never absent but they refused to leave at the end of the school day and came to the center during school holidays when they knew some of the staff were there. Using the regular school criteria for passing, all passed and were promoted to their next grade.

Clinical evaluations of all the children who attended revealed emotional growth in all the children and an improvement in their relation-

ships to the staff and their peers. Problems remained but improvement was found in the self esteem of all the children.

The results of our 1st year of operation indicate that when an attempt is made to reach the disadvantaged school failures in terms of their individual needs, they can benefit from the school experience. Their needs, however, may not be those envisioned by educators in the past. The needs of our disadvantaged children were for an experience in success at school and contact with teachers and adults who were interested in them as individuals and had the time to give of themselves to the children. Perhaps these are large demands.

As the world changes, so must educational institutions. At the present time, our children are bored by the subjects they are asked to study. They are indifferent and repelled by the irrelevant demands of our schools. Time will run out for this nation if we ignore our children's needs because in the process we will sabotage our most precious national resource.

TABLE I

MEAN VERBAL, PERFORMANCE AND FULL SCALE WAIS I.Q. OF CHILDREN AT THE ONNA MALONEY CENTER. INCLUDED ARE T-TESTS OF THE DIFFE[illegible]CE BETWEEN OCTOBER 1970 AND JUNE 1971 RESULTS.

	OCTOBER, 1970		JUNE, 1971		
	df	MEAN	MEAN	DIFFERENCE	t
Verbal	8	86.9	91.6	4.7	2.86*
Performance	8	93.2	104.1	10.9	6.16**
Full Scale	8	89.1	97.1	8.0	5.18**

* Significant at .05 level of significance

** Significant at .01 level of significance

TABLE II

MEAN PSYCHOLOGIST GLOBAL RATINGS AND T-TESTS OF THE SIGNIFICANT CHANGE ON FOUR DIMENSIONS BASED UPON TAT RESPONSES.

DIMENSION		MEAN	t
Perception of Self	8	3.11	0.43
Perception of Peers	5	2.11	-1.78
Perception of Adults	8	3.44	2.53*
Perception of Family	8	2.89	-0.36

* Significant at .05 level of significance

Evaluation of the protocols indicates that for the group as a whole there was detectable improvement in their perceptions of adults.

TABLE III

MEAN PSYCHOLOGIST GLOBAL RATINGS AND T-TESTS OF SIGNIFICANT CHANGE ON THREE DIMENSIONS BASED UPON FIGURE DRAWING RESPONSES.

DIMENSIONS	N	MEAN	t
Perception of Self	8	3.33	0.89
General Coping	7	3.44	1.15
General Anxiety	7	2.89	-0.28

TABLE VI

FREQUENCY DISTRIBUTIONS, OCTOBER AND JUNE, ON STUDENTS PERCEPTIONS OF "HOPE, PROGNOSIS AND SELF CONCEPT"

ITEM		APPLIES TO SELF YES	NO
Sure of Self	October	7	5
	June	11	-
Worry To Much	October	6	5
	June	3	8
Can Make Up Mind	October	9	2
	June	8	2
Take Care of Self	October	12	-
	June	12	-
Pretty Happy	October	8	4
	June	10	2
Things Don't Bother	October	7	4
	June	5	6
Parents Understand Better	October	10	2
	June	8	4
Problems Never Straightened Out	October	3	8
	June	8	4
Able to Do The Work	October	10	2
	June	10	1

TABLE V

MEAN RATINGS IN OCTOBER AND JUNE AND T-TESTS OF THE SIGNIFICANCE OF THE DIFFERENCE ON NINE BEHAVIORAL CHARACTERISTICS BY TEACHER 2, N=9

CHARACTERISTIC	OCTOBER MEAN	JUNE MEAN	DIFFERENCE	t
Awareness	3.40	3.20	- .20	-1.00
Attention	3.80	3.60	- .20	- .20
Thinking	3.00	3.20	.20	1.00
Phys. Cooperation With Others	1.80	2.00	.20	1.00
Activity Level	2.40	2.40	0.	0.
Social Behavior	3.20	3.20	0.	0.
Persistence	2.60	3.20	- .60	1.00
Cooperation	3.00	2.40	- .60	- .74
Emotional Level	3.40	3.20	.20	-1.00

TABLE IV

MEAN RATINGS IN OCTOBER AND JUNE AND T-TESTS OF THE SIGNIFICANCE OF THE DIFFERENCE ON NINE BEHAVIORAL CHARACTERISTICS BY TEACHER 1, N=10

CHARACTERISTIC	OCTOBER MEAN	JUNE MEAN	DIFFERENCE	t
Awareness	2.60	2.40	- .20	-0.34
Attention	2.80	2.60	- .20	-0.39
Thinking	3.10	2.50	- .60	-1.20
Phys. Cooperation With Others	2.50	2.10	-0.40	-0.71
Activity Level	1.90	1.60	-0.30	-0.82
Social Behavior	2.80	3.00	-0.20	0.36
Persistence	2.20	1.80	-0.40	-0.77
Cooperation	2.90	1.90	-1.00	-2.02*
Emotional Level	3.00	2.10	-0.90	-2.08*

* SUGGESTIVE OF CHANGE AT THE .10 LEVEL OF SIGNIFICANCE.

Cooperation: The group as a whole has shown movement away from a point where "they volunteered nothing" to a position of being seen as "conservatively cooperative".

Emotional Level: The group as a whole has shown movement away from a point where they were "easily aroused", to a position where "emotions are slowly aroused".

TABLE VI CONTINUED

ITEM		APPLIES TO SELF YES	NO
Able To Keep Rules	October	7	5
	June	7	4
Able to Get Along With Kids	October	11	1
	June	12	-
Afraid Of Going Back To Regular Class	October	3	9
	June	1	10
Expect To Graduate	October	12	-
	June	11	-
Expect To Turn Out Like Everybody Else	October	10	1
	June	10	2
Will Have More Problems All Life	October	4	7
	June	2	10
Sorry For Things I Do	October	9	3
	June	7	5