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ABSTRACT

This paper describes a tutoring program in which a children's psychiatric clinic, a city university department of education and school personnel collaborated to provide additional services for underachieving elementary school children who were receiving psychotherapy. An additional aim of the program was to upgrade the quality of the training programs in psychiatry and teacher education. College students in a teacher education sequence did the tutoring under joint supervision of clinic staff, classroom teachers, and college faculty. In about half the cases, tutors worked with the child exclusively at his school, for 2 and 3 one-hour sessions a week; other tutors worked with the child in school and at home. Lectures on child development and small group clinical supervision sessions supplemented the tutors' training. Program strengths and weaknesses are reviewed. (BFT)

A PRELIMINARY REPORT ON COMMUNITY COLLABORATION: HOW IT ENHANCED TRAINING OF PROFESSIONALS AND PRE-PROFESSIONALS, INVOLVED PARENTS AND SCHOOLS, AND EXPANDED SERVICES FOR CHILDREN'S PSYCHO-EDUCATIONAL NEEDS.

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INTRODUCTION

The burgeoning demand for mental health services among increasingly diverse populations has outstripped the supply of professional resources leading to the use of non-professionals to help in rendering adequate care to the growing number of patients[4, 7, 9, 11] (Cowen et al., 1967; Guerney, 1969; Rappaport et al., 1971; Sobey, 1970). Each of these populations needs more and better services, but none more than the differing groups of children. While many children in the pre-school or latency age group are already seriously damaged psychologically and in need of therapeutic rehabilitation, in a vast number early intervention at a critical time could result in prevention of more serious problems.

It has long been recognized by educators, psychologists, psychiatrists, and pediatricians that a large group of children (estimates range from ten to forty percent) having average or above average intelligence fail to utilize their potential in school learning. These children have become a source of confusion and frustration to all concerned: their parents, their teachers, mental health personnel and most of all, the children themselves. They fail to learn despite seemingly adequate cognitive abilities, intact sensory abilities and exposure to educational opportunities. Often they are referred from one service or agency to another, in the prospect of finding a conventional category for special education that aptly pertains to them, where they can "fit" and receive help. Not surprisingly, many of these children finally end up in mental health clinics because their aberrant behaviors in school and/or at home often overshadow their learning difficulties and compel parents to seek the help that is indicated.

Barten and Barten[3] indicate that clinicians, particularly those without substantial experience, organized in the team approach of psychiatrist,

psychologist and social worker tend to proceed too "slowly, cautiously and thoroughly, obtaining mountains of information, and incorporating as much of their data as possible into highly complex, sophisticated, but unwieldly formulations." They suggest that this approach should give way to "a conceptualization of behavior patterns that permit more direct, focused, action-oriented interventions" (p. 2). While agreeing basically with the thrust of Barten and Barten's criticism that child psychiatry has generally remained tradition bound, it is our contention that much in the traditional approach is inherently sound but that variations are warranted. Our sentiment echoes that expressed some years ago by Redl[10]:

> There is no need at all for a new 'school of thought' in child therapy. But there invariably arises a need for modification of existing techniques of any given school of thought, so as to fit them to the changing range of child disturbances a given society produces at a given time and to changing life conditions and the changing social scene.

The treatment of disorders in children is difficult, and is often compounded by the need to differentiate first between a genuine pathological condition and a transient "growing-pain" state. Further, clinical syndromes for the stages or phases of child development are not nearly as clearly defined as they are for adults. The "catch-all" diagnostic classification, "Adjustment Reaction" often denotes little more than that the child is experiencing a painful emotional reaction to some event in his life history. A more differentiated approach is necessary. In many cases one must delve into the many facets and levels of the child's life space in order to understand his problem and intervene effectively. Thus the salutary contributions of the clinical team approach should not be sacrificed even though time consuming. In other cases such extensive investigation is unnecessary. In both instances "direct, focused, action-oriented intervention" may be rendered more effective by enlarging the team to include non-clinically

trained persons from the community who have the opportunity to exert direct and immediate influence on the troubled children referred to the clinic.

Kelleher[8] makes a cogent point in saying that "...one should not have to choose between explaining that a child has reading problems because of a psycho-dynamic equating of forbidden hostility with intellectual curiosity, or because of poor teaching methods in the first grade." Since there are elements of truth in both, he says that one might better ask,

> As this child comes to us today, what are all the different levels and perspectives of explanation that can be applied to his problem, and what course of action does each view or explanation suggest? Then, given these explanations and these potential action choices, and given the current resource potentials of the child, family and community, what are the most feasible and strategic points of attack on the problem? (p. 263)

If competition and blaming are to be avoided, and if the total needs of children with problems are to be met, then programs in education and mental health must attempt to integrate the efforts of professionals and interested non-professionals alike.

The purpose of this paper is to describe a program which has evolved over a three year period in which a children's psychiatric clinic, the department of education from the local city univeristy and school personnel collaborated with parents to give more comprehensive services to a group of children. While service to the children was the primary goal, upgrading the quality of the training programs in psychiatry and teacher education were also important considerations.

PROGRAM DESCRIPTION

Long Island Jewish-Hillside Medical Center is one of the largest voluntary teaching hospitals in the greater New York City area. In this capacity it has affiliations with surrounding colleges, including Queens College of the City University of New York. With one of the authors a member of both

the Queens College faculty and of the clinic staff, it was less difficult to establish an integrated program and an effective working relationship between the two institutions.

In the two-semester course in "Human Growth, Development and Learning" required of Queens College students in the teacher preparation sequence, there is a field work component that entails spending a minimum of four hours per week each semester, in a school or social agency working with children. Since it was evident that not every college student would want to, or be capable of "tutoring" a child with learning difficulties for the entire academic year, and especially of taking on the added requirements of a field work assignment through the Children's Psychiatric Clinic, a flyer was circulated prior to course registration describing in detail the course offering and the field work requirements. The instructor of the course briefly interviewed each college student prior to admission to the course, and had the prerogative of denying admission if the student appeared to lack the necessary personal characteristics i.e., stability, seriousness of purpose and enthusiasm for the work. Having the college course taught by a person who was also on the clinic staff proved to be doubly advantageous: first it allowed for the full integration of theoretical course content and the practical field placement experience and secondly, the instructor's access to each child's medical record permitted the child's precise academic, emotional and social needs, as well as the geographic location of his home and school to be taken into account when matching the tutor and child.

Early in September, a letter was sent to the principals, describing the intent of the clinic and college to jointly provide tutoring services for "learning disabled" children who were being serviced within mainstream elementary or secondary education programs and who were in treatment in the Children's Psychiatric Clinic. The letter clearly stated that assignment of a

tutor would be made only for those children whose parents had given consent. Each of the guidance counselors and classroom teachers of the children to be tutored also received a detailed statement of the rationale of the tutoring program, along with a formal letter introducing the assigned undergraduate college students.

At the beginning of the academic year the tutors attended a general orientation session at the clinic. They met key personnel and were given an overview of the clinic's goals and operations. The instructor of the course, or the therapist, reviewed the child's case history with the assigned tutor and suggested tentative remedial prescriptions based on psychological test findings. To increase their understanding of prescriptive teaching the tutors were asked to attempt to make their own psycho-educational evaluation* of the children with whom they were working. The tutors then conferred with the classroom teacher and guidance counselor to determine if their assessment of the childrens' needs and their proposed tutoring goals were consonant with those of the school personnel. The college students were challenged to develop

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* The battery used was developed by Dr. Lillie Pope, Director of the Psycho-Educational Clinic at Coney Island Hospital. It consisted of an informal reading comprehension inventory; the Dolch Basic Sight Word List; tests for visual and auditory recognition of initial and final consonants, and of consonant blends and diagraphs; tests for reading knowledge of short and long vowels and for vowel combinations; a test for reversals; a simple test of number concepts and arithmetic processes, and the copying of geometric forms. In the second semester the tutors used "A Psycho-educational Inventory of Basic Learning Abilities," by Dr. Robert E. Valett,[12] (Belmont, California, Fearon Publishers, 1968).

their own materials and were encouraged to be as innovative and non-traditionally textbookish as possible in their approach to working with the children and in motivating them to want to learn. They were cautioned, however, not to lose sight of the demands a given child had to meet in his actual classroom situation.

In most cases, the therapist introduced the tutor to the child and his parents at the clinic. The parent, child, therapist and tutor jointly decided on the location, frequency and the amount of time of the tutoring sessions. Although the teacher's opinion about the preferred time and place for tutoring was sought and taken into account, it was not possible to have the teachers physically present at the clinic for this "get acquainted" session. Tutoring sessions were started in the first week of October and continued through the first week of June of the following calendar year.

In about half the cases, the tutor's work was done exclusively at the child's school, where the tutor was given a "quiet" spot with some privacy. The child would leave his regular class for 45 minutes to an hour, 2 or 3 times a week, to work with the tutor. Each tutor was invited by the classroom teacher to observe the child in the regular classroom. This enabled the tutor to see how the class was conducted in general, to ascertain what were the teacher's expectations of the particular child and to observe the behavior of the child in his interactions with teachers and peers. In the other half of the cases, the tutors worked with the child both in his school and at home, either after school and/or weekends. Some of the out-of-school sessions were devoted to academic work, notably homework. In the majority of instances, however, the tutors had planned activities that had recreational and social as well as educational goals. Each tutor kept a detailed log of the remedial and/or recreational activities engaged in, and pertinent observations of the child's behavior. Brief weekly progress notes on each child were submitted to the therapist.

A major objective of the college course in "Human Growth, Development and Learning" was to help the tutors become more skilled observers of children's behavior. In order to stimulate them to use their own intellectual resources and not to inhibit the freshness and spontaneity of the tutors' reactions, formal lectures, discussions, and readings on alternative models for viewing human behavior (intrapsychic, interactional and systems approaches), were reserved until the tutors had been working with the children for about two months. The didactic material offered during this early period centered on the general topics of "Genetics and Development," "Prenatal Environmental Influences," "Motor Development and Sensory Experience in Infancy," and "The Foundations of Cognitive, Language and Social Development." In clinical supervisory sessions with the tutors during this period, a conscious effort was made to refrain from using the terminology and constructs of any particular theoretical position to interpret the problem-behaviors the tutors described. A modified "non-directive," Socratic approach was purposely attempted to draw the tutors out and to encourage them to formulate their own hypotheses about the possible factors underlying the phenomena they had observed.

The small group clinical supervision sessions conducted bi-weekly by an experienced staff psychologist supplemented the weekly seminar at Queens College. The content of these sessions was determined by the type of problems the college students had encountered while tutoring. It largely had to do with the "tutoring role" - how the student was to conduct himself with the child in a variety of situations, viz. in school, both in and out of class, in his home, taking him out on field trips, etc.

PROBLEMS ENCOUNTERED BY TUTORS

At the outset of the program some of the clinic staff expressed doubts that college students would have the maturity, good judgement and sufficient knowledge of the dynamics of human behavior to be entrusted with confidential

information about the child's development and family history and assume a proper helping relationship with the children. However, the majority of the college students rather quickly came to understand their role as tutors.

Most did not attempt to act as professional therapists. Recognizing that they were allies or auxiliaries to the primary work of the therapists, they sought the guidance and insights they needed to make their tasks more effective.

Good will, overzealousness and inexperience did lead several students into embarrassing and difficult situations. When parents asked their views and opinions about their children's need for medication, the accuracy of diagnosis and the qualifications of the therapist or teacher, several tutors fell prey to the flattery inherent in being so consulted. Their responses, though sincere, most often were not based on theoretical knowledge nor a full awareness of their implications and led to conflicts among all involved with the children. Lack of knowledge of clinical psychology and the dynamics of human behavior created problems for several tutors. They felt the need to make parents feel better by participating in their denial that there was really nothing seriously wrong with the child. Early in the semester it was not uncommon to hear tutors comment that the children to whom they had been assigned were really not too seriously troubled and were very much like the tutors remembered they had been as children.

The high motivation of the tutors functioned as a two-edged sword. The effort they extended in working with a child in many cases helped the parents and child regain the belief that greater achievement was possible. But where the tutors developed "rescue fantasies" the goals for the children and their notions of what they could achieve became unrealistic and the tutors ended up driving both themselves and the children too hard.

In the beginning, most of the tutors admitted having a fear that they would not be "liked" by the child, especially if they said "no" to any of his requests or demands. With a number of the children who were very restless and highly distractible, or with others who were manipulative or quite insatiable, the tutors needed a great deal of guidance and support. They needed to learn how to structure the learning and play situations, and to set firm limits. Several of the tutors reported feeling guilty or sad because they could not satisfy the children's requests to come to their homes every day, or to take them places, or to buy them things, etc.

An additional set of problems arose in some instances where the tutoring was conducted in the children's homes. These were brought about by the parent's intrusion into the relationship between the tutor and the child. The tutors required guidance on how to respond to both parent and child when the parent openly criticized the child, was "helpful" by answering questions for the child, or threatened to punish the child by cancelling the tutoring sessions. In this latter situation, it also aroused the student's concerns about meeting the field placement requirements of their course. Parental manipulation of the tutoring sessions was an issue that ultimately had to be referred to the child's therapist to be dealt with in family therapy sessions.

Tutors had to learn that building a close and trusting relationship with a child did not mean that they could promise the children complete and total confidentiality, especially when confidences entrusted to the tutors had to do with anti-social behaviors such as lying, stealing, cheating, or with the children's worries and fears.

In the first year of the program, a difficulty commonly experienced by the tutors was the handling of termination of the tutoring relationship. Even though the clinic staff had discussed the necessity of setting a final

date for official termination and of abiding by it, several students tried to ease the pain of separation by stalling and couching the issue in statements like, "we'll always be friends" or "even though we're ending tutoring, you can call me at any time." The process for working termination through for both tutor and child had to be extended for several weeks in these cases.

THE TUTOR AS A RESOURCE

In many cases information which emerged incidentally during social/play or school/tutoring situations and when shared by the tutors with the therapists was important for the conduct of the therapy. Such benefits were not restricted to the psychotherapy situation but also extended to altered interventions in the school. As Adelman[1] points out, a substantial number of school learning problems may be attributed to the interaction of the child and the learning situation. Tutors were in the strategic position of being able to observe the child's behavior at school, to watch the child-teacher interaction, to see the effect of the school and classroom environment on the child and his achievement, as well as to get insight into the atmosphere surrounding school work and learning in the home situation. There were times where the tutor was able to help a child come to terms with his misconception and distortions about what had caused him to misbehave in school.

In other instances, tutors were able to bring to teachers' awareness how certain aspects of classroom management procedures and expectations either precipitated or exacerbated a child's negative behavior or learning difficulty. Thus, a tutor often functioned as an advocate for the child in helping the teachers see him in a more positive or objective light.

Some teachers were not receptive to the tutors' observations or efforts. One expressed the fear that the tutor would be in the classroom "watching her" and that the presence of an outsider would be distracting for the entire class. Another teacher's behavior caused a tutor to feel quite discouraged

when week after week the teacher would question the tutor publicly as to why she was wasting her time tutoring that particular child since he would never amount to anything. Another teacher was unwilling to discuss with the tutor the goals to be achieved by the many assignments given to the child and was unresponsive to the tutor's observation that the multiciplicity of assignments were truly burdensome for a child who could not keep up with the ordinary demands of the classroom. A fourth teacher refused to have a tutor work with her stating plainly that "If anyone could do anything for this problem child, she could and would."

Though the level of work this teacher was presenting in class was clearly beyond the comprehension of the child who was being tutored, under no condition would she allow the child to leave the room to be worked with on a one-to-one basis.

Tutors and therapists were often amazed and always distressed when these kinds of attitudes on the part of school personnel were encountered. However, from the viewpoint of preparing future teachers and mental health practitioners for the realities of their future work, it was very valuable experience. It allowed them to experience the conflicts that arise when different professionals have to work with an individual child and the necessity to learn how to resolve such conflicts successfully.

THERAPIST'S ROLE

In the three years this program has been in operation, it has seemed that the most important factor in its success was the therapist's attitude. When the therapist had a positive attitude about the role of the tutor and was not threatened by it, he was open to seeing the college student as a helper ready to reinforce and extend the therapist's influence in the life of the child at home, at school and in other social situations. Signs of such a positive attitude on the part of the therapist were manifested in small but

significant ways. For example, the therapist invested time in coming to know the tutor. He introduced him as part of the team to the child and his family. He also contacted the guidance counselor and the teacher in the school which his patient was attending and personally requested that the tutor be permitted to function as his ally in the school life of the child. Finally, the therapist frequently exchanged observations and information with the tutor and gave, when needed, specific directions and advice in conferences and by telephone. All of these actions gave importance, structure and support to the tutor in his work with the child and his teacher. These were the critical elements in the forging of an open, trusting and supportive relationship between therapist, tutor and teacher. In these instances, the role of the tutor was more appropriately enacted within the context of the overall therapeutic and educational setting.

As has been suggested, the therapist-teacher-tutor team did not function smoothly at all times. Each member did not always understand and respect the territorial domain of each of the other members. There were some difficulties in delimiting roles. Theoretical orientation, professional convictions and values, personality variables, inexperience and human error were the main sources of the difficulties that emerged in the operation of this program. For several of the less experienced therapists, the expressed fear was that the tutors might develop "a closer relationship" with the children than they would. Therapists in training voiced conoern that the transference would be diluted; the tutor, all too easily, might become the person to whom the children would bring their feelings and problems, rather than "saving" them for the therapy sessions. One neophyte therapist, for example, adamantly insisted that the tutor should have only a "didactic" role and should not form any personal relationship with the child. These, as well as other issues, had to

be addressed in supervision so that the therapy, as well as the tutoring, were permitted to proceed unhampered.

ATTITUDE OF SCHOOL PERSONNEL

From the start, the cooperation of the principal, guidance counselor and teacher of the children in the program was deemed essential. When the therapists extended themselves to the school personnel in the form of personal conferences, phone calls, invitations to case conferences and through the medium of the tutor, good things happened. They shared their understanding of the etiology and dynamics of the child's problem and powerful allies in the classroom were mobilized. Teachers and guidance counselors appreciated the fact that the therapists did not drown them in technical psychiatric terminology, which left them only with confirmation of their original judgment that the child had a serious problem. Almost always overburdened and perplexed at how to meet the individual needs of the 30 or more children in their care, most of the teachers were eager for concrete suggestions about how they could more effectively help the child with a serious behavior and/or learning problem. They were doubly appreciative of the addition of the "two helping hands" of the tutor in the implementation of the suggestions offered by the therapist.

Almost all of the teachers who collaborated in this program expressed feelings of pride and satisfaction that derived from their perceiving themselves as integral and valued team members, whose opinions and observations were sought by others, and with whom they enjoyed genuine professional relationships. Barriers which have been known to exist between mental health and school personnel were thus broken down to concentrate on helping the child.

SUMMARY

This article describes a tutoring/companionship program for underachieving children who were also receiving psychotherapy. College students in a teacher education sequence did the tutoring under the joint supervision of clinic staff, classroom teachers, and college faculty. The aims of this program were to: expand remedial services to children; better equip future teachers with first-hand knowledge and skills for working with problem children; help residents and fellows in psychiatry better understand the impact that school experiences have upon their child patients and become more aware of the ways in which school personnel can support and enhance clinical therapeutic efforts.

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