Collaboration of educators and mental health professionals for the delivery of services to young children.

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COLLABORATION OF EDUCATORS AND MENTAL HEALTH PROFESSIONALS FOR THE DELIVERY OF SERVICES TO YOUNG CHILDREN

A Dissertation Presented

By

MARGARET C. SMITH

Submitted to the Graduate School of the University of Massachusetts in partial fulfillment of the requirements for the degree of

DOCTOR OF EDUCATION

February, 1978

Education
COLLABORATION OF EDUCATORS AND MENTAL HEALTH PROFESSIONALS FOR THE DELIVERY OF SERVICES TO YOUNG CHILDREN

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By
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ABSTRACT

Collaboration of Educators and Mental Health Professionals for the Delivery of Services to Young Children

(February, 1978)

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This is an exploratory field study of therapeutic/educational programs in Massachusetts serving preschool children with special emotional needs. The aim was to discover the ways in which collaboration had been effected between mental health professionals and early childhood educators to meet the interrelated educational and mental health needs of emotionally disturbed preschool children. Attention was paid to the professional training of those providing services, to the status differences between teachers and mental health professionals, and to the differences between programs operated by mental health facilities and those operated by public schools.

A telephone search for programs was followed by a telephone survey of fourteen programs identified during the search. The aim of the survey was to identify the sample for the main phase of the study. To be included in this
sample a program had to offer therapeutic classrooms and individual therapy, be staffed by mental health professionals as well as educators, and had to have been serving emotionally disturbed preschool children for at least one year.

Eight programs, seven in the eastern part of the state and one in the Connecticut valley, comprised the sample for the main phase of the study. Five of the programs were operated by mental health facilities and three by public school authorities. Site visits were made to all the programs in the sample, classes were observed--at least one at each program site--and taped interviews were conducted with 23 staff members. The interviews explored the services offered, staffing patterns and practices, administrative structures and policies, methods of diffusion, and staff evaluations of programs.

The study indicates that more than three years after Chapter 766, the Comprehensive Special Education Law, went into effect in Massachusetts, there were still very few programs available in the Commonwealth for preschool children with special emotional needs. The prohibition against public schools labeling children as "emotionally disturbed" appeared to be related to the failure of many school districts to provide appropriate mental health services to children in need of them.
Classroom teachers in the preschool programs studied were providing a range of child and family intervention services, including individual psychotherapy, parent guidance, and home visiting. The teachers had arrived at their competencies through in-service training, work experiences and a variety of academic preparations. The teacher/therapists were generally functioning at a high level of professional performance, but they had achieved that despite the absence of appropriate specialized professional training to prepare them as preschool psychoeducators. The study suggests that specialized professional training based on a systematic generalized knowledge from the relevant disciplines in mental health and early childhood education is needed. Such training would prepare teacher/therapists who could meet the affective and cognitive needs of emotionally disturbed preschool children most effectively. In the absence of such comprehensive training a tendency was found for programs to focus either upon children's emotional development or upon the development of academic and social skills. In spite of these different emphases among teachers with different training histories, there was a shared sense of professional concern that suggests the emergence of a new profession which integrates the approaches of mental health professionals and teachers of preschool children.
ACKNOWLEDGMENTS

I wish to express my gratitude to the directors and staff members of the eight programs upon which this study is based. I thank them for allowing me to observe their classrooms in operation and for their generosity in making time, in spite of their crowded schedules, to talk with me about their work. Without their willingness to share their experiences with me this study could not have been done.

I am indebted also to the members of my dissertation committee, Louise J. Farnham and Donald W. White, and especially to my committee chairperson, Grace J. Craig, for their encouragement and constructive criticism and suggestions during all the stages of the preparation of this dissertation.
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CHAPTER I
INTRODUCTION

In September 1974 the full mandate of the Comprehensive Special Education Law, Chapter 766 of the Acts of 1972, took effect in Massachusetts. Since that time it has been the responsibility of the school committees of each city and town in the Commonwealth to provide, directly or indirectly, for the special educational needs of all children with substantial special needs. Children as young as three years of age are covered by the law and disabilities in the area of emotional development are among those to be assessed and addressed with individualized special programs. When dealing with preschool age children with special emotional needs, many professionals would agree that programs are needed which combine early childhood education and psychotherapeutic services if the educational needs of these children are to be met, and their healthy emotional development is to be assured. The nature of child development is such that a disability can seldom be understood or treated adequately as an isolated and narrowly defined educational or emotional problem. It must be addressed in the total context of the child's experience and development.

In a recent publication of the Joint Information
Service of the American Psychiatric Association and the National Association for Mental Health, Glasscote and Fishman (1974) report that, among their collaborators in their field study of mental health programs for preschool children, there was unanimous agreement that among "the most important considerations for bringing up a child in the ways that we think will make him mentally healthy . . . the principle outranking all others is this: the child should be treated as a whole child (or person or organism)" (p. 11). Their collaborators were from the disciplines of Education, Psychology, and Psychiatry. The authors say further that in spite of this agreement in principle, in practice many professionals continue to function in isolation, within the limits of their own professional expertise.

There is ample evidence from the literature that the experience of appropriate early stimulation has an important positive effect on cognitive development (Levenstein, 1970; Hunt, 1961; White, 1973; and others). There is equally cogent evidence that the experience of parental availability and nurturance is essential to healthy emotional development (Alpert, 1959; Bowlby, 1951, 1960, 1973; Freud, 1965; Mahler, 1975). Other studies indicate that appropriate nurturance during infancy may be related to cognitive as well as to emotional development (Dennis, 1973; Hunt, 1961; Provence and Lipton, 1962; Skeels and Dye, 1939; and others). From the first weeks of life, the child's perceptual endowment,
the degree of constancy of his need satisfaction, and the amount of perceptual stimulation all interact to determine his ability to conceptualize and cathect reality. Any condition which interferes with perceptual, affective and cognitive processes developing in concert will inhibit a child's ability to learn (Edgcumbe and Burgner, 1972; Fraiberg, 1969). It has been pointed out by numerous authors that the experience of failure in learning leads to further failure. Belle Dubnoff of the Dubnoff Center for children with special needs, has reiterated that whatever the underlying cause of failure, the results are destructive to self esteem and motivation. "Severe emotional overlays develop in addition to whatever problem the child had, so that his adjustment to the learning process and to life becomes further complicated" (Glasscote and Fishman, 1974, p. 35). Successful learning experiences can be expected to enhance ego strength, and promote further development and learning.

In trying to pinpoint a causal explanation of a developmental disorder of early childhood we are confronted not just with a circle which has no beginning, but with an intricately interwoven fabric of emotional experience, learning, and development. It is obvious that to separate a single thread in the fabric for treatment would be to put further strain upon the child's total personality, which must be addressed as a whole. The needs of young children who suffer from such disorders can be adequately met only by
bringing to bear the full expertise of the early childhood educator and the early childhood psychotherapist.

While the need for a "whole child" approach clearly exists, there is at this time no single profession which encompasses all relevant disciplines. There are mental health workers who specialized in the psychodynamics of early childhood, and individual teachers who have received training to equip them as special educators or psychotherapeutic teachers. Glasscote and Fishman (1974) suggest lack of one comprehensive discipline may be responsible for the fragmented view of children that persists in so many programs. They advocate a comprehensive discipline plus the broadening of the curricula of existing training programs to include a strong core of child development in the training of all professionals dealing with young children. Perhaps it is time for those who would serve the developmental, educational and therapeutic needs of children under the age of six to organize into an autonomous group with their own comprehensive specialized training program which would in Moore's (1970) terms qualify them as a true and separate profession. In the absence of such a profession at this time, ways must be found to tap the resources of the preschool master teacher and the mental health professional which will make full use of the training and experience of both.

For members of two separate professions to work as
cooperatively as this situation demands would seem to require at a minimum the formation of a new cohesive group. Only a truly cohesive group can be led successfully to achieve the mutual long range goals of its members (Fiedler and Meuwese, 1963). Allegiance to such a new group is difficult, since members of any profession tend to identify with their own discipline. Social psychologists have demonstrated that a person's ego involvement with his own group interferes with true cooperation with others (Sherif, 1948; and others). The problem is exaggerated in the present situation where the need for equally important contributions from each profession calls for cooperation among equals. The monetary rewards and privileges that are enjoyed by members of the mental health profession far exceed those of educators (Wittlin, 1965; and others). Social workers, psychologists and psychiatrists all enjoy the status that comes from association with the medical profession, the most prestigious of the professions. Educators are at the other end of the continuum. Furthermore, in education, the younger the population the educator is concerned with, the lower is his status. It is not surprising then, that it is difficult for early childhood educators and mental health workers to work together in ways which pool their different training and knowledge. Yet both are equally essential to the design and implementation of programs which address the broad spectrum of needs of the whole child.
Preschool programs for children with special emotional needs provide a natural context for cooperation between teachers of young children and mental health professionals. Nursery schools began in this country with the opening in 1920 of the Gesell Guidance Nursery School at Yale. Teachers trained there by child developmentalists in a setting permeated with clinical concerns saw the child's emotional health as their major concern, for which they provided nurturant care in a safe stress free environment (Pitcher and Ames, 1964). The Gesell school remained the almost undisputed model for nursery schools in this country for nearly forty years. Other universities followed Yale's example and Child Study departments established their own schools where the normal development of children could be observed and nursery school teachers could be trained.

There are several reasons why this auspicious beginning did not result in what would now provide a ready solution to the problems facing Massachusetts in providing for its preschool children with emotional disturbances. The Gesell Nursery School was certainly committed to mental health concerns, and strove to foster the mental health of the children in its classes. It was, however, a school for normal children. When it first opened, the school included some emotionally disturbed children, but the practice was stopped when it appeared that the emotionally disturbed children were not being helped and the normal children were
beginning to imitate some of their undesirable behavior (Pitcher and Ames, 1964).

Training nursery school teachers in child development departments served to separate them from the mainstream of public school teachers, who were trained in teachers' colleges and schools of education. Nursery schools were almost unheard of in public schools, so the estrangement continued. Nursery school teachers were not only at the disadvantage that all teachers of young children are in dealing with the relatively prestigious mental health professions, but they were also isolated from other educators. Kindergartens might have provided a bridge between the public schools and preschools. Evelyn Weber (1969), speaking of G. Stanley Hall and John Dewey on the kindergarten movement said, "... with Hall exalting the emotional side of development and Dewey putting stress upon social interaction, it is small wonder that kindergarteners began to interpret their goals largely in terms of the social and emotional adjustment of the young child" (p. 54). The similarity between this approach to kindergarten education and the traditional nursery school philosophy did not, however, bring nursery school teachers any closer to public schools. In many areas kindergartens never became fully accepted as full fledged and necessary members of the public school community. In Massachusetts it did not become compulsory for public schools to offer kindergartens until September 1972, just two years
before Chapter 766 required them to offer programs for preschool children with substantial special needs. By then the goals of kindergarten education had become very different from those described by Weber and from those of traditional nursery schools.

Traditional nursery schools did not remain entirely static. It became clear that providing nurturance and freedom from stress was not enough, and under the influence of ego psychology (Hartmann, 1939), attention was given to developing skills. Skills essential to social and emotional growth, such as relating to others, sharing attention and materials, and cooperating in groups were stressed (Omwake, 1963).

Beginning in the late 1950s a new group of early childhood educators began to influence preschool content and structure. In the aftermath of Sputnik some Americans were insisting on more rigorous academic content in the public schools. As parents sought answers to Why Johnny Can't Read (Flesch, 1955) there was pressure on the schools to concentrate more on basic skills. Others were concerned about the inequities in the system in which children of poverty were failing to learn in the schools at a greater rate than middle class children (Gray and Klaus, 1968; Holt, 1964). Forces in the society at large and in the academic community converged to focus attention upon the education of young children. Early intervention programs were developed for
children of the poor as ways were sought to equalize opportunity for success by taking advantage of the earliest years of life which Bloom (1964) and Piaget (1936) revealed as times of great learning potential. Early Childhood Education became a regular offering of schools of education and teacher training colleges.

The sudden prominence of the nursery school years within the educational establishment was viewed with caution by the traditional preschool educators who feared that the influence of the cognitive psychologists would cause too much stress to be put upon academic learning, while the child's social and emotional growth would suffer. At one extreme there were fears that as public school educators became interested in young children they would simply force feed the first grade curriculum to four year olds. At the other extreme were accusations of inhibiting a child's natural curiosity and need for intellectual stimulation by providing an environment of songs and games which offered no challenges to the mind, no problems to be solved. In the middle were sensitive programs which attempted to offer developmentally appropriate challenges and stimulation to three and four year olds within appropriately nurturant environments, but by the mid '70s the differences between the extreme positions were far from resolved.

It was in this climate that Chapter 766 became law in Massachusetts. Clearly, providing for the special edu-
cational needs of preschool children would not be easy in this setting, but it had to be done, and, to obey the spirit of the law, it had to be done well.

**Aim of the Study**

This study first sought to identify the programs in Massachusetts which are providing educational and therapeutic services to preschool children with special emotional needs. It then took a close clinical look at eight of those programs which are providing therapeutic education with some apparent success in an attempt to determine how these programs perceive and address the problems which arise from the lack of a single comprehensive profession of therapist/teacher for preschool children.

The study is concerned with the relationship between members of different professions within programs and between an individual's professional identity and his/her role within a program. The study considers differences which exist between programs operated by mental health facilities and those run by public schools. The study attempts to determine the specific services offered, staffing patterns employed and administrative policies characteristic of programs which have achieved some success in combining the traditional concerns of the mental health professions and early childhood education to provide comprehensive services to emotionally disturbed preschool children. Finally, the
study addresses the question of professional training for those who will staff such programs in the future. Because these programs represent a new venture for public education in Massachusetts, an open-ended exploratory field study was judged to be the appropriate method of approaching the subject. To that end, observational visits were made to the programs and intensive interviews were conducted with members of the staff of each program.

With the challenge of Chapter 766 comes also a great opportunity to bring to the most needful children in the state hope for normal lives as productive members of society. To provide expertly, efficiently and humanely for many children covered by the law whose needs are beyond the traditional expertise of the public schools, will require extensive research. It is hoped that this exploratory study will contribute to the effort by bringing together the knowledge and skills acquired by these eight pioneering programs in their efforts to resolve some of the difficulties involved in serving one segment of this special population.
CHAPTER II
A SELECTED REVIEW OF COLLABORATIVE PRESCHOOL PROGRAMS

Long before Chapter 766 became law in Massachusetts, child experts around the country were concerned with the plight of the special child, the need for professional cooperation in the delivery of services, and the need for a broader base in the professional education of those trained to provide a variety of different but related human services to young children. Before examining the present situation in the Commonwealth it will be useful to review some of the available educational and therapeutic services for preschool children which already existed in different parts of the country prior to the enactment of the current legislation in Massachusetts.

The decision to close the Gesell Guidance Nursery School to disturbed children did not set a binding precedent. In fact, it became common practice for doctors and guidance clinics to recommend nursery school for young children whose social and emotional development indicated the need for experiences which were not available in the home, as psychoanalysts, developmental and clinical psychologists, educators and pediatricians attempted in research and service to piece
together the puzzle presented by the young atypical child. Child study centers were established in major universities and colleges, from Iowa west to Berkeley and Stanford and east to Smith and Mt. Holyoke Colleges and the University of Massachusetts. Many of the nursery schools they operated accepted children with special needs. In 1948 the Child Study Center succeeded the Gesell Clinic at Yale. Under the direction of Milton Senn it was designed as a multidiscipline, multipurpose center for training child psychiatrists, psychologists, nursery school teachers, social workers, and pediatricians, and for studying child development ecologically and longitudinally, and finally for providing diagnostic, therapeutic and educational services to young children and their families (Solnit and Provence, 1963). The nursery school, which was one facility of the center, served normal children, but not exclusively. At least one child, discovered in the longitudinal study to be in special need, was reported to have been enrolled at an especially early age to allow him additional opportunities to benefit from the school environment and curriculum (Ritvo, McCollum, Omwake, Provence & Solnit, 1963).

At the Yale Center there was a strong emphasis on Child Development in the training of early childhood specialists from all the disciplines. A few years earlier, in 1941, a cross disciplinary Committee on Human Development had been established at the University of Chicago. Sears (1975,
pp. 24-25) speaks of the "catabolic fractionation" of Human Development there, as "doctoral candidates were necessarily specializing in the knowledge and techniques of specific disciplines, mainly psychology." He says further that "final destruction" is not the result because "in the home, the school, the courts, the clinics, in education . . . there are still whole children to be dealt with and practitioners who must integrate what researchers have fractionated." As more and more knowledge is generated by Child Development and related research a trend toward greater specialization can be anticipated among scholars and researchers. In the training of practitioners, however, multidisciplinary integration, attempted at Yale and Chicago and now being advocated by Glasscote and Fishman (1974) a quarter of a century later, warrants serious professional attention.

In addition to the research and training oriented Child Study Centers, other programs existed which were specifically providing for the educational and therapeutic needs of special children. Some of these were developed by mental health professionals to meet the growing need for new techniques in treatment, as more and a greater variety of cases came to the attention of child analysts. For many of these children, especially emotionally disturbed pre-latency children, classical analysis, developed originally as treatment for adult neurosis, was not seen as the treatment of choice (Freud, 1946, 1965). Psychoanalysis, with its reliance on
verbalization and on establishing a relationship between patient and analyst, could not be carried out with young children whose problems included an inability to relate and for whom a major symptom was language deficiency. This led to a new role for education in the form of therapeutic nursery schools. Augusta Alpert (1954) points to the shortage of psychotherapists trained for work with such young children as one impetus to use nursery schools therapeutically.

**Therapeutic Nursery Schools**

One of the more interesting experiments in the use of nursery school education both to provide service to children and to train child analysts in treatment procedures with preschool age children was the Hanna Perkins School in Cleveland started by Anny Katan in 1951 in conjunction with the medical school of Western Reserve University and the University Hospital (Furman, R. and Katan, A., 1969). The school was planned as an optimal educational environment where children could develop healthy personalities, using to the fullest their innate potentials for work, play and constructive relationships and satisfactorily moving through each developmental phase. To this end, we expect to help children become acquainted with themselves and their feelings so that they can learn to cope with and control them responsibly; to offer appropriate academic tasks that build ego strength, develop skills, build up self-esteem and offer gratification at varying levels of ability. (Archer and Hosley, 1969, pp. 33-34)
All of the children enrolled in the Cleveland Therapeutic Nursery had some special problems, and in addition to the educational program they received individual treatment. Some worked with a therapist at the school, but most of the children were given therapy via the mother (Furman, E., 1969). In this modality the therapist works with the mother each week, but only the mother works directly with her child. For mothers who are suited to this work it obviates much of the preliminary work necessary when the analyst is a stranger to the child (Freud, 1946), and it increases the amount of therapeutic contact for the child. Some parents are not able to carry on this work, but mothers who do so successfully experience maturation in their own development as mothers, which helps them in raising all their children, in addition to benefiting the child whom they are treating.

The total program of the Therapeutic Nursery School was meticulously coordinated to insure the greatest possible reinforcement of, and lack of interference with, the educational and therapeutic work. Opportunities for communication between teachers, therapists and parents were formally scheduled. The cooperation between the therapeutic and educational efforts was not allowed to cloud the distinctions between the two, however. The separation between education and therapy was considered a distinguishing factor of the program (Archer and Hosley, 1969).

A very different form of therapy is described by
Alpert (1954) at the Council Child Development Center in New York. Children who have suffered from disturbed mother-child relationships with a resultant pathological over-dependence and a variety of developmental disorders were treated in the nursery school, although the Center also included a clinical department where other individual services were offered. After the children were helped to separate from their mothers upon entry to the school, the new dependence upon the teacher was used as a corrective identification, and the child was given support within this relationship for a "guided regression" (Alpert, 1954, p. 334). With "persistent stimulation, dosing, and structuring of new experiences" (Alpert, 1954, p. 334), the child was given a second chance to negotiate his early development. He learned to relate to adults and children, to sublimate, and to develop age-appropriate ego functions. Alpert develops this approach more fully as Corrective Object Relations (Alpert, 1959).

Alpert's therapeutic model, COR, provides an opportunity for children who did not develop a satisfactory need satisfying relationship with a mother or a surrogate during the first months of life, who did not in Erikson's (1950) terms develop trust, to have a second chance by developing a close one to one relationship with a need satisfying adult, and within the context of the relationship the child is encouraged to regress to the earliest phase of development.
The child's attachment to the therapist permits the development of normal progression through developmental phases resulting in normal adaptive behavior. Whereas the Cleveland program used the nursery school as supportive of and supplementary to the therapeutic work, the program described by Alpert used education in the nursery school as a therapeutic tool and the teachers as therapeutic agents.

Still a third model for therapeutic nursery education is that of the Cornerstone School, developed at the Center for Preventive Psychiatry in White Plains, New York. There, in therapeutic classrooms for six to eight children, the child receives individual psychotherapy and a regular nursery school program. The psychotherapist comes into the classroom and spends up to twenty minutes each day with each child according to his readiness for this interpretive work (Ronald and Kliman, 1970). The many educational functions which Anna Freud (1946) has described as being essential for an analyst to engage in before and during analysis proper are, in the Cornerstone method, assumed by the teacher, freeing the psychiatrist for his unique and central work of interpretation.

Communication between the teacher and the therapist is a continual, ongoing process as the two work in "tandem." The teacher is responsible for providing a preschool program supportive of normal growth and development. She must set limits for the child and describe "what is real"
(Ronald and Kliman, 1970, p. 4). She must assist the child in developing ego functions, and she supports his sublimations. As energies are released by the therapist's interpretive work, the teacher is ready to channel them into constructive activities. Because the teacher observes the child's therapeutic sessions she is likely to have a better understanding of the child's behavior and play communications. She can make use of this increased understanding in her own relations with the child and she can relay her observations of the child outside of his therapeutic time to the therapist for his use.

It has been mentioned earlier that interpretive therapy derived from classical adult analysis is inappropriate for many preschool children. Children who cannot relate, who do not communicate verbally, or who are ego-deviant cannot benefit from the Cornerstone method. For such children the Center for Preventive Psychiatry provides a different educational modality. Educational-psychotherapy is provided for such children on an individual basis several times each week. Educational psychotherapy is reminiscent of COR therapy as a "mothering" therapist helps the child to relate, and within the relationship to develop ego functions and in other ways to move forward developmentally. Psychiatric supervision is provided for the educational psychotherapists and specific goals are set for each child (Stein and Ronald, 1974).
Using nursery school as a therapeutic tool for children in need of mental health services is useful in a number of ways. Many, though certainly not all, children come from families which have at least in part contributed to the problem. In many cases the etiology of the disturbance can be seen as clearly residing in unhealthy family relationships and behaviors. Even though other children can be seen to survive emotionally unscathed from such environments, the noxious effect for a particular disturbed child would be difficult to dispute. A nursery school where a child can spend many hours daily provides the primary service of removing the child from the harmful environment. The other side of that situation is that many disturbed children are very difficult to live with, and parents, however much or little they contributed to the problem, can benefit from hours of relief from the full minute-to-minute responsibility for their child. Any benefit to them is an indirect benefit to the child.

When a therapeutic nursery school is operated by a mental health facility, the teachers are usually given some clinical training so that their relationship to the children can serve a positive therapeutic goal, thus multiplying the therapeutic effects of whatever specific individual therapy the children may also be receiving (Archer and Hosley, 1969; Cary and Reveal, 1966; Ronald and Kliman, 1970). The clinicians, however, are much less likely to be given any training
to help them to understand the teachers' goals and methods, and how the clinicians' work might support or interfere with realizing important educational goals.

The mental health facilities which operated nursery schools as therapeutic tools quite naturally used the traditional model which had begun in the Gesell School and continued to be used in many Child Study programs. Psychoanalytic theory had strongly influenced theory and practice in these nursery schools, where the emphasis tended to be on healthy social and emotional development. It was implicit to the philosophy of many of these schools that attempts to stimulate intellectual growth by direct teaching could be potentially harmful to a child's emotional development. Instead he should be given nurturance and allowed to await the natural unfolding of his capacities (Hymes, 1955). This approach to early childhood education came under serious attack during the nineteen fifties.

**Academically Oriented Preschools**

During the late 'fifties, while clinical programs for children were operating therapeutic nursery schools, educators and cognitive psychologists were questioning the usefulness of the traditional nursery school model for providing the stimulation children needed if they were to develop their intellectual capacities to the fullest. In response to traditionalists' claims that pressure for children to learn
before they were ready would have unhealthy effects on the children's emotional development, the new educators claimed that readiness was brought about through experience, and that it was the responsibility of early educators to provide the experience that would render children ready for school success. Nothing, they claimed, could be more harmful to a child's emotional well-being than failure, and nothing could be more beneficial than success which would insure future success. Poor children particularly were seen as lacking the early childhood experiences necessary to cognitive growth, so as part of the federal poverty program, early childhood intervention programs were initiated during the late 'fifties and 'sixties (Frost, 1968, 1973; Hechinger, 1966; Hess and Bear, 1968).

Among these cognitively oriented early childhood programs of the mid-century was the Institute for Developmental Studies under the direction of Martin Deutsch. Some fundamental assumptions of the Institute were that the schools were the most significant institution for intervening and breaking the cycle of poverty (a view not shared by all (Lazerson, 1970)), that preschool age (three and four) and the primary grades were the place for exerting the greatest effort, that children of poverty do go to school with deficits which inhibit learning, and that these deficits are in the area of "language, conceptual abilities, reading, and self concept and social interaction" (Powledge, 1967, p. 41).
The classrooms operated by the Institute focused on compensating for these deficits by a meticulously planned broadly conceived curriculum which emphasized language and cognitive skills and which made a deliberate attempt to "move away from the middle-class focus on emotional development" (Powledge, 1967, p. 51). The teachers for the program were carefully chosen and special attention in their training was given to sensitizing them to the special life condition and needs of these children. There was a parent program, but it was undertaken not to respond to any real needs of the parents or even because of a belief in the fundamental significance of the parents in the life of a child, but to attempt to provide continuity between home and school by changing parental attitudes about school.

Other model programs were developed including the operant conditioning model of Bereiter and Engelmann (1966) and the Piaget based Perry Preschool Project in Ypsilanti, Michigan (Sonquist and Kamii, 1967; Kamii, 1972). Some Head Start programs were designed with a cognitive enrichment program, although most tended to use a more traditional nursery school format.

All programs, cognitively based or otherwise, which were part of the first wave of intervention programs were designed around classrooms for three to five year old children, intended to compensate for deficit experiences of a cognitive or social order seen to exist among the disadvan-
taged children of poverty. The concerns were social and educational and although there was a growing concern for children developing a positive self image, this was seen by the cognitivists to be related to success in the social environment of school, and there was inadequate attention given to its beginnings in early mother-child relations, which affected subsequent development of ego functions. Parent involvement was sought in many of the programs to enlist the parents' cooperation with what the program planners saw as best for the children. Head Start programs did include delivery of medical, dental and social services to participating families, in an attempt to get at the roots of the educational deficits which could be attributed to the conditions of being poor. While there was no uniformity of quality in Head Start programs, in many families it was an effective catalyst for change which has had long ranging effects. In terms of the stated objectives which were to insure children's subsequent school success, the long range effects of all these programs have been disappointing (Bronfenbrenner, 1974; Evans, 1971).

Before the cognitive psychologists influenced early childhood education intervention programs, early education had been dominated by developmentalists who emphasized the child's social and emotional growth. For many of these early childhood educators an attempt to teach, or even to encourage interest in, numbers, reading, or any intellectual
or academic pursuits was seen as harmful and contrary to the needs of the whole child. The cognitivists made an important contribution to the field by demonstrating the possibilities and the advantages of professional concern for the intellectual growth of the very young child. In many intervention programs, however, the reaction of the cognitivists was too extreme and programs were too narrowly focused on academic skills and cognitive development.

**Programs for the "Whole Child"**

It is possible to provide programs which recognize the real, whole child who is part of a family and in need of both education and nurturance. This can be seen from a study of the Dubnoff Center in California which operates two nursery programs in addition to the special education classes for older children. Although Dubnoff's formal education was in psychology, the Center is very much a school, not a mental health center. Specialized education is the primary therapy for the children and for their families, although education is conceived of in very broad terms, with Gesell, Piaget and Erikson being credited with providing the theoretical base of the program. Mental health and educational goals appear to be genuinely meshed in this school which uses student teachers from the fields of education, psychology, early childhood education, and social work. The child psychiatrist who consults at the school shares Dubnoff's
conviction of the appropriateness of using education as the primary therapy for these children. Dubnoff herself "sees her program as using the Eriksonian framework as the source of a step-by-step development of ego identity which 'has pointed our work in the direction of building ego strength through mastery'" (Glasscote and Fishman, 1974, p. 35).

The social worker who works closely with one of the Dubnoff Center nursery programs sees a problem in the teachers being intimidated by mental health professionals in spite of the fact that their experience and in-service training at the Center gives them an expertise beyond that of the average mental health worker.

The Dubnoff Center does appear to have achieved the same degree of successful collaboration as the Hanna Perkins School, suggesting that the deciding factor is not whether a program is operated by a mental health facility or a school. In either case it is possible, although the scarcity of such programs indicates it is not easy. The Preschool Unit of the Cambridge-Somerville Mental Health and Retardation Center is a further example of successful collaboration. It is described by Glasscote and Fishman (1974), as "probably one of the most comprehensive and well-thought-out preschool programs in the country" (p. 161). This program is co-directed by an early childhood educator and a psychiatrist who have "learned a great deal about each other's fields" (p. 161). A variety of services are offered, including
several therapeutic classrooms serving children with the whole range of developmental problems, diagnostic nurseries, individual psychotherapy, and consultation to other early childhood programs. Extensive opportunities for staff interaction and in-service development are scheduled into the busy weekly schedule of the Preschool Unit. This program lacks funds for formal evaluation but according to the informal follow-up of children who have been served, investigations of parent satisfaction, and observations of staff morale undertaken by Glasscote and Fishman (1974), it seems clear that this is a program which deserves to be emulated in other localities.

Mental Health Consultation

While good therapeutic preschools for children whose needs have been identified fill an important need, other major roles for the mental health profession in early education are prevention and early detection. This requires the availability of mental health services in facilities for "normal" children. Furthermore, many professionals believe that many children known to need mental health intervention can benefit from being in a program with normal children, but only if that program is able to provide appropriately for the child's emotional needs. When a child's individual needs in any area of development deviate from the norm, it is often difficult to meet them in the social setting of the early
childhood classroom. One effort to meet special emotional needs of children in regular preschool classrooms has been through consultation by mental health professionals. Research into mental health consultation to teachers has revealed many difficulties (Bower, 1961; Caplan, 1959). Traditionally a mental health consultant to a nursery school is a psychologist or social worker or psychiatrist who visits the school to observe and advise concerning a child who is having some difficulty or with whom the teacher is having some difficulty. Successful consultation is invaluable, but all too often collaboration between nursery school teachers and mental health consultants is marred by suspicion and mutual distrust. The teacher may have the same sense of having failed that a parent seeking help often has, or she may feel that she is being judged and found wanting. Her defensiveness will not be relieved by having an outside "expert" come into her classroom and, after a few hours of observation during which time a battery of tests might be administered, make a "definitive" assessment of the child's condition and needs. Many, probably most, mental health workers who are cast in this consultant role have had no experience as early childhood classroom teachers. Even if their suggestions to the teacher are appropriate to the needs of the child, the chances are overwhelming that they will be impossible to carry out consistently within the limits set by school policies for classroom management.
This is particularly threatening to a young and inexperienced teacher. The teachers who are most in need of the supportive help that consultants should provide are for the very reason of their inexperience least able to benefit from the new insight. Mental health consultants are frustrated by what appears to them a total disregard of their suggestions. If professionals who are used to working individually with children are to provide useful consultant service to teachers, they must become more aware of the limits imposed by group settings for young children, and classrooms must become more flexible. Neither of these goals is likely to be realized within the typical current consulting mode.

When the responsibility for seeking help for children in need resides with the teacher, some of the most seriously disturbed children may never be referred to the consultant. It has been frequently observed that teachers can better tolerate and therefore less likely perceive as ill, a quiet, withdrawn child who does not disturb the class.

A traditionally trained teacher with a smattering of clinical training might correctly perceive the child as suffering from an inadequately nurturant home environment, but she might also wrongly conclude that the nurturance of the school environment would be sufficient treatment for a child who actually needs a much more intensive intervention. A teacher whose background has emphasized cognitive development may actually exacerbate a problem by exploiting a
child's particular precocity, which may exist as an unhealthy adaptation. This child also may never be brought to the attention of the consulting clinician.

Sometimes a clinician can help a teacher to understand the unmet needs or troubled feelings which underlie a child's undesirable behavior. The teacher can learn to respond to those needs and feelings in such a way that the child's behavior no longer disrupts the classroom. In some cases, however, the consultant may see the nursery school environment itself as contributing to the undesirable behavior, and if she has no background in educational techniques or classroom management to equip her to make useful alternative suggestions to the teacher, there is an impasse. The teacher may resent what she sees as criticism which is not accompanied by constructive suggestions. This creates tensions between the two professionals which interfere with their ability to operate cooperatively on other cases, which in themselves may present solvable problems.

An interesting version of the consultant system has been developed at Project Enlightenment in Raleigh, North Carolina. Recognizing the problems commonly associated with clinical consultants to nursery school teachers, the project decided that their consultants must have teaching experience as well as mental health training. The emphasis is on helping teachers learn to help children with special needs in the regular classroom, so the emphasis is on in-service
teacher education more than on direct treatment for the child. Most of the full time staff, including the program director, have been trained as educators. Most of the part time regular staff are mental health professionals. Most of the consulting work and teacher education is done by the teacher/consultants, but when necessary a clinical team will visit a program to provide a more extensive diagnosis of a child. As a last resort there is a therapeutic nursery school to which a child can be referred, but even there, some "normal" children are members of the class to demonstrate that special needs can be met in integrated classrooms. The aim is to return the special children to the nursery schools from which they have been referred as soon as possible (Glasscote and Fishman, 1974).

This program recognizes the lower status and self esteem of teachers and has developed a strategy to compensate for this situation. The result is an attempt to attend to the child's mental health needs efficiently with the least interruption of his broader educational program.

Summary

This brief survey suggests some of the practical and theoretical issues which were raised during the fifty years preceding the enactment of Chapter 766 in Massachusetts as child developmentalists, educators, mental health professionals and others throughout the country turned their
attention to learning about and providing services for preschool age children. Child Study Centers were the loci for research, professional training and laboratory nursery schools. Efforts were made to provide broad based training in Child Development for students from different disciplines having to do with children, but the demands for in-depth scholarship and research caused "fractionation" rather than integration of the curriculum.

Most early programs for preschool children were designed primarily to address social and emotional needs. Later, other programs were created to encourage intellectual development. Many early childhood educators were not convinced of the need to give equal attention to addressing the whole range of a child's needs. In trying to meet the special needs of preschool age children with emotional problems, early childhood educators and mental health professionals combined their services to offer therapeutic nursery schools and consultation services to nursery school teachers whose classes included some children with emotional difficulties. At this practical level of service delivery the need for every practitioner to have a broad knowledge of the whole child remained apparent, but it was a difficult need to satisfy.

Design of This Study

When Chapter 766 became law in Massachusetts it became
the responsibility of public school educators in the cities and towns across the Commonwealth to grapple with these problems. The fact that public schools themselves in most localities had no previous experience in providing services to preschool age children with emotional difficulties added a new dimension to the problem. This lack of experience seemed to necessitate the collaboration of public school educators with mental health professionals. Collaboration between the two professional groups could be expected to present problems of its own.

This two phase study looks at that collaboration. Phase I is a survey of programs in Massachusetts now serving preschool children with special emotional needs. Phase II is an exploratory study of eight of those programs identified during Phase I which appear to be successfully responding to the challenge. During site visits to the programs classes were observed and interviews were conducted with members of the staffs.
CHAPTER III

PHASE I: PRELIMINARY SURVEY

The Method

This study was conducted in two major phases. Phase I was a telephone search and survey of programs in Massachusetts in which mental health professionals and educators work together to provide services to emotionally disturbed preschool children.

Securing the sample. Regional and central offices of the Departments of Education and Mental Health were contacted by telephone for a master list of programs serving emotionally disturbed children in Massachusetts. Neither department had a master list of such programs or a comprehensive listing of currently functioning programs serving preschool children having either specific or general special needs.

A card file of possible programs was compiled using the 766 Approved Day Facilities Report from the Children's Information Center at St. Ann's Home, Inc. Other sources consulted by telephone include:

- The Department of Public Health
- The Federation for Children With Special Needs
- Office for Children
- Individual school systems
- Educational collaboratives
- Mental health clinics.

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Lists provided by some of these sources include:

Massachusetts Organization of Educational Collaboratives (MOEC)
Community Clinical Nursery Schools (CCNS)
Head Teachers
Department of Education list of private schools approved under Chapter 766
recipients of federal early childhood grants
mental health clinics providing services under Chapter 766.

In most cases the information received from all these sources was inconclusive for the purposes of this study. In each such case a telephone call was needed to determine if a particular program served preschool children with special emotional needs and, if so, to identify an appropriate contact person.

The phase I sample. Seventeen programs offering educational and therapeutic services to preschool children with special emotional needs were identified during the initial stage of phase I. Fourteen of these comprised the sample to which the investigator was able to administer the preliminary survey protocol. Six of these were programs conducted by public school systems or educational collaboratives, six were conducted by, or in close collaboration with, a mental health facility, and two were independent programs.

Construction of the survey protocol. The purpose of the preliminary survey was to identify an appropriate sample for phase II of the study. Programs were sought which had been in operation for at least one year in which educators and
mental health professionals worked together to provide services to emotionally disturbed preschoolers. To this end, the Early Childhood Educational/Therapeutic Services Survey was constructed.

**Identifying information.** The first section of the protocol provides identifying information. Questions one through four identify the programs by name, sponsorship and length of time in operation. Question five, "Describe any affiliation this program has with a mental health facility," seeks information on inter-agency cooperation. When directed to a respondent from a mental health facility rather than an educational establishment, the question asked was "(a) Does this agency have a regular relationship with a school system? (b) How many of your preschool referrals come from public schools under 766?" Question six identifies the contact person.

**Services provided.** Question seven provides information about the specific services offered and the ages and specific needs of the children served. School systems and educational collaboratives do not identify the populations they serve as "emotionally disturbed," so the protocol was designed to elicit the most specific information possible about the kinds of special needs served. The intention was to include in phase II only programs offering special classrooms and individual therapy in order to insure that both teachers and therapists would be included on the staff of a
1. Name of EC program or activity.

2. Agency or person (by title) responsible for establishing and operating EC program.

3. How long EC program has operated.

4. Major sources of EC funding.

5. Describe any affiliation this program has with a mental health facility.

6. Name of person responding to this form.

7. Please check each of the following which are included in EC program:

- [ ] Observational or diagnostic classroom
  - How often does it meet?
  - How long does child usually remain?

- [ ] Therapeutic EC classroom
  - Special needs served
  - Hours per week
  - Ages served
  - Expected length of child's stay

- [ ] Normal EC classroom
  - Hours per week
  - Ages served

- [ ] Integrated EC classroom
  - Total number of children served
  - Number of special needs children served
  - Hours per week
  - Ages served

- [ ] Consultation services to other EC programs.

- [ ] Individual therapeutic services to children under seven years of age. Please specify services included.

- [ ] Other. Please describe briefly.
Early Childhood Survey Cont.

7a. How many children with special needs are served? 

8. Please list EC staff* by job title, special training, and hours per week devoted to this EC program.

<table>
<thead>
<tr>
<th>Job Title</th>
<th>Special Training</th>
<th>Hours in EC program</th>
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</tbody>
</table>

9. What in-service training and supervision does staff receive?

10. Describe briefly the frequency, purpose and style of staff meetings.

11. Do you use volunteers?  

   In what capacity? 
   How are they recruited and trained? 

12. Describe briefly the future plans and aspirations for this EC program.

* Please include consultants.
program. Because the number of programs being surveyed was small, information about other components was also sought in the event that the results identified fewer than eight programs which met the intended criteria.

**Staffing information.** Questions eight through eleven provide information about the staffing policies of the programs. Question eight concerns job titles, special training, and hours devoted to the program by the regular staff and the consultants. Questions nine and ten provide information about the in-service training, supervision and staff meetings within the program. Question eleven concerns use, recruitment and training of volunteers. These questions are intended to provide further assurance that both educators and mental health professionals are represented in the delivery of services and to provide information about the relative positions of the two professions within the programs. These questions also suggest the priorities the programs have in addressing the needs of children with emotional difficulties.

**Future plans.** The final question of the protocol provides information about future plans and aspirations. It is intended to elicit further information about the breadth of concerns of the program which might relate to its commitment to professional collaboration in behalf of children with emotional problems.
Procedure. Telephone calls were made for the purpose of scheduling telephone interviews with each of the 17 contact persons identified during the program search. During the month of March 1977, ten protocols were completed before any site visits were scheduled. During the last week in March the scheduling of the two phases of the study overlapped as site visits began to be scheduled to insure their completion before the end of the school year. Three more telephone interviews were completed during the spring of 1977 and the final preliminary protocol was completed in June during a site visit, because the director of the program had been unwilling to respond by telephone. Three of the original seventeen programs could not be reached to complete the interview.

When conducting the survey the investigator identified herself by name and described the project as a study of preschool programs in Massachusetts serving children with special emotional needs. The respondent was told that the study was being conducted for a doctoral dissertation in Early Childhood Education at the University of Massachusetts in Amherst. The questions were asked in the order in which they appear on the survey, and except for question five, which was different for programs operated by schools and those operated by mental health facilities, all respondents were asked the same questions. The protocol took from twenty to thirty minutes to complete. At the close of the interview the respondent was told that the investigator hoped to visit
some of the programs and to interview members of the staff, and was asked if it would be possible to visit this program. All the programs agreed to the visits by appointment, but some expressed uncertainty about the availability of time for staff interviews.

Results and Discussion

According to the original design for this study, during phase I a preliminary survey was to have been mailed to all the educational programs in Massachusetts serving preschool children with emotional disturbances. It was assumed that, since Chapter 766 had been in effect in Massachusetts since September of 1974, all such programs would be known to this state's Department of Education to enable school departments and other professionals to make appropriate referrals. The Department of Mental Health was also expected to be a source for locating existing programs. When such lists were not available from either department, the original plan for phase I was altered to include a program search before the preliminary survey protocol could be administered.

The telephone search. The search for programs further highlighted the difficulty of locating services for preschool children with emotional problems. The Department of Education avoids the use of any diagnostic label indicating
emotional problems, and speaks instead of children with special needs. During the search, contacts were therefore asked about "programs for preschool children with special emotional needs."

The available lists, which were expected to include all programs to serve emotionally disturbed preschool children, were not comprehensive and still necessitated a tedious and time consuming search. The term "early childhood" on a list can refer to any age from zero to eight, and lists of special programs in that category include home teaching, early reading, and programs for a whole range of special needs, often unspecified on the list, which on further inquiry are revealed to be outside the scope of this study, having nothing to do with special emotional needs. The Education Department's listing of private schools approved under Chapter 766 is equally uninformative concerning appropriate programs, since here also programs serving all kinds of needs are listed together, with the special needs not always specified. Some are normal classes which accept a limited number of children with special needs and programs for all ages are included, again with needs often unspecified. Listings which specify programs for emotionally disturbed children usually do not specify ages served, or if they do, preschool is usually not included.

Although many individuals and offices were suggested as possible sources of information, most of them were able to
provide little information which actually resulted in locating programs offering the services being sought. The same few persons and offices were referred to over and over and several programs which were recommended as serving the population of concern to this study were, upon further contact with the program itself, found not to be programs for emotionally disturbed preschool children. Some preschool programs offered by the Department of Public Health were frequently mentioned, but they were designed for a different population, so they were not included in this study.

Seventeen programs were located by the search and ten of the fourteen programs for which the preliminary survey was completed were from the eastern part of the state. Of the four remaining, only two were actually found to be providing for the needs of emotionally disturbed preschool children in classrooms.

The decision to administer the preliminary survey protocol by telephone was the result of having only 17 programs found. It was too small a number to expect that the returns from a mailing would result in a large enough sample for phase II, and it was small enough to allow the time necessary for completing the protocol by telephone.

The difficulty of finding programs to serve preschool children with special emotional needs highlights two problems which result from insufficient professional involvement with this population. First, there is the actual dearth of
services for these children, which has been a matter of concern for those relatively few who have been professionally involved with emotionally disturbed preschool children. Secondly, the lack of awareness and concern for the needs of these children which prevails among other professionals results in minimal awareness of the programs which do exist, so that they are not publicized and listed as they should be in a way that would make them easier for parents and other professionals to locate.

The injunction on the Department of Education not to label children as emotionally disturbed needs special consideration. It is claimed that such labels are to be avoided because they stigmatize a child. They cause some adults, even teachers, to regard the child more as a problem than as a child and as a result exacerbate his problem. It is further claimed that having socially undesirable labels on a child's record can have a deleterious effect on the child for life. These claims can be neither denied nor ignored. There is clearly a need for public education concerning mental health, particularly preventive mental health, services. There is a need to develop a climate in which parents and children can seek assistance with the psychological aspects of development as readily as they now seek routine medical care. Meanwhile, a child's need for appropriate psychotherapeutic services cannot be denied. Labels need not be pejorative. Professionally meaningful yet benign labels can be
used which indicate a child's need for particular psychotherapeutic services which must then be available and readily accessible to parents and professionals who seek them. The apparent lack of programs, as well as the difficulty of finding ones which do exist, suggests strongly that many school systems, in addition to avoiding the labeling of emotional disturbance, in effect deny its existence. Perhaps they are just denying responsibility for dealing with the problem which is seen as being the responsibility of the mental health professionals. There is certainly some justification for that position, but, since Chapter 766 has given schools responsibility for educating children with substantial special needs, and since the existence of substantial special emotional needs impinges directly upon a child's ability to benefit from normal educational opportunities, it would seem to be imperative that the Departments of Education and Mental Health resolve the problem jointly. For the Department of Education to be able to acknowledge emotional disturbances in small children would seem to be among the necessary first steps.

The telephone survey. Fourteen programs located during the telephone search completed the survey protocol. Six of these are operated by public educational facilities, six by mental health facilities, and two are independent programs. The public educational programs have been in operation for from
six months to three years. All public school programs are supported primarily by regular school funds allocated for Chapter 766 programs. Only one of these programs reports any additional funding source. The six mental health programs have been in operation for from $3 \frac{1}{2}$ to 20 years. Two of them are currently funded entirely with money allocated by school systems for special education services according to Chapter 766 regulations and all receive some payments directly or indirectly from such funds. None of the school programs reports a regular relationship with a mental health center although one collaborative reports using some mental health facility resources and one reports that they do manage some collaborative relations with a mental health facility. The director of a third program expressed the wish that such a relationship existed. Four of the six mental health programs report a formal relationship with individual school systems or collaboratives. The other two encounter school systems as they serve individual children referred under Chapter 766.

Upon completion of this protocol the two independent programs were eliminated from further consideration in this study because one of them had been in operation less than one academic year and one did not include therapeutic classrooms in the services it offered. The program which one school system had been operating for only six months was also eliminated from further study. The 11 remaining programs
appear from the survey to have been in operation for at least one full academic year and to serve preschool children with special emotional needs in classrooms and with some individual therapy. In some programs the individual therapy offered was not psychotherapy provided by a mental health professional, but all the programs did list some mental health professionals among the staff. Because there were so few programs remaining for possible inclusion in the sample for phase II, no further effort was made to select the sample on the basis of the results of the telephone survey. An effort was made instead to visit as many of the 11 programs as was necessary to find eight programs for the phase II sample.
CHAPTER IV

THE PHASE II METHOD

The Sample

It was possible to make site visits to ten of the eleven programs which appeared from the preliminary telephone survey to satisfy the criteria for inclusion in the phase II sample. At one of the ten programs visited, it proved impossible to interview the staff, and at another it became apparent from the site visit that the program did not in fact meet the criteria for inclusion in the phase II sample, although the information from the preliminary protocol had indicated otherwise. The resulting sample of eight programs includes five conducted by or in conjunction with mental health facilities and three by a public school or educational collaborative. At these eight programs, 14 classrooms were observed and a total of 23 staff members were interviewed. The respondents include 10 administrators, at least one from each of the eight programs. Administrators interviewed include a psychologist, a psychiatrist, a social worker, six early childhood educators, and one special educator. One of the administrators who is now a mental health professional was formerly an elementary school teacher. Thirteen of the respondents teach classes
in the programs. Nine of these teachers also function as therapists to individual children or are involved in some form of therapeutic intervention with families. One of these teacher/therapists is also an administrator. One other respondent is a social worker. In seven programs at least one of the persons interviewed is performing a service usually associated with the mental health profession. Four are members of traditional mental health professions. Classroom teachers from each of the programs were interviewed. Five staff members were interviewed from one program, four from two programs, three from one program, two from three programs and one from one program.

Table 1 summarizes the respondents from the sample programs according to their professional role(s) within the programs.

**Interview Protocol**

The interview schedule was designed as the major tool of this exploratory field study of programs of service to preschool children with emotional disturbances. An open ended interview format was chosen as the most fruitful tool for gathering data in this study of programs providing what the investigator recognized as rare and badly needed services. The criteria for selecting the phase II sample were expected to insure that the programs chosen would be examples of reasonably successful intervention. The knowl-
<table>
<thead>
<tr>
<th>Program</th>
<th>Total Respondents</th>
<th>Administrators</th>
<th>Teachers</th>
<th>Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alpha</td>
<td>1</td>
<td>1 Early Childhood Educator (Director)</td>
<td>Teacher/Therapist</td>
<td></td>
</tr>
<tr>
<td>Beta</td>
<td>2</td>
<td>1 Early Childhood Educator (Director)</td>
<td>1 Head Teacher/Therapist</td>
<td></td>
</tr>
<tr>
<td>Gamma</td>
<td>3</td>
<td>1 Psychologist (Associate Director)</td>
<td>2 Head Clinical Teachers</td>
<td></td>
</tr>
<tr>
<td>Delta</td>
<td>4</td>
<td>1 Social Worker (Director)</td>
<td>3 Teacher/Family Workers (psychoeducators)</td>
<td></td>
</tr>
<tr>
<td>Epsilon</td>
<td>4</td>
<td>1 Psychiatrist (Clinical Director)</td>
<td>1 Co-Teacher (psychotherapist)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Early Childhood Educator (Educational Director)</td>
<td>1 Co-Teacher (tutor)</td>
<td></td>
</tr>
<tr>
<td>Zeta</td>
<td>2</td>
<td>1 Early Childhood Educator (Director)</td>
<td>1 Head Teacher (parent guidance)</td>
<td></td>
</tr>
<tr>
<td>Eta</td>
<td>5</td>
<td>1 Special Educator (Director)</td>
<td>1 Head Teacher (Core Evaluator)</td>
<td>1 Social Worker</td>
</tr>
<tr>
<td></td>
<td></td>
<td>1 Early Childhood Educator (Coordinator)</td>
<td>1 Head Teacher</td>
<td></td>
</tr>
<tr>
<td>Theta</td>
<td>2</td>
<td>1 Early Childhood Special Educator (Coordinator)</td>
<td>1 Head Teacher (home visitor)</td>
<td></td>
</tr>
</tbody>
</table>
edge, experience and insights of professionals currently
engaged in providing these services appeared to the inves-
tigator to be the most valuable source of pertinent in-
formation (Katz, 1953; Kerlinger, 1973; Selltiz, 1967).

The purposes of the protocol were to:

generate factual data about collaborative programs to supplement that provided by the phase I protocol.

suggest relationships which might exist be-
tween a person's professional identification as an educator or a mental health professional and his/her perceptions of the program and his/her role in it.

indicate any differences which might exist between programs operated by mental health facilities and educational establishments in terms of program design, theoretical founda-
tions, staffing patterns and administrative policies.

reveal the strategies used in these programs to attempt to incorporate the traditional concerns of both professions in the delivery of services to emotionally disturbed pre-
school children.

To this end an open ended flexible interview format was designed in five sections. The topics covered in the five sections include: services offered, staffing, adminis-
tration, outreach and diffusion, and self evaluation.

Services. The first question in section I is about the goals of the services. This offers a logical beginning to a discussion of a program to which each respondent can be expected to have given some thought. It assumes a serious-
ness of purpose while being non-judgmental and open ended.
I. Services

A. How would you describe the overall goals of the services offered by this program?

B. Can you tell me now what services are included in this program?
   1. How does this program function in relation to Chapter 766?

C. Is there a particular clinical orientation to the program?

D. Would you describe the therapeutic classroom?
   1. Could the structure and content be described in terms of a particular educational model?
   2. What are the overall goals?
   3. What are the means used for meeting the individual needs of the children within the classroom?
   4. number of children in classroom? ages?
   5. diagnostic categories?
   6. classroom staff?

E. Can you tell me about the individual therapy that is offered?
   1. nature of the therapy?
   2. Who receives it? Are they involved in other components of the program?
   3. Who provides it?

II. Staffing

A. Would you tell me about your role in the program?
   1. title?
   2. extent of direct contact with children?
   3. contact with other professionals working for same children?
      a. those outside the program.
      b. those in program for whom you consult.
         time spent observing.
      c. those who consult for you. time being observed.
Staff Program Analysis (Continued)

d. those whom you supervise. time spent observing.
e. your supervisors. time spent observing you.
f. others.
g. Would you prefer to have more contact with any of the people who work with you or with the children? How would you prefer to use any additional time?
h. Are you satisfied with the quality of the consultation you receive? Can you tell me something about the difficulties?
i. Are you satisfied with the quality of the supervision you receive? Can you tell me something about that?

4. What is the extent of your contact with parents? Is that satisfactory?

5. a. Would you tell me about your professional training and experience in terms of its relevance to your role in this program?
b. Are you currently involved in any in-service program? Would you tell me about that?
c. Are there any further training opportunities you would like to have that you think would be useful to your work in this program?

B. Could you tell me briefly what other staff positions there are in this program and what services are provided by them?

C. Are there any other comments you would like to make about staffing and staff training for this kind of a program?

III. Administration

A. Were you involved in the original planning for this program? Can you tell me something about the original planning? Who was involved?

B. Are you involved now in the ongoing planning for the program and for its future?

C. I'm interested in how the staff was recruited and hired for this program. Can you tell me about that in your case?
Staff Program Analysis (Continued)

1. already with the agency. Who participated in decision for you to become involved in this program?
2. hired specifically for this program. Who hired you? What other members of staff had you met before being hired? Did you participate in hiring of other staff? Could you tell me about that?

D. Are there staff meetings other than those we've discussed in relation to consultation and supervision? Can you tell me about them?

1. frequency?
2. purpose?
3. who attends?
4. who chairs?
5. Can you say something about the style of the meetings?
6. How are decisions reached?

E. Who has final responsibility for decision making in this program?

F. What is the professional background of the director(s)?

IV. Possibilities for effectiveness outside of the immediate program.

A. Is this considered a demonstration program?

B. Do you provide consultation to other programs other than the consultation already discussed?

C. Do you conduct training programs for other than your own staff?

D. Is there any ongoing research connected with this program?

V. Self Evaluation

A. Are there any particular factors you would like to single out as being most important to the success of the program?
Staff Program Analysis (Continued)

B. Even in the best of programs, perhaps especially in the best programs, the staff involved usually have ideas for changes they would like to see for improving their programs. Could you tell me about any changes you would like to see in this program?

C. Based on your concerns and experiences, what advice would you give to others interested in developing a program of services for young children with special emotional needs?
   1. planning and administering?
   2. services to offer?
   3. staffing?

E. Are there any other comments you would like to make? Anything that you think is important to understanding the program that my questions have not given you the opportunity to express?

F. Programs providing educational and therapeutic services to young children with special emotional needs would seem to require some degree of cooperation between educators and mental health professionals. Would you comment on that in relation to this program?
It should provoke a thoughtful analysis. If there were fundamental differences between educators and mental health professionals working within the same program or between programs sponsored by educational institutions and mental health organizations, they could begin to appear immediately. In a well organized program all participants could be expected to display considerable agreement about goals, so differences in emphasis could be significant. If different programs which have similar goals used different methods to achieve them it would also be of interest.

The remaining questions in this section on services ask for a listing of the services offered and for descriptions of the therapeutic classrooms, the individual therapy, and the clinical theory on which the services are based. These questions are intended to provide basic program data expanding and clarifying the information gathered during the telephone survey. The questions also could indicate the degree of integration between clinical and educational concerns.

Staffing. This section is intended to elicit information about the role within the program and the training of some individual staff members in greater detail than the information that was gathered by the telephone survey. Central to this study is the observation that there is currently no one recognized profession dedicated to serving this special
population. This section of the protocol was intended to indicate which professional roles actually prevail in programs of service to this population and what kinds of professional training and experience prepare an individual to perform these roles. Respondents were expected to include those trained to be preschool teachers as well as those trained in the traditional mental health professions. Therefore, the protocol was designed to suggest which aspects of those traditional training programs are most relevant to working educationally and psychotherapeutically with emotionally disturbed preschool children.

In this section the protocol asks for evaluative responses for the first time. The evaluations sought include the relation of the respondent's training to the actual role assumed within the program and includes also the respondent's satisfaction with supervisor/supervisee and consultant/consultee relationships within the program.

Administration. In this section of the protocol are questions about involvement of staff in program planning and hiring practices, the purposes and conduct of staff meetings, responsibility for decision making and the professional background of the directors. These questions were expected to suggest any interprofessional biases and authority patterns in the administration of these programs and any differences in administrative policies which exist between
mental health operated programs and those conducted by school authorities.

**Outreach and diffusion.** This section of the protocol was designed to collect data about the program's use as a demonstration model and to provide consultative services to others who were establishing programs of service to preschool children with emotional disturbances. Questions in this section also concern the program's involvement in training and research. Services to this population are judged to be an underdeveloped area of human services, and information was sought to suggest the degree to which these current practitioners are addressing that issue through research and dissemination.

**Self evaluation.** Section V is the most subjective section of the protocol. Here the respondents are asked to evaluate their program according to which factors they considered most important to the program's success, and what changes they would like to see to improve the program. They are asked to advise others who might be interested in establishing a program of educational and therapeutic services to this population about the services which ought to be included, and how the program ought to be planned, administered, and staffed. Here, more than in any other section of the protocol, the accumulated knowledge and experience of those persons currently providing services to this
population are exploited in the hope of finding important guidelines for the development of other programs for this special population. In this section the respondents are also asked to comment on the need for cooperation between educators and mental health professionals in the delivery of these services.

The insights of professionals actively involved in providing services are regarded as appropriate guides when reflecting upon and integrating the factual data resulting from the interviews. Both are needed in planning new programs of service to preschool children with special emotional needs.

Procedure

Site visits to ten programs were scheduled by telephone. At the eight programs which comprise the sample, at least one morning was spent observing the therapeutic classrooms. In three programs the entire morning was spent observing in one classroom. In five of the programs the observation time was split between two classes. One program was observed in session more than once; there the same class was observed for two full morning sessions, and one class was visited for one hour during an afternoon session.

At four of the programs, operated as extensions of mental health facilities, the observations were conducted from an observation booth. In one case the rooms were
equipped with one-way mirrors and in three the investigator observed from behind screening. In one program a point was made of introducing the observer to some of the children and in two the observer was acknowledged or introduced only if a child became aware of her presence and showed some concern. In one mental health center-sponsored program the observer was in the classroom as a non-participant observer and invited to interact with the children during outdoor time. At three programs, operated by educational facilities, the observations took place within the classroom and the observer was invited to interact freely with the children.

Observations were included in order to verify the data from the preliminary survey and, if necessary, eliminate from the phase II sample any program not delivering appropriate services. The observations also allowed the investigator to form an impression of the classroom component of the programs, which could be useful in interpreting the respondents' answers to questions about the therapeutic classrooms and in framing follow-up questions.

The investigator was an experienced preschool teacher and administrator who also had experience conducting individual and small group therapy with young children with emotional difficulties. An unstructured observation seemed to be the most flexible and unobtrusive way to acquire the necessary validating information. Extensive note taking or use of a formal observation check list arrived at
apart from a knowledge of the particular program's goals and assumptions was deemed an unnecessary obstacle to the establishment of rapport between the classroom staff and the observer.

When scheduling site visits, the investigator told the contact person that she wanted to interview as many members of the staff as possible, including teachers and directors and any individual therapists, psychologists and social workers who provide services in the program. The problem of time was usually raised by the contact person, and when it was, the investigator said that the full interview would probably take about an hour, but that if there was not enough time to interview everyone for that length of time she would appreciate the opportunity to talk with several staff members for a shorter time as long as she could conduct the full interview with some member of the staff. She explained that some questions were simply factual and needed only to be asked once, but that she was interested in hearing several persons' views about some aspects of the program.

Most of the staff members of these programs had crowded daily schedules, and the way to insure the maximum amount of interview time was to have the interviewer be available to them at the sites of their programs at times convenient to them. In all but one program some interviews were conducted on the same day that a class was observed,
but after the observation. Six programs had to be visited twice to complete the interviews.

Several precautions were taken to help insure that the interviews would be fruitful and the data thus obtained would be valid and reliable.

The interviews were conducted individually and in private. Candor, self reflection and critical analysis were further encouraged by the establishment of an easy relaxed rapport between an appreciative, non-judgmental interviewer and each respondent. Before asking the first question the interviewer thanked the respondent for making time for the interview and, in the case of the eight programs in the sample, was able to express her interest and enjoyment in the observation. She explained that the study was a non-evaluative field study of programs in Massachusetts providing services to preschool children with special emotional needs and was being conducted for a doctoral dissertation in Early Childhood Education at the University of Massachusetts. She said that she would like to tape the interview. A tape recorder was used to allow the interviews to flow in a more natural, relaxed, conversational way and also cover more material in the time available than would be possible if the interviewer took extensive notes during the interview. All but two of the interviews were tape recorded. One of the untaped interviews occurred on a playground and one in a secluded corner of a large, somewhat noisy classroom in
which other groups were talking. In those two situations it was not convenient to use the tape recorder. The taped interviews were conducted in whatever private space was available at the program sites. These spaces included empty classrooms, conference rooms and observation booths, offices, and in one case an automobile. Only one respondent expressed any discomfort at the use of a tape recorder, but she agreed to its use and asked to have it turned off for just one response. During one other interview the respondent asked to have the recorder off briefly.

In the interests of natural candor, no effort was made to keep with a rigid order of questioning. The full interview was designed and tested to take one hour. The time available for some interviews was less than an hour, so in six cases only a partial interview was conducted. Two interviews exceeded an hour. One director spent three hours being interviewed.

Treatment of the data. As soon after each interview as possible the interviewer listened to the tapes and took detailed notes, including quotations. During this first processing of the tapes the responses were recorded according to the five sections of the interview schedule, with each section assigned color coded cards. As themes and issues began to emerge which cut across sections of the interviews, the notes were reorganized according to the
emerging issues. The tapes were listened to again and sections which related to the major themes were transcribed. These notes and transcriptions were used as the basis for the discussion of the issues in collaboration which emerged from this exploratory field study.
The eight programs selected for this study are providing educational and therapeutic services to preschool age children with emotional difficulties. Observations in the classrooms and discussions with staff members confirm the delivery of services and the client population served. There is no attempt to make evaluative comparisons between the programs but rather to consider some issues that recur as each program attempts to deal with the problems of providing educationally and therapeutically for these special children. Because this is a study of certain issues related to collaboration between professions rather than a study of specific programs, the programs used to demonstrate the issues will not be identified by name. Four of the programs are relatively small and are operated by or in close collaboration with mental health facilities. They have been designated as Alpha, Beta, Gamma and Delta. One large program, Epsilon, is also operated by a mental health facility. Zeta and Eta are programs operated by large educational collaboratives and Theta is operated by a single school system. A brief description of each of the programs will be given before discussing the issues.
Alpha

Alpha is a small intensive mental health affiliated program serving twelve children and their families. The aim is "to integrate preschool children who have emotional disturbances back into regular classrooms as fast as we possibly can, and to work with families regarding the difficulties that they're having, particularly with that child . . . in our school." The program offers two "relatively simple safe nursery school" classrooms with six children and two teachers, one man and one woman, in each class. The two large adjoining classrooms are in a building housing other therapeutic schools for children of different ages. The programs are all separate but all are operated in close collaboration with a mental health center. The location is an affluent suburban neighborhood adjacent to a major city. The preschool morning includes the usual free play, group and snack times of a traditional nursery school. "It's a group psychoeducational approach so within that milieu there's also individual work which teachers do with children which is . . . individual psychotherapy." The atmosphere during the observation was extremely warm and informal. Teachers were all highly nurturant but selectively confrontative. The teachers talked a great deal to each other and to the children. They talked about the children's feelings and related what was happening in the
classroom to other circumstances in the children's lives, especially what was happening at home. They also talked about individual children's impending departures from the program. During the observations there was little discussion of the specific activities that the children were engaged in. Attention was focused instead upon building relationships.

The children in the program also receive recreational and speech therapy individually or in a group, depending on the needs of each child. An extensive variety of parent services are provided to the parents of the children in the school, including individual counseling, family therapy, behavior management training in the home, and a weekly mothers' group. For children who spend some time in integrated classrooms in the afternoons, the staff of Alpha provide consultation to that program to help the integration process for that child.

Beta

Beta is operated by a mental health facility and is located in a outer suburban area. It serves 18 children in three classes. The classrooms are large, attractive, and well equipped and maintained on the ground floor of a building attached to a church. Each class is taught by two teacher/therapists, one of whom is the head teacher/therapist, and they are assisted by a student or volunteer intern.
A moderately structured traditional nursery school format is used as a framework within which the group therapeutic intervention occurs. Here each child is helped to "develop an appropriate sense of self and to explore his feelings and the areas of his life that are causing difficulties." The children who are being readied for integration into regular school classes are helped to develop social skills through verbalizing and modeling. The program emphasizes developing relationships, including techniques for getting along with parents. One child in the school is on a behavior management program. Although the respondents expressed greater concern for emotional development than cognitive growth, during the observation the teachers, especially in one of the classrooms, helped children who had chosen to use manipulative "educational" toys and discussed the concepts involved with the children.

In this program parents are involved in groups which are concerned with exploring what it means to be the parents of a special needs child. They also have regularly scheduled individual contacts with staff members, during which information is shared concerning the different issues which arise in the different environments of the school and the home, and how these are dealt with by parents and teachers.

Gamma

Gamma is operated by a mental health facility but is
funded by Chapter 766 funds from the three school systems which it serves. It serves 18 children in three classes which are located in the basement of a suburban elementary school. The rooms are large and are equipped like traditional nursery-kindergartens. Each of the classes is taught by a clinical teacher, an assistant, and a volunteer. The children are being prepared for integration. Within the traditional structured nursery school format the children are given "group therapy in the context of a solid educational program the focus of which is on developing social and emotional skills which are necessary precursors to cognitive skills." It was described as a "child centered family program" for children with emotional problems who are helped to learn to relate to each other and to adults. Teachers in this program rely on modeling and verbalizing to achieve their classroom goals. The teachers discuss children's feelings and relate them to events in their lives outside of school.

This program offers extensive parent work, which includes groups and individual work and is tailored to the needs of the individual families.

Delta

Delta is located in a large urban mental health center of which it is a part. The twelve children it serves represent a wide range of severe disorders. Delta utilizes
a "psycho-educational" approach to promote each child's progress on to the next stage in each area of development, while helping the child to work out the emotional issues that are raised. The concern is with the child as a whole, functioning within the family, so the intervention consists of classroom work and home training.

There are two classroom teams of six children, two teachers, and several graduate interns and student teachers. The additional part time staff provides speech and occupational therapy and psychological consultation. Each team occupies two small classrooms separated by an observation booth. The six children are separated into speaking and non-speaking groups and each group occupies one of the small rooms while the teachers alternate between classrooms. The classrooms are very carefully structured to provide stimulation without too much frustration. There is variety within a consistent routine. The almost one-to-one adult/child ratio allows for completely individualized programs and a great deal of individual professional attention for each child each day. All of this therapeutic teaching is possible and effective because "... a relationship of trust with the child comes first by responding to their needs and interests."

Delta began as a home training program and the intensive classroom work was developed later. Parent work is still central and involves parents in observation and
participation in the classroom, in home visits and in parent groups. The purpose and tone of most of the family work is educational, a sharing of experience and knowledge. In addition to learning techniques for working with their children, the aim is also to help the families understand their feelings and modify their expectations for their children, thereby improving relations within the family and increasing their own enjoyment of parenting. In the design and implementation of the program there is a commitment to a "psycho-educational" approach in which education is used to further developmental and psychotherapeutic aims.

**Epsilon**

Epsilon is a large urban program operated by a mental health center and directed by a psychiatrist and an early childhood educator. The program serves families with children from birth to age six who have anything from a mild problem to severe multiple handicaps. It aims to further the development of children and their families to the end that some children will be saved from having to be institutionalized and others will be prepared to be successful in normal or integrated public school classes. The service is available to any family willing and able to make the necessary commitment. At the time of the original interview there were ninety children being served in groups and many more receiving diagnostic, consultative and individual
therapeutic services.

The classes vary in size. The one observed for two full mornings for this study was a class of 13 children being readied for kindergarten. It was taught by two co-teachers and three interns, and was located in a church basement. The personal atmosphere in the class was warm and informal within a very structured nursery-kindergarten format. There was stress on skill development in an atmosphere where feelings were acknowledged and supported. Classes were described by a director as "no different ... from any nursery school" in terms of what they say they'll do, but "more capable of doing it because there are fewer bodies to contend with ... you can socialize more easily ... if it's eye contact you want ... you can get it because you have time ... The kids care ... for one another" because of the example of the teachers.

One director said that "without the parent work the nursery school would be a dead end." In the view of the directors of Epsilon, social and cognitive skill development is the aim of the classroom but the emotional problems are addressed ecologically. During home visits teachers model appropriate child management and interaction for the parents. Teachers help the parents to achieve "simple minded goals" which will either prepare them to use other mental health services or might obviate the need for them.
Zeta

Zeta is the early childhood component of a large educational collaborative in a suburban city. Its purpose is "to reach children at the youngest level possible . . . to help each child develop to his own potential . . . and to mainstream as much as possible." As a public school program it was mandated under Chapter 766 to provide for all children with substantial special needs. Although some children referred may be placed in other special programs, the approximately 50 children who were being served directly by Zeta at the time of the initial interview represent a wide range of special needs. The services offered vary according to the specific needs but the Community Clinical Nursery School model is used with appropriate modifications in the classrooms where the concerns cover: meeting needs of children to increase their ability to function; language, social, fine motor and self help skills; and increase in cognitive skills. None of the classes is said to be specifically for emotionally disturbed children, but the class the investigator was referred to serves eight children, most of whom were described as having primary behavior problems and some as being developmentally delayed. They are all seen as lacking a sense of self. Their teacher said that a "functional behavior problem would be treated with a more clinical approach." She described the approach
to language development, beyond the specific program, as one where the teachers try "to get the child to communicate, not through asking questions but just through developing interest and trust in us." The large classroom is located in a suburban elementary school adjacent to another special class. It is taught by a teacher and two highly trained assistants.

**Eta**

Eta is a large collaborative program for children from ten communities which was developed to provide good quality programs for children with low incidence special needs over which the schools which provide the funding would have control. This allows for appropriate, effective grouping of children rather than "dumping grounds" classes in the separate towns. The aim is to reach children as early as possible with programming for them and their parents which is not otherwise available, which will expedite the children's return to normal school classrooms. Gradual mainstreaming is an important principle of this program. Careful placement into one of the six therapeutic/educational classrooms located in public schools gives children the opportunity to be grouped with others who can serve as models in some area of development, while they excel and serve as models themselves in a different area of development. Other children are integrated into normal
early childhood classes such as Head Start and teacher training laboratory schools where their progress is carefully monitored by Eta. Many other individual tutorial and therapeutic services are included in the total program, including services for parents.

At the time of the interviews and observations the program did not include services for severely emotionally disturbed children who were then being served in a Community Clinical Nursery School, but they were to be included the next year and plans were under way to hire a teacher who had experience with such severely disabled children while teaching in Delta. "Mild to moderately disturbed" children were included in the classes observed by the investigator. Each of two classes observed was in a large classroom in two different suburban elementary schools. The classes were designed for eight children, but had grown to ten.

The children were developmentally at a preschool level and would be going on to public kindergarten. The children manifested a variety of behavior problems and developmental delays understood as stemming from a variety of causes, including emotional. The program aims to develop the children's confidence as well as their skills, but skill building is seen as essential if children are going to be able to be successfully mainstreamed. Each child's goals are determined individually but the whole range of developmental needs are addressed in the classes, including attention to
language development, social and emotional growth, especially appropriate interaction, verbal expression of feelings, self organization, perceptual and motor skills, problem solving, task completion, and math and reading readiness. Children are encouraged to develop awareness of what they can do, to accept their own limitations without fear of making mistakes, and to develop independence. The classes are taught by a teacher, an aide, and special therapists who come to the class each week. The rooms are divided into learning centers within which each child has individual assignments to complete each day using a variety of manipulative materials. The day is also divided into time periods for different activities, including time for free choice of activities, snack, and outdoor play.

**Theta**

Theta is the early childhood component of the special education department of the school system of a small residential city. It was designed to implement Chapter 766 as it applies to children from preschool age to eight years old. Integration into normal classrooms is the primary goal for those children for whom it is feasible. In accordance with the requirements of the law it provides a variety of direct services and contracts out to other agencies and special schools for other needed services, according to the
early childhood coordinator responsible for administering the program. Theta provides assessments, speech and language therapy, physical and occupational therapy, home teaching, and parent work. Parent work and individual psychotherapy for some of the seven and eight year olds is provided by social workers on the staff of the school system. Theta also conducts four therapeutic classrooms for children with a wide range of disorders and needs. The classroom observed for this study was not designated particularly for emotionally disturbed children but it was the one class for preschool age children who were not severely physically handicapped or retarded. The class meets five mornings a week in a classroom of an elementary school which houses, in addition to the normal classrooms, one special class for older children, and the home base of the speech therapists. Designed for eight to ten children, the class has grown to twelve under the heavy pressure of referrals and was being taught by a head teacher assisted by two interns. There were plans for hiring an aide. Within the nursery-kindergarten format of the classroom the emphasis of the curriculum content was on academic skill development. The atmosphere was emotionally therapeutic, in the sense that the children were clearly addressed as individuals who were given individualized loving attention along with their specially assigned learning tasks. There was no apparent attempt to address separate emotional issues directly
or to talk much about feelings, but the teachers did verbalize about what was happening in the environment and children were carefully prepared for each change which occurred.
CHAPTER VI
RESULTS AND DISCUSSION

The initial interview brought the complexities of the subject being investigated into full focus. The respondent was a classroom teacher and an individual psychotherapist in a program operated by a mental health facility. Asked about cooperation between educators and mental health professionals, she said,

Well, we certainly get cooperation from the public schools. They have some of our kids going two days a week and coming to us. And if they're good in academic skills they can go on to first grade. They've really worked at it.

Agencies I think, they have a hard time. Like social work agencies. They have their specific way to do things. We give a lot. They're not as flexible. They have three or four years to work with a person. We have to work within [a shorter] time. Sometimes it works to our advantage to have that little block of time to work. You make a contract with the parent and then you set your goals with the parents and you say we have to do this, this, and this and we need your help to do it.

Clearly, there is more involved than a balancing of the two distinct professional entities of Mental Health and Education. There are mental health facilities and educational institutions, both of which operate programs. Sometimes a single child is being served by two or more facilities. Within the programs of each facility there are teachers and mental health professionals. This aspect of
the problem is further complicated by the fact that in many programs individual staff members function in both roles. There are two sets of concerns which are being addressed by these programs. One set clusters around emotional issues concerning a child's feelings, relatedness and sense of self. The other set concerns learning and skill development. No serious professional of the calibre of those interviewed for this study would regard these concerns as unrelated or believe they could ever be completely separated in the development of a child, but there are different emphases in these programs, as the following discussion will show, between concerns that are primarily emotional and those that are cognitive.

The problem of collaboration was originally conceived of as a problem between persons having two distinctly different professional identifications and affiliations. The differences between facilities and concerns were expected to reflect the differences between the two professional groups which were affiliated with them. The preliminary survey was designed to assure that programs in the study sample would have both professional groups represented on their staffs. The interview schedule was designed to reflect differences which might exist between the members of the different professions within the same programs in terms of the relations between their training and their role, and also in their perspective on all aspects of the
program. Finally, in scheduling interviews, an effort was made to interview representatives of the two separate professions of mental health and education.

The expectations were not entirely borne out in the way in which they had been anticipated. Mental health and educational services in the programs studied were not provided by two separate professional groups. Only four of the respondents were members of traditional mental health professions. These respondents do provide some direct service. Further mental health services to children and families are provided by nine of the classroom teachers interviewed and by one non-teaching director of one program who is an early childhood educator. These educators receive varying amounts of clinical supervision for their mental health work from traditional mental health professionals, including three of the four interviewed and others who were not available for interviews. It appears, however, that to a large extent, collaboration which exists in these programs to provide services to preschool children with emotional problems takes the form of merging the sometimes disparate, but always complementary, concerns and functions of the two professional groups into multidimensional services delivered by individuals who in effect bridge the two professions. Professional differences between educators and mental health professionals working within the same program do not therefore emerge as an issue. Although there is considerable
evidence that the respondents recognize that there are potential problems between the two professions, these programs which, with some apparent success, are serving young children with emotional needs in Massachusetts have resolved most of those problems within their own programs. The inter-professional difficulties which remain appear from this study to be between those concerned with preschool children with emotional difficulties and those in positions of power whose expertise is with a different population.

The discussion of the complex collaboration represented by these programs will focus therefore upon the need for comprehensive training and upon the differences among the various groups involved which highlight the need for comprehensive training and sometimes impede its realization. These emerge as the significant issues.

**Need for Comprehensive Professional Training**

Multidimensional roles of program staff. Thirteen of the 23 persons interviewed serve as classroom teachers in their programs. Twelve of them have other major professional responsibilities within the programs which are not usually part of a classroom teacher's role. Nine of the teachers provide services which are traditionally the prerogative of the mental health professional, such as individual psychotherapy with children, individual parent work, or leading
parent groups. Even in their roles within the classrooms seven of the teachers interviewed have titles such as teacher/therapist or clinical teacher, or are considered to be providing psycho-education in the classroom. In terms of their roles within their programs, the teachers interviewed are typical of the other teachers in the programs. The professional roles of the teachers in all five mental health programs are similar and all represent a merger of educational and mental health functions. Only four of the teachers interviewed teach in public school programs. Only one of the four is among the nine with a mental health function; she does parent work. Two of the other teachers in public school programs are among those with major program responsibilities beyond their classroom responsibilities. One does home teaching and the other does testing and evaluation.

**Academic backgrounds of staff.** In spite of the similarities of their functions, the program teachers brought very different backgrounds to their programs. The variety of backgrounds, which became evident early in the study, prompted the investigator to inquire about the training and experience of some of the other staff members who were not interviewed, so some information is available for 20 teachers. One teacher/therapist is without any degrees and has been entirely in-service trained over several years. A teacher/therapist in another program is
a pediatric psychiatric nurse by training. Among the teachers interviewed in mental health programs, four had undergraduate majors in Psychology or Child Development, as did two others not interviewed. Three others were reported to have majored respectively in English, Sociology and Special Education. Among the teachers in public school programs, two had studied Psychology as undergraduates, one took her degree in History, and one majored in Early Childhood Education. One other public school teacher not interviewed did her undergraduate work in Early Childhood Education. Nine of the teachers interviewed hold Masters degrees, including all four of the public school teachers, and some of them did not specify the field of their undergraduate concentration.

Practical experience. The practical experiences which the teachers brought to their work are telling, in terms of how one is now able to acquire the necessary skills for providing these services. Four of the 20 teachers for whom training information is available do not hold advanced degrees and do not have college degrees in Education, Child Development, or Psychology. Their experiences, however, include seven years working on a children's ward of a psychiatric facility, clinical work with adolescents, and Head Start training and experience for two, one of whom also worked in a residential treatment facility. Two of the mental health programs studied offer intensive training
programs to students. Among the thirteen teachers with Masters degrees, six of them from four different programs trained as interns in one of these two programs. Others acquired their experience teaching special needs children in Community Clinical Nursery Schools, integrated day care programs, programs for disadvantaged urban children, and in a clinical nursery school in a mental health center. One of the teachers studied in a psychoanalytic institute in France.

Staff attitudes toward training. What teachers themselves say about their training and their work is significant when considering the problems presented by the lack of a formally recognized, comprehensive professional training. One teacher, discussing her training and experience relevant to her present work, said that her undergraduate work in Child Development "taught by clinicians" and her training as an intern in the program where she now teaches were the most valuable parts of her training. Of her M.Ed. she said, "I don't know what that contributed." This attitude was reflected in the responses of many of the teachers, most of whom never even specified the field in which they had earned a Master's degree. Seven are known to be in Education, five of those Special Education, but only one of those Early Childhood Special Education. Most of the teachers with these graduate degrees are among those who spoke of their internships in these intervention pro-
grams as the source of their most important training. One director spoke of the four teachers in her program as having no degrees in Special Education, but all their experience in that field. This is true of a teacher from another program who has no graduate degree and grimaced as she said her undergraduate degree was in Elementary Education. She reported having no degree in Special Education but seven years of working in Special Education programs. Among the twenty teachers for whom the information is available, only three have undergraduate degrees in Early Childhood Education. One teacher in a public school system who has a Master's degree in Guidance and School Psychology specified that it is not in Early Childhood.

The academic content of the training of these professionals appears to have been a relatively insignificant part of the preparation of these Early Childhood Special Teacher/Therapists. That they find this to be the case is reflected not only in their disparaging comments about their own training but in their general comments to the effect that "Degrees aren't important" and "Personal qualities are as necessary as training" and "You need to go slowly and learn as you go along." Teachers in these programs have been given enormous responsibilities, and all the teachers interviewed expressed an interest in acquiring more formal training to assist them in performing their present responsibilities with greater expertise. For most of these teachers
the interest expressed was different from the usual interest of a serious professional to keep up in his field.

These teachers gave the impression that they were aware of real gaps in their training and knowledge in areas which are essential to their work. Several are studying in non-degree programs to fill those gaps and others have plans to return to school for further training in specific areas. Family therapy and parent work, normal child development, psychology, and organic difficulties are areas in which teachers expressed the wish to have more training.

Training components of these programs. All but two of the programs utilize students to some extent in the classrooms. In two programs they are Movement students, so their role is specialized, but in the other programs students serve as general classroom teachers under supervision. All the programs which use student teachers do so at least in part to benefit from the special service of the students or to raise the teacher/pupil ratio in the classrooms. As mentioned earlier, two of the programs do provide extensive internship training programs.

Even these intensive internships, however, cannot be expected to provide the students with the full professional education and experience needed to fulfill the role that appears from this study to be the typical responsibility for teachers in these kinds of programs. There are large bodies of knowledge from the disciplines of Develop-
mental and Clinical Psychology, Psychiatry, Early Childhood Education, Special Education and others which relate directly to problems of service delivery to preschool children with special emotional needs. In a program which has good consultant services, each person providing direct service need not be a general expert, but had better be an expert generalist with a broad background from these disciplines. Classroom teaching alone requires that breadth if the child is to be well served. The trend apparent in these programs of having individual staff members serve a variety of roles makes a broad based professional preparation even more necessary.

Professional credentials. The need for training more personnel to carry out the mandate of Chapter 766 in Massachusetts is discussed in Thursday's Child: A Guide to the Implementation of Chapter 766, published by the Institute for Governmental Services at the University of Massachusetts. According to that report, because certification requirements in special education have been in a state of flux in Massachusetts, universities and teacher training colleges have been reluctant to offer new programs at both pre- and in-service levels until they could be sure that they would result in certification and jobs for their graduates.

The problem of staffing in preschool programs is even greater. The state does not offer any certification
for preschool teachers. Early Childhood Education, also in flux, has been a branch of elementary education and requires some practice teaching at the kindergarten level or higher, but does not require any experience with three and four year olds. Many child development specialists and preschool teachers insist that the issues involved and the skills needed in teaching preschool children are very different from those for teaching children of kindergarten age and older (Leeper, Dales, Skipper, Witherspoon, 1974). When the preschool age children are in special need, it can only be assumed that the differences between their needs and those of older children are increased. Denying the validity of preschool teacher training and experience by refusing to recognize it with its own professional certification makes it difficult for schools to hire teachers with the most appropriate preparation for teaching in the preschool programs operated by public schools. This situation also prevents some preschool trained teachers from becoming certified as early childhood special needs teachers because certification as a special needs teacher has required preliminary certification as a teacher. One problem which this presents to the teachers who choose to work in public school programs for preschool children is that much of their training time will need to be spent in acquiring skills and fulfilling requirements which are not germane to their intended professional function, leaving them less time to
become proficient in areas where their skills will be crucial to the children and parents whom they will serve. An even greater danger to the children is that the teachers who qualify for being hired under the present certification laws could be teachers whose primary interest is not to serve three and four year old children.

**Supervision and consultation.** A comprehensive specialized training for therapeutic work with emotionally disturbed preschool children would include more than a broad academic base in the relevant fields of study. There would also be opportunities for continued professional growth under clinical supervision of the sort typical in the mental health profession, but not often available in education. A certified tenured teacher in a Massachusetts public school is unlikely to receive any regular supervision beyond the mandatory periodic unannounced visit of the principal. If there is a problem, a member of the administration or the guidance department might be called in as a consultant. In many school classrooms, whether the teacher is being checked up on or helped with a specific problem, there are definite negative overtones to both supervision and consultation.

In this regard, one clinical teacher interviewed, who also serves as a consultant to other classrooms, spoke of teachers feeling threatened if any children in their classes needed to spend some time in a therapeutic setting,
because to them it seems to mean that "she couldn't handle the child ... it was some fault of hers." She said of teacher training that it's "geared towards the teacher being in charge ... [I] don't think ... they're trained how to use a consultant ... and that's unfortunate." Only during their student years do teachers receive supervision regularly as part of their professional development.

In the mental health profession supervision plays a more positive role and has more positive connotations. Staff supervision time is regularly scheduled into the work week of therapists in mental health facilities and is looked upon as an opportunity to learn from more experienced practitioners or to brainstorm and pool insights with peers who may be facing or who may previously have confronted similar therapeutic questions.

These two different attitudes persist in the programs studied. The director of a school-based program spoke of providing individual supervision "as the need arises" and said that "the psychologist comes to the class as needed if there's a particular problem." Clearly, she sees supervision and consultation related to problem solving and special need. A clinical teacher from one of the mental health operated programs was asked if she found the amount of supervision available to her in the program to be adequate. She answered, "... for any professional it's always nice to have as much supervision time as you can ... I'd love
to have more time . . . but . . . in a practical sense . . . there is enough." There supervision is seen to be related to normal professional growth. With the persistence of these attitudes it is not surprising that one major difference between the school-affiliated programs and the mental health programs found in this study is in the amount and kind of supervision and consultation that is available to the teachers.

Mental health supervision and consultation. In the four small mental health programs the teachers have supervision or consultation with a psychiatrist or psychologist at least once every week. In most of these programs there are even more frequent contacts between the classroom teaching staff and professional mental health workers. Teachers receive consultation and supervision for their classroom therapeutic work as well as for individual therapy and family work. In only one of these programs the teachers reported that the formal supervision in family work is inadequate.

In the large mental health program, the staff who provide individual therapy to children meet weekly for group supervision with the psychiatrist who is a co-director of the program. The entire staff meets weekly for general business, but the full staff supervisory sessions with the psychiatrist are less frequent. He is, however, readily available to the staff for individual questions throughout
the week. His informal availability was attested to by all the staff interviewed.

One of the school programs has a weekly meeting between the teachers and the psychologist, but because it is the only regular supervision the teachers receive, and because there are so many teachers who share that session, members of the staff consider it inadequate. What psychological consultation there is concerns the teachers' classroom work, since in this program the teachers are not responsible for individual therapy or parent work. In explaining the small amount of supervision available, one of the directors of the program explained that with such an experienced and skilled staff he had not expected them to need as much supervision as they have been asking for. In a separate interview, one staff member, who is a social worker, said that supervision should be viewed as necessary "not because they can't do a job, but it is necessary for professional growth." Future plans for this program call for more mental health consultation and more supervision.

In two of the school-run programs social workers do the family work. In one of these programs only the family workers and not the teachers have weekly supervision with a consulting psychiatrist. In that program the teachers theoretically have access to, but no regularly scheduled meetings with, a psychologist. A program teacher reports that the psychologist's busy schedule makes her in fact
unavailable. In the other program, even the family worker has no supervision provided by the program. In the third school-run program there is no regular clinical supervision for the teachers. One teacher interviewed has a background in guidance and school psychology and, unlike the rest of the program’s teachers, she does extensive parent work. She is dissatisfied that clinical supervision and back up services are so scarce. She said, "We could use a full time social worker to consult with the teachers and support their work . . . specifically in the teachers' work with the parents . . . and also in doing play therapy kinds of work with the children." She reported that earlier in the year a psychiatrist had consulted with the teachers for classroom therapy, but that that sort of thing needed to be greatly expanded and regularized. The early childhood educator who directs that program expressed the same sentiments, saying "... that's the one thing we miss very much."

Educational supervision. In two of the small mental health programs, team planning and peer group meetings replace educational supervision for the head teachers. In these programs two teachers co-teach each class of six children and they supervise students, assistants, and volunteers who work in the classes. The other two small mental health programs also have regular team meetings for much of the planning, but in one the early childhood educator, who
is the director, and in the other the psychologist, who is the associate director, act as educational supervisors. The public school affiliated programs each have an early childhood coordinator who is the official supervisor, but because of the increased administrative demands upon their time, they report that as the year progresses the amount of regular supervision tends to diminish. Early childhood educators provide regular educational supervision in Epsilon, the large mental health program for all the teachers and interns regularly, twice every three weeks. To a large extent the differences in the amount of supervision between mental health and school operated programs can be attributed to the size of the school programs over which the programs have no control, since they are mandated to serve all who have a need. Epsilon has taken upon itself the same responsibility, which falls unbidden to the schools, and still manages to maintain a regular supervisory schedule. It is less than some teachers would like, but more than the other large programs have. It appears that the convictions among mental health professionals concerning the importance of staff support in the form of supervision is in part responsible for the difference in supervisory patterns. Teachers from all the programs in this study are well aware of the limits of their own expertise and expressed either satisfaction that the needed supervisors and consultants were available to them or--particularly in the school-run programs--
dissatisfaction because adequate supervision and consultation were not available to them. In all of the school programs the early childhood coordinators responsible for the programs share the teachers' dissatisfaction with the quantity of mental health services available. In each of these programs the early childhood director, although autonomous as far as programming is concerned, is responsible to and is funded through special education directors who have no experience with the needs in preschool programs.

In the mental health programs the top fiscal officers are also the program directors, who are free to allocate funds in support of their convictions concerning the need for staff supervision and consultation. If educators could learn from mental health professionals to understand the value of good supervision and consultation these services could be used to compensate for some of the deficiencies in pre-service training for preschool therapist/teachers. There is some evidence from the literature (Goldhammer, 1969) that the situation is changing as educational supervisors in some programs are being taught a clinical model. There is, however, a lag in the widespread acceptance of educational supervisors as resources to be used by teachers to help them to grow professionally.
Goals and Methods in the Therapeutic Classrooms

There is a remarkable degree of consensus among the programs in terms of stated aims. Preparing children for integration into regular public school classrooms is a major goal for seven of the programs. There is less agreement when it comes to deciding what is the appropriate classroom intervention in order to achieve this goal. All the classrooms observed in phase II of the study are taught by experienced accomplished teachers and the children in them are being well served. Yet while all of the teachers expressed an awareness of the needs of the children in all areas of development, there is a decided tendency in six of these programs either to emphasize skill development or to direct attention primarily toward emotional difficulties in the classrooms.

Emphasis on emotional issues. In three of the small mental health programs it was made clear by all the respondents that the primary emphasis is on addressing the children's emotional problems. In two of the programs the teachers have the titles of teacher/therapist or clinical teacher and in all three programs the teachers' interactions with the children are largely therapeutic, as distinguished from educational interactions. Much of the classroom conversation concerns individual children's feelings and clarifications
of situations at school and in the lives of the children outside of school. One teacher's description of her work was that it "focuses on child's affective development first and foremost . . . to help the child to bring that emotional conflict and struggle to his conscious awareness and support this and be available to them . . . " In another of these programs a teacher said, "Generally the goals . . . are of a more therapeutic nature than educational. . . . To resolve emotional concerns the child has:" Another teacher in that same program said "It's a therapeutic nursery class, so what goes on is of a therapeutic nature . . . we have enough people in class so there are times when one child receives a lot of individual help of the nature of what would go on in individual therapy . . . with a teacher/therapist." She described the classrooms as:

not . . . educationally oriented in the sense that you think of a school program as being. We aren't as concerned with academic issues . . . one of the least popular things that I do . . . is have to plan curriculum and materials . . . [it's] not what I am best at or enjoy most.

A teacher from the third program in this group said the program focused on feelings, self concept and social skills. She said that some attention was paid to academic skills near the end of the year so children would not be at a disadvantage in their next placement where other children would be from programs which emphasized academics. Another respondent from this program considers group therapy their
"primary responsibility" because the children "cannot deal with the social situation which education certainly is in some great part, given the state of anxiety some of the kids are in." She sees "some understanding or changes needed before [the children] can use standard education," therefore they emphasize developing a sense of self, and allowing "the child to explore those areas that are creating most difficulty for him" and helping him to "learn techniques for getting along with parents."

These are sophisticated programs, aware of the integrated nature of children's development, so one respondent described the classroom as:

group therapy in the context of a solid educational program, the focus of which is on developing social and emotional skills which are necessary precursors to cognitive skills . . . but all that goes on at the same time, we don't have one time that's . . . your book learning time and . . . your feelings learning time. It's a very integrated approach . . . appropriate motor development skills . . . speech . . . [we] integrate everything into the stream of the class, but the primary emphasis is almost always on social and emotional development.

Another respondent explained:

We take some interest in readiness skills, in identifying what kinds of readiness skills children have motorically, cognitively, socially to make it in say a public school kindergarten or a normal nursery class and so we're conscious of that kind of thing . . . teachers expertise is not in remediation for specific learning disabilities.

The director of another of these programs said that their program was "not just a totally psychiatric approach . . . focuses on the whole child . . . [we] don't just pro-
vide therapy, we work on child's preschool academic skills."

It is clear, however, that the primary emphasis in these programs is on emotional issues which it is thought must be addressed before a child can be expected to progress in his cognitive development.

**Emphasis on skill development.** Three of the programs studied are operated by or for public school systems. In these programs there is far more emphasis on skill development. Social skills are emphasized, but so are reading and math readiness and other pre-academic skills. An early childhood coordinator in one of these programs explained that she had found over the years that if too much attention is paid to the child's feelings without attending to skill development, you might help resolve his problems only to have them recur as soon as he is in a regular class and not able to keep up with the work. Asked to describe their classrooms or to talk about the classroom goals, the teachers in these programs tended to talk much more about specific programs used or areas of development attended to. A teacher from one school program said:

The goals are multiple, they're for socialization, to increase cognitive skills . . . just to meet the needs of the children to increase their ability to function. For some of the kids their language deficits need work . . . for other kids their socialization skills, for other fine motor and language and for some children every area needs work.
A teacher from another program said:

There are a lot of different things these children need as far as emotional needs, fine motor needs... I try to weave their individual needs in and out of the curriculum throughout the day in language... writing... reading readiness, math readiness.

In all these school programs, much of the verbal exchange between the teachers and the children that was observed involved the specific activities the children were engaged in, relating the activity to a concept being learned. In one program the rooms are divided into learning centers and each child is given specific assignments each day in several areas. Planned activities observed included work with numbers, sequencing, and color and shape matching. In another school program during part of the morning the children were assigned to specific groups according to their pre-reading skill development and specific lessons were conducted by the teachers.

Teachers in these programs expressed and demonstrated their awareness of these children's special emotional vulnerability and the desire to help them overcome their anxiety and develop stronger senses of self. In this regard one teacher spoke of her efforts:

to have the group learn to be more independent, to be aware of what they can do... not to be afraid to try. If they make a mistake not to feel that an adult is always going to be hovering over them saying 'you're wrong'... they've had so much failure... all of these children were very anxious, had a lot of inner fear... when they do try we try to reinforce them verbally.
Another teacher spoke of the importance of preparing the children emotionally for kindergarten where they'll be in a class of 25 children. It is because of the teachers' awareness of the children's emotional needs that they want to have more mental health resources available. The teachers in these programs, however, spend less time talking about feelings and more time planning and preparing particular curriculum materials for developing mastery in different areas. Again, it is a matter of emphasis. Here social and emotional skills are not regarded necessarily as precursors of cognitive skills, but their importance is understood and cognitive mastery is seen as a contributor to emotional growth.

Two of the mental health programs do include emphasis upon the development of skills. In one of these programs, most of the children exhibit extreme developmental delay with a major physical as well as an emotional involvement. It is understood that many of these children will never be integrated into normal schools. Occupational and speech therapy are major components of this program, in which very basic human skills need to be taught, but more advanced academic skills also form part of the individualized programs for some of the children. In this program, however, the educational content and methods are integrated with the psychological concerns which appear to be of equal importance to these teachers. In the other mental health program
which emphasizes skill development in the classroom, many of the children served also suffer from multiple handicaps and many are retarded. The directors arrived at their present position on skill development from years of experience with Head Start and with mentally retarded children where attention to skill building and learning problems often masked by behavioral disorders "has always paid off."

I think we as administrators think an awful lot about helping kids develop skills, pre-academic, whatever. Sometimes I think that's a hard thing to convey to staff, especially trainees who come to a mental health center . . . thinking that they'll spend more of their time with feelings and fantasies.

In this program emotional issues are dealt with directly through parent work and, if necessary, individual therapy, but in the classrooms the directors spoke of the need to be "bossy," "intrusive," "imposing" themselves on the children "for the purpose of getting them to function at a higher level." The teachers reported that while they (the teachers) "run the classroom" they'll "hear about it" if it's not structured enough. While the interviews suggest a difference in emphasis between the teachers and the administrators, it appears in observing the classrooms that there is a comfortable blending of task oriented curriculum with sensitivity to the individual emotional needs of the children.

Traditional classroom format. Whether programs emphasize
skill building or direct attention to emotional issues in the classrooms, respondents from all programs mentioned the need for structure in the classroom programs for these children. To achieve the necessary structure and to meet individual needs within the classroom settings, seven of the programs rely primarily on a high teacher/pupil ratio within a traditional nursery-kindergarten format. There are varying degrees of attention given to the environment, even among the small mental health programs. In one program, building relationships with persons within the environment is a primary emphasis for these children for whom relationships are frightening, so less attention is given to the space itself than the director would consider appropriate in a class for normal children. In this program the only environmental concern is to provide a "simple safe nursery school environment." In another of these programs the need of the impaired and disorganized children is understood to be for a meticulously controlled and predictable environment. Whether the environment is seen as of fundamental or only incidental importance, and whether the primary content of the curriculum is directed toward emotional or cognitive issues, only one of the eight programs in this study deviates substantially from the traditional nursery school-kindergarten format.

The Gesell Guidance Nursery School is the prototype of the traditional nursery school. Pitcher and Ames (1964)
in their description of the Gesell School discuss the extent to which it might be used to integrate the "exceptional child" (pp. 222-237). They say that while a nursery school "should ideally make every effort to meet the individual needs of each individual child" (p. 223), this general rule applies to children who "are all well within presumably normal limits" (p. 223). They advise that "schools should not, in an excess of kindness or zeal, adopt a blanket policy of throwing open their doors to any and all handicapped children" (pp. 223-224). They say further that in considering nursery school placement for a specific handicapped child the question to ask is "Can the special child adapt to the school?--not, Can the school adapt to the child?" (pp. 236-237). Pitcher and Ames are talking about integration rather than special schools, but it seems fair to conclude that a model which is designed primarily to address itself to needs within the normal range is not ideally suited to the special child. Structure in the traditional nursery school is a product of the scheduling of time to include group times when all the children participate together in an activity. Pitcher and Ames warn that the schedule must be flexible and individual children must be allowed not to follow all aspects of the schedule at all times. This requires enough staff to have a teacher with any child who is not joining the group.

The teachers in the programs in this study solve their
need for structure with a high teacher/pupil ratio. In all the programs which have the desired ratio the teachers expressed satisfaction with the amount of structure achieved. Respondents from all five mental health programs, however, indicate that the battle for funds is an ongoing problem. The scarcity of programs and their concentration in one area of the state suggests that the struggle for funding such programs has never reached fruition in many areas. Public school programs are not funded for the teacher/pupil ratio enjoyed by the mental health programs in this study. These considerations suggest that programmatic solutions to the therapeutic/educational needs of emotionally disturbed preschoolers need to be found which are less costly than programs relying for their effectiveness upon the better than one:three teacher/pupil ratio characteristic of the mental health programs in this study. The opportunity exists here to explore possible creative adaptations of a variety of educational models to serve the overall development of emotionally disturbed preschool children, an exploration which would be more readily available to professionals who had been exposed to a study of various program models as part of their professional training. One major area within the discipline of Early Childhood Education is a study of program models and the uses of educational environments and materials in curriculum development. The responses of many staff members to questions about the educational
model on which their programs are based indicate the lack of awareness of or concern for this valuable resource in programming. One teacher responded,

I don't know, could you give me an example . . . I'm not up on names so I don't know . . . they're certainly not open education . . . that's for sure. They're quite heavily structured. They're very similar to a normal nursery . . . we have free play times, and we have group times, and circle times, and story times, and outside times and we try to go from a more structured everybody comes kind of time to a more free choice kind of time.

Unfortunately this is a typical response. Persons concerned with social and emotional development of children and who do not have a strong background in education appear automatically to adopt the traditional nursery school format. This is true of five programs in this study, and to a lesser extent it is true of two others. Only one program studied deviates substantially, to the extent of having developed a recognizably distinct structured format.

The ability to do this depends upon first having the attitude that space, time and materials are educational tools which can be used in a vast variety of combinations to achieve a variety of goals. Educators know this and combine these elements in different ways to find better ways to help children learn. Some of these combinations become formalized and labeled as educational models, but it is not specific models themselves which are important for teachers and program designers to know because, even if adopted, a packaged, labeled model must be adapted to each classroom if
it is truly to serve the needs of those particular children. What is important is the idea that different ways of using the time and the environment and using different kinds of materials can make significant differences to what and how children learn. A specific model can be used effectively as a deliberate point of departure for program or classroom planning.

The respondent's attitude just cited toward open education is an example of a common misconception among those unfamiliar with a wide range of educational formats. As the director of one of the school-based programs said, "A good open classroom is very structured, really." It is an example of a model which has been used as a point of departure for many programs which run the gamut from highly structured to chaotic (Featherstone, 1970 and many others). Many of the best known models in early childhood education were developed for the purpose of fostering cognitive development in children who were believed to be culturally disadvantaged and in need of compensatory early education if they were to succeed in public school (Bereiter and Engelman, 1966; Gray and Klaus, 1968; Moore and Anderson, 1968; Powledge, 1967; Sonquist and Kamii, 1967). It is not surprising that those interested in social and emotional development and who believe social and emotional skills are precursors of cognitive skills are suspicious of models which are associated primarily with cognitive emphasis. The fact that many
cognitivists consider a high degree of structure necessary to achieve their classroom goals gives the two groups a common ground from which to begin developing a classroom format which might serve the two sets of goals equally.

**Some alternatives to a traditional curriculum.** Outside the mainstream of traditional nursery school education and apart from the cognitively oriented early childhood intervention movement, innovative educators have developed methods for helping children to grow in ways which simultaneously involve children affectively and cognitively. Three of those approaches will be described briefly as examples of directions which might be followed in program planning for emotionally disturbed preschool children which could help to obviate the necessity for choosing between affective or cognitive emphasis.

**Creative movement.** Two of the programs in this study include Creative Movement in their classroom programs. This is an integrative activity which could be made an important element in all such programs. In a good creative movement program, children, using only their own bodies, can be helped to develop emotionally, socially and cognitively. Describing her creative movement work with children with special needs, Norma Canner (1968) lists the aims of a continuing program as follows:

- to allow the child sufficient freedom to express himself
- to promote the growth of a healthy personality by encouraging awareness of the whole self through body action, by helping the child feel good about himself, by helping him become a member of a group

- to foster self-respect and respect for the individuality of others

- to help develop social awareness, the ability to make contact with another person and to sustain this relationship

- to resolve conflict and hostility by channeling it constructively into body action and dance

- to foster and sensitize the child's sensory abilities, stimulating emotional, physical, and intellectual growth to define and refine concepts (p. 16).

**Organic reading.** The same principle of addressing multiple needs in one activity which is directly related to the child's affective and cognitive life underlies the teaching of reading by Sylvia Ashton-Warner (1963). Children learn to read by learning the "Key Vocabulary" made up of words chosen because of their significance in the children's own inner lives. They are not the words describing a teacher planned activity or excursion, but rather the words relating to the children's strongest feelings of fear and love and hate and anger. In her classes children are encouraged to express and discuss their important emotional issues, and with mastery of their feelings comes also mastery of writing and reading.

**Montessori.** Montessori is an example of a program model which has been used as a point of departure for a variety of very different programs. There are Montessori
classrooms for normal and special needs children and integrated classrooms. There are very structured Montessori classes, some of which would be seen as very structured open classrooms. Some structured Montessori classrooms are not open and some open Montessori classrooms are not structured (Lillard, 1972; Montessori, 1912; Orem, 1969; Rambusch, 1962; Skutch and Hamlin, 1971; Standing, 1966; and many others). Some educators' interests in Montessori education focus upon the educational materials which are designed to develop perceptual motor skills using all the senses, and then to move on to a multisensory approach to developing math, writing and reading skills. Some other educators, who are more interested in helping children to develop a positive sense of self, see in a Montessori classroom a non-threatening atmosphere where individual work with self-correcting materials allows a child to develop skills at his own rate without fear of failure or competition. They see the carefully prepared and maintained Montessori classroom, where each piece of well-kept equipment has its place, conveying to the children the respect which the teachers have for them and their activities and providing the predictable structure which is necessary to young children with special needs.

It might be useful to attempt to design a therapeutic preschool classroom for children with special emotional needs based on a Montessori model. The aim would be to
design a program in which no choices had to be made between focusing on emotional needs or cognitive skills, but to address both simultaneously. In the programs observed for this study the teachers clearly understand their pupils to be whole children with a whole range of needs, none of which can be ignored. In the emotionally oriented programs the children are exposed to the full preschool curriculum of the normal nursery school including perceptual motor activities and preacademic skill building, as well as social skill building experiences. In the more skill and cognitively oriented programs the teachers provide ego support and nurturance to the children in their ways of relating to them as they guide them toward mastery. There is, however, room for greater integration through the introduction of a curriculum which itself addresses several needs simultaneously. To a large extent now the academic goals are addressed largely by the educational materials and the emotional goals by the teachers' interactions with the children. The personal relationship with the teacher must continue to be the cornerstone of the therapeutic intervention, but appropriate materials and curricula can be made which have multiple purposes. Some Montessori materials do that by developing hand-eye coordination and visual discrimination in a single piece of self-correcting apparatus which allows a child to discover his own mistakes and practice until he achieves mastery. Many of the newer preschool learning
materials have been designed on this same principle. Dressing frames, which have spread from Montessori into many early childhood classrooms are another example. They develop small muscle coordination in the process of teaching real self help skills which in turn develop independence and self respect.

Elements of Montessori, Ashton-Warner's Key Vocabulary, and creative movement suggest the direction curriculum and program planning might take to make fuller use of the expertise of all those interested in the total human development of preschool children with special emotional needs. Using such integrated approaches and developing more would mean that teachers would no longer have to choose to emphasize one area of development over another, but could truly meet the whole child where he is in all areas of his development.

**Status Problems**

The teachers in all the programs studied expressed their awareness of the need for mental health consultation and supervision. In the mental health programs where it is available, it is recognized as essential to the program's functioning. Programs operated by educational facilities have far less mental health consultation and supervision and direct therapeutic services to children and parents. Respondents from all the school programs spoke of the need for
greatly increased services from mental health agencies and personnel. There was, however, no indication from the mental health programs that the teachers there were aware that there was much that they could learn from the field of education. Those considering returning to school for more formal training were mostly planning to study psychology, family therapy, and social work. Only one of the nine teachers from a mental health program spoke of her interest in learning more about curriculum development. She spoke of the ideas she had gotten from an early childhood educator who was part of a multidisciplinary evaluation team which had evaluated her program the year before the interview. She also said she learned from teachers in classrooms where she served as a consultant. Although she acknowledges that she does not have much background and knowledge in early childhood curriculum, she assumes she can pick up what she needs to know in this informal way. Her eventual graduate school plans are for more study in psychology, in which field she has an undergraduate degree.

The attitude that teachers need help from mental health professionals but that mental health professionals have nothing to learn from educators is widespread (Sarason, 1963) and is related to the status problem which does exist between teachers of the young and mental health professionals. Even in programs where the problems are being dealt with, it was clear from the interviews in this study that status is
an issue. There is one program in the study, Alpha, which has attacked the problem head-on with some very interesting and professionally productive results. Throughout the interview with the early childhood educator who is a teacher/director with the program, it was clear that the staff played a far more expanded role in the treatment of the children and families served, and in the broader therapeutic community than is typical of clinical preschool teachers. The problems which had to be resolved before that could happen had been dealt with long enough ago that there was no indication from the responses given in the interview that the relations of the staff with the medical and mental health professionals with whom they had regular dealings was at all unusual. The staff consists of four teachers, including the director, a social worker, and a psychiatrist. The psychiatrist wrote the original proposal to fund the program and now spends several hours each week working with the children and the staff. When asked about decision making in the program the director indicated that most decisions were arrived at jointly and she, as director, only rarely made decisions apart from the staff. Asked then if the psychiatrist ever made decisions for the program, she laughed and replied, "not necessarily, no ... maybe some clinical decisions, but not until he has conferred with us." She then went on to say:

We've worked through a lot of struggles regarding
that, because more often than not, in the hierarchy of clinical settings, teachers are seen as the lowest . . . we make a real effort to change that . . . that we all have something important to contribute to the decision.

The director explained that, according to the original proposal, the traditional hierarchy was to prevail, with an assistant teacher, head teacher, director and psychiatrist. The treatment philosophy remains as it was originally, but the hierarchy has been completely abolished. The four teachers run the program jointly themselves with occasional administrative decisions by the teacher/director, and ample clinical consultation from a "very competent, caring child psychiatrist who puts lots of time and effort into the program, is open to his own growth and really cares about young kids." The teachers also participate in the training of child psychiatry fellows who are helped there to develop skills in observing the interaction of children in groups. Later, when asked about cooperation between educators and mental health professionals, the director reported that relations had been good but,

it's taken a lot of work and aggressiveness on our part to say we have something to say to you because there's often again that certain condescension that teachers and non-medical people have less to say or haven't an important perspective on that child.

She said also,

We've had very good relationships with the medical component of our program, we work closely with . . . the medical services for each family. The interest comes more from the educators than from the medical component. There's more of a sense that they only
have something to teach us, that we can't teach them something . . . need to change that . . . we've made a beginning with our work in child psychiatry . . . there must be that sharing of knowledge.

The direct services which this staff provides to the children indicates that they are seen by the consulting psychiatrist as primary therapists; they are not just there to provide backup for the "real" therapy provided by the psychiatrist. What goes on in the classroom is referred to as psycho-education. "The aim is to bring the child's emotional conflict and struggle to his conscious awareness . . . and to be available and provide support during this process."

For teachers to be given psychiatric supervision for that kind of intervention indicates that they have been acknowledged as being capable of exercising a mental health professional's prerogative. To do so in a classroom setting indicates that their skills bridge the two professions. In this program some children receive individual therapy from a teacher outside of class time, and still others are referred to the clinic for further therapy. The teachers insist on their place as professionals with something important to offer, including the ability to provide important psychotherapeutic intervention. They also recognize the different professional expertise of the psychiatric staff of the clinic with which they are affiliated. Just as some children are referred to the clinic for needed therapy which is only available there, so the needs of some families are seen as
outside the particular expertise of the Alpha staff and they too are referred to the clinic.

Within the other programs in this study where children are being served the problems often resulting from the status differences between the professions have also been overcome, although in somewhat less dramatic form than in Alpha. One of the programs is co-directed by a psychiatrist and an early childhood educator. When the psychiatrist was asked to comment about cooperation between educators and mental health professionals within this program he said, "I can't separate them . . . people come on board here to do both . . . would not want to hire anyone who would separate the two . . . it would be crazy." The co-director also had "trouble with the question . . . so entwined here . . . most of direct work done here by education with lots of backup from mental health." At another point in the interview the psychiatrist reported that the "traditional guidance clinic or medical setting way of doing things was not productive [in this community where] education is more respected" so the program was "light on mental health and heavy on education." In this program "curriculum planning is as important as family work." Education is seen here as a practical form of group treatment which helps to control the costs.

Only one other program in the study is directed by a psychiatrist. She was the only director not available for an interview, but all the staff who were interviewed report
a very collegial relationship among the whole staff. Only decisions about termination are sometimes made by the director because sometimes the teachers don't want to let go. All other decisions are arrived at jointly. While a program teacher could say, "One of the neat things about this program . . . is that we're really a team and we work together very well," they had a good deal to say about professional tensions between mental health professionals and educators outside of their immediate program. One teacher said,

I think there's a lot of misconceptions . . . and fears . . . and all kinds of feelings that go between them both and I think that a lot of times teachers feel that and mental health people feel that they're up here . . . and these little teachers are somewhere else. Boy . . . put a psychologist in the classroom for a while and let them try to . . . make 30 kids or 15 kids or 10 kids deal with each other! I think there should be more mutual respect.

She tends to identify more with mental health than with education, but finds that being a teacher "is very helpful in working with teachers . . . I know what it's like to be in a classroom and I'm less threatening because I'm a teacher."

The belief that nursery school teachers are likely to feel more threatened by receiving consultation from a mental health professional than from a teacher is the reason that Project Enlightenment, described in Chapter II, uses teacher-consultants rather than psychologists (Glasscote and Fishman, 1974).

The psychologist from one program studied credits the public schools with showing foresight in contracting out
for services which they felt unable to provide themselves when they became responsible for preschool services and became understandably threatened and overwhelmed by the responsibility that was "dumped in their lap." She suggested that people who are aware of the needs of preschoolers should work with the school people . . . should be inservice training back and forth . . . preschool people have a lot to learn about what the real school requirements are for kids going into kindergarten and first grade . . . I think it will take time for psychologists and psychiatrists to appreciate the needs and the development of educators and vice-versa . . . it will take educators a while to learn to live with the peculiarities of the more psychiatrically oriented people . . . the best help for that would be more interdisciplinary training all along.

She suggests further that it would be helpful if early childhood educators were taught in ways to increase their sense of their own worth.

Nursery school people often feel defensive about the work that they do . . . nursery schools are always in basements . . . but it is indeed important and they should learn to view themselves as professionals with something to offer.

In one mental health affiliated program headed by an early childhood educator, cooperation between the professions is seen as essential and within the program the staff see themselves as both. That there is a potential difficulty is "reflected at the clinic when people don't know whether to call our people teachers or therapists; we're both. Some of our staff are more comfortable being both and some more comfortable being clinical than educational." It
is interesting that when selecting a psychiatric consultant the program was free to hire a psychiatrist who was not on the staff of the clinic with which the program is affiliated.

Speaking as a representative of a mental health program about the situation which exists between mental health agencies and public schools, the director expressed the belief that Chapter 766 has had an enormous impact upon the schools and that they really want to provide for special needs children, but are struck by the enormity of the costs. They are seen as wanting cooperative programs but not being sure of what the boundaries are and being understandably suspicious of programs over which they have no control but are expected to support financially. The schools are seen as not wanting to provide therapy, and it seems reasonable to this director that they should not be expected to pay the bill for therapy for a three-year-old. She says they must come to a recognition of the difference between therapy for a three-year-old and for a twelve-year-old and arrive at some relationship with therapeutic facilities based on trust and confidence. She said, "Many school systems have not had a lot to do with the mental health systems . . . and come to the meeting . . . with as many prejudices as the mental health worker does coming to the educational community." She recognizes that lots of education is needed and that that is difficult but says that we "need to get some information moving back and forth between the two groups."
In the three public school affiliated programs where early childhood educators are program directors, there is less evidence of a professional status difference directly influencing the staff members of the programs. The tensions there are more between public school special educators, whose concerns have been with older children, and the early childhood people, who are more used to considering social and emotional development of young children. The problem here appears to be getting enough money allocated for mental health services and not giving unrealistically heavy case loads to those mental health professionals who are affiliated with the programs.

In the one mental health program which is directed by a social worker, who at one time was an elementary school teacher, the reports from all four respondents indicate that within the program a collegial relationship exists among the staff. The members of the staff of this program represent a meshing of the two professions of mental health and education. Their responses to the interview indicate that the concerns of the two professions are unified in their own attitudes toward their work. Asked to comment on the need for cooperation, one teacher said:

I don't see the discrepancy . . . work in mental health is to help development emotionally, . . . goes hand in hand with child's development in other ways . . . can't be separated in this program in the way we look at children.

Another teacher commented that in this program "It's always
worked." She noted that the staff have both educational and clinical backgrounds. Even the psychologist who consults to the program has a background in developmental as well as clinical psychology and the speech therapist comes from a clinical setting. The third teacher interviewed said, "I feel that I'm both . . . I don't know where to draw the line between educator and mental health professional." The same teacher noted that the psycho-educational model combines the two by providing an educational treatment within a mental health rather than a predominantly cognitive context.

While educational and mental health concerns and methods are well blended within the program, two of the respondents expressed the concern that inter-agency cooperation is less than ideal. Some neighboring mental health agencies are insufficiently aware of this program and others, so they are limited when screening and placing children by not being aware of all the possible placements. The attitudes of the public schools vary in their acceptance of the needs which some of their children have for this kind of a program so that relations with some of them are strained.

It appears from this study that professional status is a real issue in the minds of staff people, even in programs which have resolved the difficulties among their own staff. In the three small mental health programs the teachers have very little formal training in education. In
view of their training, institutional affiliation, and the higher status of mental health professionals, it is not surprising that they tend to identify with mental health. In those circumstances they are less likely to perceive themselves as needing to learn more about early childhood educational models and curriculum development.

Two mental health programs emphasize skill development in all areas of development, thus combining most completely the goals and methods of education and mental health. It is interesting that in these programs the respondents had the most difficulty responding to the question about cooperation between the two professions because they perceive themselves as both. For these respondents, as for those in the other programs, ongoing experiences of inter-professional difficulties concern interagency relations. Each of these programs conveys a sense of cohesiveness among the staff around the shared problem of service to special needs preschool children. This includes teachers, administrators, and therapists. All eight programs face the need to justify and publicize their programs to mental health agencies and public school administrators, for many of whom the children in these programs are a new and unfamiliar population.

Administration

The three public school programs are directly supervised by early childhood coordinators, all of whom have many
years of experience as early childhood special educators. They all report a high degree of autonomy in program planning, which two of them attribute to the fact that the other public school people, including the special education staff, are limited in their knowledge of young children. They are, however, dependent upon others within the system for allocation of funds, so it is important for them to be able to "sell" their ideas. Only one of the three early childhood coordinators reported being satisfied with the degree of support given their program by higher administrators.

Administrators and other staff members from all five mental health programs also reported serious problems with funding, but for them the difficulties were with outside funding sources. All of these programs receive some of their income from Chapter 766 funds with only one program being funded entirely by these funds from three towns. Four of the programs report difficulties in their relations with the schools or with the Chapter 766 funding procedures.

Three of the mental health programs also have early childhood educators for directors. One was formerly a teacher in the program and now, in addition to her administrative responsibilities, does some individual therapeutic work. Another early childhood director is a head teacher and a therapist in the program that she directs. The third early childhood educator shares direction of her program with
a psychiatrist who was also interviewed. A psychiatrist directs one of the other programs, but was not available for interview. The associate director of that program is a psychologist who was interviewed. A social worker is the director of the other mental health program.

In one mental health program only the teacher/director was interviewed, but the observation confirmed her report of a completely egalitarian relationship between herself and the rest of the teaching staff who with her arrive jointly at all important decisions. A peer relationship between the social worker director of Delta and the teaching staff was reported, with the differences between them being in the areas of responsibility rather than the degree of authority. In the other three mental health programs the directors "really are directors" and they take responsibility for decisions but the sentiment expressed in the remark of one of the directors that they "rarely have to make a decision as such, . . . that comes down from above" was reflected in the responses of teachers and administrators from all these programs. One result of the fact that in these programs the staff and directors "really are a team" is that a director reported that "some of the best things we do have come out of a grass roots movement."

Another director, speaking of program decisions based on ideas from the staff, many of which have been highly successful, said "I don't always agree with everything that
happens, neither does anybody else, but we tolerate it."
A teacher in one of these programs considers that administrators should be "very experienced, knowledgeable and have common sense in dealing with staff . . . coordinate ideas that people have," which is her perception of the administration of her program. In addition to program planning in collaboration with the teaching staff, the directors "keep bureaucratic detail away from the direct service staff" and they provide supervision.

In all the mental health programs the staff is involved in the hiring process. The description given by one teacher of the hiring policies in her program as "good nepotism" could reasonably be applied to all these programs, where many of those interviewed learned of their job by word of mouth and no one hired is "a stranger." The programs which offer training programs like to hire their own trainees who "find it desirable to stay on." In all these programs the administration has veto power over a hiring decision, but classroom staff are always involved in a decision before anybody is hired with whom the staff members will be working directly.

In the three public school programs the early childhood coordinators decide who will be hired, although sometimes head teachers participate in the choice of their aides. In these programs, as in the mental health programs, the administrators' responsibilities include program planning,
supervision, and administrative detail, but there is greater variety among the public school programs in the amount and kind of staff involvement in planning and decision making. In one program the teacher is responsible for most classroom decisions, and responsibility for other decisions "goes right up the line" of the school administration. In this program there are no regularly scheduled meetings of the early childhood staff, but meetings are called for "special problems." The staff meetings that the early childhood staff are regularly involved in are for the whole school or for the whole special education department.

The only program in which there was any serious staff dissension within the program was in a public school-affiliated program in which a special education administrator with no early childhood experience is directly involved in the administration and supervision, although the early childhood program planning is left in the hands of the early childhood coordinator. This was the only program from which the interview results were contradictory between an administrator and other staff members. The special education director described staff meetings as workshops reflecting needs expressed by staff at the beginning of the year, but staff find that the needs for communication and support for the whole staff are not being met. They "feel stifled" as the director began setting the agenda at those meetings rather than allowing for a free flow of ideas. One staff mem-
ber expressed the feeling that even when there is a semblance of a discussion there is a sense among the staff that the decision has already been made by the director. It was made clear during the interviews that the staff has been very vocal in registering their complaints and expect to be more involved in planning and decision making in the future. One teacher said that the administration was "hierarchical" but that it did "try to be responsive."

The director of Zeta, the final school based program, believes much of her administrative work could be handled by a very good secretary. That would leave her more time for her more important work of supervision. All the early childhood coordinators of the public school programs agree that there is "nowhere near enough time" for supervision. The director of Zeta does make time for "very informal" staff meetings however, because she thinks "it's very important for teachers to get together and just have a time to talk."

**Mutual Staff Support**

Even though the early childhood director of Zeta believes in the importance of teacher support and planning time, even the monthly team meetings with the director, psychologist and nurse for each classroom team, which were held early in the year, have had to be stopped because of a lack of time. In all the school affiliated programs there is a lack of sufficient time for staff planning and "just
... time to talk." It is recognized as a problem by staff in all the programs and is attributed to school administra-
tors who fail to support all aspects of the programs.

Time for staff communication and mutual support is
considered of primary importance in all the mental health
programs. There was general agreement in these programs
that work with troubled children and families is emotionally
draining and can only be sustained if the staff members have
the opportunity to express their own negative feelings with-
out guilt and to be nourished and supported by their col-
leagues. In the words of one director, an "isolate" could
not "survive here very long."

Outreach and Diffusion

In view of the difficulty the investigator had in
finding programs for this study, it is not surprising that
staff members from four of the mental health programs spoke
of the feeling of "isolation" they have and of their desire
to have their programs better known. Problems in this area
that were mentioned include: public schools not appreciating
a child's need for this kind of a program; parents being un-
aware of the help that is available; mental health agencies
not being well enough informed about such programs to make
appropriate referrals and pediatricians' failure to recognize
and refer a child who needs treatment at the earliest pos-
sible time when treatment would be simplest and most effec-
tive. The problem takes a slightly different form in the public school programs where the classes keep enlarging and the staff is sometimes spread thin. Staff of those programs find that budgetary decisions made by administrators who are unaware of the needs of the preschool population affect the programs adversely. Although the classes in public school programs sometimes exceed the planned size, there is still the belief expressed by some staff members that there are many more children in need of the service than are receiving it, because parents are unaware or fearful of the programs. One school program administrator also spoke of the need for pediatricians to be more involved in early detection. Teachers from several of the programs studied are involved in workshops and in-service programs for teachers and other professionals involved in working with young children. These activities serve the two purposes of reducing the isolation of the programs, and of filling the pre- and in-service gap for training to work with this population. In addition to the in-service workshops and the internships available for students in some of these programs, four supervisory level staff members of these programs teach in colleges and graduate schools.

In addition to direct teaching, the ideas behind and the methods used in these programs become known as the programs become recognized as demonstration models and as they provide consultation to other groups working with this popu-
lation. One director expressed the need as follows:

Our becoming more visible is very important now. The public school department is creating more and more classrooms for emotionally disturbed children and they're still very cognitively oriented and in our experience we just realize that that approach doesn't get to the issue. It covers over in many ways. Programs like ours do get to the issue and can make change, can help a family with their struggle.

A somewhat different view was expressed by the director from a different program who said, "I don't think this ought to be a model to anybody. I'm against models just as a matter of general principle." In spite of that attitude, it was clear from the discussion that the program has many visitors and is consulted frequently. The director's fear was that all aspects of the model might be adopted indiscriminately. The approach recommended was to find out what is available in the area and not duplicate services, and then to make the services fit the community. For instance, a rural community would probably not find the extensive home visiting of a centralized urban program feasible. Several of the other programs were set up as, or have become demonstration models, but the number of visitors that brings was spoken of as a drawback.

None of the large programs reported any research being conducted there, but one director believes there ought to be. In one of the small programs an assessment profile was being developed and funds were being sought for additional research. In this program also the director was
co-authoring an article about the program. There was no program-wide research in the other programs, but in each of the other three small programs some individual staff members were conducting their own research in connection with graduate work. A teacher from one program was doing a follow-up study of children who had gone on to public schools.

Seven of the programs visited evinced a major concern for disseminating knowledge of their own work through consultation and education, while staff members in some programs were involved in research and publication.

**Parent Participation**

The interview schedule did not include an extensive inquiry into parents services, but they are seen as such a major component of therapeutic/educational work with young children that they are an important component of all eight programs. During many of the interviews the subject was raised spontaneously by the respondents without being mentioned by the interviewer. One program began as a home training program with more time spent with parents than in direct service to children. While direct service to children has increased to over sixteen hours of classroom time each week, the parent support and training is still extensive.

In several of the programs studied, children can be accepted into and remain with a program only if the parents participate fully. In some programs parents observe regularly in
the classrooms and in some they are active participants in classes. Home visiting, parents groups and even individual therapy are services offered to parents to assist them in their development as parents.

The parent component is much more extensive in the five mental health programs than in the three programs run by educational organizations. The mental health profession has a long history of parent involvement in the treatment of young children, which is documented as far back as 1905 in Freud's classic case of Hans, whom he treated for a phobia via the child's father. Half a century later, the treatment of children under five by way of parents was described by Furman (1957). The history of psychoanalytically informed parent education as a preventive mental health method is described by Anna Freud (1965). Observational studies of infants and mothers (Brody and Axelrad, 1970; Mahler, Pine and Bergman, 1975, and others) confirm the significance of the role of parents in the early years of a child's development. This belief in the significance of the parental role underlies the commitment to parent work of the mental health programs studies.

The staff of Alpha works intensively to provide truly individualized family services, "really recognizing that one style isn't appropriate for every family." The aim is to help whole families become more integrated with the school and the community. The various needs of the
different families are met through individual counseling, family therapy in the home, observation in the nursery school, behavior management training in the home or weekly two-hour parent meetings with two teachers. Although parenting issues are a major concern of the program, parents are given supportive services for dealing with other issues. If the individual therapeutic needs of family members exceed the scope of the program staff, the program acts as a link between the family and the clinic where their needs can be met.

The parent work of Beta is aimed at helping parents "develop the ability to recognize their child's needs, to develop empathy, and to learn techniques for working with them." The program offers bi-weekly afternoon mothers' meetings which focus on child management, on what it means to be the mother of a special needs child, and on support for the mother. These meetings are run by two head teacher/therapists and the consulting psychologist. There are also bi-weekly evening parent meetings to include fathers. In addition to these groups meetings, each child's "special teacher" meets with the child's parents every three weeks. Two informal meetings of parents and staff are held, one at the beginning of the year so parents can meet the whole staff and the consultants, and one again near the end of the year.

Gamma, the third small mental health-affiliated program, approaches parent work with the same commitment that
characterizes the work of Alpha and Beta. They offer similar services, which include a weekly mothers' group, a monthly fathers' group, and home visiting. In some cases these home and parent services are provided in lieu of a child's placement in the nursery school. Parents of children of the school have parent conferences and three parent nights yearly. Additional informal contacts between parents and staff are encouraged to achieve greater involvement of the parents in achieving appropriate goals for the children. A primary aim of the parent work is to "help parents to understand their child's behavior in the context of the family and to set reasonable goals." The clinical teachers in Gamma share the parent work with the psychiatrist, the psychologist, and the social worker, all of whom work together as a team. This flexible teamwork helps the staff to provide truly individualized family services. The staff also sees their functioning as a team as a good example to families and to children in the classrooms. The psychologist believes all nursery school teachers should be taught to work with parents so that they could have a sense of themselves as being helpful to whole families rather than as allied with the child against the parent, as is now sometimes the case.

Delta began as a home training program, so that family work actually preceded the extensive classroom program which now exists. Parents are still seen as important
contributors to the team effort on behalf of the children's growth and development. Actual participation of parents in the classrooms is preceded by guided observations from behind a one-way mirror. In addition the teachers make bi-weekly home visits and on alternate weeks there is a parent group meeting. The purpose and tone of most of the family work is educational, and involves a sharing of experience and knowledge. Families are helped to learn techniques for working with their children and also to understand their feelings and modify their expectations for their children, thereby improving relations within the family and increasing their own enjoyment of parenting.

In Delta and in Epsilon parents' participation in the programs is a prerequisite for a child's being served. In Epsilon each family is seen at least once a week by some member of the staff. During home visits teachers model appropriate child management and interaction for the parents. This work of the teachers is seen by the administration as preparing parents to use other mental health services or making other services unnecessary. The program also provides parent groups and family therapy when needed. In order to reach families in need with all the services which can help them, the program also works closely with other agencies.

Educational research into early intervention programs for young children also supports the involvement of parents if professional services are to have the most lasting effects
(Bronfenbrenner, 1974; Levenstein, 1970). Respondents from all school operated programs in this study expressed a desire for more parent involvement.

Public schools are mandated, however, to serve all who qualify as needing services. Children cannot be excluded from programs if parents refuse to cooperate. Public schools and collaboratives established to assist them in carrying out the mandate do not have the natural leverage that other programs do to insist upon parent involvement, and yet they are required to offer supportive parent services.

One school program offers parent groups, but attendance has been extremely poor. It has been difficult to get working parents involved. Only the group for single parents is seen by the director as being successful. Home visiting is important in this program, but it is also understaffed and undersupervised according to the respondents.

In another school program the teacher makes regular home visits to keep in communication with the families, to talk over what is going on at home and what techniques are being used at school, and to be supportive.

In cases where . . . there may be some real problems the social worker would be much more involved . . . that's how it is supposed to work . . . but a lot of times we find the social workers' schedules are so incredibly crowded they don't get out when they should.

The social workers responsible for providing this service
are not assigned especially to the preschool program, but are the regular school social workers from the child's home school. Both respondents from this program would like to have the service expanded, but they do see an advantage in having the social worker on a case be from the child's home school, because it frequently means that she will already have a working relationship with the family because of an older child in the school.

In the third public school program one social worker is responsible for most of the direct parent work for the families of children in six special classrooms of eight children each. She does short term crisis intervention, helps get parents in touch with special resources as needed, runs a parent group, and brings in outside lecturers to an evening program for parents. She has other program responsibilities in addition to her parent work, and while she believes more parent groups are needed, she and the teachers interviewed agreed there needs to be more staff involved in parent work. In this program the teachers maintain parent contact by notes written in notebooks which the children carry back and forth between home and school. There is also an open visiting policy for parents in the classrooms and a monthly newsletter. The teachers also make a minimum of two home visits yearly for each child in their classes. The early childhood coordinator in this program expressed dissatisfaction with the small amount of contact she is able to
maintain with parents. She described plans for expansion of parent services for this relatively new program which include individual lectures and lecture courses for parents, counseling, mothers' groups, and home teaching by teachers to be supervised by a social worker, a psychologist and the early childhood coordinator. Parents will also be included in a volunteer training program which will result in their being able to participate in classrooms. They will work in special classrooms, but not in the classes in which their children are enrolled.

Imaginative enticements such as these are needed to involve parents in ways that will help their children and make the job of parenting more rewarding, but it should be understood that schools do operate under a disadvantage that does not prevail in some private or voluntary programs.

Professional training for teachers does not usually include preparation in working directly with parents (Sara-son, 1963). In all of the mental health programs psychiatrists, clinical psychologists or psychiatric social workers are available to do the parent work or to supervise teachers who provide the direct service. In all three school programs the psychologists, social workers or nurse who conduct the parent work are considered by all the staff members to be carrying far too large a case load. Apparently those who make budgetary decisions for the school programs are used to budgeting for group services and are unprepared by their
experience for the number of professionals needed to provide the individualized parent support services understood by early childhood professionals to be required. Contracting for supervision and consultation from mental health professionals to assist teachers in providing parent support and education is not without problems. The larger classes which prevail in the public school programs and the lower trained teacher/child ratio there militate against the teachers having the time for parent work in addition to classroom and classroom preparation time for the number of children for whom they must provide individual programming. Class size cannot easily be controlled because schools cannot plan and budget for a specific number of children and then close enrollments, but must provide for any child who is referred and whose assessment indicates a substantial need. As these problems become resolved under the pressure to provide increased parent services and programs expand from direct work with children outward to include influencing the child's whole environment, it is important that professionals never lose the traditional conviction of teachers and of some individual child therapists such as Axline (1969) and Moustakas (1970, 1974) that direct work with children can itself be of primary importance in helping them to grow and develop in healthy ways.
Early childhood educators and mental health professionals who were interviewed for this study recognize the need to provide both educationally and therapeutically for preschool age children with emotional difficulties which need to be addressed directly. Even in programs which choose to concentrate primarily on skill development in the classrooms, early childhood specialists from every program in the study recognize the need for consultation from mental health professionals to help the teachers provide appropriately for these special children. In the skill oriented programs it is recognized that some preschool children need psychotherapy in addition to their classroom intervention. In spite of this, public schools are under injunction not to refer to children as "emotionally disturbed." One respondent, a psychologist, suggested that "It's scary for people to think about preschool kids with emotional problems [it makes us feel] out of control in relationship to little kids." That may be a contributing factor behind the regulations which forbid the labeling of children. Another is surely the valid concern that a child might be stigmatized
for life by a label suggesting mental illness. While dedicating the Mailman Research Center at McLean Hospital in Belmont, Massachusetts on October 3, 1977, Rosalynn Carter said,

We can speak out forcibly about the need to erase the stigma connected with mental illness. This is what we have found so much in our President’s Commission on Mental Health—the stigma that is attached to mental illness. We need you to help us overcome this stigma. And the need for communities to support, in every sense of the word, those who have been or are afflicted.

Overcoming that stigma through public education would obviously be a more enlightened approach than banning the diagnostic labels. The effects of not fully identifying the emotional needs of the children in some of the programs in this study can be seen in the failure to make adequate mental health services available to children, parents, and teachers in those programs. Mental health operated programs reported the difficulty some school officials have in recognizing the need to refer children to a mental health program.

In programs which are successfully providing for children with special emotional needs, the participants recognize and have had to deal with problems which are related to the difference in status between teachers and mental health professionals. Such status problems, with the early childhood educator in a chronically disadvantaged position for influencing program policy, must be resolved within each program as a minimum condition of its survival
and its ability to provide effective services.

The results of this study suggest that the major strategies used to provide both educational and psychotherapeutic services to preschool children with special emotional needs have, in effect, evolved a new professional role, which includes functions and concerns of early childhood classroom teachers and psychotherapists. These dual functions are being performed by individuals who are emerging as a new professional group which manifests several of the attributes of all professional groups (Barber, 1965) as they struggle for recognition and the right to provide services as professionals. These early childhood teacher/therapists function with a high degree of orientation to the community interest rather than individual self-interest, and the performance of their professional role requires mastery of a specific body of knowledge. These are two necessary attributes of a profession (Barber, 1965). Since it is a still emerging profession (Barber, 1965), there is a lack of sufficient generalization and systematization of the knowledge basic to this group. Only the formal institution of professional training for early childhood therapist/teachers can systematically provide that. There is also no separate organized code of ethics by which this group exercises its own self-control, another criterion provided by Barber's analysis.

There is some evidence from this study that this
group may be moving toward autonomy and control over its own behavior. Wittlin (1965) speaks of the general lack of autonomy and decision making power among teachers and suggests that this leads to general professional dissatisfaction. The teachers in this study report having considerable autonomy within their own classrooms, and in most programs they influence decision making beyond their own classrooms. In two of the programs the teacher/therapists are the educational supervisors for their own classes in which role they supervise their students and coordinate the suggestions from the special consultants. The use of specialized consultants as resources rather than authority figures is typical of all these programs to some degree.

Barber (1965, p. 25) says:

One of the essential attributes of the professional role . . . is autonomy, or self control by the professionals themselves with regard to the development and application of the body of generalized knowledge in which they alone are expert.

This is indeed the situation of the early childhood special educators in this study who work in public school programs where the school administrators clearly recognize the special expertise of the early childhood staff. The failure of the school administrators to support all aspects of the programs for preschool children, especially their failure to budget sufficient funds for mental health services, is an example of the strain which can exist in an organization which includes a specialized professional group within a larger
organization as "professional roles confront organizational necessities" (Barber, 1965, p. 25). One solution to this situation is the use of "professional administrators" (p. 27) which is the solution observed in mental health programs where the fiscal decisions are made by the same mental health professionals who are responsible for program decisions.

As noted above, there is as yet no formal, widely accepted specific training for early childhood therapist/teachers. The staff members of the programs in this study have arrived at their special expertise via very diverse routes. Some of the programs offer training programs for therapist/teachers. As occupational groups seek recognition as professionals, they tend to establish professional training centers in universities, according to Barber. In this regard it is of interest that four administrators in these programs teach in colleges and universities. Barber notes that the obligations of the university training schools are the transmission of "generalized and systematic knowledge" to students and practicing professionals and the creation of new knowledge. He says that

the better the university professional school, the more likely it is to use resources from all the other professional schools in the University and from all the departments of basic knowledge in so far as they are relevant. (p. 20)

It appears that neither departments of Education nor of Psychology in the universities in Massachusetts are meeting
their obligations to prepare professionals for therapeutic-educational work with preschool children or helping to establish appropriate professional standards leading to licensing or certification for preschool therapist/teachers.

Comprehensive specialized training would more sharply define the professional identity of these therapist/teachers, in addition to preparing them for their educational and therapeutic functioning.

Appropriate professional training for preschool clinical teachers would prepare them in all areas of child development (cognitive, affective, linguistic, motoric) and in understanding the ways in which these areas are interrelated. Clinical preschool teachers would learn to recognize and remediate abnormal development to the extent that the abnormality is understandable and remediable in terms of personal or environmental dynamics which can be approached educationally or psychotherapeutically. They would become proficient in educational methods, program models, curriculum development and the use and design of educational materials. They would also become proficient in psychotherapeutic methods and learn to provide corrective emotional experiences for children and assist them in developing relationships, in understanding their feelings and in learning to express them in healthy ways. Professional training would focus on ways of integrating these two different but complementary sets of skills. In addition, these
new professionals would be taught the effective use of specialized consultants and of ongoing supervision in the performance of their profession. Preparation for working with parents would also be included in the professional training of clinical preschool teachers.

In all the programs in this study the classroom is the nucleus of the program or else a major component. In all the programs other components are found to be essential if the work in the classroom is to be most effective. In addition to fully trained clinical teachers, then, programs providing for the needs of preschool children with special emotional problems ought to include mental health and educational supervisors, and also consultants whose specialties include a wide range of competencies such as parent counseling, speech and language therapy and movement therapy. It is imperative that these specialists also have a demonstrated competence in early childhood development and learning.
REFERENCES


