Criteria of recovery of Maladjusted children in residential schools

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PART ONE:

INTRODUCTORY.

INTRODUCTION

The education and treatment of the maladjusted child is a field which needs a great deal of clarification in both its theory and its practice.

This is particularly true of the work carried out by residential special schools, which tend to take the more disturbed children, and with which this enquiry is concerned.

These schools were pioneered and, until very recently, almost exclusively carried on by people who were not professionally trained as educationists, psychologists or psychiatrists, people whose methods, and, in many cases, theoretical concepts, were based rather on their intuition, their natural abilities and their sympathy for the children in their care, than on objective or clear thinking. They have often met with great success in their work with the children, and have put forward views which have often been stimulating and challenging, even when, as may be seen in later chapters of this work, their thought has been vague, muddled or uninformed. They have left behind them a great deal of theory that is confused and contradictory.

I have chosen to discuss one aspect of work with maladjusted children, namely, the criteria of recovery.

This is a subject which has been strangely neglected in the literature. All too often a writer refers to recovery as having resulted from a particular form of treatment, without offering any information on how recovery was recognised.

This is a particularly important matter for those who work in residential schools, since they must attempt to assess how far a child is ready to adjust to the outside world, basing their assessments on observations made within the institution.

The subject resolves itself into two specific questions, namely:-

1. What criteria of recovery are used in the residential treatment of maladjusted children?

2. Which of these criteria, if any, are associated with actual recovery?

This work represents an attempt to provide answers to these questions. It has followed this plan:-

1. After definitions of the terms of the title, a survey is made of those writers in the literature of the subject who deal specifically with residential treatment. Their work is discussed with particular reference to any contribution they make, explicitly or implicitly, to the present topic.
2. Four schools were chosen, whose principals had, in every case, made some significant contribution to the theory or practice of the treatment of disturbed children. An account is given of as much of the work and organisation of the school as is necessary to fill in an appropriate background to the views on recovery which were obtained there.
3. Criteria gathered from these sources are discussed from the point of view of their theoretical implications and of their practical application. Their association with subsequent recovery is assessed in respect of a sample of maladjusted children.
4. Conclusions are drawn from the above.

DEFINITIONS OF THE TERMS OF THE TITLE:-

"Criteria of Recovery". Two of the headmasters[1.] of schools I visited remarked that the best sign of recovery is that the child has grown up and is managing successfully in his work, in his marriage and in bringing up his children.

Now, although this is undoubtedly true, it is of no value in judging a child's progress while still at school, nor in assessing his chances of future success in a more normal environment. Decisions about the child's future must be based on what can be observed of his behaviour at the school. When such a decision is made, some criteria must be employed, if it is not to be a matter of guess-work, and these are of the greatest importance.

This work, then, is concerned with those criteria which can be employed while a child is still in the last stages of school, and which have, or should have, a good predictive value regarding future continued recovery.

"Maladjusted Children". Briefly, I am concerned with those children who have been ascertained[2.] as maladjusted and in need of special educational treatment. The term "maladjustment" is so widely understood to imply an unspecified emotional or psychological disturbance that further comment would be unnecessary were it not for the fact that so eminent a writer as Professor C.W. Valentine, in a book intended for a wide public,[3.] uses it in a way which gives it a much narrower and more precise meaning than that which is usually accepted. He says:-

> ... bullying and boastfulness may be due merely, or largely to excessively strong innate tendencies of assertiveness and aggression, in which case one would speak of "maladjustment" rather than "neuroticism".
>
> We shall see later that we may expect to find great individual differences in the strength of such innate tendencies and the extremes may lead to trouble even where there is no repression or dissociation and so nothing genuinely neurotic as we have defined it.[4.]

Now, quite apart from the theoretical implications of this statement,

it must be born in mind that "maladjustment" is now a legal rather than a psychological term.

Maladjusted pupils are defined in the School Health Service and Handicapped Children Regulations as:-

> pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social or educational readjustment.[5.]

This legal definition is phrased in the widest possible way, and makes no attempt to exclude "neuroticism".

Further, in 1955, the Committee on Maladjusted Children continued to use the word in a much wider sense than Valentine does:-

> Its (Maladjustment's) worst effects are seen in mental hospitals, divorce courts and prisons ...[6.]

This seems to include not only neurosis but also psychosis and delinquency. And:-

> ... it is a term describing an individual's relation at a particular time to the people and circumstances which make up his environment. In our view a child may be regarded as maladjusted who is developing in ways that have a bad effect on himself or his fellows and cannot without help be remedied by his parents, teachers and the other adults in ordinary contact with him.[7.]

Burt and Howard[8.] also give the word a wider significance when they suggest the following provisional definition:-

> A maladjusted child may be defined as one whose adjustment to the recurrent situations of his everyday life are less adequate than might reasonably be expected from a child of his mental age, and whose condition or circumstances therefore require special treatment.[9.]

In the summary and conclusions of the same paper the authors state that "maladjustment can hardly be regarded as forming a single homogenous group."[10.]

In view of the legal[11.] rather than psychological origin of the term, this conclusion is not unexpected, but it is a further indication that the word is not being employed in the restricted way proposed by Professor Valentine.

The term will be used throughout in this wider sense.

"Residential Schools". All the schools in this enquiry are boarding special schools, approved by the Ministry of Education as suitable for the education and treatment of maladjusted children. All are to be found in the Ministry of Education List 42.[12.]

The four schools selected for special attention are all "non-maintained" special schools, and in each case the school is still run by the person who started it. This last consideration was adopted as a result of suggestions by Mr. J. Lumsden (H.M.I., Special Services Branch, Ministry of Education) and Professor F.V. Smith.

PART TWO:

HISTORY AND LITERATURE OF THE SUBJECT.

CHAPTER I

THE NEED FOR HISTORICAL PERSPECTIVE

It is not easy to make a satisfactory survey of the early attempts at residential treatment of maladjusted children. Most of the pioneers were concerned primarily with their dealings with the children in their care and had little time to make any contribution to the literature of the subject, to relate their work to general psychological theory, or even to give a factual or historical account of the progress of their schools or institutions. Nevertheless, some assessment must be made, not only in order to provide a historical background or perspective to present day methods of treatment, but also because certain differences in approach and outlook which can be found in schools at the present time and with which we shall be concerned later have their origins in different historical traditions. They are the product of different lines of evolution as it were, and reconciliation of the differing viewpoints may not always be easy.

Three names spring to mind when one considers the early attempts at treatment of maladjusted children - August Aichhorn,[1.] Homer Lane[2.] and A.S. Neill.[3.] We shall largely be concerned here with the first two, since Neill's contribution to the field is much more diffuse; there are in the category of schools we are considering none which has developed principally or largely from his theories or methods and there is no work being carried out in this field which arises directly from his beliefs - except, of course, that Neill is still working in his own school.[4.] Aichhorn and Lane, however, have their "descendants", and, although their ideas have been greatly developed and changed in many respects, the imprint of their thoughts can be found in varying degrees in all the schools which were visited.

Reference was made above to the fact that certain differences in approach arise out of differing historical origins. Aichhorn and Lane

represent the starting points of many of these differences. The reasons for their prominence are perhaps to be found not only in the originality of their thought, but also in the fact that they were the most prolific among their contemporaries. We do not know how many other people were engaged in this kind of work at that time, if indeed there were any. It is this complete absence of other literature that makes by comparison the work of these writers seem prolific. In the case of Lane, there is only one book made up from material which he wrote himself[5]. and one book written about his work at the Little Commonwealth.[6] There are, in addition, two books which are concerned with subsequent experiments which were developed from Lane's approach.[7] In the case of Aichhorn, there are 25 papers on various topics, and one book. Only the book exists in an English translation.[8]

CHAPTER II

HOMER LANE

The work of Homer Lane is probably known more widely than that of any other of the earlier workers with maladjusted children, though it is probably true to say that his reputation is generally higher amongst those who are not directly concerned with this specific field of education. This may be accounted for by two factors: firstly, the element of self-government is something which is easily grasped, (though, in the opinion of the present writer, insufficient attention has been given to the theoretical implications of this aspect of his work), and secondly because of the existence of a very readable book on the subject.[1.] In addition, the scandal and controversy attending the closure of the Little Commonwealth probably aroused interest at the time even among people who were not directly concerned in educational work.

It is not necessary at this stage to give a detailed account of the organisation of the Little Commonwealth; the existing accounts by Bazeley and Lane himself[2.] give an adequate picture of the way it functioned. What is less explicit, however, is the account given of the psychological assumptions on which the work was based, which, for the most part, must be gleaned from here and there in the two books already cited, or inferred from the few case histories given there.

What I intend to do here is to examine the psychological bases of Lane's work - in so far as these can be distinguished - to discuss whether these throw any light on Lane's views on recovery, and, lastly by consideration of actual case material contained in the two books cited above, to attempt to discover what were the criteria actually employed by Lane and his associates to evaluate recovery.

The idea of self-government is the one which is most widely associated with Lane's work, and this is, I think, a just evaluation, not only judged by Lane's own words,[3.] but also because it implies a fundamental assumption about the nature of maladjustment and delinquency

about the process of recovery, and hence about the signs of recovery when it is taking place. Lane's standpoint differs in essentials from the views of other writers and workers in the field, and this essential difference has not been sufficiently widely understood; it has therefore led to a certain amount of confusion, both of thought and practice, on the part of later workers, and has given rise to a number of rather lame attempts to reconcile what are in fact basically irreconcilable points of view.

This inconsistency is in fact already apparent in the work of Lane himself; it arises from the existence of two approaches to the problem of delinquency, namely that which regards it essentially as a matter of problems in personal development and that which regards it as a question of social adjustment.

Lane, for example, states at one point unequivocally:-

> The problem of the reformatory school is to resolve these problems which come from the unconscious mind; for crime is fixed energy left over from childhood.[4.]

Now, even without enquiring into the precise meaning of the unexpanded final statement, this must be taken to imply that the causes of delinquency are to be found in the personal history of the individual, that it is in fact a question of deviant or deficient development of the personality, and the use of the concepts of "unconscious mind", unresolved problems and fixed energy are reminiscent of the psychoanalytic views which, since that time, have played an increasing part in work of this kind. (Lane was in fact familiar with Freud's earlier works, but he appeared to adopt these views only as a general guiding principle. He does not appear to have made them the subject of detailed study, nor does he seem to have made any attempt to develop his own views in a methodical way).

This impression of apparent affinities with psychoanalytical methods is strengthened by Lane's statements, for example that:-

> ... the development of the diseased mind is traced back, step by step, by association, until the abnormality is found in the delinquent's childhood.[5.]

Or again, "the cause of every wrong act can be traced to its source by careful analysis."[6.]

It is difficult to reconcile this with Lane's own description of his cases at the Little Commonwealth. He says:-

> These boys and girls had no idea of social order.... the victims of an especially narrow and restricted environment their faculty of self-control was almost wholly undeveloped... It was necessary to employ extraordinary measures to free them from their misconceptions of social order.[7.]

This description makes no reference to unconscious motivation, or unresolved problems. It appears, on the contrary, to place the blame on a lack of adequate experience which would give them sufficient understanding, not of their own problems, but of the nature of "social order". In other words, it seems to place a premium on intellectual insight into the reasons for the demands of society, and recovery seems to come about as a result of a learning situation rather than as a result of psychotherapy. The "extraordinary measures" employed are, in fact, the organisation of the Little Commonwealth, with its freedom (and disorder) gradually developing into a rather complicated system of self-government as the delinquents "arrived at the point where the need for formal rules and laws was felt."[8.] This point was reached not by psychoanalytical treatment of all the individual cases but by the young people learning, under Lane's leadership, the advantage of, indeed, the necessity for, social structure.

This method of treatment, if this is a proper term to employ, is very different from what one would expect from the references, cited above, to "careful analysis" of a "diseased mind", and is the source of the inconsistencies already mentioned. Lane himself was aware of the existence of this problem, and proposed a solution, which, though very simple, has not been widely adopted. He postulated a tendency to recovery, which, given a favourable environment, would operate in all but the most stubborn cases; he states that although the cause of delinquency can be traced to its source by analysis:-

> I have found that almost all delinquent children will resolve their own difficulties in an atmosphere of freedom and encouragement. Occasionally special help is required and special knowledge.[9]

Diagnosis and treatment will only be necessary "in special cases".

It is this postulate of spontaneous recovery which has received scant attention from those who have followed Lane's lead,[10] and, without it, it becomes extremely difficult to reconcile what might be called the social aspects of his work with views concerning the recovery of deviant personalities.

Once accepted, this view implies that the worker can concentrate on social rehabilitation, which, in fact, was the case with Lane and his colleagues, and this concentration of their attention might be expected to have an effect on their views concerning the criteria of recovery (the fact that recovery is regarded as occurring spontaneously does not absolve them from assessing the progress and probable success of their cases).

Given Lane's approach, with his stress, as far as the practical side of his work was concerned, on social rehabilitation through insight into the workings of society, the logical view of recovery is to regard it as being accompanied by (if not actually consisting of) an increasing degree of social adaptation. This, one would presume, would be manifested in an institution like the Little Commonwealth by an increasing ability firstly to meet the social demands and pressures of the institution without breaking down and, later, to make positive contributions to its communal life. In other words, where the problem of treatment is regarded primarily as a question of social adjustment, one would expect a similar view to be taken of the nature and recognition of recovery.

Unfortunately, neither Lane nor Bazeley discusses this question directly. It is possible, however, to look for confirmation of this in the case histories which are given by both writers. This task is not made easy in some of the cases discussed by the loose thinking and imprecise writing which characterises Bazeley especially. We are told,

for example, in the case of Ted that, after he had been sent for a visit to his mother at the expense of the Community, "he returned a changed boy."[11] We are left to guess how he had changed.

There are also a number of cases about which no information is given about what criteria were considered appropriate in judging the success of recovery.

Leaving aside such cases, and those reported by Lane, which concerned children who did not receive residential treatment and who therefore are outside the scope of the present work, we find that the criterion most commonly employed is the successful carrying out of a regular job within the Little Commonwealth.[12] It is said of James H- , for example, after the incident which was held to be his turning point towards recovery "the next day he applied for work as a bricklayer." Edmund's work was greatly improved - he kept the farmyard tidier, he was able to keep a job and earn a regular wage. Annie successfully carried out outdoor work, Jason "became the best carpenter in the community", and John "had applied for work to the head carter and was doing excellent work on the farm." It is clear that such behaviour is regarded as indicating recovery.

This appears to be a special instance of the use of social adaptation as a sign of recovery, for work of this kind played an important part in the life of the Little Commonwealth.

It is surprising that more reference is not made to the successful carrying out of duties in the Legislative Council or the Citizens' Court as a criterion of recovery. One assumes that, if a "Citizen", like Jason, "was elected Judge of the Citizens' Court, over which he presided with unusual ability", then this would be a very hopeful sign, as it was in Jason's case, but references to this as a criterion are few. It is, in any case, only another instance of social adaptation being regarded as having a predictive value.

The next commonest criterion employed in the case histories is rather surprising, since it does not arise out of any of Lane's

theoretical considerations; it may therefore have been arrived at empirically. It is improvement in personal appearance, tidiness, cleanliness and so on. It is used in the cases of Margaret, Edmund, Annie and John. It is not possible at this time to be sure to what extent the use of this criterion was influenced by the social conditions prevailing in England at that time. There seems to be little evidence at the present time of any correlation between untidiness or lack of personal care and maladjustment in general, or with delinquency, though that is not to say that it may not appear as a symptom of some particular maladjustment.

There are two other criteria, each of which is used in one case only. We are told that Margaret developed "a feeling for the Little Commonwealth" and there is the case of Philip, who paid off a debt which everyone had forgotten about; this latter may perhaps be described as the awakening of a conscience - or, in psychoanalytical terms, - evidence of a superego.

The most surprising omission in the published work of Lane and Bazeley is of any reference to the rule of personal relationships, either as a means towards or a sign of recovery, - especially surprising when one considers the importance which has been attached to this since. It is not likely that Lane and his staff and the Citizens could live and work together in the Community for so long without any relationships of this kind developing. Nor is it likely that Lane could be completely unaware of them. What is surprising is that he did not consider them of sufficient importance to include them in his book.

The nearest we come to this kind of concept is in Bazeley's description of the residential houses - the "families", as they were called. The importance of these to the recovery process was realised; as Bazeley puts it:-

> The family was one of the most powerful forces in the Commonwealth. The family made you; your failures could make or break the family.[13]

But the importance of the family is never further accounted for; the point is not followed up. It is easy to be wise afterwards, but one

can guess at a connection here with later work and theory about the importance of healthy relationships with parent or family substitutes in the recovery of disturbed children.

Another important omission, from the point of view of assessing Lane's work, is the lack of adequate information about the background of his cases and the referral symptoms. This is in part due to the fact that there was no School Psychological Service or Child Guidance Service in existence at that time; and the fact that all his cases were delinquents who had been before the courts and thus, in a limited sense, had similar backgrounds, may have led him to be sparing in his provision of such information.

CHAPTER III

AUGUST AICHHORN

Turning to the work of August Aichhorn we find a striking contrast with Lane in almost every way. While Lane made only a general and not very methodical concession to psychoanalytic views, Aichhorn took them up enthusiastically and made them a subject of serious study; so much so in fact, that he made significant contributions to psychoanalytic thought and became ultimately a leading figure in the Vienna Psychoanalytical Society.[1] Lane dealt entirely with delinquents and, though he believed that delinquency was the outcome of personal, largely unconscious problems, he attached a great deal of importance to deficiencies in what might be termed the social environment and put his faith in a tendency towards spontaneous recovery coupled with a system which gave opportunities for re-education in social obligations; he stressed the importance of a conscious or intellectual understanding of the "social order". Aichhorn, on the other hand, did not limit his attention to the problem of delinquency, considering this to be only one aspect of a much wider problem:-

> By "wayward youth" I do not mean merely delinquent and dissocial children, but also so-called problem children and others suffering from neurotic symptoms.[2]

In considering the relative significance of social influences and unconscious problems, while regarding both as important, he reverses Lane's emphasis:-

> When I ask parents how they account for the dissocial behaviour of their children, I usually receive the answer that it is a result of bad company and running around on the streets. To a certain extent this is true, but thousands of other children grow up in the same conditions and still are not delinquent. There must be something in the child himself which the environment brings out in the form of delinquency.[3]

> Can we make any general formula out of what we have learned up to this point? If we regard all behaviour as the result of psychic influences in the psychoanalytic

> sense, then we must think of dissocial behaviour, too, as being so determined, and we can express the desired formula thus: dissocial behaviour indicates that the psychic forces which determine behaviour are not functioning harmoniously. This formulation enables us to define the problem of delinquency psychoanalytically, and points the way towards a solution.[4.]

It also points to a further difference between Aichhorn and Lane. Lane believed in freedom and self-government; Aichhorn held that it was the duty of those concerned with "wayward youth" to provide the treatment that is best for the child, whether or not this is what the child would ask for, so that we find one of his cases saying to him towards the end of treatment:- "It's a good thing people aren't always allowed to do what they want to do."[5.]

For Aichhorn, and for those who have followed him, treatment, consisting of specific techniques, is an inescapable duty of those who undertake the care of maladjusted children.

Before considering Aichhorn's views on recovery and its manifestations, it will be as well to examine in greater detail his views on the nature and treatment of maladjustment. This is an easier task than it was in the case of Lane, since Aichhorn develops his theories more explicitly and uses case histories sparingly to illustrate particular points rather than to build up, anecdotally, an impression of how his institution worked. An incidental result of this is that we do not have such a clear or detailed account of the day-to-day life or the organisation of Aichhorn's training school[6.] as we do of the Little Commonwealth, but this is compensated by the fact that we need to rely far less on inference in order to understand what was the underlying theory: we can rather let Aichhorn speak for himself.

Aichhorn, then, was concerned with maladjustment in a wider sense as we understand it today rather than with delinquency, as has been pointed out above. He worked specifically within a psychoanalytical framework, constructing from the basis of Freud's theories a new technique, applicable to his own cases and to the situation in which he worked.[7.]

Maladjustment is regarded as being a deviation from normal development, brought about by disturbances or fixations in the libidinal development of the growing child:-

> The task of upbringing is to lead the child from this asocial to a social state. But this training can not be successful unless the libidinal development of the child pursues a normal course. Given certain disturbances in the libido organisation, the child remains asocial, or else behaves as if he had become social without having made any actual adjustment to the demands of society.[8.]

> In dissocial behaviour we see the result of disturbed psychic patterns, of abnormal accumulation of affect.[9.]

As far as the treatment of neurotic children is concerned, this represented no new departure from the then existing Freudian view of neurosis. What was new was the development of the idea of a close parallel between the aetiology of neurosis and that of delinquency. In both cases, the overt behaviour is regarded as a symptom of a problem which can be traced back to the earliest years of infancy.[10.] This view leads directly to the supposition that delinquency, like neurosis,[11.] can only be fully understood by relating it to pathogenic events or circumstances in the child's history:-

> We must seek the causes of the latent tendencies (to delinquency) in his constitution and in his childhood and other experiences just as we would in the case of a neurotic.[12.]

Delinquent behaviour may therefore be regarded as the outward manifestation of a psychologically abnormal condition, and the true motivation which lies behind a dissocial act may be expected to be unconscious motivation, to be discovered only be careful analysis.

> Delinquency can now be considered as a dynamic expression. It can be attributed to the interplay of psychic forces which have created a distortion which we call dissocial behaviour.[13.]

Aichhorn carries his parallel still further by distinguishing between the symptoms and the pathological condition of which they are the expression:- "When we look at dissocial behaviour, or symptoms of delinquency, we see the same relation as that between the symptoms of

a disease and the disease itself."[14]

This distinction is most important as regards treatment, since it clearly implies that the behavioural symptoms which give rise to the referral of a case to, for example, a clinic, are not the essential problem which requires treating, and that treatment which confines itself only to the removal of symptoms is leaving the real cause of the trouble untouched:-

> If the physician limits himself to clearing up symptoms, he does not necessarily cure the disease. The possibility of a new illness may remain; new symptoms may replace the old. In the re-education of the delinquent, we have an analogous situation. Our task is to remove the cause, rather than to eliminate overt behaviour.[15]

This task can be accomplished only by psychoanalytical methods,[16] though within the framework of an institution, the technique of psychoanalysis as practised in the consulting room would not be appropriate. Interpretation and interviews of the analytic type have a place in treatment, but, above and beyond this, there is the opportunity, presented by the fact of having access to the children all day and every day, of creating an environment, which, in its entirety, tends to bring about recovery. This was the first suggestion of the idea of "milieu therapy", which was to be so important for many later workers. It is interesting that Aichhorn's translator actually makes use of this word, in the following passage:-

> Conditions other than those of the personality of the individual pupils must be considered. I refer to those external conditions which in general constitute the <u>milieu</u>. Not only are the companions with whom he lives important to the dissocial child, but also the material world around him, not only the milieu of the group, but also of the institution as a whole.[17]

All aspects of the life of the institution are organised with a view to promoting recovery. This applies not only to such things as the organisation of classes and groups,[18] but also to such details as the way meal-times are run.[19]

The parallel with orthodox psychoanalytic treatment is carried

further in the way behaviour problems and other symptoms are regarded, that is an attitude to them which is a logical outcome of the distinction between the symptom and the disease, namely that the symptoms are to be tolerated in the early stages of treatment.

> In the consulting-room of the clinic the worker accepts the misconduct of the delinquent and in the beginning does not interfere with it, but awaits the time when a change comes of itself. We can see no reason why the procedure should be different in the institution just because there are more cases and the difficulties are greater.[20].

Indeed, from what has already been said, it is clear that for Aichhorn encouraging certain forms of behaviour or discouraging others, by the use of rewards and punishments, will not do anything to resolve the underlying conflicts or unconscious motivation which determines the manifest behaviour; it may even aggravate the situation.[21].

We have made no mention until now of the factor which Aichhorn regarded as being the most useful of all the means at his disposal to bring about recovery; that is the concept of "transference":-

> What helps the worker most in therapy with the dissocial? The transference! And above all what we recognise as the positive transference. It is above all the tender feelings for the teacher that gives the pupil the incentive to do what is prescribed and not to do what is forbidden.[22].

We shall see later that many workers have since that time found it preferable to restrict the use of the word 'transference' to its original, stricter meaning,[23]. as it is applied in the analysis of neurotics and to use instead terms with other connotations; but all the schools visited in connection with this research - irrespective of theoretical background or methods of treatment - were agreed on the importance of good emotional relationships in some form.

Aichhorn's most specific contribution to the particular matter under discussion is undoubtedly the question of the proper way to regard symptoms.

If one accepts his point of view as valid, then the occurrence or disappearance of manifest symptoms is of far less importance than might

otherwise be supposed. A symptom's elimination does not necessarily indicate that a cure has been effected:-

> ... the disappearance of a symptom does not indicate a cure ... a new path of discharge will be found ... and a new form of delinquency will develop ... (or) the original signs of delinquency often reappear, more deeply anchored and pronounced.[24.]

Or, in certain cases, later workers have claimed it may reappear in the form of a neurosis or psychosomatic illness.[25.]

And, conversely, the absence of manifest symptoms does not necessarily indicate adjustment:-

> ... the child behaves as if he had become social without having made an actual adjustment to the demands of society... This state we call "latent delinquency" and it can become manifest on provocation.[26.]

However, in actual practice, Aichhorn does in fact appear to make use of the disappearance of symptoms as a means of assessing recovery.

There is, for example, the case of the boy of sixteen whose mother had been killed in an accident with a machine.[27.] His symptoms were "vagrancy and a refusal to work", and depression. At the end of his account of this case, Aichhorn says that after the institution was dissolved the boy worked on a farm and that there were "no further signs of delinquency. He did the work to which he had been assigned ... his depression disappeared."

Evidently, in spite of his warnings about the danger of the worker being misled by the disappearance of symptoms, Aichhorn did not find it possible to dispense with this as a criterion of recovery. One must presume from what has been said that it is to be used only with the greatest caution, having due regard for the psychopathology of the case; it is presumably only applicable in cases where the symptoms have cleared up as a result of treatment of the unconscious problems and never valid when they have disappeared as the result of an attempt to suppress them directly, by punishment or other means.

Similarly, an appearance of social adjustment may be misleading if

it is based on no fundamental changes; it may be merely a superficial adjustment - "latent delinquency", as Aichhorn calls it. Thus, this criterion too, according to Aichhorn, needs to be treated with caution.

There remains the question of transference. If this is, as Aichhorn says, the thing that "helps the worker most in therapy with the dissocial", then it would seem likely that its occurrence would constitute one of the most favourable portents of future recovery in his sense.

However, Aichhorn does no more than pose the question. It has been left to others to develop it further.

For Aichhorn the rehabilitation of the neurotic or the delinquent child is no small task, and the prediction of success is scarcely less fraught with difficulties, but he does suggest the existence of an alternative course of action which is appropriate in certain cases. If, for any reason, it is not thought possible or desirable to undertake the task of bringing about a full recovery in the sense that Aichhorn has described it, one can instead bring about a more superficial change in behaviour, so that it is more acceptable to society:-

> Since we could not alter the sources from which the homosexual derives the energy for his psychic life, it became our task to direct this energy into socially acceptable channels.[28].

This, of course, is based upon the reasoning that if one symptom is suppressed it will be replaced by another which has a similar psychopathology; it is therefore theoretically possible to manipulate the environment in such a way that undesirable symptoms are eliminated, and those which are tolerable are encouraged. The result will be someone who can function as a member of society, but the apparent success may be somewhat precarious, since it is always possible for the process to be reversed.

Perhaps the most interesting point which arises out of this and one which will be discussed more fully at a later stage is that, whereas Aichhorn would regard such procedures as very much secondbest - "patching-up jobs", as it were, - many workers would claim such cases as successes. This divergence of opinion seems to suggest the possibility that criteria may not be unconnected to aims of treatment.

CHAPTER IV

BRUNO BETTELHEIM

Passing to more recent writers[1.] we come to Bruno Bettelheim's account of the work of the University of Chicago Sonia Shanklin Orthogenic School.[2.]

Bettelheim's work reflects recent trends in psychoanalytical thought, and, in particular, it reflects the application to the residential treatment of maladjusted children of the results of the growing interest among many psychoanalysts in recent years in the study of the ego. Although Bettelheim works mainly within a psychoanalytical framework, his approach as regards questions of the nature of the emotional disturbances of his cases and of treatment represents in many respects a significant divergence from the methods hitherto associated with psychoanalysis.

The psychoanalytical concept of the ego was first formulated by Freud;[3.] it was regarded as having the functions of co-ordinating impressions received through the sense organs from the outside world and those from within the body; it had also the function of regulating the impulses emanating from the id. Work on the ego was carried forward by various writers, in particular by Anna Freud,[4.] who developed and discussed in detail the various defence mechanisms which may be employed by the ego in carrying out its functions.

Now theory and discussion had, up to this point, been based on the assumption that one was dealing with cases of neurosis, as discussed by Freud, and that treatment would consist of analysis. Bettelheim, however, is a representative of a school of thought which carries the study of the ego a stage further. Emotional disturbance in general, and neurotic conditions in particular, had hitherto been regarded as conflicts between the institutions of the mind, and the resulting exaggerated or inappropriate use of defence mechanisms. Bettelheim claims that there are many children to whom such concepts

are not applicable, since they have never reached a stage of ego development where conflict of this kind is possible.

> Few of our children are suffering from neuroses due to too great attachment to one or both parents, or to an inability to solve conflicts created by those allegiances, the typical neurotic conflict of adults.[5]

He regards most of his cases in terms of failure in ego organisation; the personality has failed to develop to a point where the ego is capable of taking any effective action at all, and it is certainly far from being able to bring about neurotic conflict by repression, reaction formation and so on.

> ... the greatest difficulties of the majority of our children have not come about through repressive or defensive mechanisms that interfere with the normal process of living. Although some suffer from having had too much to repress, and although all of them have worked out pathological defences for themselves, the most important reason for their inability to get on in the world is their having failed to organise their personalities from the very beginning. It is not that they have deviately organised personalities but that their personalities are not sufficiently organised.[6]

It is clear that this view entails a widening of the scope of treatment, in that categories of disturbance can be accepted for treatment which would fall outside the range of a method of psychotherapy which is based on the Freudian concept of neurosis, while truly neurotic children can continue to be treated by analytic methods. It follows, too, that there will be many cases where the approach to the problem will be quite different from the approach normally associated with analytical workers. Such a difference of approach is implicit in the following passage:-

> Some of our children show such a total lack of repression that they are hardly socialised at all. Others have failed so completely in their defensive efforts that they have given up trying to get along in this world; they have withdrawn from it totally, including an unwillingness to speak, or to eat.[7]

Bettelheim refers to these differences explicitly, and gives an

example of how they affect the approach to a particular problem in the case of Lucille.[8] Lucille was a girl of six, who had a "highly unbalanced", unmarried mother and a series of "fathers". "A frequent observation of the sex act had formed her most impressive life experience".[9] Her symptoms are recorded as "uncontrollable temper tantrums and sex delinquency"[10] and psychiatric examination revealed "schizophrenic tendencies, hyperactivity and disorders of thinking".[10] After she had settled down in the school well enough to play, she would go through the following sequence with dolls:-

> ... the mother feeds the baby, who is then thrown violently into a corner while male and female puppets jump violently on one another.[11]

Bettelheim makes the following comments about this:-

> For a child suffering from an anxiety neurosis, such play might have been a sadistic interpretation of the sex act ... In Lucille's case, however, it represented ... all she knew in the world of relations between parents. Hers was a true and not distorted picture of her parents' behaviour, or of those who took the place of parents in her life. <u>An immediate "working through" of these traumatic events would have led to nothing since nothing was buried beyond them.</u>[12]

These differences in approach lead to differences in aims of treatment and in methods:-

> ... our approach is more concerned with strengthening the ego than with bringing unconscious tendencies to light ... This we do by supporting the ego in its efforts to control instinctual desires and its strivings to master the problems of reality.[13]

Turning to the question of recovery, we find that here too there are new points which arise from Bettelheim's approach. Recovery is seen as growth and strengthening of the ego, which is manifested in an increased ability to cope with the outside world and with impulses from within. It is not easy to draw general conclusions as to the criteria by which such a process may be recognised, and Bettelheim does not make any explicit discussion of the subject in general. He does, however, discuss two particular instances, which have a very

definite bearing on our subject.

The first of these is the question of emotional relationships. Bettelheim rejects the use of the concept of "transference" in so far as his cases are concerned. Transference implies the transfer of infantile emotional attitudes from their original context to the existing treatment situation. If there was no opportunity for the formation of such attitudes, as for example when there were no parents or other consistent objects for the infant's emotions, then transference, in the normal sense of the term, cannot be said to occur.

> This is quite different from the analysis of the transference situation which is the recognised tool of the prevalent schools of psychotherapy. This method, of course, presupposes the earlier existence of relationships that can be transferred. But since many of our children have never had the previous experience of a meaningful relation, we must rely at the school on real, honest-to-goodness relationships.[14]

If such a relationship occurs, this is the real starting point in his growth and recovery.

> The relation to this person eventually challenges the child to change his personality at least in part and in the image of the person or persons who are now so important to him. He identifies with them ... and this identification is often the starting point for the organisation of the personality.[15]

We may conclude that the establishment of such a relationship is a hopeful prognostic sign.

The second point is one which is now raised for the first time in this work; that is the question of educational attainments. Bettelheim is, of course, running a school and not only a treatment institution, and so it is natural that, unlike Aichhorn and Lane, he gives some attention to this question.

If a child's behaviour is restricted or distorted in many fields by emotional disturbance, it is highly likely that in many cases school-work will be affected. This is important because this is the only factor which may be objectively measured which we have so far met. The

question is how far can we associate educational rehabilitation with emotional recovery (provided, of course, that the retardation was to some extent brought about by the emotional disturbance in the first place). At this stage, I shall confine myself to considering Bettelheim's contribution to the topic.

He points out that in many cases it is:-

> the discrepancy between failures in school and the academic achievement expected of a boy of his age which at last drove society into taking action ... the seriousness of many other children's disturbances would also go unrecognised were it not for the fact that school achievement provides a relatively objective standard against which to measure the child's lack of success.[16.]

Many of Bettelheim's cases come to the school with problems in the educational field:-

> Most children enter the school with an active aversion to learning, to going to school, or to any pressure to do so.[17.]

And he reports that most of them make good educational progress as treatment progresses:-

> Nearly all of them left the school having reached their grade level in academic achievement.[18.]

This progress is made possible by personality growth, and so in many cases educational progress is a very hopeful sign. But Bettelheim does not consider educational progress alone, as measured by attainment tests, to be a satisfactory criterion. It must be accompanied by a positive change in attitude: the early negative attitude towards school and learning must disappear until the child:-

> ... really wants to learn on his own, and is able to enjoy classroom experiences. In addition he must have become able to recognise which subject matter or learning experiences are most in line with his talents and interests.[19.]

CHAPTER V

FRITZ REDL

The work of Redl[1]. differs in certain respects from that of other writers who have hitherto been discussed. In the first place, although he was running a residential institution, it was organised as what we would call a hostel in this country, the children going out every day to a special class in one of the Detroit Public Schools.[2]. It might seem, in view of this, and in view of the fact that the title of this work limits the discussion to boarding special schools, that it is not altogether appropriate to include discussion of Redl's work at all. However, Redl gives a reasoned and methodical account of his aims and methods, and his accuracy and objectivity are probably greater than is the case with the writers previously discussed - in spite of his (deliberate) tendency to use from time to time American colloquialisms in preference to more technical language. Moreover, he is the only writer among those who deal with the residential treatment of disturbed children to discuss specifically the question of criteria of recovery.

Another point where Redl differs from other workers in the field is that he was working with a small, highly selected group of children. They were all of one particular clinical type, and were chosen from a specific type of social background.[3]. This was dictated by the experimental nature of the project which was designed to investigate a particular problem.

The final point of difference is that the project was terminated abruptly because of a lack of funds, before even clinical validation of the writer's views could be provided by the final recovery of any of the children,[4]. though they had reached a stage where "clinical gains"[5]. were reported.

The particular problem in which Redl was interested was that of the aggressive child. He makes a sharp distinction between the neurotic child in whom such aggression as appears is a secondary phenomenon, and is never wholly uncontrolled, and the child:-

> Whose aggression seems to flow uninhibited, skipping even the in-between stages of fantasy, into direct action of reckless destruction or into flare-ups of blind and murderous rage.[6]

The origins of such a distinction seem to be ascribed in the first place to differences in environment, and, in particular, Redl appears to regard them as being to some extent correlated with social class.

> ... there is still a wide gap between the hatred which a well taken care of middle class child develops as a side line to his anxiety or compulsion neurosis and that of the slum area delinquent who has to survive by aggression in a world of struggle.[7]

This point, however, is not further elaborated.

Redl says that these children present a particularly difficult problem, since they are amenable neither to educational nor psychiatric approaches, and so fall outside the scope of existing child service.

> It is clear that these children are not ready to benefit from a "good educational set-up" at all. They meet none of the requisites which even so simple a thing as a "good educational diet" presupposes as a condition for having effect.[8]

> ... "psychiatric interview technique", so well designed for all sorts of disturbances, also is tied to certain minimum conditions, without which it cannot even begin to take hold. Unfortunately, our youngsters don't meet those conditions.[9]

This presents a problem from which

> it seems that there is no way out ... but the invention of a new treatment design, which offers us opportunities of strategy in a different dimension than either good education or thorough psychiatric treatment in themselves seem to grant.[10]

The "new treatment design" suggested by Redl is a form of group therapy in a residential setting, and his "Pioneer House" project was initiated in order to investigate this. It was opened in December 1946 and closed in June 1948, dealing with a total of only ten children during that time; because of these small numbers, fairly detailed records were kept, and the two books from which most of the material for this section is taken are based upon these records.

The children selected were chosen from "the pre-adolescent range represented by the ages eight through eleven."[11] Actually, all the children were either nine or ten years old.[12] They were limited to boys of average intelligence[13] and with normal health and physique.[14] The project was designed for aggressive, delinquent children (rather than neurotics) - for those with

> symptoms of destructiveness, hyperaggression, stealing, running away from home, truancy from school, temper tantrums and lying, sassiness toward adults, and most of the rough and tumble language and behaviour which goes into the pattern of a "toughy" in the making.[15]

Children were chosen who showed such symptoms, but, because of the situation of the House in the City of Detroit, with its consequent dangers of traffic risks, health precautions, etc.,[16] it was thought advisable to impose a "ceiling on the intensity of disturbance it could tolerate, regardless of the type of disturbance with which it was prepared to cope."[17]

It was also thought inadvisable to select children who had roughly similar social backgrounds, the selection being made from "the lower socio-economic group, involving a good deal of 'open door neighbourhood style' of life."[18]

Redl's discussion of the aetiology of these children's disturbances is on two levels. Firstly, he gives an extremely brief account of the factors common to their case histories which may have contributed to their present problems; then he goes on to give a more expanded account of his views of the failures in personality organisation concerned.

First among the factors in their backgrounds is the fact that none of them had ever experienced a satisfactory relationship with their parents or with other adults.[19]

> Broken homes through divorce and desertion, the chain-reaction style of foster home placements were conspicuous events in their lives.[20]

All had experienced parental rejection "ranging from open brutality, cruelty and neglect to affect barrenness."[21]

Unlike the parents of most neurotic children with whom Redl had been in contact, the "unconcealed reaction"[22] of the parents of these children when they were taken to Pioneer House was:-

> We're glad you've got them, not us.[23]

Apart from parents, there were "no uncles, aunts, cousins or friends who seemed to take any interest in them."[24]

All this, Redl stresses, is most important.

> This whole vacuum in adult relationship potentialities cannot possibly be overestimated in terms of how impoverished these children felt or how much hatred and suspicion they had toward the adult world.[25]

Relationships with siblings were distorted by

> open, naked, sibling rivalry and tension ... usually none of the siblings was any better adjusted than the child who came into placement.[26]

In school they had fared no better -

> both on a behavioural and scholastic basis, they showed severe disabilities to the extent of having to be in special classes, or of being excluded from the school altogether.[27]

Redl sums up the factors missing in the lives of these children, the absence of which has tended to produce the delinquent behaviour-pattern under the following six points:-[28]

1. Factors leading to identification with adult, feelings of being loved and wanted, and encouragement to accept values and standards of the adult world.
2. Opportunities for and help in achieving a gratifying recreational pattern.
3. Opportunities for adequate peer relationship.
4. Opportunities for making community ties, establishing a feeling of being rooted somewhere where one belongs ...
5. Ongoing family structures which are not in some phase of disintegration at almost any given time in their lives.
6. Adequate economic security for some of the basic needs and necessities of life.

Like Bettelheim, Redl regarded these disturbances as being due to failures in ego organisation. Redl, however, is not entirely satisfied

with the concept of "ego", feeling that it is a word which is applied to too great a variety of functions,[29] but he continues to use the term for reasons of convenience. On the other hand, he lists 22 typical situations in which the Pioneer House children showed deficienoy in ego development giving a quite detailed commentary on each. Now, although these are, as the author admits,[30] purely on a descriptive level, they are extremely relevant to the matter we are concerned with: they each represent situations in which the behaviour of Redl's delinquent and aggressive children differs from that of a normal child; it is not unreasonable to assume, then, that recovery would be accompanied by improvement in those points on Redl's list which are relevant to any particular case. (The author does not imply that all twenty-two points will be affected in all disturbed children.)[31]

It is proposed, therefore, to list all of Redl's points, giving a brief indication of what is meant by each.

(i) Frustration tolerance.[32] The children Redl is describing have what he describes as "an unusually low 'frustration threshold'," i.e. minor frustrations, which can be tolerated by the normal child, will, in these children, give rise to panic, aggression and destructive outbursts.

(ii) Insecurity, Anxiety and Fear.[33] Both the healthy and the neurotic child are able to cope with these feelings by employing "defence mechanisms", and are able to carry on under the impact of such emotions. Redl's children have only two ways of dealing with them: "total flight and avoidance," and "ferocious attack and diffuse destruction".[34]

(iii) "Temptation resistance"[35] is abnormally low.

(iv) Excitement and Group Psychological Intoxication.[36]

> ... exposure to almost any type of excitement, no matter how similar or strange to their previous mood is "catching" ... even extreme behaviour forces imitation, leaving little leeway for individual freedom from the phenomenon.[37]

(v) Sublimation Deafness.[38] This perhaps not very appropriate term is used to indicate the inability of the "disturbed ego" to differentiate

between the usage "which a situation ... 'inherently' suggests ... to obtain certain satisfactions ... and the use it might be put to, in violence of its inherent potentials, as a tool for some other momentary need."[39].

Redl's description is not perhaps very clear. An example may serve to clarify the point:-

Whereas a normal child, when presented with painting or modelling materials, will see the material's 'inherent' possibilities for craft work and so on, the Pioneer House children would see it only as material to be used destructively or aggressively.

As Redl points out, this would invalidate, at least as far as concerns these children, the theory that it is only necessary to bring a disturbed child into contact with good, constructional materials to bring about good and constructive behaviour which will be of therapeutic value.

(vi) Taking care of possessions.[40]. The children appeared to have no knowledge of how to look after even prized, favourite toys and so on, and could not look ahead sufficiently to guarantee for themselves future enjoyment of these things. (It is possible that this may be a particular aspect of the total inability of certain disturbed children to visualise future concepts, reported by one of the schools which were visited; see also below).

(vii) Newness Panic need not be discussed here, since it is presumably not applicable to the later stages of treatment, and is not therefore relevant to the present inquiry.

(viii) "The areas of life situations which may bring on a sudden onrush of past case history beyond the ego's capacity to deal with it are not confined to special well-describable neurotic symptoms, but seem to encompass a much wider range of things, and the totality with which a loss of ego control takes place is not comparable with anything the normal adult or child would do in such a case."[41].

(ix) Disorganisation in the face of guilt.[42]. Although the children

at Pioneer House were characterised by fewer occasions on which they experienced feelings of guilt than are most children, their reaction, when it was experienced, was similar to the reaction to anxiety or fear, described above.

(x) Redl's children were often unable to "remember or single out their own contribution to a total causal chain"[43] which has brought about any particular unpleasant situation.

(xi) They also needed the constant support of the presence of adults, a well organised and structured situation and so on, if they were to maintain any control over their own impulses. They are not able to "institute inside controls when the outside ones have petered out."[44]

(xii) They were not able to accept "gratification offers"[45] in a normal way: they would either refuse the gesture altogether, or else they would react by increasing their demands to an absurd level.

(xiii) They were not able to retain a sufficiently strong image of any past pleasurable activity, to be able to fall back on it in moments of boredom unhappiness and so on.[46]

(xiv) They manifested an unrealistic attitude towards any rules or routines, no matter how obvious their necessity would seem to be; they tended to interpret them "in a persecutional way, no matter how skilfully such rule situations had been handled by the staff."[47]

(xv) They were deficient in their concepts of time, both as regards such ordinary achievements as knowing how to tell the time, the days, the months and so on, and also that they had little concept of "themselves in the future."[48]

(xvi) There were marked deficiencies in the "assessment of social reality."[49] Redl points out, however, that it would be

> wrong to expect them to show generally disturbed functioning of their egos in terms of social reality. We find rather ... an amazingly wide range of contrasting behaviour ... At the same time, they show most severe disturbances of this function ... towards certain people, and under certain conditions.[50]

(xvii) They lacked the ability to "make valid inferences from previous experiences."[51]

(xviii) Similarly, they were not able to draw inferences from what happened to other people.[52.]

(xix) Their reaction to failure, success and mistakes was extreme. They tended to withdraw from fields altogether if there was any possibility of failure or mistake, and even a mild experience of success would turn them into a "conceited, aggressive, reckless mob."[53.]

Redl's twentieth point is concerned with reaction to "competitive challenge." The points covered under this heading have already been dealt with in this list, and further discussion of it is not relevant to our present purpose.[54.] For the same reason, the final two points are here omitted.

Now, whether or not the items listed above can all equally be regarded as factors of what is often described as "ego function", is not relevant to our present intention. Their importance lies in the fact that they are a list of specific behaviour characteristics which were observed in a group (admittedly extremely small) of disturbed boys and which are not observed, or are only present to a very low degree, in the behaviour of normal children. The question of to what extent an improvement in any of the above points may be indicative of general recovery will therefore be examined together with criteria gathered from other sources.

Redl himself later chose certain of these points as having a higher prognostic value than others. In the epilogue to a later book[55.] he discusses what he regarded as "the most promising implications for actual change,"[56.] at the time of the closure of Pioneer House. On this occasion he lists only seven points, as compared with the list already given, and, as will be seen, the points raised are not all to be found in the first list. It is unfortunately not made clear whether this shorter list was the result of selecting the criteria with the best prognostic value (v.s. "the most promising etc...") or whether they were the only ones which had been recorded up to that point. The criteria listed are as follows:-

(i) Increased ability to use verbal modes of communication.[57, 58.]
(ii) Increased ability to relate meaningfully to image symbols.[59.]
(iii) Diminished suspiciousness of adult, which is coupled with the "ability to take affection".[60.]
(iv) Increased ability to cope with rules and routines.[61.]
(v) Diminution of major symptomatology.[62.]
(vi) Shorter duration of delusional attacks.[63.]
(vii) Increased ability to make use of "community programme resources".[64.]

These suggestions of Redl's, in part empirically based, and in part founded on his views concerning the nature of delinquency,[65.] have the immense practical advantage that, should they prove to have any prognostic value, they all relate to specific aspects of the child's behaviour, which can be determined with a certain amount of objectivity. In particular, it is noticeable that the majority of these points are concerned with increasing abilities in various directions. This is advantageous in two ways. Firstly, because it implies that the recovering child can do something which it could not do at an earlier stage - which increases the probability of accurate observations and reporting, and hence the prognostic value. Secondly, it implies a more positive view of recovery, linked with the idea of increased achievement.

Bettelheim, as we have seen, tended to develop his ideas on the subject in a similar direction, but he did not, in this respect, go as far as Redl.

PART THREE:

THE WORK OF FOUR EXISTING SPECIAL SCHOOLS FOR MALADJUSTED CHILDREN.

CHAPTER VI

FACTORS INFLUENCING THE CHOICE OF SCHOOLS TO BE VISITED.

In order to relate what has been learned from a brief survey of the history and literature of residential treatment of delinquency and maladjustment to current theory and practice in this country, visits were made to four special schools, and the problem of recovery was discussed with the principals. These discussions were informal, and were held during visits to the schools by the writer. Care was taken in each case to avoid a situation where the interviewer was putting forward various suggestions, or points of view, with which the principals of the schools were to express agreement or disagreement. The points of view expressed were, therefore, the views on which the practice at the various schools was based, and they were put forward freely, without any prompting or suggestion.

The schools were chosen because they are influential rather than because they were representative. The following factors were considered in making the selection.

1. Each school is still under the direct supervision of the person who founded it. It was hoped in this way to avoid the dilution and distortion of a person's views which might arise from hearing them second or third hand from their successors.

2. The schools visited were to show between them as wide a variation in approach and theoretical background as possible. In fact, this proved to be a matter of the extent to which psychoanalytic theory was accepted at any school, and whether or not a system of self-government was employed. As will be seen, these two factors are not mutually exclusive.

3. It was also thought desirable to show as wide a divergence as possible in the type of school visited with regard to such matters as age, sex, intelligence of pupils, and so on.

The differences in these matters, and in approach between the various schools visited is summarised in the following table:-

TABLE 1.	Bodenham Manor.	Red Hill School.	Mulberry Bush School.	St. Francis School.
Age Range.	6 - 16	11 - 18	5 - 11	8 - 16
Sex.	Boys.	Boys.	Mixed.	Boys.
Intelligence.	Average.	Superior.	Average.	Average.
Whether self-govt. was used.	Yes.	Yes.	No.	No.
Whether specifically psychoanalytic in approach.	No.	Yes.	Yes.	No.
Whether affectionless children are regarded as a specific category.	Yes.	Yes.	Yes.	No.
Whether affectionless children are admitted.	Yes.	No.	Yes.	-

It will be noticed that there was no school for maladjusted girls in the above list. This is in part a result of the small number of schools of this type in existence at the present time; of those that exist, none met all the above requirements.

CHAPTER VII

ST. FRANCIS' SCHOOL FOR BOYS.

(Headmaster: Father Owen, S.S.F.)

St. Francis' School is unique amongst those schools which were visited in that it is a religious foundation. It was started on Ascension Day 1946[1.] at Hooke[2.] in Dorset by the Anglican Society of St. Francis, and it is still maintained, and run, by the Friars. It was begun as a result of experience gained running the Dorset County Remand Home at the Friary from September 1940 to October 1945.

The founders had a particular category of child in mind:-

> We saw that numerous children were being committed to Home Office Approved Schools ... as these were the only schools available. Many of these boys were "in need of care and protection", or "beyond parental control", but were lumped together with delinquents ... It was decided that we should run a school to try and fill the gap, and to use a different approach from the discipline and deprivation necessary to a school for delinquents.[0, 3.]

With the development of the educational facilities for the treatment of maladjusted children which has taken place since 1946, this has come to mean in practice, that the children are selected from cases referred by Child Guidance Clinics as being in need of special educational treatment.

The school is for 45 senior maladjusted boys,[4.] of average intelligence (see table 2), the age range being from 9 - 16,[5.] though children as young as 8 will be accepted in exceptional circumstances. It provides long-term treatment, in the sense that the boys are expected to stay at the school until they are 16, and so it aims to provide a good secondary education as well as providing treatment for their maladjustment.

The boys are accommodated in three boarding houses

> ... two Junior School Houses from 9 - 14 approx., Bernard and Leo Houses, and a Senior House (Juniper) for the boys in their last two or three years.[0.]

TABLE 2. ST. FRANCIS' SCHOOL.

I.Q. of 39 children* in school on 1st Sept.1958.

I.Q.	f.	d.	fd.	fd^2.
125 - 127	1	7	7	49
122 - 124	3	6	18	108
119 - 121	0	5	0	0
116 - 118	2	4	8	32
113 - 115	4	3	12	36
110 - 112	5	2	10	20
107 - 109	3	1	3	3
104 - 106	8	0	0	0
101 - 103	4	-1	-4	4
98 - 100	4	-2	-8	16
95 - 97	4	-3	-12	36
92 - 94	1	-4	-4	16
	N - 39		fd - 30	fd^2 - 320

Mean = 106.8

Standard Deviation = 8.2

* Of the 46 children at the school on the above date, the I.Q.s of 7 were not available in the records. The figures are those supplied by the psychologist at the referring clinic, given on the Form 2HP.

This house system is used to mark and promote progress in the boys' behaviour.

> New boys in Leo will be given more rein than Bernard boys, who begin to learn that wrong-doing earns punishment. By the time a boy reaches Juniper, he is expected to realise that a thing is wrong because it is wrong, and not merely because it earns punishment (although he may, and probably will be punished).[0.]
>
> In the Senior House there is also a division between first and second year boys, and also between those who are capable of taking responsibility and are willing to accept it (and those who are not).[0.]

Treatment at St. Francis' is environmental in that no specific psychotherapeutic sessions are given.[6.] There is no attempt to relate the practical work done to any specific body of psychological or psychotherapeutic theory. In particular, acceptance of psychoanalytic views is of only the most general kind.[7.] One forms the impression that the success of the work at this school[8.] owes more to the personal qualities

of Father Owen himself and, in particular, to his sympathy with the boys in his care and his intuitive understanding of their needs than to the application of any psychological or educational techniques.

Maladjustment is regarded primarily as a disturbance affecting the whole orientation of the personality rather than as an expression of a specific unconscious problem. The children are seen as either over-aggressive or excessively withdrawn, a view of personality-types which reminds one of Jung and Kretschmer. This resemblance is acknowledged, but the concept of "aggression-withdrawal" as a dimension of personality is here based on the work of neither of these authors, having been arrived at empirically; it is regarded primarily as a working classification, for their own convenience. The resemblance between this view and those of the authors mentioned above is increased by the fact that aggressive or withdrawn behaviour is seen as the extreme of normal behavioural patterns.

Thus, the behaviour of a maladjusted child is regarded as extreme, rather than abnormal, excessive, rather than distorted.

The causes of this extreme behaviour are sought in the child's home life, in particular in the relationships within the family. I was told that the home environment of every child at the school was abnormal, if one counted the fact of being an only child as being "abnormal". I was later able to obtain details of the home conditions of all the children who were in the school on 1st September, 1958, which tends largely to substantiate this assertion. This information is reproduced in full in Table 3 below, in the form in which it was supplied by the school.

TABLE 3. ST.FRANCIS' SCHOOL.

DETAILS OF HOME CONDITIONS OF CHILDREN AT THE SCHOOL ON 1st.SEPT.1958.

	Age on Sept.1st.	I.Q.	D. of B.	Admitted.	Remarks.
(1)	15.7	111	3.1.43	Sept.52.	Now living with Mother and Stepfather. Only child. For first two years here lived with what was called his Step-father who wished to remove him. We found he was no relation and ill-treated the boy.

TABLE 3. (contd.)

	Age on Sept.1st.	I.Q.	D. of B.	Admitted.	Remarks.
(2)	15.5	94	16.3.43	Sept.54.	Mother and stepfather. Elder brother and sister 18.
(3)	15.4	104	9.4.43	Sept.54.	Mother died at childbirth. Calls stepmother "aunt" always. Spends holidays with an uncle and aunt.
(4)	15.2	127	30.6.43	Sept.54.	Only child.
(5)	15.0	103	22.8.43	Sept.54.	Only child.
(6)	15.0	96	24.8.43	Sept.52.	Odd man out in family. Older brothers and sisters by mother's first husband. This boy illegitimate. Younger brother by present husband.
(7)	14.8	104	8.12.43	Sept.56.	Illegitimate son of American negro soldier. Mother said to be M.D. Boy not found till 4 years old.
(8)	14.7	114	4.1.44	May 55.	Father divorced. Stepfather. A very large family.
(9)	14.4	112	11.4.44	Sept.54.	Father deserted and gone to America. Mother and two older children at home.
(10)	13.9	101	24.11.44	Jan. 56	In care of Children's Dept. No father traceable. Mother known to have 8 children by different men in various parts of southern England.
(11)	13.8	98	8.12.44	Jan. 55	Only child.
(12)	13.8	106	10.12.44	Sept.56	Adopted son. Parents had child after adoption. Father and mother divorced. Father remarrying and taking interest in the boy.
(13)	13.7	-	12.1.45	May 57	Father and mother deaf and dumb and usually in prison. One brother younger at school here. Older brother in Army band. Several deaf and dumb brothers & sisters.
(14)	13.4	106	24.4.45	May 55	Mother married to American. 2 boys; husband deserted; several "uncles" since. Mother now remarried.

TABLE 3. (contd.)

	Age on Sept.1st.	I.Q.	D. of B.	Admitted.	Remarks.
(15)	13.4	112	25.4.45	Sept.54.	Illegitimate son. Mother married, now separated.Only child; lives with mother.
(16)	13.3	116	20.5.45	Sept.56.	Mother & father separated. Only child; lives with mother.
(17)	13.2	124	28.6.45	May 56.	Illegitimate.Mother died. Stepfather remarried - no room.
(18)	12.11	103	6.9.45	May 56.	Two younger children.Mother near dwarf; stepfather. Other two children stepfather's.
(19)	12.11	114	12.9.45	Sept.55.	Illegitimate. Mother never married.
(20)	12.11	101	21.9.45	Jan. 57.	Illegitimate. Stepfather. Several other children; three half-sisters.
(21)	12.9	111	30.11.45	Sept.55.	Father older than mother. One younger brother. Father never works - suffers from asthma.
(22)	12.8	108	13.12.45	Sept.57.	Illegitimate. Mother in Mental Hospital. Father about, but not interested.
(23)	12.7	124	22.1.46	Sept.57.	Father dead.Stepfather. Two younger sisters.
(24)	12.7	-	1.2.46	May 56.	Mother deserted family. Father remarried. Step-mother over-strict.
(25)	12.6	96	23.2.46	June 56.	Father very clever chemist. Died suddenly while boy at school. Mother inadequate. Younger child offshoot of father and mother. Mother remarried foreigner - ? cruelty.
(26)	12.4	100	7.4.46	Sept.57.	Illegitimate. Parents separated. Stepfather?
(27)	12.4	-	24.4.46	Sept.57.	Fosterparents old and respectable. Only child.
(28)	12.4	98	1.5.46	Sept.57.	Only child. Father died before child born.
(29)	12.0	122	14.8.46	Jan. 57.	Large family including married children, foster children, lodgers, etc. Mother spreads her love abroad widely.

TABLE 3. (contd.)

	Age on Sept.1st.	I.Q.	D. of. B.	Admitted.	Remarks.
(30)	12.0	107	18.8.46	Sept.57.	Has younger brother. ✱
(31)	11.11	-	9.9.46	Jan. 57.	Epileptic mother separated from husband.
(32)	11.11	-	19.9.46	May 57.	Younger brother of previous boy of deaf and dumb parents.
(33)	11.11	106	20.9.46	May 56.	Mother and father. Older brother and two girls. ✱
(34)	11.11	97	26.9.46	Sept.56.	Only child. Elderly father. Possessive mother.
(35)	11.10	107	20.10.46	Jan. 57.	Mother; two sisters. Father killed in war. Second husband bigamist - in prison.
(36)	11.8	100	4.12.46	Jan. 56.	Illegitimate. Stepfather. Lived in lots of foster homes. One sister.
(37)	11.7	104	24.1.47	Sept.56.	Stepfather. One brother.
(38)	11.6	112	18.2.47	Jan. 57.	Elderly father. Only child.
(39)	11.4	114	20.4.47	Sept.57.	Only child. Mother and father.
(40)	11.3	-	17.5.47	Sept.57.	Mother and father. Elder brother and baby. Father drunken?
(41)	11.1	95	29.7.47	Sept.58.	Mother and father. Three children, one older and one younger. ✱
(42)	10.11	104	14.9.47	Sept.58.	Mother and father. Children - one older, two younger. ✱
(43)	10.6	-	21.2.48	Sept.58.	Mother and father; grandfather and grandmother - foreign.
(44)	10.4	104	25.4.48	Sept.56.	Mother and father. Mother oleft palate. Father cruel, usually out of work. One older and 4 younger children.
(45)	9.4	113	27.4.49	Sept.57.	Father and mother. 1 elder brother and 1 younger brother.✱
(46)	14.1	116	5.10.44	Oct. 58.	Mother deserted family. Father remarried. Stepmother over-strict.

Inspection of this table does indeed give a picture of abnormal home conditions, even apart from the question of how one regards only children (and of the eleven children described as only children, there are other

abnormal factors in seven of the cases). On the information provided here, however, it appears that the statement that every child at the school has an abnormal family history is not entirely true. Numbers 30, 33, 41, 42 and 45 in Table 3 (marked in the table by ⁎) appear superficially to have nothing abnormal in their home backgrounds, though this is not, of course, to say that abnormal factors would not be found on further investigation.

However, these abnormalities in the family situation are not regarded as being in themselves the prime predisposing factors in the development of maladjustment. They are, rather, symptoms of attitudes within the family which prevent the development in the child of normal affective relationships with parents or siblings. Moral standards and socially acceptable behaviour are said to be founded in the first place on such relationships, and, in their absence, a child is robbed both of adequate experience upon which to base his attempts to adjust himself to his environment, and of motive to do so. As the child grows up, his unsuccessful attempts to cope with his environment generally fall into the categories of either excessively aggressive or withdrawn behaviour. Which one of these extremes actually appears is thought to be determined largely by innate factors.

The general similarity between the above view of maladjustment and the work of Bowlby[9] is acknowledged, but the concept of "affectionless personality" is emphatically rejected, as are Bowlby's pessimistic conclusions. Father Owen prefers the term "developmental arrest", which, he says, implies a condition that can be put right, given certain conditions.

Treatment at St. Francis' aims at fulfilling these conditions. The school sets out to provide a stable, ordered and healthy environment, within which relationships between staff and children can develop. These relationships will have more in common with parent-child relationships than those normally existing between teacher and child.

> ... requirements vary ... in our attitude in the house (as parents), in class (as teachers) and in spare time (as club

> leaders). It is most important that the school-teacher attitude should not be carried into the other two spheres ... if any one side predominates, it should be the parental.[0.]

These adult-child relationships will fill the gap left in the child's experience by the abnormalities in his early home life, and will provide a basis upon which to build, in the fields of moral, social and educational development.

It follows from this that the existence of such a relationship not only forms an important part of treatment, but is also the most hopeful single factor which may point to impending recovery, and the one which is most general in its application.

In one respect, however, the formation of emotional relationships of this kind must be treated with caution, if they are to be regarded as reliable criteria of recovery. It is possible that a child may give the appearance of being attached to a member of the staff without there being any genuine feeling.[0.] In this case, the supposed relationship is merely a means whereby the child hopes to obtain for himself some advantage, either real or imagined. However obscure the motive may be, "pseudo-relationships" of this kind can always be distinguished by the fact that they do not stand up to any frustration imposed by the adult - "They vanish with the first real refusal," I was told.

Provided that this possibility is borne in mind, then, the existence of genuine adult-child emotional relationships is regarded at St. Francis' as being a valid and reliable criterion of recovery, applicable to a wide variety of cases.

Turning to the question of other criteria, we come to the matter of reduction of symptoms. This, in Father Owen's opinion, hinges entirely on the interpretation one puts on the word "symptoms". Provided that by the principal symptoms of maladjustment one means the extremes of personality-type mentioned above, in the sense that behaviour and attitudes tend to fall more within the normal range, amelioration in this sphere can be taken as a fairly good indication of general progress.

"Our bad boys become a little better, and our good boys become a little worse."[0.]

As far as the disappearance of particular symptoms is concerned, more caution is necessary. "Referral symptoms" (i.e. those which gave rise to the child's ascertainment as maladjusted, and are reported on the referral papers by the Child Guidance Clinic) may never be seen at the school. They represent the extreme or inappropriate reaction of the child to one environment; when the environment is changed, as when the child is placed in a boarding school, they may be replaced by entirely new symptoms, perhaps equally extreme and inappropriate, but quite different.

A distinction is therefore drawn between "referral symptoms" and "arrival symptoms". The disappearance of these arrival symptoms is, on the whole, regarded as a sign of recovery, provided that this is not taken to imply that the maladjustment can be cured by suppressing the symptoms. In this case

> the evil is driven underneath and comes out in other ways or in later life with added strength. We are out to cure disease, and not the symptoms of disease.[0.]

Father Owen's views in this matter are not dissimilar to those expressed by Aichhorn (v.s.).

CHAPTER VIII

BODENHAM MANOR

W.D. Wills.

W. David Wills is widely known for his work in the "Q camps" at Hawkspur,[1.] from 1936 - 1940, and for his work with "difficult" evacuees at Barnes,[2.] during the last war. His name is generally associated with his advocacy of the use of self-government in schools, and with the idea of "freedom". Although it is true that he has been a consistent advocate of these principles, it will be seen that this is by no means a complete assessment of his work, nor is it entirely accurate.

At the present time he is Warden of Bodenham Manor, in Herefordshire. This is a special school for 35 maladjusted boys, aged 8 - 16, who are all of primary school age on admission. All are referred from Child Guidance Clinics in the Birmingham area. The school fulfills, in fact, the function of the boarding special school for maladjusted children for the Birmingham Education Committee, though it has no formal connection with this committee, being an independent school under a board of managers.[3.]

It is a school for children of average intelligence. No detailed figures were available, such as were supplied by St. Francis' School, but the average I.Q. was estimated as about 95, with a range of 85 - 120.

In general, children with all kinds of behaviour problems are admitted, with the following reservations:-

1. Educationally subnormal children are not admitted, on the grounds that they require a special approach, which is not compatible with that appropriate to maladjusted children of average intelligence, and in any case they are more properly dealt with at special schools for educationally subnormal children.
2. Children whose maladjustment is primarily due to "brain damage" or other constitutional factors are not admitted.
3. When admitting new cases, care is always taken to maintain a suitable "balance" of children with different kinds of symptoms. This is partly

for practical reasons (the domestic staff, for example, could not cope with the situation arising if every child in the school was enuretic) and partly because an undue preponderance of children of any one type could militate against successful treatment (35 aggressive or destructive children could have a serious effect on the running of the school).

Treatment is on a long-term basis, in that the children are expected to remain at the school for at least three years, unless, after a short trial period, or after further investigation, they are found to belong to the two categories of children not admitted, mentioned above.

The school is in the charge of the Warden, Mr. Wills, and there is a Head Teacher, who is responsible for all matters affecting the education of the children. The day-to-day administration of the school is carried out by the children, meeting either as a legislative body, known as "Council", or as a judiciary body, known as "Court". Both of these bodies are presided over by elected chairmen, and there are various administrative and "enforcement" officers, who are also elected by the school as a whole. All of these officers may be either adults or children; at the time when the school was visited, all officers were children, but I was told that this would not necessarily be so. Discipline is maintained by a system of complaints, brought about by adults or children, to the courts. The accused may be children or members of the staff. The court hears the evidence, and either dismisses the case or inflicts suitable penalties (fines of up to a shilling, or, in the case of children, there may be the loss of certain privileges instead). Further particularisation on the details of administration would be misleading, since the constitution is frequently changed at council meetings, and, even at the time of writing, the actual details may be quite different from what is described above, even though the essential principles would be the same.

The influence of Homer Lane can clearly be seen in all this, an influence which is freely admitted by Wills, at least as far as his early work is concerned - "Homer Lane was the root and inspiration of all our work at Hawkspur Camp."[4] There is, however, a fundamental

difference in their views on the purpose of self-government.

In Wills' work, as in Lane's, the use of a system of self-government, or "shared responsibility", as Wills prefers to call it,[5] is the most striking feature, if only because it has been so rarely employed elsewhere, and it is true, in a sense, to say that self-government, and the rejection of the use of punishment are the two most important principles in Wills' scheme for the treatment of emotionally disturbed children. But it is not, in itself, his primary consideration.

> Shared responsibility is not the first plank in our platform... Because it obtrudes itself somewhat ... some think it is the most important thing about our method. That is far from the case.[6]

It is adopted, firstly, as a logical alternative to more orthodox methods involving "discipline" and the use of punishment, both of which Wills rejects in principle and in practice. In The Barns Experiment, he summarises his objections to the use of punishment in the following four points:-

1. It establishes a base motive for conduct.
2. It has been tried, and has failed; or alternatively it has been so mis-used in the past as to destroy its usefulness now.
3. It militates against the establishment of the relationship which we consider necessary between staff and children - a relationship in which the child must feel himself to be loved.
4. Many delinquent children (and adults) are seeking punishment as a means of assuaging their guilt feelings.[7]

And, in a paper written a year later, he makes the following three points:-

1. That while discipline is necessary for the preservation of order, it can be maintained without the use of punishment.
2. That discipline as commonly conceived is not itself of any value in character training, but rather the contrary.
3. That punishment can not properly be compared with the painful consequences of a breach of a "natural" law.[8]

Now, although it was necessary, out of fairness to their author to

quote these points in full, it will be seen that, for the most part, they are of a general nature and outside the scope of the present discussion. The third point in the former of these lists, however, is worth noting, in that it states that it is necessary in the treatment of emotionally disturbed children to establish a particular relationship between adult and child. (It will be remembered that a similar view is held at St. Francis' School). Wills states elsewhere[9] that it is "quite impossible to over-emphasize the importance" of this relationship.

> It is of the most profound importance socially, educationally and therapeutically. Without it, very little success can be hoped for in the sort of work of which I am writing.[10]

Like Father Owen, he draws attention to the home backgrounds of his boys:-

> From time to time I have run through our members to see in how many this situation (abnormal home conditions) can be found, and it occurs with such regularity that I have come to the conclusion that where the parents seem quite normal it is only because we do not know enough about them.[11]

This therapeutic relationship, however, is not seen as filling a gap in the child's experience and enabling him to progress after a long period of "developmental arrest". It is, rather, a transference, in the psychoanalytic sense, which may be positive or negative, and in terms of which unresolved conflicts and repressed emotions can be worked through, as in the following example:-

> They displace their father-hatred on to the Camp Chief or Camp Council, in which they can indulge themselves without the guilt feeling attached to real father hatred ... They can thus get rid of all their pent up aggression and can gradually acquire a more normal attitude to their environment.[12]

In order to be able to do this, the children need an atmosphere of emotional security, and to provide this must be one of the principal aims of Wills' therapy.[13] He considers that these aims cannot be achieved in a satisfactory way under an authoritarian regime, and puts forward the system of shared responsibility as a logical alternative.

> That is why we have the machinery of Shared Responsibility.

> The concern of the adults is with the unconscious emotional life of the child - to provide a sheet anchor for the emotions, to establish that security which the home has (so often) failed to provide. Shared Responsibility ... (also) ... provides a vehicle for the expression of public opinion, and it is through this that the child learns, this time through conscious cerebration ... how to earn the esteem and affection of ordinary acquaintances.[14]

There are, then, two different aspects of Wills' work - the therapy, concerned with the "unconscious emotional life", based largely on psychoanalytical concepts, and an attempt to modify the child's "social behaviour" by the pressure of the opinion of his peers, which is based on the view that the "affective trends are in the direction of seeking approval."[15] One might say that his methods represent a synthesis of Aichhorn's therapy and Lane's organisation.

It might be wondered whether these two aspects ever conflict with one another, as, for example, when a decision of the Court runs counter to what would be best in the interests of a particular child's progress. I put this point to Mr. Wills, and was told that such situations could normally be anticipated, and the members of the Court could usually be relied upon to co-operate with the adults in matters of therapy.

Turning to the question of recovery, we find that, in spite of the great stress laid upon the importance of affective relationships (or "the transference"), this is not regarded as one of the signs of recovery.

The first, and most important, criterion, according to Wills, is the gradual disappearance of the symptoms, in the sense of a reduction of their frequency and intensity.[16] The point is made, however, with various reservations. A distinction must be drawn between aims of treatment and signs of its success. As an aim, a remission of symptoms is rejected - it would be "a rather negative kind of achievement".[17] Hence, one must avoid directing treatment towards the removal of symptoms. "The delinquency is only the symptom and, when the 'disease' is cured, the symptom will disappear."[18]

It is only when symptoms diminish as a result of therapy rather than as a result of their repression that their disappearance can be regarded as significant. Wills also notes the distinction, made in the last chapter, between "arrival" and "referral" symptoms.[19.]

The next criterion is the emergence of socially acceptable behaviour, with which is coupled a willingness and ability to accept responsibilities under the "Shared Responsibility" system.

The following example will show how Wills uses the above criteria in reporting a case:-

> From this time on there was a very slow improvement in the boy ... The strongly anti-social symptoms became less frequent in their incidence and less violent in their expression, and at the same time he became able to accept responsibilities and to display independence and initiative of a socially acceptable kind.[20.]

A further point which is of significance when assessing recovery is the emergence of new forms of behaviour. Examples given of this include a child's beginning to take an interest in his clothes and appearance,[21.] a "tough" lad attending a poetry group[22.] and even, in certain circumstances, the appearance of behaviour which elsewhere would be regarded as undesirable:-

> When he began to use bad language freely, and with a sense of enjoyment, we were positively pleased, because it meant that he was no longer piling up future punishments for himself every time he committed some trifling offence.[23.]

Reference is also made to the use which can be made of a child's paintings when assessing recovery. There are two entirely different approaches to this question, both of which have been used by Wills.

In a series of unstructured, free painting periods, Wills says, a child may produce a series of paintings (or drawings) which symbolize pictorially his emotional problems, and which are, in addition, of considerable therapeutic value, since self-expression of this kind must involve a certain amount of catharsis. If one is in a position to make accurate interpretations of such work,

> this kind of painting is an interesting measure ... of the degree to which an emotional conflict is getting straightened out.[24].

The quality of the picture, too, may indicate recovery, quite apart from the question of detailed interpretation of the content in terms of unconscious conflict. A more ordered, or less chaotic, picture may mirror a comparable step forward in the child's mental state. Similarly, a reduction of grotesque or sadistic content may indicate progress towards recovery. The recovering child's painting may become "more coherent in design and less horrific in content".[25].

In the field of educational attainment, Wills notes[26]. the high incidence of educational retardation in his boys, regarding it in many cases as "a symptom having its original cause in those same emotional upsets that are also the cause of the symptoms we call delinquency."[27].

It may also be "of itself a cause of behaviour problems, and it certainly aggravates the behaviour difficulties."[28].

Educational progress in retarded maladjusted children is, in Wills' view, associated with general recovery; in the case of children of lower intelligence, however, although it remains a valid criterion, it has little practical value, since, by the time measurable progress has been made, sufficient steps forward have been made in other fields for impending recovery to have been recognised already.

CHAPTER IX

RED HILL SCHOOL

(Otto L. Shaw)

Attention was drawn in the Underwood Report[1]. to the shortage of places in residential schools suitable for maladjusted children of high intelligence.

Red Hill School, near Maidstone, which was founded in 1934 by its Principal, O.L. Shaw, is the only grammar school for maladjusted boys in this country. It is a "non-maintained" boarding school, with an independent Board of Governors. It provides treatment and education for 55 boys, aged from 11 - 18 or 19 years, who follow courses leading to the G.C.E. Ordinary and Advanced levels; a high proportion of the boys then gain admission to a university. Treatment is provided on a long-term basis, the time a child stays in the school varying

> according to his degree of instability and to his educational needs; these do not necessarily agree. In general it is found that the optimum stay is about four years...[2].

In practice, no boy would be discharged from the school because of a resolution of his emotional problems alone, if there were any educational advantage in his staying; many boys whose treatment has been successful remain at the school to finish courses and take examinations, scholarships and so on.

Cases are referred to the school from the Child Guidance Clinics of the various Local Education Authorities, most of which are situated in the Home Counties area. As in the cases of the other two schools visited, attention was drawn to the fact that

> ... with hardly any exceptions, the home backgrounds in all ... the cases can only be described as being very bad. The children ... are reacting ... to adultery, infidelity, dishonesty, and all manner of emotional entanglements of an extremely complicated kind within the home.[3].

All the children are highly intelligent. For many years no child

was accepted who had an I.Q. of less than 120; this figure has now been raised to 130. Bloom publishes[4] the data shown in Table 4 for 1953.

TABLE 4. I.Q. of 45 boys at Red Hill School, 1953.

I.Q.	
110 - 120	6
120 - 130	17
130 - 140	11
140 - 150	7
150 - 160	2
160 - 170	2
N. =	45

Mean = 132.4

Note:- 45 boys represent the entire population of the school at that time.

It might be claimed that, in restricting entry in this way, the school is setting itself a very easy task in comparison with the work of other special schools. Stott would go as far as to say that it amounts to selecting the less severe cases.[5] Shaw would accept these criticisms only up to a certain point. In his view, the children's high intelligence makes a successful outcome of treatment more likely, but is not related to the severity of the cases. As far as treatment is concerned, the task is made, if not harder, at least more complicted, by the relatively profuse and complex associations obtained in psychotherapy.[6] It seems inevitable, however, that those children will be excluded, whose emotional disturbance has the effect of lowering their apparent intelligence as measured in a test situation.

The recovery rate at Red Hill School appears to be very high. The figures shown in Table 5 are given[7] for all the boys who left the school from 1934 to 1957.

TABLE 5. RED HILL SCHOOL.

AFTER HISTORIES (BOYS)

Cured:-	156
Cured/Improved:-	12
Improved:-	28
Improved/Failures:-	4
Failures:-	26
Withdrawn prematurely, either as unsuitable, or against the school's advice.	17

The categories in the table are defined as follows:-

> The term "cured" means that a radical resolution of the child's maladjustment took place and that the after-history shows him to be balanced, happy and contented.
>
> To be "improved" means that the child now earns its living usefully, has not been in trouble with the law, and is most unlikely to be in that trouble, but that the resolution of its conflicts is incomplete. Superficially, the "improved" cases appear well and orderly.[8].

The "cured" group thus represents 69% of the total (excluding 17 who were withdrawn); and, if one adds to this the "cured/improved" category, the percentage of successes rises to 74%. If the top three groups are taken together (i.e. if one classes as successful all cases which are not overtly maladjusted or delinquent), the proportion of successes rises to 87%.

The school is a self-governing community, and the psychotherapy is strictly psychoanalytical.

As might be expected, when one considers the intelligence of the children at the school, the details of the administration of self-government are rather complex. In addition to the school meeting, which has a legislative function and appears to be common to all systems of this kind, there are various committees (Food and Hygiene, Sports, Library, etc.). These committees are elected annually. They are responsible to the school meeting, to which their chairman must make

periodic reports. The work of holding school courts has been delegated to a "sub-group of the more responsible pupils, with the title of Bench Members".[9.]

The use of self-government in this school inevitably invites comparison with other schools using similar methods - in this case with Bodenham Manor, which was described in the previous chapter. Superficially, the two schools have a great deal in common, but further examination will show that there is a fundamental difference in their attitude towards the place and function of self-government in schools.

We have seen how, for Wills, the therapeutic aspect of self-government, and the improved opportunities it gives for the formation of effective relationships between children and staff, is only one of the reasons he puts forward for its use. Indeed, it seems true to say that Wills would have employed such methods out of consideration for his ethical principles, even had there been no therapeutic advantages to be derived from them. The use of self-government, and the abolition of punishment, are, for him, a particular expression of general principles deriving from his religious convictions, and, as such, he treats them with respect.

Although Shaw agrees with Wills about the therapeutic importance of self-government, both as a system which permits the development of child-adult relationships and, to a certain extent, as a means of influencing the child's behaviour by the public expression of the disapproval of his peers, he attaches no more importance to it than that which is implied by its usefulness in treatment; he accords it no respect for its own sake, regarding it rather as one of a number of therapeutic tools. Its adoption is a matter of expediency and technique rather than of principle.

> The consideration which practically forces self-government on us, whatever other merits it does or does not have, is this matter of closer personal relationships between adults and pupils ... Maladjustment starts at home and difficult parents have set up in the child's mind images of adult life and purposes which now stand in the way of mutual confidence... The object of self-government is to place adults in a new and different relationship to pupils which will make it harder

> for them to be set down ex hypothesi as members of a different group with alien aims and intentions...[10].

Self-government is thus a means, rather than an end, and it is regarded with a lack of respect - one might even say cynicism - which is quite different from Wills' approach.

> If ... self-government is to serve therapeutic ends, there must evidently be, in fact, a close and very effective control of its machinery by the staff.[11].

> Whatever the difficulties, the principle of indirect control by a staff, as individual personalities, must be maintained and the necessary fictions of self-government preserved.[12].

It seems clear that the dangers of a conflict between the therapeutic needs of a particular child and the machinery of self-government, which were recognised by Wills, have been anticipated and avoided by Shaw, though the former would not find Shaw's solution acceptable.

Psychotherapy consists of individual psychoanalytical sessions with the Principal, who is a lay psychoanalyst. The frequency of these sessions varies according to the needs of the child:-

> Not all the children need intensive or frequent sessions: at any time, of the 45 boys (in 1953) about eight need daily sessions, more are seen twice a week, and most of the others come spontaneously when they want to see their therapist. In about fifteen cases, genial friendship and guidance - moral, social and personal - is sufficient to help the child.[13].

As in the case of the other schools visited, great emphasis is placed on the part played in treatment by the emotional relationships between adults and children. Bloom describes it as the "most essential part of the work of the school."[14]. Its importance is seen, too, in what has been said above on the question of self-government.

It is not, however, regarded as being a reliable criterion of recovery, but is seen rather as an essential therapeutic instrument, which can be manipulated as dictated by the necessities of treatment. In this matter of the use which is made of emotional relationships, and the approach to it by the staff, one can detect something of the almost

cynical[15]. attitude referred to above when discussing self-government. For example, in the interests of furthering a relationship of this kind, a fairly new boy at the school was taken by the Principal to a jeweller's shop and was told that he could choose any watch he liked; the watch was bought for him by the Principal. The boy did not know, however, that a telephone call had previously been made to the jeweller, asking him to bring out only those watches which were less than a certain price. The fact that the boy was unaware of this entirely sensible precaution gave him quite a false impression of the situation. This impression, however, was the whole object of the outing, and the whole experience was for the boy sufficiently striking to be an important step in treatment.[16].

The views expressed at this school on the question of criteria of recovery are particularly interesting, since they differ, for the most part, from those which were gathered elsewhere.

Symptom-reduction was rejected for two reasons. Firstly, the familiar distinction between "disease and symptom" was made, and it was pointed out that the symptoms could disappear while leaving the underlying conflict essentially unresolved.[17]. In this connection, attention was drawn to the dangers of treating the symptoms, regardless of their unconscious origins. As an example of this, I was shown the case-history of a boy who had, before admission to Red Hill, undergone an operation to correct a squint in one eye. As treatment progressed, it became apparent that this condition had in fact been a psychogenic symptom, and the second visual defect necessitated prolonged ophthalmic treatment.

The second reason given for rejecting the disappearance of symptoms as a reliable criterion of recovery is that, in many cases, the overt symptoms may persist, as a habit, even after a child's "emotional need for them has disappeared with the successful conclusion of his individual therapy."[18]. It is one of the secondary functions of self-government to discourage the tendency to fall back upon such habits by the public expression of social disapproval.

Academic progress was not put forward as a reliable criterion of

recovery, since with boys of the intellectual calibre which is expected at Red Hill School, it is assumed that many boys will be able to make good progress in school, irrespective of the progress they make in treatment, even though, in some cases, children are, on admission, working far below their real capacity.

Attention was also drawn to two points, which, it was said, are frequently interpreted as favourable signs, indicating impending recovery, but which are quite unreliable, and which can in some cases even mask serious deterioration. The first of these is the assumption of an apparently tranquil, pleasing and law-abiding facade, which is often taken for recovery, but which in fact means little. The second point is that an "active response is often regarded as an index of normality."[19.]

Six points were put forward as being valid and reliable criteria of recovery:-

1. The appearance of a sense of humour. Although many of the boys have a sense of humour of a kind on arrival at the school, it is in all cases brittle, bitter or personal. The emergence of humour which has none of these qualities is always associated with real progress towards recovery.
2. Drawings and paintings. Creative art of all kinds holds an important place in the activities at Red Hill School - in the educational field (successful exhibitions have been held at a London gallery) and in treatment,[20.] when the content of paintings, and the child's associations to them are interpreted in a similar way to the interpretation of the dream material in other analyses. As the child recovers, there are changes in the content of the creative work, though recovery is not necessarily reflected in the standard of the technique. Recovery can be inferred from the fact that the content is in some way "more wholesome" and that the concepts are more mature, rather than by detailed consideration of the significance of the items depicted.
3. Recovery is further shown by the child's acceptance of the social structure of the school and its traditions. This would not, however, be generally applicable, since it arises from the particular organisation of the school, where there is no undue pressure brought to bear to bring

about conformity.

4. The recovering child is willing to accept the domestic routine of changing clothes, keeping clean, punctuality, and so on.

5. The development of sustained interests also indicates recovery, provided that these interests are not obsessional.

6. Finally, recovery is clearly indicated by a child's being able to look forward far enough to make a vocational choice which is in realistic terms. A short-sighted boy who decides to become a pilot is not making his choice in realistic terms, no matter how competent he may be in mathematics or aerodynamics.

CHAPTER X

THE MULBERRY BUSH SCHOOL

(Mrs. B.E. Dockar-Drysdale)

The present writer has worked on the teaching staff at the Mulberry Bush School for four years. The material presented here differs, therefore, from that in the three preceding chapters in that it leans less on a formal interview, supplemented by published papers, and so on, and more on actual experience of the working of the school, and on numerous discussions of the theories described below, often with reference to particular children being treated at the school. In order to minimise this difference of situation as far as possible, however, the topic of this work was discussed with the Principal, in the same way as it was discussed with the Heads of other schools, though it was, of course, not necessary to extend this discussion to more general aspects of the work of the school and the underlying theory.

The Mulberry Bush School was founded in 1949 by Mrs. B.E. Dockar-Drysdale, who is the present co-principal and psychotherapist. Its aim is to provide "context" or "milieu" therapy for severely disturbed children. Treatment at the school is on a "short-term"basis, in the sense that the intention is to return the children to a more normal environment (home, and a day-school - or, in some cases, to a suitable home or boarding school) as soon as it is possible to do so without there being risk of subsequent breakdown. The children generally remain at the school for two or three years; in some cases recovery is more rapid than this, and in a few, a longer stay is necessary. Recent trends at the school appear to be in the direction of shorter duration of treatment.

The school accomodates 40 boys and girls of average intelligence, whose ages may range from 5 - 12 years. The upper limit is to some extent flexible, in that treatment will not be abruptly curtailed because of age, though in fact such situations are rare, being in the

main avoided by the school's policy of not accepting older children if it seems likely that their treatment will last long enough to take them well above the upper age limit.

The children are in all cases referred to the school by Child Guidance Clinics, mostly in the Home Counties. Liaison between the clinic and the school continues throughout treatment, the referring psychiatrist maintaining psychiatric supervision. Work with the parents is generally carried out by the psychiatric social worker of the referring clinic. In view of this continued close co-operation, the school tends to restrict its intake to children from clinics where such co-operation can be anticipated.

The treatment at the school is psychoanalytically orientated, but not in the sense of analysis of the transference in the classical manner. As will be seen, treatment is based, rather, on more recent trends in the study of the ego, the work of the school having a similar starting point to those of Redl and Bettelheim (v.s.), though there are differences in the subsequent development.

A distinction is drawn between two major categories of cases. There are, on the one hand, neurotic children, whose treatment proceeds along familiar lines - psychoanalytical interpretation of behaviour, exploitation of the transference situation, and so on - except that such treatment is more often carried out in the context of the day-to-day life of the school, and in situations arising naturally, than in more formal psychotherapeutic sessions. On the other hand, there are those children who may be referred to as "affectionless", "frozen" or "preneurotic" (in the sense of being emotionally at too primitive a developmental level for neurosis to be a possible occurrence).

This distinction should not be taken to imply a view that these are the only forms of maladjustment, but children who fall outside these categories, whose maladjusted behaviour arises from, say, psychosis, or brain damage, would, as a general rule, not be treated at the school.

Mrs. Dockar-Drysdale's most original contributions to the theory of the treatment of disturbed children are concerned with the treatment of the second of these categories, and it is this that will be summarized

here.

We meet descriptions of what have become widely known as "affectionless personalities" in the literature of the subject in works as comparatively old as those of Aichhorn,[1.] and the term "psychopath" has often been used in a similar sense for some years. In 1951, Bowlby[2.] reported the results of his investigation into the effects of maternal deprivation in early childhood. He associated such deprivation with a particular "affectionless" personality type, and, while admitting the possibility of prevention by the provision of an adequate substitute mother, he took an extremely pessimistic view of the outcome of any scheme of treatment, tending to the view that such a conditon, once it was well established, was irremediable.

This latter finding has, in the last decade, been widely accepted, and acted upon, with the result that many schools for maladjusted children will not knowingly accept children of this sort, understandably preferring to fill their vacancies with cases which have a more hopeful prognosis. Being outside the scope of the psychotherapeutic sessions provided by the Child Guidance Clinics, and being rejected by many schools which provide residential treatment, these children tend to move from Children's Home to Children's Home (where they can naturally not be tolerated) and to make a kind of Rake's Progress, going from approved school to Borstal, from Borstal to prison ... These unhopeful views about the likelihood of successful treatment of affectionless children have as yet not been checked by experimental re-examination; their validity has never been accepted by a small number of special schools (for varied reasons) which have continued to accept children of this kind, and to treat them with varying claims of success.

Among such workers, Mrs. Dockar-Drysdale is alone, I think, in having formulated a specific programme of treatment for such cases, with a corresponding theory of their aetiology and subsequent development and recovery.

These children present a complex picture on arrival at the school.

I would select[3.] the following aspects of their behaviour as being characteristic of all cases.

1. Although superficial contacts with adults are good, these children have no capacity for making any genuine relationships, that is relationships which will stand up to frustrations imposed by the adult.
2. The "frozen" child is invariably delinquent.
3. Frustration will often produce violent hostility, frenzied panic and unreasoning rage.
4. Time concept and understanding of cause and effect are so rudimentary as to be non-existent.
5. Only certain (delinquent) aspects of the environment are accurately perceived; the term "selective perception" has been used to describe their defects in this field.[4.]
6. In the intervals between delinquent acts, rages and so on, these children have a remarkable capacity for rapid, but superficial, adaptation to changes in their environment. This process, which is always followed by breakdown, may be mistaken for progress, or even recovery, followed by an inexplicable regression or deterioration.

The above six points are to be regarded as a syndrome rather than a number of separate symptoms; most, if not all of them may be observed in any affectionless child.

In addition, there is, in some cases, serious educational retardation, which can not usually be dealt with by the normal techniques of remedial teaching, owing to the excessive frequency with which breakdowns and tantrums may be produced by failures and frustrations.

It is commonplace to associate such a picture as this with deprivation. Mrs. Dockar-Drysdale has put forward a theoretical explanation of the causal relationships between this clinical picture and the early maternal deprivation. It will not be possible in the space available here to do more than give a brief indication of the direction of her thought, which is fully reported in the published papers cited in connection with this chapter.

Before a baby has reached the stage where an object-relationship has developed, he has no sense of self, but exists only as part of a mother-baby unity, which acts as a "barrier against stimuli", protecting the baby from the need to be exposed to excessive emotional states. Should this unity be broken (as, for example, in cases of deprivation), the baby must become prematurely self-reliant, and must undergo such experiences, which are, at that stage, devastating in their effect. The deprived child begins to develop his forms of behaviour when he is still at too primitive a level to have formed an object relationship. He never learns to do this, tending to use rather the more primitive expedient of extending (and withdrawing) himself, (reproducing the disrupted mother-baby situation), so as to include people, whom he uses for his own purposes. The personality and behaviour of such children, though pathological, is highly organised; there tend to be definite, and recognisable, patterns of behaviour, (though these, of course, vary from child to child).

Treatment of these children at the Mulberry Bush School does not follow the lines of psychoanalytic treatment of neurotic conditions. There is not (at any rate not until a very late stage) interpretation of behaviour, nor is there any attempt to establish a transference - there is in fact nothing to transfer. Permissiveness, so often advocated, is useless, or even harmful, with these children, since it merely enables them to make use of the adult for their pathological purposes. Treatment falls into four phases.

1. Observation, which enables the staff to recognise the characteristic behaviour patterns of the child.

2. This in turn enables them to interrupt these patterns, at a crucial stage, creating a situation where the child can not help but be aware of what he is doing and of the antecedants and consequences of his action. Increased familiarity with the sequence of behaviour should ideally lead to a stage where interruption can take place at so early a stage that it would be more accurate to describe it as anticipation. The child's

reaotion to successful interruption or anticipation of his behaviour patterns oonsists of panio, and rage, which may give way to an exhausted calm or sleep.

3. Depression. A state of unfoousaed depression supervenes, which is apparent in every situation of the child's life - he is listless, apathetic cries easily and often, and may keep to his bed; he may even appear to become ill.

4. In the fourth stage, the child is still depressed, but the depression now centres around a particular person, with whom the child forms a genuine emotional relationship, which is termed "primary bond", sinoe it is the first object-relationship formed in the child's life. It is therefore not a transference, though, at a much later stage, it may itself be transferred.

Evidence of recovery is found in particular signs that the various stages of treatment are effective. Such evidence is cumulative, in that signs of success in later stages of treatment are of better prognostic value than those relating to earlier phases (provided, of course, that successful progress has been made through the earlier stages of treatment).

The success of interruption and anticipation of a child's behaviour mechanisms is seen in the child's reactions, which are referred to above. Depression is usually readily disoernible; this, too, is referred to above.

These two signs are hopeful indications that treatment has begun, but prognostically are not particularly reliable, since no irrevocable change has taken place, and it is by no means impossible for the child to relapse to his old behaviour patterns, if, for example, treatment is interrupted.

The phases of unfocused depression and primary relationship, however, are at once more significant and more reliable. Although treatment is at this stage still far from complete, the formation of this first objeot-relationship is an emotional experienoe, the effects of which appear to be permanent. Once this stage has been reached, the child is no longer

likely to assume again his former way of living.

That this stage of treatment has been reached is chiefly apparent in the child's attitudes to the adult who is the object of the relationship. We see dependence, and anxiety, which now appears for the first time and which is often most acutely felt in consequence of the adult's absence for any length of time. We also see that disapproval from the adult concerned becomes intolerable for the child. In cases where educational retardation is present, educational progress may begin about this time - often suddenly, and sometimes in a spectacular fashion.

(This stage of treatment should not be confused with the pathological pseudo-relationship, described by Mrs. Dockar-Drysdale as "the reality annexe" in the paper already cited.[5.] In this latter situation the child

> uses all his charm, but makes no demands, carries out no reality testing. Frustration never has to be tolerated because he asks for nothing.

It is not a genuine relationship in any sense of the word, being merely a "safety valve"[6.] which has the function of providing an unreal, perfect figure, to whom the child can turn between one extension[6.] and the next. With the first limit of frustration, - the first real "no" - it vanishes without a trace.)

When this point has been passed and the continued existence of a primary bond has brought about a certain amount of ego development, there appears for the first time the possibility of conflict, of repression, of neurosis.

It can well be maintained that, if a psychopathic, delinquent child reaches a stage where he is functioning in a way that relates in many respects to the behaviour and motivation of the "normal person", (whatever this phrase may mean), then considerable amelioration, if not actual recovery, must have taken place - even though the new modes of behaviour are maintained only at a high cost which is measured in terms of imperfectly resolved conflict. To substitute a non-delinquent and neurotic for an affectionless personality is an achievement which would be reckoned as tantamount to recovery by many.

It is, however, possible to proceed beyond this point. As already stated, the primary bond may be transferred, and treatment may be continued in terms of more familiar psychoanalytical concepts, in which case further criteria of recovery, applicable to the progress of neurotic children, will be relevant. Among the many factors which may be significant for the recovery of particular children and which may well apply to children in this phase of treatment, it is worth mentioning, as being more general in their application, an increased insight into their own motivation and the ability to manage feelings of ambivalence.

There remains for discussion a number of minor factors which may be good additional indications of progress in "frozen children".

It has already been mentioned that concepts of time and of causality appear to be grossly undeveloped in these children. The emergence of such concepts, and an ability to make use of them may prove to be valuable additional criteria of recovery in many cases.

Recovering children may also show remarkable insight into the emotional needs and the behavioural motivation of those who are still at earlier stages of treatment. Genuine insight of this sort is not however manifested in the form of an unsolicited and facile interpretation of the conduct and motives of the other children, expressed in a jargon he has learnt in a Child Guidance Clinic (or, perhaps, in listening in to the adults in the school). It is, rather, to be seen in appropriate actions, when the recovering child is, for example, consoling a younger child, or, say, preventing a sudden tantrum; it is only expressed in words in response to a direct question - "What made you think of doing that?" The answer will, in all probability, not be expressed in any psychological jargon, but in colloquial English - forcefully, vaguely, in picturesque, or in banal and inadequate phrases, the child will attempt to express, in his own way, what he understands.

At the Mulberry Bush School the intention is to return the children to their own homes at the end of treatment whenever this is possible. While they are at the school, most of the children spend at least part of the school holidays at home. For a child to be able to live at home at

the end of treatment, without further breakdown, there must be changes not only in the child himself, but also in the attitudes of his family: a successful holiday, during which there have been no insoluble difficulties, will thus to some extent measure jointly the progress of treatment in the school and the progress of psychiatric social work in the home. Successful holidays thus have a definite, though limited, indicative value with regard to the success of treatment.

PART FOUR:

CRITERIA OF RECOVERY GATHERED FROM THE ABOVE SOURCES.

CHAPTER XI

SUMMARY OF CRITERIA

We have now examined eight sources of information relevant to the present topic, four of whom - Lane, Aichhorn, Bettelheim and Redl - were treated primarily as authors who have dealt with this subject, the remainder being existing residential special schools.

In summing up what has been learnt from these sources, one is immediately struck by the confusion and even contradiction in the material obtained. As will be seen below, no less than 49 criteria of recovery were gathered from only eight sources, many of these criteria being derived from points of view which are incompatible.

But, although it would be absurd to deny that confusion does exist, the situation is rather less complicated than would appear at first sight. The actual number of criteria is somewhat inflated by the inclusion of Redl's prolific and detailed points, and, in addition, as will be seen below, the criteria tend to fall into a relatively small number of groups, within each of which the points gathered are all related to one another.

The list given below summarises the criteria of recovery gathered from the material examined in previous chapters. Reference is made, after each criterion, to the writers or principals of schools who have proposed each point.

1. The disappearance of the referral symptoms. (Aichhorn).
2. The disappearance of symptoms, other than referral symptoms, which were observed in the early stages of residential treatment. (Father Owen: W.D. Wills).
3. The diminution of symptoms. (Redl).
4. Reduction of frequency and intensity of symptoms. (W.D. Wills).
5. Shorter duration of delusional attacks. (Redl).
6. Irrespective of what happens to specific symptoms, the child tends to manifest less extreme behaviour. (Father Owen).

7. The child can tolerate rules and routine regulations without abnormal or delusional reaction (e.g. paranoid interpretation of the intention of such rules, etc.) (Redl).

8. The emergence of socially acceptable behaviour. (Lane: W.D. Wills: O.L. Shaw).

9. The child is able to accept responsibility, or to take on jobs, within the residential community. (Lane: W.D. Wills).

10. The child is able to accept the domestic routine of changing his clothes, washing, etc. without abnormal reaction. (O.L. Shaw).

11. Increased ability to assess social situations. (Redl).

12. The child can spend holidays at home without breakdown. (Dockar-Drysdale).

13. Evidence of the development of conscience or superego. (Lane).

14. Evidence of ego development. (Redl: Bettelheim: Dockar-Drysdale).

15. Increased ability to tolerate frustration. (Redl).

16. Increased ability to cope with feelings of insecurity, anxiety or fear. (Redl).

17. Increased ability to resist temptations to delinquent acts. (Redl).

18. Increased resistance to group excitement. (Redl).

19. Increased ability to cope with unacceptable impulses by sublimation. (Redl).

20. The child begins to take care of toys and other possessions. (Redl).

21. Decrease in the "life areas" which bring loss of control, or breakdown. (Redl).

22. The child can experience guilt without denying it, breaking down or using other pathological mechanisms. (Redl).

23. The child can see, and admit, his own contributions to the circumstances that have given rise to a situation which is unpleasant for him. (Redl).

24. The child is less likely to break down in situations which are not structured for him by adults. (The child is less dependent on adult support.) (Redl).

25. The child is willing to accept gratification offers from adults. (Redl).

26. The child is able to retain an image of past pleasurable experiences. He is able to make use of it in planning future activities. (Redl).

27. The child is able to make valid inferences from his own, or others' experiences. (Redl).

28. The child can experience failure without extreme reaction. (Redl.)
29. The child can experience success without extreme reaction. (Redl).
30. The development of positive or negative transference. (Aichhorn).
31. The development of other emotional relationships. (Bettelheim: Father Owen: Dockar-Drysdale).
32. Diminished suspiciousness of adults. (Redl).
33. Increased ability to take affection. (Redl).
34. Extreme dependence on an adult. (Dockar-Drysdale).
35. Absence of some adult causes anxiety. (Dockar-Drysdale).
36. A phase of depression. (Dockar-Drysdale).
37. Increase in educational attainments. (Bettelheim: W.D. Wills: Dockar-Drysdale).
38. More positive attitude to school-work. (Bettelheim).
39. Sustained interest in school subject, or in some out-of-school activity. (O.L. Shaw).
40. Recovery may be indicated by interpretation of the content of the child's paintings. (W.D. Wills: O.L. Shaw).
41. Recovery may be indicated by more general examination of the style of paintings - they may be less chaotic, for example, or, in the case of an obsessional child, they may be less "over-organised". (W.D. Wills).
42. The content of the child's paintings becomes more "wholesome". (O.L. Shaw).
43. The child takes more care over his personal appearance. (Lane).
44. Improved time concept. (Redl: Dockar-Drysdale).
45. Increased ability to use verbal communication. (Redl).
46. Increased ability to use symbols. (Redl).
47. The emergence of new forms of behaviour. (W.D. Wills).
48. The emergence of a sense of humour which is not bitter or personal. (O.L. Shaw).
49. Realistic vocational choice. (O.L. Shaw).

The above list may be divided into seven groups or categories of criteria:-

1. Those which are concerned with what happens to the symptoms of maladjustment (nos. 1 - 6). (Aichhorn: Father Owen: W.D. Wills: Redl).

2. Those which are concerned with the child's social adjustment (nos. 7 - 12). (Redl: Lane: W.D. Wills: O.L. Shaw: Dockar-Drysdale).
3. Those which have been put forward as evidence of increasing ego development (nos. 14 - 29). (Redl: Bettelheim: Dockar-Drysdale).
4. Those which are concerned with some form of emotional relationship between the child and an adult (nos. 30 - 36). (Aichhorn: Bettelheim: Father Owen: Dockar-Drysdale: Redl).
5. Those which are concerned with the child's educational progress (nos. 37 - 39). (Bettelheim: W.D. Wills: Dockar-Drysdale).
6. Those which are concerned with the child's paintings or drawings (nos. 40 - 42). (W.D. Wills: O.L. Shaw).
7. A group of miscellanous factors, not related to each other (nos. 13, 43 - 49).

It will be clear that certain points could be regarded as falling under various headings other than those which have been assigned to them here. Thus, for example, an increase in educational attainments could be regarded as the disappearance or diminution of a symptom if educational retardation was present on referral, rather than being placed in a category of its own. Similarly, nos. 10 and 11, could be construed as indicative of personal development, rather than being factors concerned with the child's social adjustment.

This grouping, however, is not entirely arbitrary, and it is hoped that the reasons for it will emerge in the next few chapters, in which each of the above groups of criteria will be examined separately, with special reference to their application in the field of residential treatment.

CHAPTER XII

METHOD OF INVESTIGATING THE SIGNIFICANCE OF THE CRITERIA OF RECOVERY

It must be clear that the main question with regard to these suggested criteria is the degree to which they relate to subsequent actual recovery. There are basically two approaches to the problem of investigating this relationship.

Firstly, it would have been possible to investigate how the criteria relate to a large number of children drawn from a variety of schools. One could, for example, have circularised all the residential special schools for maladjusted children in the country, asking for assessments of children chosen at random. Such a method has, at first sight, certain advantages, not only in the larger size of the sample, but also in that it would give a more general picture of the position in the special schools service as a whole, rather than being limited to the diagnostic groups, age range, or intelligence, of children treated by one school.

However, after preliminary approaches had been made to the special schools in England and Wales, it was found that there were a large number of schools which were not prepared to co-operate in the completion of such a questionnaire. Various reasons were given for this - chief among them being the pressure of work, which is understandable, since the pressures, both as regards time and energy, are extremely high in schools of this sort. Several of the schools maintained by Local Education Committees were restricted by rulings of the Education Authority in the degree to which they were able to participate in research schemes. It is also possible that the failure to obtain widespread co-operation reflects a distrust, on the part of many principals, of quantitative methods, or a feeling that such methods may present an unfair picture of the success of their methods of treatment.

Consequently, although the co-operation of nearly half the special

schools in the country was assured, it was felt to be preferable to abandon this approach, since the size of the sample which had been obtained (36 children) was not appreciably greater than that obtained by the method shown below.

This alternative method, which was finally adopted, is to confine the study to a relatively small number of children, taken from one school, who were all known personally to the writer, who has taught most of them in his own class, has been concerned with the educational and therapeutic provision for all of them, in his capacity as head teacher, and has had extensive contact with all of them in out-of-school activities.

Thirty children were chosen, who had left the Mulberry Bush School, Standlake, between December, 1956 and December, 1959. The selection was random as far as the criteria of recovery are concerned since all children were included who left the school for any reason during the relevant period. The period was not entirely the result of random selection, the choice being limited by the necessity to confine the investigation to children who were known to the writer, but who had been long enough away from the school to permit some assessment of recovery to be made in terms of how they were able to fit in to the outside world. It was also thought advantageous, for reasons concerned with the statistical treatment (see below) to include in the material an appreciable number of cases where treatment was not successful, and the period chosen does in fact contain a higher proportion of such cases than is to be found in most three-year periods at the school.

The children were of primary and junior secondary age, ranging from 7 - 14 years at the time of leaving. They were of average intelligence, the intelligence quotients ranging from 80 - 156, and the mean being 108. They were of both sexes, the number being made up of 25 boys and 5 girls. The number of girls leaving during the three-year period is rather lower than would be expected from the proportion of girls being

treated at the school at any one time (10 out of 40), and is accounted for by the fact that among the girls at that time there were a rather larger number of longer stay cases than is usual.

A more detailed presentation of the above information is to be found in table form in Appendix I, together with details of the assessments of the children, described below.

Each child was considered separately, as to whether each criterion was applicable, in the sense of its having been observed and reported, and a record of the results obtained was recorded in the form shown in Appendix I. In addition, each child was classified with regard to subsequent recovery; this classification was in three groups:- recovered; improved, but not recovered; and treatment unsuccessful. Children who were withdrawn at the school's request after an observation period, as being unsuitable for treatment at the school, were included in the last category, together with all those cases where there was no reported improvement in behavioural or other problems. In any cases where it was deemed necessary to continue a child's education at the secondary level in another special school, the appropriate categories were held to be "unsuccessful treatment" if further problems were reported at the new school, and "improved, but not recovered" in all other cases, even when no difficulties were reported from the secondary school.

In this category too, were placed those cases where, though further problems were reported after the child's leaving the school, these were not deemed sufficiently disabling to necessitate further special treatment of any kind.

All cases where no further problems, or breakdown, were reported were listed as recovered.

The above judgments, concerning both the occurrence of criteria and the question of subsequent recovery were based on information gathered from the following sources:-

Information concerning intelligence level and referral symptoms

was obtained from Form 2 HP, sent to the school with each child by the referring child guidance clinic. More detailed information was available in the form of reports from psychiatrists, psychiatric social workers, probation officers, children's officers, and from previous schools, hostels, and so on. Naturally, not all of these reports are available for any one child, but in no case was it necessary to rely on the Form 2 HP alone.

In assessing whether the criteria were applicable, the following sources of information were used:-

1. Educational reports. These are written termly by the teaching staff of the school, and are concerned with the whole range of the child's behaviour in the classroom. They normally cover the following points:- social development; emotional development; emotional relationships; attitude to school work and the results of attainment tests, which are given irregularly in the earlier stages of treatment, and once a term in the later stages (with the use of alternative forms to minimise the effects of test sophistication).
2. Therapist's reports, which are concerned with the child's emotional development. These are written irregularly, as deemed necessary. Each child is usually the subject of two such reports in the course of the year, and they are always written in a child's first term and in his final term.
3. Teachers' records of work.
4. Private notes on case conferences and discussions by the staff concerning the progress of particular children.
5. The above is supplemented by the writer's own experience of the children concerned.

It was not considered proper to include case histories of the children concerned, representing, as they do, all the children who have left a named school within a specified period. All the above material, with the exception of the private notes, and some of the record books,

is kept in the files of the Mulberry Bush School.

There are a few further considerations which apply to certain specific criteria of recovery.

The main consideration when deciding whether any child could be regarded as showing signs of development of ego or super-ego, or transference, was whether the case had been reported or discussed in these terms by the principal of the school, who, as explained in Chapter X is the school's psychotherapist. It must therefore be born in mind that, in the case of these criteria, the judgments recorded are essentially those of one person.

The phrase "disappearance of the referral symptoms" is used to indicate all those cases where symptoms recorded in Form 2 HP, and in other reports made prior to the child's admission to the school, were not observed during the last terms of the child's stay. Consequently, the fact that it may be recorded that this criterion is applicable in a particular case does not preclude the possibility of other criteria under the general heading of symptom clearance being also applicable.

The interpretation of pictures and drawings painted during psychotherapeutic sessions is by no means an uncommon technique in the individual treatment of particular cases as carried out by the principal of the school. However, when dealing with those criteria which are concerned with the use of artistic productions, only in those cases where the interpretations made had a direct and prognostic bearing on the child's recovery, was a positive score given, indicating that the criterion was observed. An illustration may serve to make this point clear:- If the therapist interpreted a piece of work as symbolising some specific problem or conflict of the child, this would not count as one of the criteria of recovery. If, on the other hand, a painting was reported as symbolising ego growth, or the resolution of a conflict, then, in the case of this child, a positive score would be made for the criterion "interpretation of the content of the child's art".

Consideration of the criterion "increase in educational attainment" presented a further difficulty. The majority of the children in the school show appreciable increases in attainment age during their stay. It would therefore be easy to obtain an apparently highly significant degree of association between increase in educational attainment and recovery which meant in fact very little. In order to avoid this danger, a very narrow interpretation was given to the words "increase in educational attainments", namely, an increase, shown by standardised attainment tests, over a period of not more than a year, of more than twice the number of months of attainment age, than the number of months which have elapsed since the last test.

In order to decide which children had shown an increased ability to accept domestic routine, the material listed above was supplemented by discussions of the various children concerned with the School Matron, who was better able to form an accurate opinion in this matter.

Lastly, a record of the degree to which the children were able to take on responsibilities and jobs was available in the form of the records of the School Bank. Children at the school are paid for carrying out certain voluntary work, and these payments are recorded. Reference to jobs and acceptance of responsibilities is, of course, also frequently made in the course of the reports already mentioned.

Assessment of recovery is based mainly on correspondence from the various Child Guidance Clinics who maintain contact with the cases, and report progress, both at home and at school. In addition, contact with the child and its parents is maintained by the school; many children and their parents return to visit the school from time to time, and most keep in touch by letter, at least for some time after the date of departure.

Material gathered was arranged in the form of four-fold tables, the "improved" and "unsuccessful" categories being put together under one heading of "not recovered".

	C	not C	
R	a	c	p
not R	b	d	q
	x	y	n

These tables are shown in full in Appendix II.

The use of this form does not imply an actual dichotomy. It would be theoretically possible to arrange the thirty children in the sample in order of their degree of recovery. Similarly, it would be theoretically possible to arrange the children in rank orders which showed the degree to which each criterion was manifested. The dichotomous tabulation was necessitated by the difficulties of observation in practice.

This point has a bearing on the choice of a statistic to interpret the data. It indicates the possible use of a ranking method of correlation Kendall's τ would provide a good measure of the degree of relationship between the presence of the criteria and subsequent recovery. Fortunately, this statistic can be applied when the ranking degenerates into dichotomies

The relationship between the presence of each criterion and subsequent recovery was derived from the tables shown in Appendix II by the following formula:-

$$= \frac{ad - bc}{\sqrt{xypq}}$$

To test the level of significance the following formula was used:-

$$a = \frac{s - \frac{1}{2}n}{\sqrt{\text{var } s}}$$

$$(\text{var } s = \frac{xypq}{n^2-1} \quad ; \quad s = ad - bc)$$

The significance of the value obtained for a was found in a table for areas under the normal curve.

CHAPTER XIII

CRITERIA WHICH RELATE TO SYMPTOMS

This description, of course, admits of an extremely wide field of application. It might in fact be claimed that any of the criteria listed in Chapter XI could, in some way, be regarded as a lessening of the symptoms of maladjustment.

Nevertheless, the consideration as a separate group of those criteria which concern the symptoms is worthwhile for three reasons.

1. There is an important difference between these criteria and almost every other one which has been recorded above. Whereas any use of the disappearance (or diminution etc.) of symptoms as a prognostic criterion of recovery tends to be negative, all the other criteria are positive. In the first case, we say that the child no longer does such-and-such, but in the second case we go further than this, and say that the child is now able to do something else.

2. The concept of symptomatic behaviour is applicable to nearly all maladjusted children. Not all are anti-social or retarded educationally, for example, but their behaviour can always be viewed in the light of their referral symptoms. Thus, if we find that this group of criteria has any validity at all, we will have found an indicator of recovery which may be applicable to a wide variety of cases.

3. The question of the significance of the symptoms in the treatment of the maladjusted child is one about which there is great disagreement. It will therefore be an advantage to deal with it specifically, in so far as it affects the present topic.

Aichhorn,[1.] and others, rejected the use of symptoms in evaluating the success of treatment, or, at least, urged great caution in its application. It must however be pointed out that the symptoms cannot be ignored altogether in this respect, as Aichhorn himself discovered when he came to evaluate the success of his treatment. Perception of the behaviour of other people is the raw material - which we use when forming

conclusions about their motivation and so on. Behaviour of certain kinds is described as symptomatic, and it may be possible to come to certain conclusions, or to form certain theories, about the pathological state, which is its cause. But we are not able to be directly aware of a neurosis, or a psychopathic state, for example, and any attempt to assess progress or recovery which is entirely in terms of some theory of personality disorder, and which does not continually take account of the observed behaviour is liable to become unrealistic and even ridiculous. It may well be that the disappearance of the symptoms need not indicate recovery, but, as has been pointed out by Redl, it is difficult to maintain that recovery has taken place if the original symptoms are still in existence.

Strong feelings are undoubtedly aroused by this question of the use of symptoms to judge recovery, but this is largely unnecessary, being due, at least in part, to loose thinking which results in some degree of confusion between aims of treatment and criteria of recovery. It is possible to make out a very strong case, based on the psychoanalytical view of maladjustment and delinquency, against the elimination of symptoms as an aim or method of treatment, and this point of view has in fact already been outlined above. But this is not relevant to the present issue. The question is not "Can we bring about recovery by eliminating or suppressing the symptoms?" but "How far is the disappearance of the symptoms related to subsequent recovery?" This latter question contains no implications about methods or aims of treatment.

Such a form of the question as this, however, though adequate for the purpose of making the above distinction, does in fact over-simplify the matter in many respects.

Reference has already been made to the possible discrepancy between referral symptoms, and those which are observed after placement for residential treatment. Striking and, one would have said, important symptoms may thus disappear almost overnight and before treatment has begun. The following example will show how the whole appearance may

alter in this way.

Lilly B., aged 8, was referred to the child guidance clinic for investigation of her bizarre behaviour at home. She was not accessible to parental control, but in the sense that she seemed unaware of her parents' requirements rather than that she deliberately or aggressively refused to obey them. The most striking feature of the case, however, was her complete inability (or absolute refusal) to communicate with other people except through the medium of her dolls. She had five of these dolls, and, if anyone wished to hold a conversation with her, he or she had to speak, not to Lilly (she would not answer), but to any one of the dolls. Lilly would then answer, manipulating the doll as though it were speaking. Each of the dolls had a different personality, which was apparent in the manner and content of its replies. At least one person who was professionally concerned with Lilly about this time saw all this as the expression of different, conflicting aspects of the child's personality, and it was, in any case, the aspect of the case which preoccupied most of those who worked with her.

Lilly was ascertained as maladjusted, and a place was found for her at a boarding special school. The staff were informed in advance about her dolls and her difficulty of communication, but, when she arrived, the dolls were never unpacked and she rarely stopped talking. She was, moreover, aggressive, precociously obscene, and prone to temper tantrums.

We thus have in this case two reported sets of symptoms: those which were the reason for the referral to the clinic, and those which followed immediately upon placement.

The question which arises from cases like this is whether "arrival" and referral symptoms are equivalent for the purpose of assessing progress in treatment.

It does not, of course, always follow that the referral symptoms are indicative of the most important factors in a case. Peter L., (aged 11), for example, was referred by his school on account of his bullying and dangerously aggressive behaviour. This was not a long-standing

problem, being, rather, sudden and acute, and prior to this his school record had been unremarkable in every way. He was not outstandingly good or bad in any subject or field of activity. As in the case of Lilly B., the behaviour which led to his referral was never seen after his arrival in a boarding special school; he tended to be shy, quiet and rather withdrawn. However, another, apparently unrelated, factor had emerged during the programme of tests carried out by the child guidance clinic. Although he had for several years been working in his primary school in a "dull-average" stream, and although his attainment test results were at a comparable level, his intelligence quotient was worked out as 150 (Stanford Binet).

He had been working for some years well below his potential level, and none of his teachers had ever been aware of the fact. It was not, as it appeared, simply a case for intensive remedial teaching. He responded to this very slowly, and it took nearly two years to give him confidence in the field of school work and to remove what appeared to be a severe intellectual inhibition. At 13, Peter transferred to a normal grammar school, and was later reported to be working adequately in an "A" class.

In this case, the referral symptom, a short-lived phase of aggressive behaviour, led to the detection of a hitherto undetected handicap, which, if it had continued to be unrecognised, would have had far-reaching effects in the boy's later life. Other factors, which have been omitted in this extremely condensed account, lead me to suppose that the two problems were not unrelated, but it seems that, in cases like this, any attempt to assess progress in terms of the referral symptom, would be ignoring one of the main problems.

A further possibility is that one will only become aware of one of the symptoms which were present in the early stages of treatment after it has cleared up. The following is a case in point, which also serves incidentally as a good illustration of Stott's views[2]. on the results of intelligence tests of certain maladjusted children.

It is not necessary for our present purposes to give the details of Percy B's. referral and early treatment. When he had been in a special school for a year, he was, at the end of one term, given a number of standardised attainment tests, as a routine check. In the nine months since he was last tested, his reading comprehension age (as measured by Schonell: R4 Test B) had increased from 10 - 8 to 14 - 6. His age at this time was just over 10 years, and his I.Q. was given by the referring clinic as 108. This 40% increase in reading comprehension in nine months, beginning at a point which was in any case not below his chronological age is no mean achievement for a boy of Percy's stated level of intelligence. We may think it probable that there was, in this case, an intellectual inhibition, as in the case of Peter L., which has cleared up in the course of treatment. It is not possible to give more information at the present time, since this is a very recent case, and Percy's intelligence level is, at the time of writing, the subject of re-examination. It seems possible, however, that he under-scored on the original test in a similar way to those cases reported by Stott.[2.]

There is one final difficulty about the use of referral symptoms as prognostic criteria. The writer has known of several cases where a child has been referred by the parents for treatment on account of one symptom, without their having mentioned a whole series of other symptoms which have been present for some time. In practice, however, such unreported symptoms are usually discovered in the first week or two of residential treatment.

We now turn to the question of what actually happens to the symptoms. The popular conception of the treatment of maladjusted children (where it does not envisage the ultimate in permissiveness) seems to be based on an idealised form of psychoanalytical treatment; once the crucial conflict is brought to consciousness, the symptoms suddenly vanish as if they had never been. Such dramatic and instantaneous remissions of symptoms have been reported by, among others, Lane[3.] and Valentine,[4.] but, while they may be common enough in certain types of case, they are,

in the experience of the present writer, very rare among those children who are sent for residential treatment.

In the list of possible criteria given in the last chapter, I have therefore, in addition to the disappearance of the referral and "arrival" symptoms, put down a number of alternative courses which the symptoms may follow. It may well be that more than one of these will be applicable in a single case (see below, Derek J.), since a child with one solitary symptom would probably not be treated in a boarding special school, and there seems no reason why all the symptoms should follow identical courses.

The most common courses of disappearing symptoms has been, among those children with whom the present writer has had direct experience, their diminution and subsequent final disappearance and their reduction in frequency and intensity.

The following example is given as typical of both of the above points:-

In the early stages of his stay in a special school there were two situations where Derek J's. emotional disturbance was clearly apparent in the form of noticeable symptoms. These were in the classroom and in the diningroom.

In the classroom, he tended to panic when faced with any new work, new problems - in fact new situations of any sort. Unless intervention was extremely quick, he would burst into a mixture of tears and curses, shouting that he could not do this work, that he would never be able to do it, that he was only asked to do it so that he could be made to look a fool, and so on. This would be accompanied by a rapid, but thorough destruction of his books. Interruption of this sequence was generally followed by a violent temper tantrum which necessitated physical constraint.

There was, in this case, no sudden elimination of the above symptomatic behaviour. Derek continued to react every time he was faced with a new situation. The violence of the reaction was gradually diminished, however, until, during the two terms before he left the school, it consisted only of his saying calmly and almost casually,

"I can't do this." Only token encouragement ("Of course you can!") would enable him to look again at his problem and to take up his work again. The symptom was still there, and still recognisable; but it had been gradually diminished until finally it had lost all its emotional content, the residual reaction surviving probably as a habit.

In the diningroom, the pattern was somewhat different. In his earlier days at the school, he always insisted that he was being starved, and that everyone else had more, or better, food than he was given. He was, in this respect, completely unable to accept the evidence of his eyes, and, to "even things up", he would often try to steal food from other children, or to upset their food on to the floor. At first, this would happen at every meal, but, after a time, it was intermittent. About a year later, behaviour of this kind could still be observed; it was little changed from its earlier manifestations, but it was now comparatively rare. When such behaviour had finally ceased, no-one could have said with any certainty when it had finally stopped.

In the case of Derek J., then, we see two different forms of symptomatic behaviour, whose reduction took different forms even though the process occurred with each of them during the same period.

To sum up:-

Quite apart from those objections to the use of the reduction of the symptoms as a criterion of recovery which are based on the psychoanalytical view that the symptom is merely an outward sign of an unconscious conflict, and that the symptom may be changed or removed without materially affecting the underlying problem, there are a number of practical difficulties which arise in residential treatment (and possibly in other forms of treatment too) and which can lead, at the least, to inaccurate observation and reporting, and, possibly, wrong conclusions based on such inaccurate reports.

These are:-

1. The possibility that the referral symptoms may never be seen in

the residential school, their place being taken by an entirely new set of symptoms.

2. The possibility that severe symptoms may not be reported or observed; they may be only recognised in retrospect.

In addition to their sudden, dramatic disappearance, which may be rare in residential schools, the symptoms may be reduced in various ways:-

They may gradually dwindle or diminish.

Their frequency and intensity may be reduced.

They may be of shorter duration.

There may be a general reduction of extreme types of behaviour.

Turning to our statistical material we find that, of the six criteria listed under this heading, three are significantly associated with subsequent recovery.

Considering these first, they are:-

Disappearance of the referral symptoms: $\tau = .60$; $a = 2.2$

Diminution of symptoms : $\tau = .60$; $a = 2.2$

Although these criteria have similar distributions, they do not necessarily coincide in any particular child, as may be seen in Appendix I.

Less extreme behaviour ($\tau = .52$; $a = 2.4$) is significant at the 5% level.

These correlations do not support the view that the disappearance of the symptoms has no necessary relationship with recovery since the real problem may be left untouched to emerge later in another form. It may even be the case that the fact that these associations are significant only at the 5% level is a reflection of the practical difficulties of observation and reporting referred to above, and that

if it were possible to be more exact in this respect, the true relationship between symptom clearance and recovery would emerge as being highly significant.

There was no significant association between "arrival symptoms" and recovery (τ = .47 ; a = .88). This, of course, does not deny the existence of this problem; there remain the cases, as described above, where this phenomenon is a very real complicating factor. It is, however, probably fair to conclude that it is a very much less widespread problem than is suggested by many workers in this field.

Similarly, reduction of the frequency and intensity of the symptoms (τ = .37 ; a = 1.54), an example of which has been quoted above, can not be said to have any wide application.

"Shorter delusional attacks" is the least significant of the criteria to be considered in this chapter (τ = .12 ; a = .24). It is, in fact, the least significant of all the criteria considered in the investigation. It is possible that Redl[5], in proposing this point, had something different in mind from the way in which it was understood when making this investigation, but, after re-reading Redl's views, and re-examining the cases used in this enquiry, I have come to the conclusion that it is not likely that the significance of this criterion would be materially improved by a re-assessment.

CHAPTER XIV

SOCIAL ADJUSTMENT

The use of social adjustment as a criterion of recovery is necessarily limited in its application, since it implies that the maladjustment of the children in question takes the form of anti-social behaviour, or, at least, behaviour which, if not actively anti-social, is not acceptable to society. Children who are ascertained as in need of special educational treatment on the grounds of maladjustment do not necessarily fall into such a category; their symptoms may be excessive withdrawal, enuresis, gross intellectual inhibition, or one of a number of psychosomatic disorders, which need not affect the child's social adjustment in any way.

Nevertheless, this restriction probably affects, in practice, a smaller number of children than it might at first appear, since there seems to be a tendency for children who are aggressive or delinquent to preponderate among those sent for residential treatment. The extent of this tendency and the reasons for it are, strictly speaking, outside the scope of the present enquiry. One might, however, suggest that parents, teachers and education authorities may be more likely to take action about a child to whom their attention is brought by his persistent anti-social activities than about a child, who, though he may be seriously emotionally disturbed, does nothing undesirable which will draw attention to him. Peter L., in the last chapter, was, it will be remembered, not referred to the child guidance clinic until he began to behave aggressively, although he had, in fact, been vegetating for years.

But, be that as it may, there will probably be a larger number of children in any residential establishment to whom the use of social adjustment could prima facie be applied than the number to whom it will obviously be inapplicable.

The principal advantage deriving from the use of this criterion,

as compared with the remission of symptoms, is that it is much more positive. We are not concerned with what the child no longer does, but with what he is able to do now, which he could not do previously. There would be obvious advantages which would arise from the adoption of objective tests or scales of social adjustment, but this has unfortunately not been widely adopted within the residential special schools, and we must rely on the observation of the members of the staffs of the schools who co-operated in this enquiry. The value of such objective tests could well be a rewarding line of future enquiry.

It must be obvious that, if the concept of social adjustment is to have any meaning when applied to the recovering maladjusted child, it must be applied within the context of the residential community where the treatment is being carried out, since this is generally the only environment within which the staff are able to observe the child's actions and reactions in relation to the other people with whom he comes in to contact. The question which arises is, then, to what extent does a child's increased social adjustment within a residential school relate (a) to his general recovery? and (b) to his social adjustment in the world outside?

Clearly, much will depend on the individual school concerned. A very strict regime could well produce an enforced conformity which would disappear as soon as the constraining and supporting discipline was removed, and, conversely, a very permissive organisation could artificially prolong an aggressive or anti-social phase long after the time when it would have disappeared if the child were in another setting.

One would thus expect social adjustment to be an unreliable criterion, which would vary greatly in its significance between one school and another, though this is not of course to say that it would not be valid in some schools, or in some circumstances.

Reference was made above to the question of the child's adjustment to the world outside the residential establishment. In the case of a

younger child, this will, in many cases, be the child's home and school. It is not inappropriate to point out at this stage the possible dangers of attempting to bring about the child's adjustment to his home conditions. It has been shown that the home backgrounds of these children are more frequently abnormal than is the case with other children. Although these abnormalities may not be such that the standards or mores of the family are outside the range of what is commonly accepted by society in general, there are many cases where the home environment is markedly delinquent or so grossly abnormal in some other way that adjustment to it could never be equated with recovery.

In this connection I quote the case of Diana P., (aged 6), whose mother was a schizophrenic, and whose father was admitted to a mental hospital as a voluntary patient, and later certified (the nature of his mental illness was not specified in reports to the school). Prior to Diana's ascertainment as maladjusted, neither of the parents was receiving any kind of treatment, and the unfortunate child had had to grow up contending not only with her mother's nightmarish psychotic phantasies, which were usually acted out in a darkened, empty house, but also, as if that were not enough, with incestuous approaches from her father. It may well be imagined that the child's condition on arrival at the school was pathetic; but it is not impossible to maintain that her, admittedly abnormal, mental state represented an adjustment to the only environment she knew - perhaps even the best, or the only workable adjustment. It is clear that any attempt to assess Diana's recovery in terms of adjustment to such a grossly abnormal home background would be highly unrealistic, to say the least. Admittedly, this illustration is an extreme case, in which, in practice, it would never occur to anybody to assess recovery in such terms; but the danger is still there, and it is perhaps greater in cases where the home environment deviates less dramatically from the normal.

However, this danger, though real, does not exist in all cases, and I have therefore included in the list adjustment to the home environment as a possible criterion, which may have some predictive value in many cases.

It will be remembered that Lane tended to view recovery in terms of social re-education, except for a few more stubborn cases, and that the emergence of socially acceptable behaviour of one kind or another tended to be taken as evidence of progress in this direction. A stress on the importance of social adaptation has never, it seems, been entirely dissociated from the work of those people who make use of self-government in the treatment of the maladjusted child, even though it is no longer fashionable to view maladjustment as primarily a social disorder, and though the adherents of self-government have achieved a perhaps not altogether happy synthesis of their practice with psychoanalytical theory, which has been derived via the traditions of Aichhorn.

There are many who regard the use of social adjustment as a criterion of recovery with the gravest misgiving. Adherents of this school of thought claim that it is not only misleading, but also, in many cases, actually dangerous. The task of the residential special school is, they say, primarily to bring about emotional recovery or growth of personality, and, while it may well be true to say that personality development may give rise to socially acceptable behaviour, such a statement would most certainly not be reversible. Socially acceptable behaviour may be entirely superficial, a facade, which is useful as a means to an end, and which can be discarded at any time. This is held to be particularly true of the affectionless child, who has acquired an ability to make facile and convincing, though meaningless, superficial adaptations, which mask an unchecked capacity to carry out any kind of delinquent act.

In the list of possible criteria, all those points have been included under the heading of social adjustment which concerns the child's

behaviour in relation to his social environment. Some of these points indicate special instances or particular degrees of social adjustment. Numbers 7, 10 and 11 were suggested by Redl as being indicative of ego development. While not necessarily denying that this may be so, I have included them under this since they also clearly do relate to social adjustment.

To sum up:

1. Social adjustment may be limited in its use as a prognostic criterion by the fact that not all maladjusted children are abnormal in this direction.
2. It may be invalidated to some extent by the effects of differing school regimes.
3. Its use should be confined to actually observed behaviour within the school.
4. It has been claimed that it may be misleading and even dangerous.

To these warnings must be added the fact that, according to the findings that emerge from this investigation, social adjustment in general has no significant relationship with subsequent recovery. (We are still speaking, of course, of prognostic criteria; socially acceptable behaviour may develop very rapidly in a child after his discharge from a special school).

For the six criteria listed under this heading, four results are not at all significant, one is significant at the 5% level, and one is significant at the 1% level.

The emergence of socially acceptable behaviour ($\tau = .33$; $a = 1.3$) does not appear to be significantly associated with recovery. It should also be born in mind that these figures are based on material gathered in one school only, and so are not affected by the effects of differing school regimes, which could have the effect of further reducing the value

of this oriterion.

The acceptance of domestic routine (τ = .29 ; a = 1.05) may well depend on factors quite unoonnected with a child's recovery, even, perhaps, quite unoonneoted with his personal development at all. One might, for example, suggest the skill or personality of the matron, or increase in pressures towards conformity with certain standards, which may be felt as the child gets older, or progresses through the school, to name but two. If factors such as this are operating, then we would expect some such result as we have actually obtained, namely that the acceptance of domestic routine has no significant relationship with subsequent recovery.

Increased ability to assess social situations (τ = .16 ; a = .47) and successful holidays at home (τ = .26 ; a = 1.03) are not significantly associated with recovery.

Accepting responsibilities and taking on jobs is significantly associated with recovery (τ = .47 ; a = 2.12).

Toleration of rules without abnormal reaction is significantly associated with recovery at the 1% level (τ = .51 ; a = 2.59).

The development of a capacity to tolerate rules without breakdown was postulated by Redl (v.s. Chapter V) as being indicative not of social adjustment, but of ego development. Although this oriterion is evidently concerned with the individual's relationship to the organisation of the community within which he is living, it may well be nevertheless more consistent with the other findings reported here to accept Redl's view, and regard this as being a matter of ego development, which, unlike social adjustment, is characterised in this enquiry, as will be seen below, by significant associations with recovery.

It would also be possible to make out a case for inclusion of the oriterion "accepting responsibility and taking on jobs" among the points concerned with ego development. This might be particularly true of the children in the present sample, many of whom took on various routine

jobs for payment. The motive would in many cases be the reward rather than the wish to contribute to the good of the community (though altruism of this kind was not unknown). This kind of materialistic, forward-looking motivation could well be regarded as consistent with ego development.

Social adjustment, then, is not a reliable criterion of recovery: there are practical difficulties which hinder its use, and its occurrence seems, in any case, to bear no significant relationship with subsequent recovery.

CHAPTER XV

EGO DEVELOPMENT

It is possible to discern certain stages in the changing attitudes to the problem of delinquent or difficult children. In Victorian times, and earlier, the matter was presumably viewed from a moral and religious standpoint, with great emphasis on the idea of conscience. We have seen how Lane tended to emphasize the social aspect of the problem; this aspect is also evident in such other approaches to the question at that time as the George Junior Republic,[1] and so on. The psychoanalytical view, which regarded delinquency primarily as an expression of underlying unconscious conflict, was expounded by Aichhorn, and has subsequently been developed and extended not only in the vast library of psychoanalytic literature, which deals with the delinquent and the neurotic child, but also in the works of other writers, who, while not writing within a psychoanalytic framework, have postulated a broadly similar aetiology for these conditions. More recently, there has been a growing tendency to regard the disturbances of at least certain maladjusted children as manifestations of inadequacies or deficiencies in ego development.[2] References to the role of the superego, which have recently been made by workers in this field[3] give rise to the speculation that we may yet see the current attitudes to delinquency turn full cycle, and that we may return to a point where the older concept of conscience may return under another name.

But it would not be entirely fair to describe these changes as merely the reflections of alterations of fashion, to which the educational world is to some extent prone, as is any other. The various successive viewpoints have tended to supplement, rather than to supplant their predecessors.

Of the eight sources which have been reviewed earlier, three have made use of the concept of ego deficiency, or disturbance of the ego functions, as an important factor in the understanding of maladjustment.

The psychoanlytic theoretical division of the personality into three institutions - the id, the ego and the superego is one which has become so familiar that it has gained a very wide currency among those who deal with disturbed children. Perhaps the greatest danger arising from their use is that they should become so familiar that no-one stops to ask what they mean. It is all too easy to discuss a case in terms of "ego development" without attaching any specific significance to the term.

What, then, is implied by "ego development"?

Freud described the ego in the following terms:-

> ... in every individual there is coherent organisation of mental processes which we call his ego. This ego includes consciousness and it controls the approaches to motility, i.e. to the discharge of excitations into the external world; it is this institution in the mind which regulates all its own constituent processes, and which goes to sleep at night, though even then it continues to exercise a censorship upon dreams. From this ego proceed the repressions, too, by means of which an attempt is made to cut off certain trends in the mind not merely from consciousness, but also from other forms of manifestation and activity...[4.]

> The ego has the task of brining the influence of the external world to bear upon the id and its tendencies, and endeavours to substitute the reality-principle for the pleasure-principle which reigns supreme in the id. In the ego perception plays the part which in the id devolves upon instinct. The ego represents what we call reason and sanity...[5.]

Flugel summarises the Freudian concept of ego by describing it as

> that part which we recognize most intimately as ourselves, the part which is conscious (or mostly so), which interprets and co-ordinates the impressions from the outer world and from our own bodies that reach us through our sense organs, and which controls the voluntary movements that we execute through the agency of the striped muscles.[6.]

The above descriptions encompass so wide a range of human activities that it occurs to one to question the propriety of ascribing them to a single "coherent organisation of mental processes". Without further definition, there can be few abnormal mental conditions which could not be brought under the heading of disturbances of the ego, from perceptual

disorders, or even mental defect, on the one hand, to hysterical paralysis on the other, the latter being normally regarded in psychoanalytical literature as of psychoneurotic origin, rather than arising from ego disturbance. Clearly, then, some further clarification is needed if the term is to have any useful significance in practice.

The functions of the ego may be summarized under the following five headings (each of which does itself cover a wide range of functions):

1. "Reality-testing" and the perception of the external world.
2. Perception of internal stimuli.
3. Cognitive processes.
4. The carrying out of movement, action, etc.
5. Controlling impulses emanating from the id.

The concept of a deficient ego, as normally used, does not imply a generalised or uniform deficiency in all five aspects. Just as the ego was postulated as the antithesis[7] of the id, so disorders of ego development are seen as the antithesis, as it were, of the neuroses, which arise from conflict between the ego and the id. In other words, in the child whose ego is poorly developed, there is no possibility of neurotic conflict, since the ego is incapable of exerting sufficient influence on the id impulses to bring this about.

This usage is based, it would seem, primarily on Anna Freud's work on the defence mechanisms of the ego, rather than on a generalised or abstract view of the ego as a whole. It is, in other words, a question of the disturbance, or deficiency, of certain ego functions, and chiefly of those which are concerned with the hypothetical "energy" of the ego which enables it to control the id impulses.

We would expect, then, that "ego-disorder" and analogous terms would cover a wide range of observed behaviour and symptoms with, perhaps, little in common except the absence of neurotic conflict or inhibitions. In so far as these conditions have anything in common with one another, we should expect to find that they share a lack of control of one kind or another.

This is reflected in the list of suggested criteria in Chapter XI. The part of the list which is concerned with ego development consists of a comparatively large number of separate points. Of the fifteen points which are listed, ten are concerned with the "controlling functions" of the ego, two (nos. 23 and 25) are concerned with perception of external situations, albeit of a rather sophisticated kind, and two (nos. 26 and 27) are concerned with cognitive processes. The 20th point, which is concerned with the child's taking care of possessions, is difficult to classify under any of the above headings.

In addition to these specific points, it was thought advisable to include one which referred directly to ego development rather than to observations from which it may be inferred. The fifteen specific points which were gathered from our eight sources are certainly not a complete or exclusive list, and the inclusion of no. 14 ("evidence of ego development") gave an opportunity for other observations which might come under this heading to be included, if they came to light at a later stage of the investigation.

The above discussion has necessarily employed psychoanalytical terms, since Freud's concept of the institutions of the mind is implicit in the use of the term "ego" as it is generally understood by those people who carry out residential therapy of disturbed children. But it does not necessarily follow that the validity of the specific criteria which are claimed to be indicative of ego development is dependent on acceptance of the psychoanalytical theory in general, or on the concept of ego disturbance in particular.

Each of the points raised relates to some aspect of a child's behaviour which was abnormal or deficient, and in respect of which improvement is reported. It may be that empirical observation has led various workers to associate certain factors with subsequent recovery, in which case the association could well hold good regardless of what explanatory hypothesis has been put forward to account for it.

It might of course be claimed that each of these points is simply a specific example of symptom clearance, which has been discussed earlier. But there is one important difference, which has already been noted in connection with those criteria which are concerned with social adjustment, namely, that these points are positive in their approach, and deal for the most part with increased abilities. Their specificity would seem to lend itself to objective observation, which would have a favourable effect on their reliability as prognostic criteria (presuming, of course, that they were valid).

Up to this point we have discussed the ego largely in terms of its various functions and have tended to take these functions separately.

Such a procedure would however be by no means acceptable to all workers in this field. Many prefer to regard the ego rather as an entity, using the word in a sense which is analagous to the use made of the word "Self" by certain philosophers. In particular, Winnicott[9]. and Dockar-Drysdale regard certain ego disorders as being marked by an almost complete failure to develop a sense of self, or identity. The possible criteria which are based on this point of view have already been discussed. Since they are primarily concerned with the development of emotional relationships between the child and the therapist, they have not been listed separately: it was considered preferable, for reasons which will become apparent below, to treat the question of emotional relationships as a whole.

The depressive phase, reported by both the above writers as marking an important stage in the recovery of the affectionless child (regarded as an ego disorder) has been listed among the miscellaneous criteria, since its connection with the development of the ego is less direct than is the case with those which have been included under the heading of criteria which are concerned with ego development. The same holds true of the development of improved time concepts, which, too, has been placed amongst the miscellaneous criteria.

Summing up, the concept of maladjustment as a disorder or deficiency of ego development gives rise to a larger number of criteria than is to be found under any of the other headings in this list, a fact which must at least in part be due to the wide variety of functions which are ascribed to the ego. These criteria have the advantage that they are specific and lend themselves to objective reporting; they are concerned, for the most part, with the child's increasing capacity for self-control in various forms; a few are concerned with cognition or with perception, and apply to cases where disorder of these functions does not arise from physical causes. They are not necessarily dependent for their validity on the admissibility of any theory of personality structure, or the nature of the ego, but, if they all do relate to some common factor, we would expect to see a tendency for them to be present or in conjunction with each other, as a group, rather than as entirely separate items.

Inspection of the table shown in Appendix I shows that this is, in fact so, but one would not be justified in drawing general theoretical conclusions from the present material.

Turning to the results obtained from the statistical material, we find that of the sixteen points listed under the general heading of "ego development", four are significant at the 1% level, and three at the 5% level.

The generalised concept of "evidence of ego development" gives a particularly good result ($\bar{C}$ = .71 ; a = 3.45). This highly significant result may perhaps be unexpected after what has been said concerning the diversity of the various functions ascribed to the ego. This result, however, does not in any way serve to validate the concept of the ego. It will be remembered that the classification of the 30 children as to whether or not they had shown evidence of ego development during the later stages of treatment was based entirely on the reports of one psychotherapist. The results, then, validate the work and the insight of this therapist rather than any theoretical view-point, and it does

not neoessarily follow that similar results would be obtained by other workers using a similar terminology, since the term itself permits wide latitude of interpretation.

Increased ability to tolerate frustration has a highly significant assooiation with recovery:-(τ = .59 ; a = 2.74). The lack of such an ability is one of the most striking characteristics of the behaviour of disturbed children, and it is one which is not confined to one type of case. Inability to face frustration may take various forms - it may be manifested by tantrum, or withdrawal, to name two, but it is a phenomenon which can be accurately observed, as can improvement in this direction. Indeed, should a naturally occurring frustrating situation not present itself, it is no difficult matter to manipulate the child's environment so as to produce an objective, if informal, test of his increased capacities in this respect. This combination, of highly significant result and the possibility of objective observation makes this one of the most important criteria of recovery so far considered.

The association between increased ability to cope with insecurity, anxiety and fear does not reach a significant level (τ = .43 ; a = 1.86). This criterion does not, in any case, lend itself to accurate or objective observation, since, in contrast to the last criterion, the stimulus provoking the insecurity, anxiety or fear may not always be apparent. In the absence of an observed stimulus, it is possible that the very fact of coping successfully with these emotions may render the process difficult or even impossible for the outside observer to detect. Nevertheless, it is probably true that the result obtained does correspond to some degree of increased capacity in this direction among an appreciable number of maladjusted children.

Increased resistance to temptation (τ = .31 ; a = 1.26, not significant) is probably a good indicator of recovery amongst delinquent children. Not all maladjusted children are delinquent, however, and the consequent limitation of the application of this criterion is reflected

in the lower level of significance and the lower coefficient of correlation. It may well be useful for those cases to which it does apply, since it can be observed with a certain amount of objectivity.

A different picture is presented by the distribution of the next criterion to be discussed, which is increased resistance to group excitement. This, again, has no significant association with recovery (τ = .28 ; a = 1.11). In this case, there is no likelihood of its being valid for a limited class of children. The four-fold table for this criterion shows that there are almost as many recovered children to whom it does not apply as those to whom it does apply. But this result is not perhaps at all surprising. Lack of resistance to "contagion" by group excitement, as Redl calls it, is by no means confined to maladjusted children, and the literature of the psychology of groups and crowds is rich in examples showing that apparently normal adults are not immune from this.

The sublimation of unacceptable impulses is significantly associated with recovery, but only at the 5% level (τ = .51 ; a = 2.35). This lower level of significance may perhaps reflect a possible difficulty in the observation of this criterion, a difficulty which has already been referred to in connection with another criterion. It is possible that, the more successful the sublimation of an unacceptable impulse is, the less likely is the whole process to be observed.

Increased care of toys and other possessions (τ = .46 ; a = .05) is associated with recovery, but here again, the significance of the result is at the 5% level only. It is, however, a factor which can be observed with a fair degree of objectivity, and it may thus have a degree of utility beyond that suggested by its correlation with recovery and the significance of this distribution.

A decrease in "life areas" where loss of control occurs has a highly significant association with recovery (τ = .68 ; a = 3.26). This process, having a clear bearing on the question of symptom clearance,

has great advantages over the latter criterion, in that it avoids the practical difficulties of observation which result from the use of symptom eradication as a prognostic criterion (see Chapter XIII); if adequate records are kept, it represents a process which can be assessed with a great deal of accuracy, and it does not depend on knowledge of events which occurred before admission to the special school.

Increased ability to experience guilt without denial (τ = .51 ; a = 2.35) is associated with recovery at the 5% level. It should be pointed out that the denial of guilt cannot be expected to disappear entirely; it is surely something which is familiar in some degree to all who have had experience of any children.

The "ability to see and admit his own contribution to the causal chain" (τ = .39 ; a = 1.68) is not significantly associated with recovery. However, I would hesitate, in spite of this statistic, to reject its use completely in practice. It would seem that the above result reflects the comparative rarity of its appearance even in recovering children, rather than a haphazard occurrence in both recovered and not recovered groups. This is born out by inspection of the distribution in the relevant table (see Appendix II).

Examples will doubtless occur to the reader which show that an "inability to see and admit one's own contribution to a causal chain", though a widespread failing amongst maladjusted children, is not one which is by any means confined to the maladjusted, or to children.

In the writer's view, the fairest summing up for this criterion would be to say that, if it occurs at all, it is a good pointer towards impending recovery, but that it has no very widespread application.

Less dependence on adult support (τ = .13 ; a = .32) is not significantly associated with recovery.

It is interesting to note that this is one of a pair of mutually exclusive criteria - viz.: "less dependence on adult support" and "extreme dependence on adult" (τ = .12 ; a = .24, not significant) -

neither of which are significantly associated with subsequent recovery. These figures, of course, relate to the general application of these criteria. It is possible that subsequent, more specialised, research would indicate particular classifications of maladjustment to which each criterion would be appropriate.

No significance was found in the case of the acceptance of gratification offers ($\subset$ = .27 ; a = .79). It would appear from the distribution in the relevant four-fold table that most children are willing to accept gratification offers, irrespective of whether or not they are recovering.

The retention and use of past pleasurable experiences ($\subset$ = .22 ; a = .69) is not significantly associated with subsequent recovery. It seems possible that this ability may be related rather to the child's increasing age and experience.

The relationship between a child's increased ability to make valid inferences from his own or other's experience is highly significant, ($\subset$ = .61 ; a = 2.89). The inability to make such inferences is a striking feature of the behaviour of many maladjusted children in the earlier stages of their treatment; they persist in carrying out the same pattern of behaviour over and over again, quite regardless of its inevitable and frequently unpleasant consequences.

The abilities to experience failure and success without undue reaction were not found to be significantly associated with subsequent recovery (in each case, $\subset$ = .16 ; a = .47). Although the distribution for these criteria are identical in the four-fold tables - giving rise to identical levels of significance and coefficients of association - their distributions in the table of raw data (see Appendix I) are not the same, and they do not necessarily coincide.

These results tend to justify, in a small way, the increased attention which is being paid to the study of ego development in theoretical work on maladjusted children.

In the practical sphere, they have perhaps greater importance, since this chapter has been concerned with a number of points which not only frequently have a positive and significant association with maladjustment, but also are generally positive, being concerned with increased ability of one kind or another, and being amenable to objective assessment.

CHAPTER XVI

CRITERIA RELATING TO THE FORMATION OF EMOTIONAL RELATIONSHIPS.

In so far as it can be regarded as proper to look for a general criterion of recovery which is widely applicable within a classification which covers a great variety of conditions as the term "maladjustment", it may well be that this is to be found in the formation of emotional relationships.

There is, as has been seen, a widely held body of opinion amongst those who are concerned with the residential treatment of maladjusted children to the effect that most, if not all, maladjusted conditions arise, at least in part, from inhibitions or distortions of the child's emotional development, which are the result of deficiencies or abnormalities in the child's environment in the earliest, and most crucial, stages of development. It will be remembered that all the workers who have been discussed above (with the single exception of Homer Lane) made some reference to the importance of the role of emotional relationships, in one form or another, in the treatment of the maladjusted child; even if, like O.L. Shaw, they did not actually list it as a criterion of recovery, they put it forward as an important part of treatment.

This role is not confined to the treatment of any one kind of case. The importance of the transference in the psychoanalytic treatment of neurotic conditions has been frequently emphasized by Freud and by those who have adhered to his theories. In the case of those children who are described as deficient or disordered in the sphere of ego development, the part played in treatment by emotional relationships of another kind has been stressed by Redl, Bettelheim and Dockar-Drysdale. The matter has even been extended to apply to psychotic children; Dr. G. O'Gorman, in an article on the treatment of the schizophrenic child, has claimed that the formation of an emotional relationship "with another human being" is necessary to bring about the recovery of such children.[1.]

There is, of course, in practice, the danger that one may be misled by a superficial "pseudo-relationship" which has little real significance. This danger has already been discussed in connection with the special schools which were visited. In the experience of the present writer, this danger can be overcome, if one bears in mind the consideration suggested by Father Owen, namely that the unreal emotional relationship, which is used by the child merely to further his own ends, will not persist in the face of frustration.

The observation and recording of the presence of this criterion should present few difficulties in the actual treatment of cases. It should be clear to anyone who has even a little experience of work in this field whether or not an emotional relationship has been formed (leaving aside the question of whether it should be interpreted as a transference in the psychoanalytic sense). The actual signs by which it can be observed are manifold, and only those which have been suggested as criteria of recovery in their own right have been included in the investigation. These signs of the presence of an emotional relationship might be expected to vary widely from case to case; we would therefore expect the results for these criteria to be less significant than the results for emotional relationships considered more generally.

This is in fact found to be the case; for the sample of thirty children considered here, none of the signs of the presence of an emotional relationship is significantly associated with recovery. The actual results are as follows:-

Diminished suspicion of adults:-	$\tau = .29$; $a = 1.05$, not significant.
Increased ability to take affection:-	$\tau = .16$; $a = .37$, not significant.
Extreme dependence on adult:-	$\tau = .12$; $a = .24$, not significant.
Absence of particular adult causes anxiety:-	$\tau = .13$; $a = .32$, not significant.

The reported presence of transference phenomena is, for this sample, not significantly associated with recovery ($\tau = .47$; $a = .88$).

However, this may be largely accounted for by the fact that a high proportion of the cases treated at the Mulberry Bush School are not regarded as being neurotic, and the concept of transference is therefore not held to be applicable.

Contrary to what would have been expected from the general trend of opinion referred to in the foregoing discussion, the presence of any other emotional relationship is not significantly related to subsequent recovery for this sample (ζ = .40 ; a = 1.67).

It could be argued that these low correlations, and poor levels of significance, arise in part from the fact that the occurrence of emotional relationships has here been split between the two headings of "transference" and "other emotional relationships". There is no heading in the list of the 49 suggested criteria which refers to the concept of emotional relationship generally, including transference and other forms. A distribution relating to this concept can however be formed by combining the figures shown in Appendix I for transference and for other emotional relationships. This distribution shows under "C" those children who have been reported as showing either a transference or any other emotional relationship (i.e. those who have developed an emotional relationship of any kind), and, under "not C", those who have shown no evidence of any emotional relationship. This four-fold distribution is shown as an additional table at the end of Appendix II.

The measures derived from this table (ζ = .49 ; a = 2.11) show a degree of positive correlation, significant at the 5% level only. Neither the correlation, nor the degree of significance, is as high as might be expected if one accepts what has been proposed by the writers referred to above who have postulated the occurrence of emotional relationships as a vital factor in the recovery of disturbed children of all kinds. Indeed, one might have expected that an investigation of this kind, being concerned with general trends, and criteria which have a wide application, would have tended to give high results for a

criterion for which such widespread application has been claimed.

The present writer would not, on the basis of this discrepancy, seek to minimise the importance of this factor of the formation of emotional relationships, but the discrepancy remains to be accounted for.

It seems likely that the explanation lies in the distinction, already drawn by O.L. Shaw (v.s.) between methods of treatment and criteria of recovery. Establishment of a good emotional relationship in one form or another may be a prerequisite for successful treatment. But, if this is so, it means that this group of criteria is different in kind from all the others, since in this case we have a state which is presumably a contributory cause of recovery, rather than a criterion which results from progress towards recovery. In this group we are concerned with causes, in the others with effects.

The present writer's opinion, based on his own work with maladjusted children, is that the formation of good, positive relationships is one of the most important tools available for bringing about recovery. Though it may not in all cases constitute a therapy in its own right, it results in easier management of difficult children, and creates a situation where teaching and treatment become possible. It would be true to say that it thus creates an opportunity for successful treatment, rather than that it leads diredly to recovery.

This view is not inconsistent with the results obtained, and the slightly lower significance and correlation may reflect that the opportunity can not always be taken, and that not every case where a good relationship is established will end in recovery.

CHAPTER XVII

OTHER CRITERIA.

The importance of the role played by the work carried out in the classrooms of residential special schools must not be overlooked. This must be stressed at the outset, since it is all too easy to view the problem of the treatment of the maladjusted child purely in terms of behaviour disorders, or the aetiology of neurosis, and so on, to the exclusion of other aspects of the matter, which, though less striking, are not necessarily less significant.

Educational progress has a part to play both in treatment and in the assessment of impending recovery. It also constitutes a major aim in the rehabilitation of the maladjusted child. If maladjustment is regarded as a remediable handicap, the conclusion of successful treatment must imply that the recovered child will be able to cope with a return to a more normal environment. A high proportion[1.] of maladjusted children is educationally retarded, and any treatment which failed to remedy this deficiency in what is, after all, so important a factor in the environment of the normal child, could scarcely with any justification make a claim to all-round success. It could also be argued that, if the "recovered" child is not in a position to compete on reasonably equal terms with his peers in a normal school, a degree of stress is imposed which could in many cases lead to a further breakdown, or relapse.

In treatment, the part played by education has been regarded by Bettelheim[2.] as being a matter of ego development. Other workers have assigned to it a role which is important in its own right. It has recently been argued that a suitable remedial approach to educational difficulties can produce a radical and general resolution of behaviour problems in a large number of cases, with no psychotherapeutic intervention of any kind.[3.] Pending publication of factual information in support of this view,[4.] it may be as well to treat it with caution, but

there is, in the experience of the present writer, a considerable amount of truth embodied in it, even though the above expression may be extreme, or exaggerated. It would be impossible to deny the general progress (the "therapeutic gain", as Redl calls it) arising from a child's increased confidence and pride in achievement which can result from the successful use of remedial educational techniques.

It is, of course, not always easy, or indeed possible, to distinguish between cause and effect in this matter. In many cases, psychotherapy and remedial teaching are both employed during the same period, and their relative importance in any subsequent general improvement can not be objectively assessed. It may be claimed that the success of the remedial teaching is simply another sign of the effectiveness of the psychotherapy, or, on the other hand, that the psychotherapy was irrelevant to the main issue, and that the teaching was the prime causative factor. However, such claims are often based upon the prejudices and preconceptions of those who make them, rather than upon real evidence.

As a criterion of recovery, educational progress has the advantage that it is more amenable to objective measurements (in the form of standardised attainment tests) than any of the others suggested in the course of this work.

Increase in educational attainments (limited for the purpose of this work to the degree of progress described in Chapter XII, namely twice as many months of attainment age as the number of months which had elapsed since the previous test) was, in this case, based upon Schonell's series of attainment tests. The tests used were:-

For mechanical reading (word recognition):- Graded Word Reading Test.

For reading comprehension:- Silent Reading Test B.

For mechanical arithmetic:- Essential Mechanical Arithmetic Tests Forms A and B.

For problem arithmetic:- Essential Problem Arithmetic Forms A and B.

The tests were not given specially for this research, but were

carried out as part of the routine educational work at the Mulberry Bush School. In no cases were the tests less than three months apart, being given not more frequently than once in any term. The figures were obtained from the termly educational reports in the file of case papers of past cases kept by the school.

The tests were, in all cases, carried out by the school's Head Teacher.

Of the three criteria of recovery which are concerned with educational progress, a highly significant positive association was found in two cases.

For increase in educational attainment (ζ = .61 ; a = 2.89) the association was significant at the 1% level.

The association was highly significant too in the case of a more positive attitude to school work (ζ = .60 ; a = 2.84).

It is, of course, not surprising that similar results should be obtained for these two criteria, since they would be expected to tend to occur together. In many cases, increased educational attainment will arise from a more positive attitude to school work.

No significant association was found between the development of sustained interests and subsequent recovery. (ζ = .30 ; a = 1.46). It seems possible that the age of the children in the sample may be an important factor in this result, and that different results might be obtained with a sample of older children. Of the total sample of 30 children, only eleven were reported as having developed sustained interests. It may be that, in the primary age range, children are less likely to maintain any serious interests for long without continued adult guidance and stimulus.

We may conclude that, in increased educational attainments (as measured by standardised tests) and more positive attitude to school work, we have two useful and significant criteria of recovery.

* * *

There are three basic ways of approaching the question of the use of art work in judging the progress of the maladjusted child.

Firstly, there are those methods which involve the interpretation of particular items in the content of the child's work. These may involve the use of some kind of symbolism, which may be based, for example, on the sexual symbolism of Freud's dream theories, or on the archetypal symbolism of Jung. A similar approach, based on the assumption that it is possible to make valid interpretations of particular aspects of the child's pictures and drawings is that which seeks to find significance in the choice of materials or colours and so on.[5.]

Secondly, it is possible to ascribe a general significance to artistic productions, without making detailed interpretations. According to this approach, the disturbed child's paintings may be characterized by features which are grotesque, morbid, bizarre, over-organised, or abnormal in some other way, dependent on the nature of the maladjustment of the child in question.[6.] These abnormal features are held to disappear as the child progresses towards recovery, being replaced by a content which is more wholesome.

Lastly, it can be claimed that the work of the maladjusted child tends to be more immature than that of his better adjusted age peers, and that the narrowing of this difference in maturity is closely associated with recovery.

In the present survey no significant association was found between any of the criteria representing the above views and subsequent recovery. The detailed results for these criteria were:-

Interpretations of the content of the child's art:- $\tau = .20$; $a = .66$, not significant.

More mature style of paintings:- $\tau = .20$; $a = .66$, " "

More wholesome content of paintings:- $\tau = .18$; $a = .55$, " "

These results, even if confirmed by future research with more widely selected samples, should not be interpreted as denial of the important

place of art, both in the education and the psychotherapy of the maladjusted child.

It has already been pointed out in the previous chapter that much can be achieved in the classroom, in the fields of academic attainments and of general emotional or social progress, by the child's experiencing a sense of attainment and pride in his own achievements. Successful art education can bring about a great deal in this direction.

In psychotherapy, discussion of the content of a child's paintings may give the therapist the opportunity to raise topics which are of the greatest importance for the resolution of the child's problems, and thus to make it possible for him to talk about these problems indirectly or symbolically. Much good may arise from such methods, particularly as, in many cases, the child would not permit direct discussion. However, it must be pointed out that successful treatment along these lines does not necessarily provide a demonstration of the validity of the psychotherapist's theoretical views. The treatment may be none the less effective, the discussion none the less relevant to the underlying problems, if the symbolism has been imposed on the picture by the therapist.

To the present writer, it seems that what may be termed standard schemes of interpretation can be misleading, though it must be admitted that this is an only opinion based on the writer's experience of art work in classes of maladjusted children, and not a conclusion based on experimental evidence. It may well be possible to assign significance to a child's painting, or some aspect of a painting, if one knows the child well, and if one is present while the picture is being painted, thus being perhaps able to make some assessment both of the child's mood, and of those factors in the child's personality, or in his environment at the time, that are relevant to what he produces. But this is a very different matter from ascribing latent significance to, say, a tower, a house, or a mandala-like pattern, wherever and whenever it occurs. It is by no means uncommon to find children, who, if given insufficient

encouragement, will reproduce time after time stereotyped repetitions of some picture which has been praised or admired in the past, in which case the contents of the picture may be quite void of any emotional content, latent or otherwise.

* * *

Finally, we come to a consideration of nine unconnected miscellaneous criteria of recovery. Only two are significantly associated with recovery, and, for the most part, they can be dealt with briefly.

Evidence of superego development (τ = .60; a = 2.2, significant at the .05 level) is significantly associated with recovery. This does not of course imply confirmation of psychoanalytic views concerning the nature of maladjustment and the process of recovery. Many would describe the same observations in quite different terms. Father Owen, of St. Francis' School, would, for example, prefer to use the older, and equally comprehensible term "conscience".

The emergence of new forms of behaviour (τ = .51 ; a = 2.35) is significantly associated with recovery at the 5% level. This is in line with what one would expect. If the old, pathological patterns of behaviour are broken down, it is reasonable to assume that some new forms of behaviour will emerge in the process.

The remaining criteria are not significantly associated with recovery:-

A phase of depression:- τ = .31 ; a = 1.26, not significant.

Increased care over personal appearance:- τ = .37 ; a = 1.54, not significant.

Improved time concept:- τ = .21 ; a = .73, not significant.

Increased ability to use verbal means of communication:- τ = .36 ; a = 1.54, not significant.

Increased ability to use symbols:- τ = .36 ; a = 1.48, not significant.

The emergence of a sense of humour:- τ = .12 ; a = .24, not significant.

Realistic vocational choice:- ζ = .26 ; a = .81, not significant.

This last result is probably inconclusive, since realistic vocational choice could not reasonably be expected from children of the age range of those in the sample. A similar investigations which was based on a sample of older children might well produce different results.

CHAPTER XVIII

FURTHER CONSIDERATIONS ARISING FROM THE DATA AND SUGGESTIONS FOR FUTURE RESEARCH

Inspection of the tables shown in this chapter and in Appendix I will show that there is some degree of agreement between the number of criteria reported for any child and the classification of that child as recovered, improved, or unsuccessfully treated. This agreement is increased if one considers only the totals for those criteria which were found to have a significant positive association with subsequent recovery. Such agreement is, of course, not surprising, since it might be expected on mathematical grounds alone, but it is worth further consideration in view of its possible practical applications to the question of the assessment of recovery.

In the following discussion, case 22, which, it will be seen, is completely atypical when compared with the rest of the sample, will be omitted from all totals and ranges of scores. This is not because the reported facts in this case appear to weigh against the general findings of this research, but for the following reasons:- The child concerned was discharged from the school, showing no improvement in any field, after a short observation period, lasting less than a term. He had been referred by the school for examination by electroencephalograph; this examination was reported as indicating that the child's disturbed behaviour was due, to a large degree, to a cerebral lesion. This factor was taken into consideration in deciding that the child was unsuitable for treatment at the school. Little was heard of him for some time, after reports had been received that his disturbed and dangerous behaviour had continued, that no local headmaster would keep him in his school on account of the physical danger to other children, and that consequently, until such time as a place in a Children's Unit of a Mental Hospital

became vacant, the responsible education authority had assigned a home teacher to him. The child was, for some reason, never admitted to hospital, and nothing at all is known of what happened during the period until he was next heard of, except that no psychiatric treatment was given, and that he continued to have the services of a home teacher.

However, three years after his discharge from the school, the psychiatrist who originally referred the case reported that the child had now recovered, and that he had been admitted to a normal secondary modern school. Eight months later the boy was still working successfully in his new school.

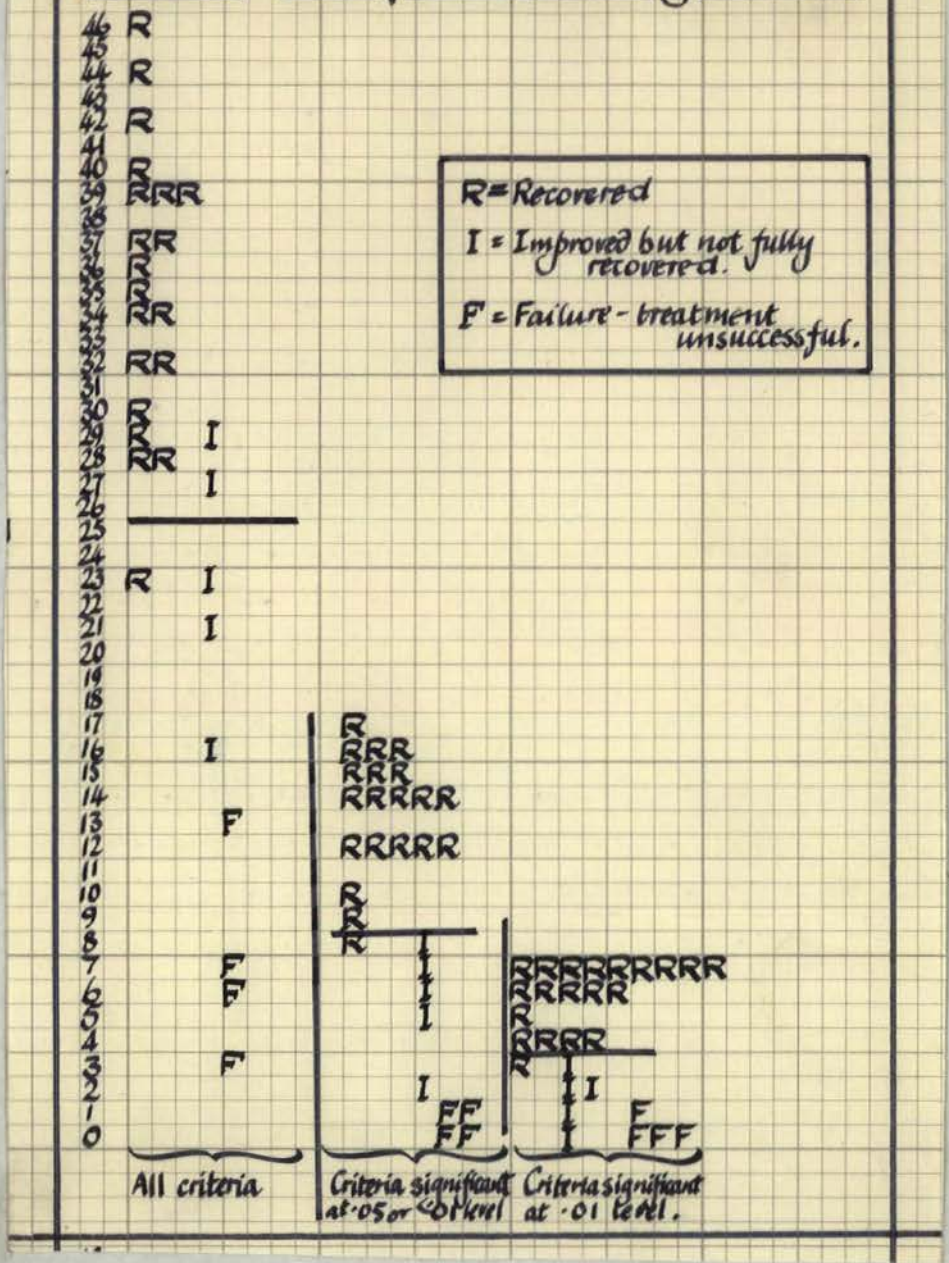
Leaving aside the interesting theoretical questions arising from consideration of this case, which are outside the scope of this work, the outstanding features, which distinguish the case from others in the sample, are, firstly, the time-lag of three years between his discharge as unsuitable for treatment, and the reported recovery, and, secondly, the lack of information about the period immediately preceding recovery. It is not possible to say whether any of the criteria reported here were observed, and, even if it were, their relevance may be doubtful, since they do not refer to residential treatment. This lack of information, covering a period which, for our present purposes, is crucial, is the reason for the omission of this case in what follows. The question does not arise in the case of the other two children in the sample who were withdrawn as unsuitable for treatment, since neither subsequently recovered.

Comparison between the number of criteria reported for each child and the result of treatment was made in two ways:-

1. A simple comparison was made in terms of the range of the number of criteria reported for each grade of recovery (see Table 6).
2. The data in Table 6 was arranged in four-fold tables, as shown below.

	More than half criteria reported	Less than half criteria reported
Recovered		
Not recovered		

TABLE 6. Totals of criteria shown by each child.



From these tables, the statistics which have already been described in connection with the consideration of individual criteria were obtained, the same methods being used in each case.

This method has the advantage that the results obtained are directly comparable with those obtained for the individual criteria.

This procedure was carried out for all criteria, for those which were significantly associated with recovery at the 5% level, or better, and for those which were significantly associated with recovery at the 1% level.

Two sets of figures were obtained at each level. Firstly, the statistics were calculated from tables drawn up like the example shown above, in which improved cases and failures were classed together as "not recovered", and secondly, they were taken from tables in which recovered and improved cases were classed together as "improved".

The results thus show the degree to which the total of the criteria reported can be taken as an indication of recovery or improvement.

Taking all the criteria reported for the children in the sample, we find the following scores (expressed in terms of the number of criteria reported for each case):-

Failures:- 3, 6, 7, 13.

Improved:- 16,21,23, 29.

Recovered:- Range 23 - 46 (Mdn. = 35).

It will be immediately evident that there is some correspondence between the number of criteria reported and the classification with regard to recovery . The differentiation between the failures and the two other categories is good, but there is a certain amount of overlap between the recovered and improved categories.

The four-fold tables for all criteria were as follows:-

Table 7.

	25 - 50	0 - 25	
R	19	1	20
I + F	2	7	9
	21	8	29

τ = .75

a = 3.53

significant at .01 level.

Table 8.

	25 - 50	0 - 25	
R + 1	21	4	25
F	0	4	4
	21	8	29

$\tau = .65$

a = 2.69

significant at .01 level.

The number of criteria reported appears to give a good indication of future recovery, and of improvement. It will be more reliable in the case of the former.

Taking the totals for those oriteria which are significant at the 5% level, or better, we have the following figures:-

Failures:- 0, 0, 1, 1.

Improved:- 2, 5, 6, 7, 8.

Recovered:- Range 8 - 17 (Mdn. = 14).

It will be seen that the differentiation between the categories is improved, in that there is now less overlap between the recovered and improved classes.

Limiting the criteria used still further, to those which are associated with recovery at the 1% level, we have the following totals:-

Failures:- 0, 0, 0, 1.

Improved:- 0, 1, 2, 2, 3.

Recovered:- Range 3 - 7 (Mdn. = 6).

The differentiation has decreased, in that there is now some overlap between all three categories. This might, of course, be expected, simply in view of the much smaller number of criteria involved.

The four-fold tables for the criteria significantly associated with recovery at the 5% and 1% levels are identical:-

5% level 1% level	9 - 17 4 - 7	0 - 8 0 - 3	
R	19	1	20
1 + F	0	9	9
	19	10	29

$\tau = .92$

a = 4.7

significant at .01 level.

Table 10.

5% level 1% level	9 - 17 4 - 7	0 - 8 0 - 3	
R + 1	19	6	25
F	0	4	4
	19	10	29

τ = .55

a = 2.36

significant at .05 level.

The number of these criteria reported appears to give a very good indication of recovery, but a poorer indication of improvement.

We may conclude that those criteria which are more positively associated with recovery tend to occur together in recovering children. They will provide a good indicator of future recovery. They are less helpful in evaluating the likelihood of recovery; to do this, the larger number of criteria would appear to give better results.

This suggests the possibility that future research could evolve a more standardised scheme for assessing the progress of maladjusted children, embodying a number of different criteria which had been found to be associated with recovery. In this case, the evidence would seem to suggest that it would be better to employ a greater number of criteria, (even though there may be in this case a lower degree of association), in order that it may be sensitive not only to recovery, but also to improvement.

Further suggestions for future research would be:-

1. The relationship between theoretical views and aims of treatment.
2. The relationship between each of the above and the definition of actual recovery employed.
3. The effect of these factors upon the choice of criteria used to assess impending recovery.
4. Further investigation of those criteria, in respect of which the sample used here was not satisfactory.

5. Further investigation of the role of education (and especially remedial education) in the general recovery of maladjusted children.
6. Investigation of the application of particular criteria to specified syndromes, or categories of maladjustment.

CHAPTER XIX

CONCLUSION

It is an inevitable handicap of a general, exploratory, thesis, as this one is, that the results tend to be couched in general terms, and that the more specific aspects of the question under discussion may, of necessity, be passed over. In the case of this work, before presenting a summary of conclusions, it should be stressed that we have been considering criteria of recovery which are generally applicable to maladjusted children in general, rather than those which may be appropriate for specific categories of maladjustment. It may be that some of those suggested criteria which, for the sample used here, were not significantly associated with recovery, will, in future research, be found to have considerable value in dealing with specified kinds of cases.

Although only seventeen of the fifty suggested criteria examined were significantly associated with recovery at the 5% level or better, none was found to be negatively correlated with recovery. It would perhaps be surprising if any were, for they were all based on clinical observations made by experienced workers. On the other hand, it is an indication that these observations, none of which were backed by experimental techniques or statistical procedures, were not so far wide of the mark as might be feared.

The group of criteria connected with ego development contains seven of the seventeen significant results (41%). This is in part accounted for by the size of the group (16 criteria, or 32%), but it can probably also be taken as some degree of justification for the increasing interest in ego development which has characterised the study of maladjustment in recent years. In this group of criteria, the following were found to be significantly and positively correlated at the 1% level with subsequent recovery:-

Ego development; increased tolerance of frustration; decrease in loss of control; increased ability to make valid inferences from experience.

The following were positively correlated with recovery at the 5% level of significance:-

Increased ability to sublimate unacceptable impulses; increased care of toys and other possessions; increased ability to experience guilt without denial.

In addition, it has been suggested that the only two criteria from the "social adjustment" group, for which significant results were obtained (namely, increased ability to tolerate rules and routines and the acceptance of responsibilities, or jobs, within the school, which were significant at the 1% and 5% levels respectively) could in this sample be regarded as aspects of ego development.

Except for the two criteria just mentioned, social adjustment was not found to be a good indicator of recovery. This is not to say, of course, that socially acceptable behaviour in the outside world should not be expected from the recovered child. It may be that the idea of symptom tolerance, often regarded as necessary to the early stages of treatment, is so built in to the system and structure of many of these schools, that dissocial behaviour, while not encouraged, may be tolerated to an extent which makes it more likely to disappear after the child has left the school than while he is still resident.

Improved educational attainment was found to be positively and highly significantly correlated with recovery. The same was found to be true of an improved attitude to school-work. The objectivity with which these can be assessed, coupled with the high incidence of educational retardation among maladjusted children, make this result particularly important.

Reference has been made above to the widely divergent views held by various writers to the role of symptom clearance in the treatment of the maladjusted. The results obtained here can not be said to give firm

baoking to either view. Of the six suggested criteria which were concerned with the symptoms, only three were found to have a significant correlation with recovery, and this was only at the 5% level of significance. These three criteria were:- disappearance of the referral symptoms; diminution of symptoms; less extreme behaviour.

It has been seen that many workers have attached a great deal of importance to the formation of good emotional relationships. While the results of this research can not be taken to reflect on the importance of these relationships as part of the scheme of treatment, they seem to indicate that they may not provide so good an indication of the outcome of such treatment as might be expected by some writers. The formation of emotional relationships of any kind was found to be associated with recovery at the 5% level of significance only. Transference was not significantly associated with recovery, though this may be due to the fact that the proportion of neurotic children, to whom this concept would be applicable, was probably unusually low in the sample used.

Of the miscellaneous criteria, two were found to be significantly associated with recovery, both at the 5% level. These were:- superego development; the emergence of new forms of behaviour.

No support was found here for the general utility of the child's artistic productions as a criterion of recovery, though it could perhaps be claimed that this result merely reflects an inability on the part of the writer and his staff to recognise, and make use of, material which was actually there.

A tendency was noted for the criteria to coincide in the recovered cases. This tendency was present even when the criteria not significantly associated with recovery were included. The suggestion was made that a schedule could be prepared, which would use a large number of criteria for more objective assessment of recovery.

A further point which emerges from this work is that the ease and objectivity with which criteria of recovery can be observed and reported by the worker in the field may be at least as important a factor in

determining their usefulness and validity as the soundness of their theoretical basis.

It might be appropriate to conclude with a description of the typical recovering maladjusted child, as he appears here.

He is better able to tolerate the rules of the institution where he is living. This does not mean that he will always obey them, but rather that he can appreciate their necessity, and that he is less likely to view them as tyrannical or vindictive restrictions of his liberty. He is also better able to tolerate frustrations without breakdown, and the kinds of situation in his life which can produce abnormal reaction have become fewer. He has learnt to make valid inferences from his own, and others' experience, and to use these in modifying his behaviour. He has probably become very fond of some adult on the staff of the school. In the classroom, his attitude to school work has improved, and this is reflected in his increased scores on attainment tests - his educational retardation is diminishing. All this may be summed up, in some schools, as ego development, but the use of the term in this context is by no means universal.

These points need not apply to every recovering maladjusted child, but most of them are likely to be observed, and the more of them that are present, the more probable is future recovery.

The same applies, to a lesser degree, to the following observations.

The symptoms for which the child was referred may well have disappeared entirely, or they may have diminished; his behaviour tends less to extremes. He may be more willing to accept responsibility, and to take on jobs within the school. His toys, or other possessions, may be looked after better. He is less likely to express unacceptable impulses directly, tending to use, rather, such mechanisms as sublimation. It may be possible to observe the emergence of new interests and new forms of behaviour.

NOTES.

NOTES

DEFINITIONS OF THE TERMS OF THE TITLE

(1) Father Owen, S.S.F., Headmaster, St. Francis School for Boys.

Mr. O.L. Shaw, Headmaster, Redhill School.

(2) Education Act 1944, s. 34.
In spite of the comments by the Committee on Maladjusted Children in par. 140 of their report, in which they state that the term "ascertainment" has no "special technical significance", it continues to be widely used to indicate that the Certificate prescribed by the Minister under Section 34 (5) of the Education Act 1944 (Form 1 H.P.) has been properly completed.
Similarly, the term "de-ascertainment" is also widely used. (Cf. also Ministry of Education Pamphlet No. 5. "Special Educational Treatment" (1946). Par. 16 states that "the process of selecting children who need special educational treatment is known as "ascertainment".")

(3) C.W. Valentine. "The Normal Child". Pelican Books, 1956.

(4) Ibid. p. 21.

(5) School Health Service and Handicapped Pupils Regulations, 1953 14 (g). These regulations are made under the authority given to the Minister in the 1944 Education Act, s. 33 (1).

(6) Report of the Committee on Maladjusted Children. H.M.S.O. 1955, par. 15.

(7) Ibid. par. 89.

(8) Cyril Burt, M. Howard. "The Nature and Causes of Maladjustment in Children of School Age". B.J. Stat. P. (March, 1952).

(9) Ibid. p. 43.

(10) Ibid. p. 57.

(11) Cf. ibid. p. 40. The statutory definition is not, however, in the 1944 Act, as Burt and Howard state. The definition was first formulated in the School Health Service and Handicapped Children Regulations (1945) and subsequently repeated in the 1953 Revised

Regulations, which are still operative (see note (5) above).

(12) List 42. (Schools Approved for the Education of Handicapped Children). H.M.S.O. Published annually.

CHAPTER I. THE NEED FOR HISTORICAL PERSPECTIVE

(1) August Aichhorn (1878 - 1950) was a teacher in Vienna. Interested from the first in the problems of neurotic and delinquent children, he successfully led the opposition to military settlements for boys, and in 1908 became chairman of a board for organising boys' settlements. He took over an abandoned refugee camp and organised an experimental institution for the treatment of delinquent and neurotic children in Oberhollabrum, Austria.

Working at first largely through intuition, he cast about for a psychological system which came close enough to his methods to provide an adequate and coherent theoretical background to his observations. He found this background in psychoanalysis, and his work and writings became fundamentally psychoanalytic, although his methods differed from those of the traditional analytic situation.

On his retirement from the Municipal Service he became Chairman of the Child Guidance Clinic of the Viennese Psychoanalytic Society. He stayed in Vienna throughout the German occupation, and after the war was elected President of the Society.

(Source: - Searchlights on Delinquency - ed. K.R. Eissler, M.D., Ph.D., biographical note by the editor. This note was reprinted in the 1951 edition of "Wayward Youth" - see below).

(2) Homer Tyrrell Lane (1879 - 1925) was born in Hudson, New Hampshire, U.S.A. He did not become interested in education until after his marriage and the birth of his first child in 1899. He then went to the Sloyd Training School, Boston, where he was trained as a teacher of "manual work". During the next few years he was a teacher at the Pennsylvania State Penitentiary, public school teacher in Detroit and Director of the Detroit Playgrounds. In 1906 he became Superintendent of a Boys' Farm Colony run by the Boys' Home and D'Arcampbell Association of Detroit, which, in the following year, after a disastrous fire, was rebuilt, and reorganised as the Ford Republic. This was a self-governing community. Lane's experimental work there won wide recognition, so much so that in 1912 (1913 according to Bazeley) he was invited to England, where he became Superintendent of the Little Commonwealth, a "Self-governing Reformatory School" in Dorset. This school was run

under the auspices of the Home Office until 1918 when it was closed by the Managing Committee after a dispute with the Home Office.

It is with his work during this period that we are principally concerned, for, in spite of the fact that it finished under a cloud of scandal and suspicion, it is widely known in this country and has influenced later workers.

Lane did not live to finish his projected books. "Talks to Parents and Teachers" is made up of some of his public lectures, and of notes and papers found after his death. They were edited by H.H. Symonds and G.H.C. Osborne.

(Source:- a biographical introduction to "Talks to Parents and Teachers", written by Dr. A.A. David, the then Bishop of Liverpool (1928). There is no other printed biography of Homer Lane, but one is in preparation).

(3) A.S. Neill's work, which still continues at Summerhill School, is too well known to need further comment here, except to say that, although he is widely known in the educational world generally, and although his views on "problem children" have been made known to a wide public through a series of books over a period of 30 years (see bibliography), he appears to have made no specific contributions to the work of schools which specialize in this handicap, as will be seen in later chapters.

(4) Summerhill School.

(5) Homer Lane: "Talks to Parents and Teachers", London (1928).

(6) E.T. Bazeley: "Homer Lane and the Little Commonwealth", London, 1929.

(7) W.D. Wills: "The Hawkspur Experiment".
W.D. Wills: "The Barnes Experiment".
Mr. Wills' work will be dealt with in detail in a later chapter.

(8) A complete bibliography of Aichhorn's publications is given at the end of "Searchlights on Delinquency" (London, 1949), a symposium dedicated to Aichhorn on the occasion of his seventieth birthday. K.R. Eissler, M.D., Ph.D., is the editor. This book could be included in a list of works concerned with Aichhorn, since, although it is concerned with the question of delinquency in general, rather than with an appraisal of Aichhorn's work, there are references made in several papers to the nature and extent of Aichhorn's contribution to the study of delinquency.

CHAPTER II. HOMER LANE

(1) Bazeley: op. cit.

(2) See Lane: op. cit.

(3) In spite of his references, mentioned below, to the unconscious motivation of delinquency.

(4) Lane: op. cit. p. 162.

(5) Ibid. p. 105.

(6) Ibid. p. 162.

(7) Ibid. p. 162

(8) Ibid. p. 162

(9) Ibid. p. 162.

(10) I visited two schools where self-government was used, in connection with which the question of self-government will be raised again.

The postulate of spontaneous recovery was only discussed at the two schools which did not employ self-government. Dr. Eysenck's views on this subject are obviously relevant, but, without entering into the controversy around them, which is only incidentally relevant to the present discussion, I must point out that his conclusions concerning the superfluous nature of psychoanalytical treatment cannot be held to apply to the work of schools of the kind under disoussion here: even if it were established that the children concerned would recover without treatment, there is still a need, pending such recovery, to provide suitable educational and other facilities for children whom parents or normal schools find it impossible to deal with.

(11) Bazeley. op. cit. p. 53

(12) All the cases quoted, except that of Jason, are to be found in Bazeley: op. cit.:-

James H - .	p. 47	et seq.
Ted	p. 52	et seq.
Margaret	p. 83	et seq.
Edmund	p. 109	et seq.
Annie	p. 114	et seq.
John	p. 126	et seq.

The case of Jason is reported in Lane: op. cit.:- pp. 162 et seq.

(13) Bazeley: op. cit. p. 59

CHAPTER III. AUGUST AICHHORN

(1) K.R. Eissler: Biographical Note to "Searchlights on Delinquency", London, 1949.

(2) Aichhorn, August: "Wayward Youth", Imago, London, 1951, p. 3.

(3) Ibid. p. 40.

(4) Ibid. p. 38.

(5) Ibid. p. 157.

(6) Ibid. "The Training School", p. 145 et seq.

(7) "In Aichhorn's hands, Freud's technique devised for the treatment of neurotics, seemingly became a new instrument, so much did it differ from the original." Eissler: op. cit. xiii.

(8) Aichhorn: op. cit. p. 4.

(9) Ibid. p. 63.

(10) This point was, of course, not entirely new. We have seen that Lane had already made a similar assertion; but Lane did not develop the point and the Little Commonwealth was apparently run on other lines.

(11) Aichhorn did not intend to push the parallel too far: c.f.: "... we should not assume that the whole aetiology of delinquency is the same as in the traumatic neurosis." (Aichhorn: op. cit. p. 47).

(12) Ibid. p. 46.

(13) Ibid. p. 38.

(14) Ibid. p. 38.

(15) Ibid. p. 39.

(16) Ibid. p. 35:- "Without psychoanalytical training the worker can not unearth the hidden factors."

(17) Ibid. p. 146.

(18) Ibid. p. 145.

(19) Ibid. p.

(20) Ibid. p. 148.

(21) Ibid. pp. 35 - 36:- "In the case of our boy, nothing could have been achieved by kind words or with punishment; either course would have aggravated his hate impulses."

(22) Ibid. p. 235.

(23) See, for example, the sections dealing with the various schools visited; also Bettelheim: "Love Is Not Enough", p. 28.

(24) Aichhorn: op. cit. p. 39.

(25) This view is, for example, implicit in the works of all psychoanalytic writers.

(26) Aichhorn: op. cit. p. 4.

(27) Ibid. pp. 41 - 49.

(28) Ibid. p. 157.

CHAPTER IV. BRUNO BETTELHEIM

(1) W.D. Wills' publications (v.s.) will be more appropriately considered in a later chapter, dealing with the work of his present school.

(2) Bettelheim, B.: "Love Is Not Enough": the treatment of emotionally disturbed children.
Glencoe Free Press, Illinois, 1950.

(3) Freud, S.: "Group Psychology and the Analysis of the Ego". "Beyond the Pleasure Principle". "The Ego and the Id".

(4) Freud, A.: "The Ego and the Mechanisms of Defence".
The Hogarth Press and the Institute of Psychoanalysis, 1954.

(5) Bettelheim: op. cit. p. 30.

(6) Ibid. p. 27.

(7) Ibid. p. 27.

(8) Ibid. pp. 25 et seq.

(9) Ibid. p. 26.

(10) Ibid. p. 25.

(11) Ibid. p. 26.

(12) Ibid. p. 26.

(13) Ibid. p. 36.

(14) Ibid. p. 28.

(15) Ibid. p. 28.

(16) Ibid. pp. 323 - 324.

(17) Ibid. p. 133.

(18) Ibid. p. 374 footnote
c.f. also p. 168: "Once the learning inhibition is overcome our problem is not that the children do not make enough progress...".

(19) Ibid. p. 169.

CHAPTER V. FRITZ REDL

(1) Fritz Redl and David Wineman: "Children Who Hate: The disorganisation and breakdown of behaviour controls". The Free Press, Glencoe, Illinois, 1951.

Fritz Redl and David Wineman: "Controls From Within: Techniques for the treatment of the aggressive child".

Further references to these works will use the name of Redl, the senior author.

(2) Redl: "Children Who Hate". p. 42.

(3) Ibid: pp. 45 - 48 "Criteria For Intake".

(4) Ibid: p. 34.
Also Redl: "Controls From Within": pp. 309 - 310.

(5) Redl: "Children Who Hate": p. 34.
"This closure coincided with .. our most visible period of consolidation of clinical gains."

(6) Ibid: p. 22.

(7) Ibid: p. 22.

(8) Ibid: p. 241.

(9) Ibid: p. 243.

(10) Ibid: p. 245.

(11) Ibid: p. 45.

(12) Redl: "Controls from Within": p.323.

(13) Redl: "Children Who Hate": p. 45.

(14) Ibid: p. 46.

(15) Ibid: p. 46.

(16) Ibid: p. 47.

(17) Ibid: p. 47.

(18) Ibid: p. 47.

(19) Ibid: p. 50.

(20) Ibid: p. 50.

(21) Ibid: p. 50.

(22) Ibid: p. 50.

(23) Ibid: p. 50.

(24) Ibid: p. 51.

(25) Ibid: p. 51.

(26) Ibid: p. 51.

(27) Ibid: p. 53.

(28) Ibid: p. 57.

(29) Ibid: p. 67.
"It seems that the "ego" has to cover quite a wide variety of functions. We think that a rebuilding of the whole personality "model" is long overdue."

(30) Ibid: p. 75.
This chapter is meant entirely on a descriptive level. All questions of just what may cause a specific disturbance are purposely excluded here.

(31) Ibid: p. 76.
"... each one of them can be disturbed in one and perfectly intact in another child."

(32) Ibid: p. 76.

(33) Ibid: p. 78.

(34) Ibid: p. 81.

(35) Ibid: p. 83.

(36) Ibid: p. 89.

(37) Ibid: p. 91.

(38) Ibid: p. 92.

(39) Ibid: p. 92.

(40) Ibid: p. 96.

(41) Ibid: p. 103.

(42) Ibid: p. 105.

(43) Ibid: p. 108.

(44) Ibid: p. 110.

(45) Ibid: p. 112.

(46) Ibid: p. 115.

(47) Ibid: p. 118.

(48) Ibid: p. 120.

(49) Ibid: p. 122.

(50) Ibid: p. 123.

(51) Ibid: p. 127.

(52) Ibid: p. 128.

(53) Ibid: p. 131.

(54) Ibid: p. 133.
"... psychologically speaking there is little justification for making this a separate item."

(55) Redl: "Controls From Within".

(56) Ibid: p. 310.

(57) Ibid: p. 310.

(58) This does not figure in the first list, and although Redl states that "we have stated in a number of places in this book as well as in "Children Who Hate", our children were extremely blocked in the whole field of word symbolization of feelings, conflicts, etc.", no reference to this is listed in the index of either book, and the present writer has been unable to trace any such reference in the texts. We may assume that this is a new point, which emerged at a fairly late stage in writing.

(59) Ibid: p. 310.

(60) Ibid: p. 310.

(61) Ibid: p. 311.

(62) Ibid: p. 311.

(63) Ibid: p. 312.

(64) Ibid: p. 312.

(65) The general tenor of Redl's views, with their stress on the study of the ego will be apparent from what has been said above. His contribution to the particular topic discussed here, however, is so lengthy that, in comparison with other authors, it has not, for reasons of brevity, been possible to give a complete or clear outline of all his views. In particular, no reference has been made to his theories of the "delinquent ego" and the "delinquent superego", which complicate the picture of "ego-weakness" given here. Redl believes that the concept of a "weak ego" is only applicable to certain fields of behaviour, while in delinquent behaviour the ego or superego can be regarded as functioning strongly and efficiently, even though its operation may be anti-social or abnormal.

CHAPTER VII. ST. FRANCIS' SCHOOL

(1) Information given in the visit to the school has been supplemented by written material, which was sent to me afterwards. I have quoted at various points in this section from an unpublished paper written by Father Owen, chiefly to be read by his staff. As quotations are made from a copy of this paper, which does not correspond in page numbering with the original, exact references to pages are not given. Quotations from this source will be marked O.

(2) It is interesting to note that the school stands on part of the land once occupied by Lane's Little Commonwealth.

(3) Some definition of the word delinquent appears to be necessary. It seems that its use is here confined to children who have appeared before a Court and have been found to be guilty of some offence, since delinquent behaviour is certainly not regarded as a disqualification for entering St. Francis' School.

(4) There are slight variations in this number from time to time - for example, 46 boys are listed in Table 3, which refers to 1st September, 1958.

(5) The statutory school leaving age for handicapped children is laid down as 16 by the School Health Service and Handicapped Children Regulations, 1953.

(6) The only exception to this is that the consultant psychiatrist of

the Local Education Authority visits the school three times each term, and sees a small number of children on each occasion, subsequently reporting to the school staff at a case conference.

(7) It is difficult to see how, in view of the Anglican High Church background of the school, this could be otherwise.

(8) St. Francis' School provided the following information about the recovery rate at the school:-

Of 119 boys who left the school for all reasons from 1947 - 1957, 14 are to be regarded as failures of the treatment, and 105 appear to be managing successfully, in that they are holding down jobs.

15 are married, but two have been divorced (these two are included, for other reasons, in the fourteen failures).

(9) John Bowlby: "Maternal Care and Mental Health." Report to W.H.O., W.H.O., Geneva, and H.M.S.O., 1951.

(10) Cf. Chap. X: "The Mulberry Bush School".

CHAPTER VIII. BODENHAM MANOR

(1) W.D. Wills. The Hawkspur Experiment. 1941.

(2) W.D. Wills. The Barns Experiment. 1945.

(3) The "responsible body" required by the Education Act, 1944.

(4) Wills. The Hawkspur Experiment. p. 137.

(5) Wills. The Barns Experiment. Chap. 5. "shared responsibilities".

(6) Ibid. p. 60.

(7) Ibid. pp. 22 - 23.

(8) W.D. Wills. "Eliminating punishment in the residential treatment of troublesome boys and young men" (1946) p. 18.

(9) Wills. The Hawkspur Experiment. p. 123.

(10) Ibid. p. 117.

(11) Ibid. p. 108.

(12) Ibid. p. 109 - 110.

(13) Wills. Eliminating punishment, etc. p. 28.

(14) Wills. The Barns Experiment. p. 65.

(15) Wills. The Hawkspur Experiment. p. 25.

(16) e.g. Case history in Wills Eliminating punishment etc. p. 32.

(17) Wills. The Barns Experiment. p. 27.

(18) Wills. The Hawkspur Experiment. p. 53.

(19) Ibid. p. 52.

(20) Wills. Eliminating Punishment etc. p. 32.

(21) Ibid. pp. 20 - 21.

(22) Wills. The Hawkspur Experiment. p. 96.

(23) Ibid. p. 56.

(24) Wills. The Barns Experiment. p. 92.

(25) Ibid. p. 92.

(26) Ibid. p. 103.
"They were all retarded educationally."
Also p. 107 et seq.

(27) Ibid. p. 116.

(28) Ibid. p. 116.

CHAPTER IX. RED HILL SCHOOL

(1) Report of the Committee on Maladjusted Children.

(2) L. Bloom: Some Aspects of the Residential Psychotherapy of Maladjusted or Delinquent Children. p. 43.
B.J. Del. 6 (July 55) 41.
Leonard Bloom was a psychologist on the staff of Red Hill School. Those of his papers which are used here are all concerned to some extent with his work there.

(3) Red Hill School: Report for the Year 1957. p. 2.

(4) Bloom: Some Aspects of Residential Psychotherapy etc. p. 44.

(5) D.H. Stott. Unsettled Children and their Families. p. 30.

(6) c.f. L. Bloom: "Aspects of the use of art in the treatment of maladjusted children". Mental Hygiene, 41, 3, July 57. p. 383.

(7) Red Hill School: Report for the Year 1957. p. 1.

(8) Ibid. p. 1.

(9) O.L. Shaw: "Underlying principles of self-government in schools". (unpublished) p. 3. (Page numbers refer to duplicated copies).

(10) Ibid. pp. 1 - 2.

(11) Ibid. p. 5.

(12) Ibid. p. 9.

(13) Bloom: Some Aspects of Residential Psychotherapy etc. p. 42.

(14) L. Bloom: "Psychological Aspects of self-government in the residential treatment of the delinquent child and adolescent". Mental Health, 16, (Autumn 56), 6.

(15) I do not necessarily use this word in any derogatory sense. I wish, rather, to indicate something more than merely "realistic". It might well be urged in support of the attitude referred to that it is at least free from the vice of sentimentalism which besets so much work in this field.

(16) This episode was related personally by the Principal during the visit to the school.

(17) c.f. Red Hill School: Report for the Year 1957. p. 1. Definition of the category "improved".

(18) Bloom: "Psychological Aspects of Self-government etc. " p. 14.

(19) Personal Communication.

(20) Bloom: "Some Aspects of Residential Psychotherapy etc." p. 43.

CHAPTER X. THE MULBERRY BUSH SCHOOL

(1) Aichhorn, however, did not actually make use of the term.

(2) Bowlby, J. Maternal Care and Child Health.
W.H.O., Geneva, 1951.

(3) c.f. Dockar-Drysdale, B.E. The residential treatment of "frozen" children.
B.J. Del. IX. 2.
p. 110 et seq. "Clinical Observations".

(4) Ibid. pp. 111, 112.

(5) Ibid. p. 111.

(6) Ibid. p. 112.

CHAPTER XIII. CRITERIA WHICH RELATE TO SYMPTOMS

(1) Aichhorn. "Wayward Youth". p. 39.

(2) Stott. "Unsettled Children and their families".

(3) Lane. (in various case histories reported in "Talks to Parents and Teachers".)

(4) Valentine. "The Normal Child".

(5) Redl. "Controls from within". p. 312.

CHAPTER XV. EGO DEVELOPMENT

(1) George, W.R.: The George Junior Republic: D.Appleton & Co.,1912.

(2) It will be remembered that three out of the eight sources considered here made use of the concept of deficiencies in ego development.

(3) Cf. Redl: "Children who hate": ch. V.

(4) Freud, S.: The Ego and the Id.: p. 15.

(5) Ibid: pp. 29 - 30.

(6) Flugel, J.C.: Man, Morals & Society: p. 43.

(7) c.f. Freud, S.: op. cit.: p. 17.

(8) Freud, A.: The Ego and the Mechanisms of Defence.

(9) Winnicott, D.W.: Collected Papers: see esp. chaps. XIII, XVII, XVIII, XIX, XXI.

CHAPTER XVI. CRITERIA RELATING TO EMOTIONAL RELATIONSHIPS

(1) O'Gorman, G.: The schizophrenic child.
Times Educational Supplement, 8th July, 1960.
pp. 48 - 49.

CHAPTER XVII. OTHER CRITERIA

(1) Burt & Howard: "The Nature & Causes of Maladjustment in School Children".

(2) See above: Chapter V.

(3) Mr. D.H. Hamblin, Teacher-in-charge of the West Ham Remedial Education Centre, (a personal communication, based on his work at the Centre.) Many of the children dealt with there are deemed maladjusted. Material which supports the views reported here is in process of preparation with a view to publication.

(4) Some confirmation of this view is to be found in:-
Kellmer Pringle, M.L., & Sutcliffe, B.,: Remedial Education - An Experiment.
Caldecott Community and Department of Child Study, University of Birmingham Institute of Education, 1960.

(5) e.g. Ahlschuler, R.H. & Hattwick. La B.W. Painting & Personality: University of Chicago Press, 1947.

(6) e.g. Bettelheim, B., Love Is Not Enough; p. 75.

APPENDIX I

Appendix I. Criteria of recovery of 30 consecutive leavers from a boarding special school for maladjusted children.

	TOT	RC	$\bar{R}C$	$R\bar{C}$	$\bar{R}\bar{C}$	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
							Pu		U																			UP.								
Recovered (R)								R			RRR		R		RRRR			R	RRRR				R	RRRR			RRRRRRR							
Not recovered (I or F)						I	F	F	F			I		I				I									I								
Sex						B	B	G	G	B	B	B	B	B	B	G	B	G	G	B	G		B	B	B	B	B	B	G	G	B	G	G	B	B	R
IQ						113	109	125	105	82	150	115	93	96	84	124	120	108	102	106	100		120	90	133	110	102	83	80	92	127	104	124	106	120
Age on admission						9	7	7	10	10	8	10	9	7	9	7	8	9	7	9	10	8	11	8	7	8	9	10	10	10	8	9	8	6	8	10
Age on discharge						12	8	7	12	10	11	12	14	12	10	13	10	13	10	12	13	12	13	11	13	13	9	10	12	11	12	10	11	12	13
Disappearance of referal symptoms	16	2	5	7		1	0	0	1	0	0	1	0	1	0	1	0	1	1	1	1	0	1	1	1	0	1	1	1	0	0	1	1	1	0
Dº on arrival	10	2	11	7		0	0	0	1	0	0	1	1	0	1	1	0	1	0	0	1	0	1	0	0	0	0	1	1	1	0	0	1	0	0
Diminution of Dº	16	2	5	7		0	0	0	1	0	0	1	1	0	0	1	0	1	1	1	1	1	1	0	0	0	1	0	1	1	1	1	1	1	1
Reduction of frequency and intensity of Dº	17	4	4	5		1	0	0	1	0	0	0	1	1	1	1	1	1	1	0	0	1	1	0	1	0	1	1	1	1	1	1	1	1	1
Less extreme behaviour	18	3	3	6		1	0	0	1	1	0	0	1	1	1	1	1	1	1	0	1	1	1	0	0	0	1	1	1	0	0	0	0	0	1
Shorter duration of delusional attacks	12	4	9	5		1	0	0	1	1	1	0	1	1	1	1	1	0	1	1	1	0	0	0	1	1	0	0	0	0	1	1	0	0	0	1
Toleration of rules etc.	17	2	4	7		1	0	0	1	0	0	1	0	0	0	1	0	1	1	1	1	1	1	1	1	0	0	1	1	0	1	1	1	1	1
Socially acceptable behaviour.	18	5	3	4		1	1	0	1	0	0	1	1	1	1	1	1	1	1	1	1	1	0	1	1	0	0	1	0	1	1	1	1	1	1
Responsibilities, jobs etc.	13	1	8	8		0	0	0	1	0	0	0	0	0	0	1	1	0	1	0	0	1	0	1	1	0	0	0	1	0	1	1	1	1	1
Domestic routine.	19	6	2	3		1	1	1	1	0	1	1	0	0	1	1	0	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1
Assessing social situations	13	4	8	5		1	1	0	0	0	0	1	1	1	1	0	1	1	0	1	1	0	1	0	1	1	0	0	0	0	0	1	1	1	1
Successful holidays at home.	13	3	8	6		0	0	0	1	0	1	0	1	0	1	1	1	0	1	1	1	0	0	1	1	0	0	1	0	1	0	0	1	1	1
Superego	16	2	5	7		0	0	0	1	0	0	1	1	1	0	1	1	1	0	1	1	1	1	0	1	0	0	0	0	1	1	1	1	1	1
Ego -	18	1	3	8		0	0	0	1	0	0	1	1	1	0	1	1	1	1	1	1	1	1	1	0	0	0	0	1	1	1	1	1	1	1
Frustration tolerance	19	3	2	6		0	0	0	1	1	0	1	1	1	1	0	1	1	1	1	1	1	1	1	0	0	0	1	0	1	1	1	1	1	1
Coping with insecurity anxiety, fear.	18	4	3	5		0	0	0	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	0	1	0	1	0	1	0	1	1
Temptation resistance.	14	3	7	6		0	0	0	1	0	1	0	1	0	1	0	1	1	0	1	1	0	0	1	1	0	0	0	1	0	1	1	1	1	1
Resistance to group excitement	11	2	10	7		0	0	0	1	1	0	1	1	0	0	1	0	1	0	1	0	0	0	0	1	0	0	0	0	1	1	1	1	1	1
Sublimation of unacceptable impulses.	14	1	7	8		0	0	0	1	0	0	1	1	0	1	1	0	1	0	0	0	1	1	1	0	0	0	0	0	1	1	1	1	1	1
Care of toys & other possessions.	15	2	6	7		0	0	0	1	1	0	1	1	1	1	1	1	1	0	1	1	1	1	1	0	0	0	1	0	1	1	0	0	1	1
Decrease in life areas where loss of control occurs.	19	2	2	7		1	0	0	1	1	0	1	1	1	1	1	0	1	1	1	1	1	0	0	0	1	1	1	1	1	1	1	1	1	1
Ability to experience guilt without denial.	14	1	7	8		1	0	0	1	1	0	0	1	0	0	0	0	1	0	1	1	0	1	0	0	1	1	1	1	1	1	1	1	0	1
Ability to see & admit own contribution to causal chain.	11	1	10	8		0	0	0	0	0	0	1	1	1	0	0	0	1	1	0	1	0	0	0	0	1	0	1	0	1	0	0	1	1	1
Less dependent on adult	10	3	11	6		1	0	0	1	1	0	0	0	1	0	0	0	1	1	1	0	1	0	0	0	1	0	0	1	0	0	1	0	1	1	0
Acceptance of gratification offers.	20	7	1	2		1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1
Retention and use of image of past pleasure.	18	6	3	3		1	0	0	1	1	1	1	1	1	1	0	0	1	1	1	1	1	1	0	1	1	0	1	1	1	1	1	1	1	1	1
Valid inferences from own or others experience	14	0	7	9		0	0	0	1	0	0	1	0	1	0	0	0	1	1	1	0	1	0	0	1	0	0	1	0	1	1	1	1	1	1	1
Experiences failure } without extreme	13	4	8	5		0	0	0	0	0	0	1	0	1	0	1	1	0	1	1	1	1	0	1	1	1	1	1	0	0	1	1	0	0	1
Experiences success } rection.	13	4	8	5		0	0	0	1	0	1	0	0	0	0	1	1	1	1	1	1	1	0	1	1	1	1	0	0	1	1	1	0	0	1
Transference.	10	2	11	7		1	0	0	1	0	0	1	1	0	0	0	1	1	0	0	1	0	1	0	0	0	0	0	1	0	1	1	1	1	1
Any other emotional relationship	19	5	2	4		1	0	0	1	0	1	0	1	1	0	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1
Diminished suspicion of adults	19	6	2	3		1	0	0	1	0	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	0	1	1	1	1	1	1	1	1
Increased ability to take affection	17	6	4	3		1	1	1	1	0	1	1	1	1	1	1	0	0	1	1	1	1	1	0	0	1	1	1	1	1	1	1	1	1	1	0
Extreme dependence on adult	12	4	9	5		1	1	1	0	0	0	0	1	0	0	1	1	1	0	1	0	1	1	1	0	0	0	0	0	1	1	1	0	1	0	1
Absence of adult causes anxiety	10	3	11	6		1	0	0	0	0	1	0	1	0	0	1	1	1	0	0	1	0	1	0	0	0	0	0	0	0	0	1	1	1	1	1
Depressed phase	14	3	7	6		0	0	0	1	0	0	0	1	1	0	1	1	1	1	1	1	0	1	1	0	0	1	0	0	1	0	1	1	1	1	1
Increased educational attainment	14	0	7	9		0	0	0	0	0	0	1	1	0	0	0	0	1	1	1	0	1	1	0	1	0	0	1	0	0	1	0	0	1	1	1
More positive attitude to school	16	1	5	8		0	0	0	1	0	0	1	0	0	0	1	1	1	1	1	1	0	1	1	0	0	0	1	1	1	0	1	1	0	1	1
Sustained interests.	10	1	11	8		0	0	0	0	0	0	1	0	1	1	0	1	1	1	0	1	0	0	1	0	0	0	0	1	1	1	0	0	1	1	1
Interpretation of content of art.	9	2	12	7		0	0	0	0	0	1	1	1	0	0	1	1	0	0	0	0	0	1	0	1	1	1	0	0	0	1	0	0	1	0	1
More mature style of paintings	9	2	12	7		0	0	0	0	0	0	1	0	1	1	1	1	0	0	1	0	1	0	1	0	0	0	0	0	0	1	0	0	1	0	1
More wholesome content of paintings.	11	3	10	6		0	1	0	0	0	0	1	0	1	1	0	1	0	0	1	1	1	0	1	0	0	0	0	1	1	0	0	1	1	0	1
Care over personal appearance.	17	4	4	5		1	0	0	1	0	0	0	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	0	1	0	1	1	1	1	1	1
Improved time concept.	14	4	7	5		1	0	0	1	0	0	1	1	1	0	1	0	0	1	1	1	1	0	1	1	0	0	1	0	1	0	1	0	1	1	1
Increased ability for verbal communication	15	3	6	6		1	0	0	1	1	0	0	1	0	1	0	1	1	0	1	0	1	0	1	0	0	0	0	1	1	1	1	1	1	1	1
Increased ability to use symbols	7	0	14	9		0	0	0	1	0	0	0	1	0	0	0	0	0	0	1	0	1	0	1	0	0	0	0	1	0	0	1	0	0	1	0
[illegible] forms of behaviour	14	1	7	8		0	0	0	0	0	0	1	1	0	1	1	1	1	1	1	0	1	0	0	0	1	1	0	0	0	1	0	0	0	1	1
[illegible]ence of sense of humour	12	4	9	5		0	0	0	0	0	0	1	1	0	1	1	1	1	0	0	1	1	0	1	0	1	0	1	0	1	0	1	0	1	0	1
[illegible]atic vocational choice	4	0	17	9		0	0	0	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1	0	0	0	0	1
Any emotional relationship.	20	5	1	4		1	0	0	1	1	0	1	1	1	1	1	1	1	1	1	1	1	1	1	1	0	1	1	1	1	1	1	1	1	1	1
Totals of all criteria for each child :-						23	7	3	37	6	13	6	0	3	7	2	8	16	3	9	2	9	6	2	3	5	3	9	2	7	4	2	8	2	9	5	2	4	2	3	0	2	3	5	2	3	4	3	6	3	9	4	6
Totals of criteria significant at 5% or 1% level :-						0	0	0	15	1	1	6	1	2	1	0	2	1	5	8	1	6	1	5	1	4	1	4	7	1	7	1	4	8	1	2	0	5	1	2	9	1	2	1	2	1	4	1	4	1	6
						2	0	0	6	1	0	7	4	4	1	5	2	7	7	7	7	3	7	6	4	6	0	0	6	3	4	6	7	7	7

P - Prematurely withdrawn, against advice of school and clinic.
U - Unsuitable for treatment at school, withdrawn at school's request.
R - Recovered.
I - Improved, but not fully recovered.
F - 'Failure' - treatment unsuccessful.
C - Criterion observed and reported - in body of table scored as 1.
O - In body of table * criterion not reported.

APPENDIX II

Disappearance of referral symptoms

	C	$\overline{C}$	
R	16	5	21
$\overline{R}$	2	7	9
	18	12	30

$\tau = .50$; $a = 2.2$; sig. at .05 level

Disappearance of 'arrival symptoms.'

	C	$\overline{C}$	
R	10	11	21
$\overline{R}$	2	7	9
	12	18	30

$\tau = .47$; $a = .88$; not signif.

Diminution of symptoms.

	C	$\bar{C}$	
R	16	5	21
$\bar{R}$	2	7	9
	18	12	30

τ = .50 ; a = 2.2 ; sig. at .05 level.

Reduction of frequency & intensity of symptoms.

	C	$\bar{C}$	
R	17	4	21
$\bar{R}$	4	5	9
	21	9	30

τ = .37 ; a = 1.54 ; not significant.

Less extreme behaviour

	C	$\overline{C}$	
R	18	3	21
$\overline{R}$	3	6	9
	21	9	30

$\tau = .52$; $a = 2.4$; sig. at .05 level.

Shorter duration of delusional attacks

	C	$\overline{C}$	
R	12	9	21
$\overline{R}$	4	5	9
	16	14	30

$\tau = .12$; $a = .24$; not signif.

Toleration of rules etc.

	C	$\bar{C}$	
R	17	4	21
$\bar{R}$	2	7	9
	19	11	30

$\tau = .51$; $a = 2.59$; sig. at .01 level

Socially acceptable behaviour

	C	$\bar{C}$	
R	18	3	21
$\bar{R}$	5	4	9
	23	7	30

$\tau = .33$; $a = 1.3$; not signif.

Accepting responsibility, taking jobs etc.

	C	$\bar{C}$	
R	13	8	21
$\bar{R}$	1	8	9
	14	16	30

$\tau = .47$; $a = 2.12$; sig at .05 level

Accepting domestic routine.

	C	$\bar{C}$	
R	19	2	21
$\bar{R}$	6	3	9
	25	5	30

$\tau = .29$; $a = 1.05$; not signif.

Assessing social situations.

	C	$\bar{C}$	
R	13	8	21
$\bar{R}$	4	5	9
	17	13	30

$\tau = .16$; $a = .47$; not signif.

Successful holidays at home.

	C	$\bar{C}$	
R	13	8	21
$\bar{R}$	3	6	9
	16	14	30

$\tau = .26$; $a = 1.03$; not signif.

Superego development.

	C	$\bar{C}$	
R	16	5	21
$\bar{R}$	2	7	9
	18	12	30

$\tau = .50$; $a = 2.2$; signifat .05 level.

Ego development

	C	$\bar{C}$	
R	18	3	21
$\bar{R}$	1	8	9
	19	11	30

$\tau = .71$; $a = 3.45$; Sig. at .01 level.

Frustration tolerance.

	C	$\bar{C}$	
R	19	2	21
$\bar{R}$	3	6	9
	22	8	30

$\tau = .59$; $a = 2.74$; sig. at .01 level.

Coping with insecurity anxiety and fear.

	C	$\bar{C}$	
R	18	3	21
$\bar{R}$	4	5	9
	22	8	30

$\tau = .43$; $a = 1.86$; not signif.

Temptation resistance

	C	$\bar{C}$	
R	14	7	21
$\bar{R}$	3	6	9
	17	13	30

$\tau = .31$; $a = 1.26$; not signif.

Resistance to group excitement

	C	$\bar{C}$	
R	11	10	21
$\bar{R}$	2	7	9
	13	17	30

$\tau = .28$; $a = 1.11$; not signif.

Sublimation of unacceptable impulses.

	C	$\bar{C}$	
R	14	7	21
$\bar{R}$	1	8	9
	15	15	30

$\tau = .51$; $a = 2.35$; signif at .05 level.

Care of toys and other possessions.

	C	$\bar{C}$	
R	15	6	21
$\bar{R}$	2	7	9
	17	13	30

$\tau = .46$; $a = 2.05$; signif at .05 level

Decrease in 'life areas' where loss of control occurs.

	C	$\overline{C}$	
R	19	2	21
$\overline{R}$	2	7	9
	21	9	30

$\tau = .68$; $a = 3.26$; signif. at .01 level.

Ability to experience guilt without denial

	C	$\overline{C}$	
R	14	7	21
$\overline{R}$	1	8	9
	15	15	30

$\tau = .51$; $a = 2.35$; signif. at .05 level.

Ability to see and admit own contribution to causal chain

	C	$\bar{C}$	
R	11	10	21
$\bar{R}$	1	8	9
	12	18	30

$\tau = .39$; $a = 1.68$; not signif.

Less dependent on adult support

	C	$\bar{C}$	
R	10	11	21
$\bar{R}$	3	6	9
	13	17	30

$\tau = .13$; $a = .32$; not signif.

Acceptance of gratification offers

	C	$\bar{C}$	
R	20	1	21
$\bar{R}$	7	2	9
	27	3	30

τ = ·27 ; a = ·79 ; not signif.

Retention and use of image of past pleasurable experiences.

	C	$\bar{C}$	
R	18	3	21
$\bar{R}$	6	3	9
	24	6	30

τ = ·22 ; a = ·69 not signif.

Valid inferences from own or others' experiences

	C	$\bar{C}$	
R	14	7	21
$\bar{R}$	0	9	9
	14	16	30

$\tau = .61$; $a = 2.89$; signif at .01 level.

Experiences failure without extreme reaction

	C	$\bar{C}$	
R	13	8	21
$\bar{R}$	4	5	9
	17	13	30

$\tau = .16$; $a = .47$; not signif.

Experiences Success without extreme reaction.

	C	$\bar{C}$	
R	13	8	21
$\bar{R}$	4	5	9
	17	13	30

$\tau = .16$; $a = .47$; not signif.

Transference.

	C	$\bar{C}$	
R	10	11	21
$\bar{R}$	2	7	9
	12	18	30

$\tau = .47$; $a = .88$; not signif.

Other emotional relationships.

	C	$\bar{C}$	
R	19	2	21
$\bar{R}$	5	4	9
	24	6	30

$\tau = .40$; $a = 1.67$; not signif.

Diminished suspicion of adults.

	C	$\bar{C}$	
R	19	2	21
$\bar{R}$	6	3	9
	25	5	30

$\tau = .29$; $a = 1.05$; not signif.

Ability to take affection.

	C	$\bar{C}$	
R	17	4	21
$\bar{R}$	6	3	9
	23	7	30

$\tau = .16$; $a = .37$; not signif.

Extreme dependence on adult

	C	$\bar{C}$	
R	12	9	21
$\bar{R}$	4	5	9
	16	14	30

$\tau = .12$; $a = .24$; not signif.

Absence of adult causes anxiety.

	C	$\bar{C}$	
R	10	11	21
$\bar{R}$	3	6	9
	13	17	30

$\tau = \cdot 13$; $a = \cdot 32$; not signif.

Depressed phase.

	C	$\bar{C}$	
R	14	7	21
$\bar{R}$	3	6	9
	17	13	30

$\tau = \cdot 31$; $a = 1 \cdot 26$; not signif.

Increased educational attainment.

	C	$\bar{C}$	
R	14	7	21
$\bar{R}$	0	9	9
	14	16	30

$\tau = .61$; $a = 2.89$; signif. at .01 level.

More positive attitude to school work.

	C	$\bar{C}$	
R	16	5	21
$\bar{R}$	1	8	9
	17	13	30

$\tau = .60$; $a = 2.84$; signif. at .01 level.

Sustained interests

	C	$\bar{C}$	
R	10	11	21
$\bar{R}$	1	8	9
	11	19	30

$\tau = .30$; $a = 1.46$; not signif.

Interpretation of content of art

	C	$\bar{C}$	
R	9	12	21
$\bar{R}$	2	7	9
	11	19	30

$\tau = .20$; $a = .66$; not signif.

More mature style of painting

	C	$\bar{C}$	
R	9	12	21
$\bar{R}$	2	7	9
	11	19	30

$\tau = .20$; $a = .66$; not signif.

More wholesome content of paintings

	C	$\bar{C}$	
R	11	10	21
$\bar{R}$	3	6	9
	14	16	30

$\tau = .18$; $a = .55$; not signif.

Care over personal appearance

	C	$\bar{C}$	
R	17	4	21
$\bar{R}$	4	5	9
	21	9	30

$r = .37$; $a = 1.54$; not signif.

Improved time concept

	C	$\bar{C}$	
R	14	7	21
$\bar{R}$	4	5	9
	18	12	30

$r = .21$; $a = .73$; not signif.

Increased ability for verbal communication

	C	$\bar{C}$	
R	15	6	21
$\bar{R}$	3	6	9
	18	12	30

$\tau = .36$; $a = 1.54$ not signif.

Increased ability to use symbols

	C	$\bar{C}$	
R	7	14	21
$\bar{R}$	0	9	9
	7	23	30

$\tau = .36$; $a = 1.48$; not signif.

New forms of behaviour.

	C	$\bar{C}$	
R	14	7	21
$\bar{R}$	1	8	9
	15	15	30

$\tau = .51$; $q = 2.35$; signif. at .05 level.

Sense of humour

	C	$\bar{C}$	
R	12	9	21
$\bar{R}$	4	5	9
	16	14	30

$\tau = .12$; $q = .24$; not signif.

Realistic Vocational Choice.

	C	$\bar{C}$	
R	4	17	21
$\bar{R}$	0	9	9
	4	26	30

$\tau = .26$; $a = .81$; not signif.

Additional table for presence of any emotional relationship, formed by combination of figures for transference and other relationships

	C	$\bar{C}$	
R	20	1	21
$\bar{R}$	5	4	9
	25	5	30

$\tau = .49$; $a = 2.11$; sig. at .05 level.

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