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A Psychiatric Approach To School Achievement

As teachers become aware of the varied causes of poor school achievement, and the serious problem it may pose, they are turning more and more for consultation to professions such as child psychiatry. Psychiatrists who work with seriously disturbed children are also coming to recognize that those who regulate the child's learning experience are important partners in their efforts to help the child. Furthermore, improved medical management has led to an increased survival of multiply-handicapped children and the public school system has been expanding its programs for groups such as the mildly retarded, hard of hearing, poor sighted, emotionally disturbed, reading disordered, and aphasic. As a result, teachers are turning to hospital-based facilities for help with these children.

Society is also delegating to the schools an increased total concern for the child. Instead of merely stimulating his brain, the schools are now expected to nourish the whole child, his feelings as well as his intellect. The increasingly complex nature of our society also imposes on the schools greater scholastic demands, so that there are now many "normal" children who are failing to cope with the regular curriculum. Some of the implications and repercussions of school failure are examined in the following pages.

Without an adequate understanding of the factors which contribute to a child's poor school performance, one can take remedial measures only on a hit or miss basis. An adequate understanding of the child's problems may involve several aspects including: (1) the primary aetiology; (2) the cultural pressures, which influence the ways both child and family react to the child's learning difficulties; (3) the educational diagnosis which involves the formulation of

a clinical hypothesis, which in turn, leads directly to remediation.

THE AETIOLOGY OF POOR SCHOOL ACHIEVEMENT

When one assesses a poor school achiever, one needs to delineate the interaction of multiple factors which operate at different levels and may have operated over different time intervals. These can be arranged along a spectrum. At one end are environmental causes. These may be expressed in general cultural terms, such as deprivation, or they may be expressed in terms of individual psycho-pathology, for example emotional deprivation or learning inhibitions, which are neurotic in origin. The other end of the spectrum comprises cases with obvious brain damage, and those who are poorly endowed genetically. The presence of brain damage does not imply that psychological or environmental factors are not important. In fact, brain damage is likely to have psychological repercussions, which accentuate the difficulties of the child. For example, emotional deprivation and brain damage are viewed as distinct entities. Yet, when both conditions are present, their effect may be far more serious than when either is present alone.[21]

Although genetic factors may be important in some cases[12], the aetiology of many cases of specific reading disability[6] and minimal brain dysfunction[4] remains obscure. One author argues that almost all children who have trouble learning to read, have neurological difficulties[1]; yet some psychoanalysts emphasize emotional aetiological factors almost exclusively.

The aetiology of poor school performance may be emotional in origin, but problems in learning are also a potent cause of psychological disturbance. This view was supported by Gates[9] who concluded that 75% of children with severe reading disabilities also had emotional problems, but the emotional problems were the primary cause in only 25% of the cases.

The schizophrenic child may be caught up in his own phantasy and self-absorption, leaving little energy for learning. Deficiencies in perception and conceptualization are very common in children of this type.[10]

Primary Psychogenic Factors in Poor School Achievement

Although the ability to work is a criterion of emotional health, there is no simple connection between emotional disorder and school performance. Children who have severe emotional disturbance will frequently be successful scholastically. Conversely, children with relatively minor emotional problems may be appreciably handicapped. The initial problem may be unrelated to school — a child

mourning the loss of a parent may have less energy available for learning; or the learning difficulty may be directly related to the nature and level of the school work or to the meaning of the learning situation.

The most well-known reference to the psychogenic intellectual malfunctioning is Freud's *Psychopathology of Everyday Life*[8], in which are described the dynamics involved in ordinary mistakes in reading, writing, speech and forgetting. Many other works have been concerned primarily with an elaboration of the content of the phantasies and the dynamics found to play a significant role in children with learning disorders.[2]

Learning disabilities have been related to a child's being required to inhibit his curiosity about pregnancy, death and the difference between the sexes. For this inhibited child, looking is dangerous, reading is prohibited, and knowing is forbidden.[16] Reading disorders in specific cases[13] have been described as originating from an effort to solve guilt conflicts. The symptom affords disguised expression for repressed instinctive drives but, at the same time, relieves anxiety and guilt about those drives through the self-punishment of illness or punishment from others. The learning difficulty may be ascribed in more general terms to a fear of growing up. The passive-aggressive child will often appear as a poor achiever. By passively refusing to do what is expected of him, he is expressing his underlying hostility against those who wish to see him do well.

There has recently been more focus on the role of the parents in the aetiology of learning problems. For example, the child's fear of growing up may be fostered by mothers who promote a "symbiotic tie" and this fear may express itself in the form of learning difficulties.[3] There may also be an unconscious acceptance by the son of a role that will not challenge his father[7]. Because the child is afraid to succeed, he will not achieve promotion.

In some instances, a child's poor performance at school will be the expression of a family need. Some mothers find it necessary to keep a child passive and stupid.[14] In one study[11], a significantly greater hostility, greater punitiveness and less affectionate warmth in the father-son relationship was found for the "learning inhibition" boys than in a control group. Further, in the "learning inhibition" pairs, the father has a negative evaluation of his wife, but an even lower evaluation of his own worth. The author concludes that the occurrence of the emotionally based "learning inhibition" is related to specific inadequacies in the parental role at a crucial stage in the child's development.

As mentioned previously, it may be difficult to determine to

what extent emotional factors contribute to learning difficulties. This is illustrated by some, [17, 15] who argue that cases described by other authors as being neurotic in origin could be explained as manifestations of constitutionally based problems such as a developmental aphasia. The same kind of general criticism could be levelled against those family studies which attribute learning difficulties to a disturbance in the father-son relationship. For example, the relationship distortion may have been caused by the child's learning disabilities rather than vice versa. The presence of a severe learning difficulty in the child may produce a serious strain on the family equilibrium and this may have profound repercussions on the parent-child relationships and on the parents' self-esteem.

SECONDARY PSYCHOLOGICAL REACTIONS

The nature of the reactions of both parents and child to the latter's difficulty at school has a significant influence on the child's developing sense of identity. For example, the parents may, by their reactions, convey to the child the feeling that a minor setback is a major tragedy.

Because retarded children, and children with learning problems, tend to suffer frequent failure, they are apt to be denied the reward that comes with success. These children may try to protect themselves from further distress by avoiding situations which carry with them the possibility of failure.[5] For this reason they may give an unduly poor account of themselves in a test situation or in a competitive classroom setting. Their avoidance of challenge will further handicap their learning.

Secondary Reactions in the Family

It is natural for parents to see their children, to some degree, as extensions of themselves. Parents' capacity to produce a healthy, normal offspring is psychologically and culturally important for their sense of personal adequacy. If parents produce an obviously defective or handicapped child, all their inner doubts about themselves will be reinforced, and will be projected onto the child. This threat to the parents' inner sense of integrity and identity arouses tremendous anxieties and parents try to protect themselves in any way they can. The dominant cultural pattern, which over-values intelligence, will increase the impact on the family of a child's retardation or school failure and contribute towards the stigma which is associated with retardation. In our culture, despite an increasingly liberal and sympathetic awareness, parents perceive a child's retardation as a major tragedy. They may develop feelings of worth-

lessness which, when projected onto the child, serve to compound his problem.[20]

Parents may be anticipating a child's university career, from the time he is a year or two old, and any school difficulty may be perceived by them as a tremendous threat. There are, of course, many individual factors. For example, the more insecure the parents and the more lacking they are in a feeling of positive identity, the greater will be the threat to their personalities in having a child who is failing at school. In working class families the pressure may not be intense. On the other hand, when parents are university educated and the siblings are bright, a child of only average intelligence may feel intellectually inadequate. The retarded child will generally be better accepted in a rural community than in an urban one.

Parents may try to deal with their grief or depression over a child's performance by the use of denial. They may deny the reality of a child's difficulty and insist that the child is not making an effort and they may push the child to try harder. This brings to mind the case of the parents who brought their eleven year old son to see the psychiatrist because he was doing poorly at school. There was a history of repeated school failure and each time the boy failed a year, he was taken out of his school by the parents and placed in a different private school. The parents told the psychiatrist that their boy was intelligent, but his problem was that he was too lazy to work. On testing, it was apparent that the boy was retarded and the impression was gained that far from being lazy, he had, in fact, been trying very hard to cope with his schoolwork. This was an only child and the mother, who was a basically unhappy woman, unconsciously made the boy a focus for her personal dissatisfactions and was therefore enormously ambitious for him to succeed. When her son failed, she could not accept his limitations and preferred to believe that his problem was simply one of laziness. The whole family had adopted the premise that it was better to be lazy than stupid. This included the boy himself, because he too was emphatic that his problem was that he was just lazy. By deceiving themselves, members of the family were not only postponing the inevitable disappointment, but were making it more difficult for the boy to make a realistic adjustment. They reacted to this psychiatrist as they had done to others — by ignoring his advice and placing the boy in yet another private school.

Secondary Reactions in the Classroom

In the past, there was a tendency for the child who was doing poorly at school, to be held up as a bad example to the rest of the

class. This child was forced to play the scapegoat role. Nowadays, we are more achievement oriented and more sophisticated and the teacher will often feel that, if the child is not doing well in class, it is a sign of her failure as a teacher. This may affect the teacher's relationship with the individual child. In a special class, where the children progress at a slower pace, the teacher cannot obtain the usual satisfaction associated with her investment of time and effort. She may come to feel that the children's poor progress is a reflection of her own incompetence.

As both teacher and parents may react to the child's failure to progress with feelings of discouragement, they may end up projecting their guilt and blame each other. The parents accuse the teacher of not being able to teach and the teacher accuses the parents of not facing up to their responsibilities.

THE ROLE OF THE PSYCHIATRIST

In the past, the child psychiatrist's main area of interest was usually the practice of individual psychotherapy. There is now more emphasis on the team approach and in serious school problems the teacher should generally be included in the team. However, in contemporary practice some clinicians of two schools of thought — namely, psychoanalysts and behaviour therapists — are not always in tune with the needs of teachers. For example, Morse states

> Those fixated on the inner nature, paid so little attention to the day-by-day difficulties of developing actual behaviour changes in these children that they are in danger of becoming prophets speaking mainly to each other. Well adjusted academic failures have no place. In their stead have come those who would lead us around by the nose of symptoms as if nothing else were germane. Even a long nose is not half a child.[19]

As Morse infers, the psychiatrist can make a meaningful contribution by evaluating the problems which confront the teacher in relation to the whole child (including his emotional needs and learning abilities).

A psychiatric appraisal includes an evaluation of the child's development from a longitudinal and cross-sectional point of view. The child's interaction with his own family, peers and adults, and his behaviour in learning situations are assessed. The psychiatrist's training as a physician is relevant in the evaluation of the child's physical health and possible neurological dysfunction.[22]

Multidisciplinary Evaluation in a School Setting

A section of the outpatient clinic of the Department of Psychiatry of The Montreal Children's Hospital specializes in the diagnosis and management of problems of retardation and poor school achievement. About six years ago the clinic was asked to aid in the setting up of special classes in one school. This provided the initial impetus for what has since become a regular practice, with the clinic travelling out several times a year for the purpose of visiting various outlying school systems. The team consists of a psychiatrist, psychologists, social workers, a pediatrician and a specialized teacher who works in the hospital.

The organization of these visits posed various problems. As the number of children who could be seen by the clinic was limited, the school and clinic had to establish priorities. Another difficulty was that, as the number of disciplines represented in the clinic increased, the question of assigning cases became more complex. It was recognized that, although a standard multi-disciplinary evaluation would ensure completeness, it would be time-consuming while a flexible procedure could lead to a more productive and economical use of the clinicians' time. For this reason, pre-assessment meetings were arranged. These were attended by members of the clinic and representatives from the schools. During the course of these meetings, the roles of the various team members were interpreted and assignments of cases made. In some circumstances, arrangements were made for a social worker to visit a child's home. By discussing the cases on an individual basis, it was possible to cut down on the number of children requiring assessment. At times, it was decided that the assessment could be more appropriately carried out in a more clinical setting.

In a typical visit, the team member would be given the child's school records and a questionnaire, which had been filled out by the teacher, and before the child was seen, his case would be discussed with a member of the teaching staff. After the child and his parents had been assessed, the child might be referred to another team member. On completion of the interviews, the team members would meet with the teaching staff, generally the principal, guidance consultant and teacher. In these meetings, a specific plan and general principles of management would be worked out. The psychiatrist might recommend the child be placed in a regular class with a competent teacher or be assigned to a special class. The teacher, too, would contribute her ideas for treating the special difficulties involved. After the meeting, the clinic member would inform the

parents about the plan. In cases where parents had been using well meant but inappropriate measures, the psychiatrist might set out new guidelines.

The psychiatrist should be able to play an integrative role in the team, evaluating where intervention is likely to be fruitful and considering this in relation to available resources. In some cases, there may be a serious family problem, but the parents may be unwilling or unable to use help. The psychiatrist may be able to assist the school to modify its goals accordingly. He has a number of techniques at his disposal, including psychoterapy and consultation with the teacher. He may prescribe in order to improve the child's problem of impulse control or hyperactivity.

The Psychiatrist and the Family

An individually tailored curriculum and appropriate grouping may be crucial in giving the child the opportunity to achieve. A remedial program especially designed for a child with a learning problem may enable both parents and teachers to recognize the child's limitations and assets. This may also make the child feel that at last people are able to understand his difficulties. Because the parents or teachers are able to channel their energies into a positive, structured program, they may feel less impotent and frustrated and therefore more adequate in their roles. Psychotherapy and remedial help should not be considered as mutually exclusive. Parents may also react negatively to progress in the child. For example, when the child responds to treatment for a learning difficulty, other family members may develop severe psychiatric disturbance.[18] A concomitant family problem needing help and understanding is usually found with a child who has a severe reading problem.[15]

As parents need to absorb what they are told both emotionally and intellectually, they may be prevented, by their feelings, from accepting the initial interpretation or recommendation. Intensive work with the parents may be required in order to help them work through their depression about their unrealized hopes and expectations. However, this is generally not possible for the psychiatrist, in which case, the parents are likely to appreciate having someone from the school discuss the psychiatrist's findings and recommendations with them. It is often surprising how little they remember of what they were told at the time of the initial evaluation.

The Psychiatrist as Consultant to the Teacher

By helping a teacher (and parent) to understand a child's difficulties, the psychiatrist may bring about a positive change in her attitude to the child. For example, the teacher may look upon children with neurological dysfunction as "spoiled and undisciplined." They tend to show a variability in attention and may respond well to having a teacher stand over them. The teacher will then mistakenly attribute their problems as being due to a "need for attention." However, if the teacher is told that the child's behaviour or inability to learn is not her fault, she may be very reassured. This may, in turn, help her to cope better with the child.

When a consultant establishes a relationship with the teacher, the latter may feel free to discuss her own difficulties. There are teachers who feel they should never experience, let alone express, such feelings as anger, hatred, futility and helplessness. When the teacher learns that these feelings are human and understandable and when she is supported by a consultant or administrator, a change often begins to take place in her relationship with the child. More energy is released for teaching and learning. Special class teachers often feel isolated and this tends to inhibit personal development. For this reason, they have great need for opportunity to express their feelings.

In contra-distinction to those who see certain non-directive frames of reference and "behaviour therapy" as quite incompatible, this writer sees no conflict between these approaches. One may institute a program of positive reinforcement (i.e. systematic rewards) to promote desired behaviour which can be administered by the teacher and one may investigate how undesirable behaviour is being reinforced in order to enable the teacher to avoid reinforcing it. This may be illustrated by the boy who had screaming attacks in his kindergarten class. A consultant psychiatrist decided that the boy's screaming was being reinforced by the attention he obtained by screaming. For three weeks the teacher tried not paying attention to him when he screamed, but paying attention at other times. Yet the screaming continued. Further observation of the classroom revealed that, though the teacher did not respond verbally when the boy screamed, she would always glance at him. When the teacher was made aware of this and ceased responding in this way, the screaming stopped after three days.

SUMMARY

It is suggested that the child psychiatrist can make a useful contribution in the diagnosis and management of poor school achievers.

Many varied factors may contribute to poor school performance. The problem may be the focus for the expression of a family disturbance or come to fulfil a family need. As non-achieving children generally require a team approach, interdisciplinary liaison is important. School visits have illustrated the value of face to face contacts between clinic members and school personnel in promoting a better understanding of the needs of children who are having school difficulties, and in the development of better principles of management of this group of children.

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