CLINICAL PREPARATION OF TEACHERS FOR THEIR DIAGNOSTIC ROLE IN THE CLASSROOM

DOUGLAS E. LAWSON
Southern Illinois Normal University, Carbondale, Illinois

One of the vital, as well as interesting trends in teacher education during the past decade is to be noted in the increased emphasis upon the preparation of teachers for what might be termed a diagnostic function.

In the full sense of this term, no unspecialized person is a diagnostician, and there is no attempt here to imply that a teacher can adequately perform the duties that properly lie within the province of the medically trained person, the psychologist, or the school nurse.

However, it is of interest to note that during the past fifteen years nearly a thousand teacher-preparing institutions have established bureaus of child guidance, while others have set up various other programs for the preparation of teachers in the specialized performance of functions that serve a diagnostic purpose.

It is the purpose of this paper to outline the major skills that the newer type of training is giving to teachers who formerly were taught merely the methods of subject-matter instruction.

In my own institution of Southern Illinois Normal University we have a *Bureau of Child Guidance* under the directorship of Dr. Wellington A. Thalman. If, in the present paper, I devote most of my attention to the kind of work that we are performing, it is because I believe that our own program is somewhat typical in its aims and organization.

Two major purposes are recognized. The first is that of preparing teachers for the field. The second is that of service to cases which appear before us. I propose merely to discuss the former purpose, that of preparing teachers for improved guidance of their children.

To begin with, both graduate and undergraduate courses have been established in the nature of research seminars. The prospective teacher is required to have a relatively heavy background of prerequisite courses in psychology, education, sociology, psychometric measurements, health education, and sociology.

In the seminar courses, each class member is required to select a patient. Usually the patient is one which has been referred to the Bureau by a social agency, a court, or a school administrator. The child is usually one who has failed to perform at a satisfactory level in his school work. Usually there are complicating factors of delinquency and personality maladjustment.

After the selection has been approved by the director, the teacher is guided in the building of a case history, the giving of tests, and the study of guidance and diagnostic procedures. The teacher must bring the patient to the Bureau, must see that a competent physician makes a

complete medical examination, must visit the home, and must gather data on the patient's past school record, medical history, family background, and present symptoms of maladjustment.

We feel that it is wise for the teacher to accompany an experienced social worker in the first visit to the patient's home. If rapport is attained on this first visit, the teacher may then make some of the subsequent visits alone.

A large part of the teacher's training deals with techniques of holding conferences with the patient and parents, evaluating the patient's performance in the light of his special abilities and disabilities, and administering tests for the measurement of achievement, aptitudes, and intelligence. If a case appears to be one in which there is danger that damage might be done by an inexperienced person, it is not left in the hands of this teacher but is handled by the professional members of the staff.

It should be mentioned here that the staff which guides the learning teacher includes one or two physicians, one or two psychologists, a specialist in reading problems, a nurse, a social worker, one or two specialists in education and teacher training, and, for occasional help with some cases, a psychiatrist or some other specialist who may be brought in for study and staffing of particular cases.

The aim of the entire program of training is capable of being broken down into three main areas, as follows:

First, the development of a "clinical" approach in which the teacher will see child conduct not as an entity upon which she is to pass judgment, but as a symptom for which she is to seek the underlying causes;

Second, the development of skill in evaluating a child's performance and behavior, not in terms of standard performance norms alone, but in terms of the child's own previous performance; and

Third, the development of skill in making at least preliminary diagnosis of performance and behavior to find abnormalities, to suggest possible causes, and to seek professional service in final diagnosis and therapy.

The teacher not only follows the case through a full twelve-week period of observation and study, but participates in the final professional staffings in which the individual case is considered by the physicians, psychologists, and other staff members who have been working with the patient.

A somewhat incidental but interesting aspect of the teacher's growth through this kind of training is frequently noted in cases where a parent, teacher, or other person has mishandled a child's problem. Our own record files are full of such cases to provide the learning teacher with evidence. A few illustrations from these files will show what is meant here.

One was the case of a boy whose teacher was sure that he suffered from some kind of "degeneration" of his brain. The boy was in the fifth grade of a public school and was reported to be the "bully of the school grounds." His teacher said that he could not learn and that he was at the foot of his class. He could not read. She was confident that he was undergoing a deteriorating process mentally; for he had been known as a "bright" pupil in the first grade and had led his class. Various sorts of punishment had been administered and he had been retained in his grade once. None of the teachers liked him. His room

teacher admitted that she couldn't stand the thought of having him another year, for he had completely antagonized her.

The boy was taken as a case by one of the students in the guidance seminar. This student saw every conceivable test used; saw the child's responses in psychological interviews; saw the complete case history developed; and participated in the professional staffings. This student learned that the diagnostic approach is one which regards the patient's behavior impersonally, regardless how much it may be calculated to antagonize; and in the staffing this student remarked that, had she not had this kind of training experience, she would be inevitably inclined toward a complete loss of patience because of the child's unruly behavior. When it was discovered that, during the first months of the second grade, this boy had been absent from school because of illness, he was immediately given a simple test in phonics. He was found to be utterly without any concept of phonic analysis. In fact, and almost unbelievably, he was unaware that certain letters have specific sounds. He did not know, for example, that the letter "r" could not sound like "b" or "n" or "t." Such a complete lack of understanding is hard to explain; but investigation showed that, in his school, all phonics are taught during the first six weeks of the second grade, the very period during which he was absent. His native intelligence was high and he apparently had been able to memorize words and word forms in the first grade more readily than the other children. But after phonics had been taught them, the second-graders were left to their own initiative in identifying new words; and when the boy returned to school, he found himself unable to compete with his classmates, who now had acquired an essential skill of which he was ignorant.

By way of compensation for his loss of prestige in the recitations, the child apparently developed an aggressive tendency to play the part of the schoolground bully at the recess periods.

The recommendation of the staff included a strong appeal to his teachers that they should do nothing whatsoever about this boy's misbehavior. He should be individually tutored in phonics over a period of some months. These recommendations were carried out; and within six months the staff received a report from the fifth-grade teacher. She said—to quote her exact words—"Bobby is his old self again." And she stated that, not only was he now near the head of his class but that, to her great surprise, he had ceased to be the bully of the schoolgrounds and was making friends.

It seems needless to point out that a student who plans to teach children will get a point of view through clinical training that only such training can give; namely, that point of view which sees the child's behavior, not as an entity in itself, but as the symptom of underlying causes. Thus the teacher will learn that behavior is not to be judged or punished as such but is to be studied clinically with a view to determining the caustive factors.

A further case may be cited for the sake of contrast in the etiology of a somewhat similar problem. A fifth-grade boy was severely slapped about the face by his teacher for apparent refusal to cooperate in a timed drill test for which the teacher used a stop-watch. He again and again spoiled the experiment by delaying his beginning of the drill after the teacher's signal to start. The teacher complained also of the

boy's "impudent" way of looking at her when she gave the command for the class to begin the drill.

As in every case referred for guidance, the student member who had this boy as a patient, saw the complete building of a case record, participated in the consultation with parents and teachers, studied the medical report, and interviewed the patient himself. The medical history showed an unusual operation in early infancy, followed by infection and prolonged high fever. There was evidence to indicate that here might be a problem growing from purely physiological causes. Tests by a skilled physician and neurologist showed that the boy's case was one of post-encephalitic epileptiform behavior, explaining both his inability to react in normal time to a command as well as his partially paralyzed facial muscles which gave the "impudent look" that so angered his teacher. The result of the clinical staffing was that the boy was placed with a teacher who was given full information concerning his difficulty; and his adjustment to his school became very satisfactory.

In all cases of training, the teacher is given knowledge and experience in the proper place that vision and hearing tests play in diagnosis of children's disability diagnosis. The teacher, while not becoming an expert in the identification of disease symptoms, learns to at least note the presence of such symptoms through the regular health inspection and learns the proper procedure in isolating the child and securing medical aid.

Emphasis is placed upon the teacher's entire role in adjusting the curriculum to the child's aptitudes and special weaknesses, in studying his vocational interests and giving him guidance, in adjusting the school's requirements to the child's intelligence, and in attempting to see his total personality in the light of all causative factors.

In summary, it may be stressed as a fact of modern teacher education, that the past decade has seen a new movement in the scientific approach to the study of children. As a consequence, less emphasis is now placed upon subject matter as such and more emphasis is placed upon the individual child. At least eight hundred teacher-training institutions in America now have some kind of a guidance bureau functioning with this purpose in mind. Their advent has marked a turn in the history of teacher preparation. Under this new direction the trend of scientific thinking is away from punishment of the child and toward the development of a clinical approach to the study of his needs and his problems. This movement has supplied one of the chief characteristics of the newer program of teacher training. It is hoped that it will likewise supply one of the greatest modifications, or at least the beginning of modifications, in the methods by which teachers in our public schools make their professional work more scientific.

When it is recalled that, of the forty-five million children in the United States, only about two thirds are without handicaps or abnormalities of some kind, the need for such a scientific approach in education becomes apparent. Some two and a half million children of school age are handicapped in some way that necessitates facilities for their specialized education. Evidence indicates that not more than twelve percent of them are at present receiving such special education. These children include the blind, the near-blind, the crippled, the deaf and near-deaf, and the speech defectives but do not include the mentally de-

fective nor those children who, by reason of their superior talents or intelligence, need special adjustments in their curriculums. Six million children are improperly nourished, according to a rather recent report to the National Council of Childhood Education; and one million have weak or damaged hearts; half a million are mentally retarded; three million have impaired hearing; 300,000 are crippled; one million have defective speech; 200,000 are delinquents; and 382,000 are tubercular.

Training the teacher to recognize a child's problem is, therefore, no mere fad of the newer program. It is not mere publicity. It is not just an attempt to streamline education in terms of its superficial appearance. It is a new effort, long overdue, to make education more of a science and to equip it with the scientific materials for its job.