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A BABY CLINIC IN AN ELEMENTARY SCHOOL:
TOWARDS AN INTEGRATION OF SCHOOL,
FAMILY, AND COMMUNITY LIFE

ABSTRACT: This paper describes how a public health nurse established a baby clinic in an elementary school and the effects it had on family, school, and community life. It will be shown how the nurse responded to the lack of community facilities for young mothers by encouraging the mothers to develop their own program, how the 6th and 7th graders became involved, and the role of the counsellor. It is hoped that in sharing such an experience others may be encouraged to devise and implement their own models.

BACKGROUND

Ideas for this programme emerged in February, 1970, while the nurse was located in the Renfrew district of East Vancouver. (This is a predominantly lower middle class area of mixed racial origins: Italians, Greeks, Indians, Canadians, and Yugoslavs). Her time in the school was only two half days a week. In the course of her work she became concerned with many of the young mothers whom she saw

*The writer thanks Miss Ann Gibson, PHN, for asking him to participate in the above mentioned project. It should be stated that the author's contribution (i.e. the mothers' group) was but a small part of an on-going and ever-evolving programme.

during her home visits. Some mothers felt isolated and lonely; they did not know their neighbours; they never seemed to enjoy their babies or pre-schoolers. The children whined and cried excessively and the mothers complained of being tired, depressed, and irritable. Many demonstrated the "pep-pill—tranquilizer" syndrome. Repeated home visits did not significantly alleviate their distress.

Other mothers wanted more for themselves and their children. They wanted the opportunity to ask questions, to receive reassurance, and to talk over and share experiences with others. They also wanted the chance to observe children with their mothers, with strangers, and in play.

It occurred to the nurse that some of these problems seemed to be a function of the nature of the community itself; that is, there was no "feeling of community" among the inhabitants, no centre to identify with (no gathering place), very poor transportation services, and totally inadequate play facilities for young children. The nurse felt that many of these mothers could benefit from getting out of the house, meeting and chatting with other mothers, and by having a breathing space from their children. On this basis, the nurse asked the principal of one of her elementary schools if she could have a room and the use of a TV so that the mothers could watch a series on children and family planning. This was arranged and an adult volunteer took over the responsibility for the children. Afterwards the mothers and nurse had an informal discussion about the programme. An average of 6 mothers and 10 children attended each of the 13 sessions.

INVOLVEMENT OF THE MOTHERS

When this series was over the mothers asked that the group be continued and that a few of the traditional baby clinic functions now be held in the school. Some of these services were immunizations, hearing tests, weighing, and counselling with the nurse. The principal once again agreed to provide facilities and the city supplied another public health nurse.

Wednesday afternoons then became "Open House." Toys were made available, children and their mothers stayed on after immunization, and other mothers brought their children in even if they did not require any physical attention. It was observed that mothers of first-born infants sought out and were given some time alone with the nurse.

During these open-house sessions the children were left to play as much as they wanted and were watched by a volunteer and their mothers. Frequently the mothers voiced surprise at how well their children played when they did not interfere with them. Some came to see the importance of the child's play, how a child wished and often needed to get messy, how a child learnt through play, and the great variation there was between children of the same age. These mothers became better able to accept their children as they were and became less concerned with comparisons and age norms. During these afternoons, one nurse would be available to the group of mothers while the other carried out the clinic functions. Thus the mothers could air

their problems, hear how other mothers had handled similar situations, or find out that they were not alone in experiencing certain problems. If any interesting disorders were spotted in the children, such as communicable diseases, squints, or pigeon-toes, the nurse would show the child to the mothers, identify the symptoms, and describe the treatment.

The mothers then began to ask for "outside speakers" and in due course, dental hygienists, speech therapists, family service workers, optometrists, and school medical officers became involved. This turned out to be particularly helpful as the mothers became familiar with various local resource persons and could then turn to them in time of specific need. Interestingly enough, over time the mothers came to be seen by their own friends and neighbours as resource persons themselves — they made suggestions regarding childcare problems and their friends started attending the clinics.

On any one afternoon there might be 3 to 4 small groupings occurring at the same time. For example, a formal group with a resource person, an informal one with the nurse, and two groupings of mothers only — chatting and observing the children. It became apparent to the nurse that the informal groupings of mothers were just as important as those around a resource person in that *mothers learnt a lot from each other*. In sum, there was usually something both formal and informal offered and mothers were free to choose, depending on their needs and feelings on a particular afternoon.

After about a year the mothers got together and asked the nurse if she would help them set up a cooperative play school for the 3- and 4-year-olds. Her response was to encourage the mothers to go about it themselves. They solicited the help of a family service worker who wrote up the charter, the school principal who once again provided a room, the use of library and audio-visual equipment, and the nurse who volunteered her services. The programme is still in operation and is run entirely by the mothers. Some of the effects have been that the mothers and pre-schoolers both tend to feel "at home" in the school and the transition into first grade is noticeably easier. It is felt that the mothers will continue to see the school as an integral part of community life and one that they can play an active and important part in. With these mothers, their sense of alienation has been greatly reduced while their feeling of effectiveness has been increased.

INVOLVEMENT OF THE 6TH AND 7TH GRADERS

In the second year of operation the nurse decided to involve some of the 6th and 7th grade girls who were having difficulties with their class work as "aides" with the toddlers. Each girl was "assigned" to a child as his "play companion" and encouraged to "follow" the child, to stay at his level, and to interact on the child's terms (i.e. not to try to *teach* the child). One nurse supervised this and was there to answer the girls' questions and occasionally would make some suggestions for play activities if this was indicated.

As a result of this programme, several "problem" girls began to flourish — they felt better about themselves, their appearance im-

proved, and the teachers observed that they were happier and more animated in the classroom.

However, this activity became so popular that some of the other girls started to act out so that they could "help the nurse with the babies." In order to counteract this, the nurse started a Health Club in the school and any 6th and 7th grader (boys included) who was interested could join. The children have lunch meetings with the nurse, design their own programmes (such as placing dental posters around the school, giving short lectures on health topics, weighing and measuring), and help out with the baby clinics. If their school work suffered their teacher would ask them to stay out of the programme for a while.

At first it was noticed that during clinic time some of the very bright girls stayed together as a group and tended to overidentify with the mother role. Most of the time they wanted to hold, feed, and change the babies and thus missed out on much that was fun. As time went on, the boys in the club let it be known to the girls that they too wanted to come to the clinics. The girls told the nurse. This was arranged and after an initial hesitation (On the first day that the boys were to go down to the clinic room, one adult said to them, "Surely, you don't want to go in there with girls." Overhearing this, the nurse replied, "Well, they are all going to be fathers someday." The boys felt good about that and walked on down.) the boys soon became very spontaneous with the toddlers and seemed to obviously enjoy the children more than some of the girls. The girls observed this and slowly became more relaxed themselves. After each session the children would meet with the nurse, ask many questions concerning child development, and later write observations of "their child" during the afternoon's play.

Other children in the school tended to "look-in" and chat. When they saw the preschoolers in the hallways they often patted them on the head and exclaimed, "Aren't they cute." Some children have even gone home and asked their mothers to "Bring our baby down to the school." Changes will be made in this programme, for the nurse feels that only a handful of 6th and 7th graders are involved, many more are interested, and that selection is still too haphazard.

INVOLVEMENT OF THE COUNSELLOR

The involvement of the present writer stems from his special interest in primary prevention and his strong support for the public health movement. The nurse asked him to give a talk and show his film on "The use of holding with difficult babies" (Allan, 1972). This led to some of the mothers asking for longer sessions with the writer and it was arranged that he would come to the group meeting once a week for an hour for eight weeks. Following this the mothers asked him back for another 10 weeks.

A room was put aside for the meeting and the purpose of the group was to provide the mothers with an opportunity to raise questions and to share problems that they were having with their children. The group was open-ended and informal so that mothers could come

and go as they wished. About 14 to 18 mothers attended each session and there were usually 3 or 4 children playing on the floor or sitting on their mothers' laps. The mothers of very young babies (if under nine months) tended to stay in the activity room. The age of children discussed ranged from 1 to 9 years.

The counsellor's role evolved in a number of ways but overall seemed to lead in the direction of providing training in the parenting process. Three steps were involved:—

Listening and facilitating group interaction

Initially the writer saw his task as that of actively listening to the mothers and helping them "unburden" some of their feelings and problems in the presence of other mothers. Slowly the mothers learnt to talk out, to share, and to listen, and came to realize that many of them experienced the same kinds of difficulties and lived with similar feelings.

When impasses were reached, the counsellor helped the mother focus on the problem at hand and explore and verbalize her feelings around this. Other mothers were encouraged to share how they had handled or would handle similar situations. If these suggestions did not satisfy the mother concerned, the writer would then present alternative ways. Much of this involved concrete suggestions for discipline, limit setting, and the handling of aggression with children.

Sharing concepts of developmental stages and tasks

Once immediate concerns and worries had been handled, the mothers wanted to learn more about basic child development. This included concepts relating to physical and emotional growth, developmental stages, and common problems (Havighurst, 1972).

Slowly they became aware that some anxiety (within certain limits) is normal in the preschooler and that distress can be viewed as a normal state of tension that frequently precedes the mastery of a new developmental task. In addition, they learned to see that the anxieties of a 2-year-old are different from those of a 5-year-old and require different understanding and management. In short, they came to see growth in terms of a succession of stress-to-resolution (or mastery) cycles. Before this they had tended to get upset and frustrated by the "problems" of their children, viewing them as behaviours that "should not be present in normal children."

Among this group of mothers, the following problem areas were brought up:

Sibling rivalry:

How do you prepare your child for the new baby?
 How do you handle the feelings once the baby arrives?
 Envy, jealousy and fighting especially in the under fives.

Sleep problems:

Refusal to go to bed.
 Failure to fall asleep.

Nightmares, fear of the dark.
 Wanting to sleep with parents.

Separations:

Preparation for hospitalization or moving.
 Sudden separation due to illness.
 Handling of feelings around divorce or death, loss of a pet, or grandparents.

Adoption:

When do you tell?
 How do you tell?

Aggression:

Temper tantrums — How do you handle anger at different age levels (i.e. in a baby, at 18 months, at 3 years, 5 years etc.)?
 Destructive play towards objects, pets, self, and others.
 Negativism and sulking.
 Expression of anger towards mother or father.

Fears:

Excessive shyness.
 Fear of leaving mother.
 Fear of baths, toilets, birds, dogs, etc.

Other areas:

How to motivate husband to play with his child.
 How to handle interfering in-laws.
 Helping a mother see her expectations were idealistic and unrealistic.
 Interestingly, feeding, toilet, and speech problems were hardly ever mentioned. This probably reflects the help the mothers had received in these areas from the nurse prior to the group meetings with the counsellor.

Communication skills relating to the world of feelings

Once immediate problems and basic development questions had been answered, the mothers began to ask for more understanding of their child's inner mental life ("What do their fantasies mean?" "Are fantasies indicative of problems?") and ways of communicating with this.

The writer became aware that most mothers were puzzled and often frightened by their child's fantasy life. Yet it is well known that in the oedipal phase (2½ - 5 years) imagination is at its height (Baruch, 1956) and plays an important part in development of creative thinking skills (Hudson, 1966). Frequently, the mothers reported being upset when their children "played dead" (or asked them to "lie down as if dead") saw "monsters or ghosts," had "imaginary playmates," wanted to "play dracula" or "were going to marry mummy (or daddy)".

In response to these concerns the writer demonstrated to them some simple communication techniques. The purpose of these techniques was to help them start and maintain a feeling-level dialogue with their children and to help them become aware of some of the feelings contained or being expressed in the fantasies. To do this the writer adopted a similar format to that of Gordon (1970). Though in these cases the writer would start with fantasies and incidents that the mothers were concerned about rather than specific training exercises. For example, when relating a problem or fantasy, the mothers were shown how to (1) *actively listen to and perceive the feeling tone around the child or his story*, (2) *restate the child's question or phrase in order to encourage the child to continue talking*, (3) then *reflect back to the child the feelings being expressed underneath or behind the fantasy*, and (4) *use "Self" or talk from Self* (i.e. sending or giving clear "I" messages). If after trying these methods, they were still concerned or worried about a child's behaviour or fantasy, they were encouraged to (5) *set effective limits*.

Many mothers initially resisted the idea of talking to a child's feelings and were more comfortable with traditional limit setting. However, the on-going nature of the group enabled them to try out some of these communication skills, have feed-back, and learn accordingly. Soon they were quite surprised at how effective the methods were, how much more freely their children talked, how they as mothers felt closer to them, and how less frequently they had to use or set limits. They began to understand their child's fantasy life, overcame their fear of it, and became freer to enter into it when appropriate. It was pleasing to the writer to see how quickly (within 10 sessions) the "average" parent could pick up and use effectively a few basic (and yet new to them) communication skills. The group was a real living and learning experience for the mothers and the nurse noted that some of the mothers began to feel a lot better about themselves and their relationship to their children.

DISCUSSION

It is well known that many suburban communities are plagued with poor community amenities and many social problems. In the age of the "nuclear family experiment" it is probably young mothers and their pre-school children who suffer most from the lack of community identity, few or no gathering places, poor public transportation, and inadequate child-care facilities. Also, in today's age of "women's liberation," the status "housewife" (or "mother") seems very low on the totem pole. To compound the problem, many community institutions (hospitals, schools, and universities), while seemingly acting as part of a community, in reality manifest many signs of cultural lag, isolationism, and often assume a superior posture: "We are the experts. Parents please do not interfere." The result tends to be considerable animosity between members of a community and the institutions which are meant to serve them.

In this paper I have tried to show how a nurse's insight, combined with a flexible principal, was able to turn one area of the local elementary school into a community gathering place for mothers and their children. Over the past few years there has been considerable evolution in the program. Most importantly, this evolution has followed *the expressed needs and wishes of the mothers, and the mothers, to a great extent, have carried out this growth by their own efforts.* (This once again underlies the importance of the "expert" (whether he or she be a nurse, teacher, or counsellor) as a "facilitator" rather than a "dictator.")

This project was started because the nurse realized that one of her learnt intervention strategies (i.e. home visits) was, in many cases, totally inadequate. She was flexible enough to develop new approaches. The effect of the project was that young mothers began to feel more a part of their community, felt that they had some say in the early development of their children and in their own on-going education. Their actions changed existing community structures and enhanced their own sense of worth. In doing this, they also felt part of the elementary school to which their older children went and to which their younger ones would go. This pattern of participation, the nurse felt, tended to facilitate parent involvement once a child was in grade school.

The introduction of a baby clinic into a school helped reduce the rigid separation of school and family life. The sharing of facilities and frequent mother and preschool-child exposure to the school helped reduce their fear of and hostility to the school. The development of favourable attitudes facilitates future dialogue between teacher, parent, and child in times of problems and troubles if they occur.

The sight of mothers wheeling prams into the school and the sounds of babies had quite a dramatic effect on the school environment. It brought some of the emotions of home life into the school and elicited caretaking responses from many of the school children regardless of grade. The involvement of the 6th and 7th grade girls and boys and their recording of observations and play interactions seemed to be particularly valuable as a learning experience.

It has been my experience that children of this age are far more interested in babies and toddlers than are high school students. Exposure in elementary school then becomes a highly "teachable moment" and is very appropriate. Learning about child care in this way will be based on practical experience, peer support, immediate feedback, and an on-going relationship with a younger child. High-school students tend to be more interested in forming close peer relationships and "dating" than they are in babies. Indeed, any high-school male showing an interest in babies tends to be deemed as "a little odd" by his peer group.

Other advantages are that developmental stages of life tend to flow into one another and occur in the same location. Elementary children will be able to get a better understanding of the stages of life and how these stages change and how they are part of this continuing process. Having the baby clinic and pre-schoolers in the school reduced the fear and anxiety of the youngsters involved and facilitated the

transition into first grade. The children come to "know" the school very early on in their lives, and in part they came to associate it with play, pleasure, and then learning. It more easily becomes "their school"; they belong to it and it belongs to them. This positive attitude, I am sure, greatly facilitates the motivation to learn, enhances the arousal of emotions that inhibit the acquisition of some intellectual blocks and probably vandalism.

It will be remembered that the counsellor was only one of several "resource personnel" to be involved in this project. The resource personnel circulated in and out, and stayed as long as the mothers felt they needed them. Sometimes this was for one or two visits, other times for up to twenty weeks. The main advantage of this was that, over time, the mothers came to know, under non-threatening circumstances, a wide range of professionals in their community. The nurse found that this approach enabled the mothers to call up and use the services of these professionals, at a late date, if needed.

In other words, having the mothers use the school as a "home base" enabled them to become acquainted with many community-service workers on an informal, yet personal, basis. This facilitates communication between lay workers and professionals and gives mothers some choice of professional helper in time of need. This point should not be underestimated, for it has been my experience that many professionals, and particularly those in the mental health fields, underestimate the fear and reluctance of the community to approach them. Mental health centres, public health clinics, and offices are perceived with much anxiety and so are not used by many people who could benefit from the services offered. Part of this stems back to the isolationist stance of the professionals: they expect people to come to them and have been unwilling to leave their offices and to go to meet the people on their terms and in their own territory or community. Having a baby clinic in a school greatly facilitates contact, access, and development of service relationships. Once this access is established, the professional then can truly begin to carry out "primary prevention," with parents and mothers who might not have been accessible or willing to come for help before.

It is well known that the first 5 years of life are highly important to a child, and yet we as a society do not train for the parenting process and gravely underestimate the emotional plight of young mothers and young families. The school can provide a natural gathering place for the mothers to meet, have a rest from the youngster, and receive some support and guidance. The writer felt that the first stage of his experience (i.e. listening and allowing the mothers to unburden) was so important to them — they had to be able to get the "daily or current problems" out before they could listen to alternate suggestions for limit setting, or to pay attention to concepts of developmental stages and tasks. In other words, in this project, training in parenting best followed release of current tensions. Also, the on-going nature of the group allowed for the testing out of ideas and concepts and a chance for feedback and modification. In this way the school became not only a centre of learning for their children but also for the mothers themselves.

It is my feeling that many mothers and fathers of elementary aged children would also benefit from such an on-going group (maybe meeting once every two weeks in the evenings). These groups probably could be run by a school counsellor and an interested teacher. It seems to me that the school represents a common meeting place and an ideal (i.e. nonthreatening) location for parent education and for preventative mental-health services. Towards this end, and towards more effective counsellor training, the Department of Counselling Psychology at the University of British Columbia, in conjunction with two local school districts (Richmond and New Westminster) have just established two school-based counsellor-training centres.

RESUME: Cet article décrit la façon dont une infirmière a mis sur pied une clinique pour bébés dans une école primaire ainsi que les effets consécutifs sur la famille, l'école et la communauté. On démontre comment l'infirmière a compensé aux lacunes communautaires en encourageant les jeunes mères à développer leur propre programme. On voit aussi quel a été le rôle du conseiller et comment les élèves de sixième et de septième année ont été amenés à participer. On espère qu'en partageant ainsi cette expérience, d'autres personnes seront inspirées et encouragées à développer et à réaliser leurs programmes propres.

REFERENCES

- Allan, J. A. B. *Use of holding with difficult babies*. A short 16mm film, 1972.
- Allan, J. A. B. *Stories for pre-schoolers*. A partially annotated bibliography, 1973. Available on request from the author.
- Baruch, D. *New ways of discipline*. New York: McGraw-Hill, 1956.
- Gordon, T. *Parent effectiveness training*. New York: Wyden, 1970.
- Havighurst, R. *Developmental tasks in education*. New York: D. McKay Co., 1972.
- Hudson, L. *Contrary imaginations*. London: Penguin, 1966.