A PROPHYLACTIC APPROACH TO CHILD PSYCHIATRY

By

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IT has long seemed apparent to workers in the child guidance field that many of their patients show evidence of longstanding emotional disturbance; either the symptoms now complained of have been present for many years, or there has been a history of symptoms earlier on which have disappeared only to be replaced by the existing ones. Some of these patients whose present condition may be almost intractable, might have been helped had they been treated at an earlier date, while recent work by Bowlby (1951) and others has emphasized how important are security and satisfactory emotional relationships in the early years for the establishment of a stable personality. Thus it appears that any prophylactic approach, aimed at reducing the incidence of emotional disturbance in older children, and it is hoped ultimately in adults, may need to be made very early in life.

Little has been published, apart from accounts of individual patients, of work on any series of very young children who were psychiatrically disturbed, particularly from a prophylactic point of view. Joseph (1948) has described some of the patients she has seen in a child guidance clinic attached to a child welfare centre, and Gillespie (1954) has compared the symptomatology of a series of pre-school children treated at Infant Welfare Centres with the pre-school histories of older children treated in a child guidance clinic. She points out that the type of problem dealt with in the under-fives was seen in a high proportion of the earlier histories of those who needed treatment at a later age. The importance of early treatment for parents in the prevention of serious disturbance in the children has been emphasized by Fries (1946) by Jacobs (1949) and on a community scale by Caplan (1951). His experience in Infant Welfare Centres in Israel over a number of years has led him to concentrate on the treatment of cases where abnormal symptoms were not yet manifest, but where pathogenic relationships of the parents to the child were such that he felt that emotional difficulties in the child might later develop. In this country such a prophylactic approach is relatively unexplored, although the possibility of preventing mental ill health in children is one which has interested public health authorities for some time.

PSYCHIATRIC FINDINGS IN SCHOOL-AGE AND PRE-SCHOOL CHILDREN

That psychiatric disturbance seen in the ordinary run of child guidance patients may be longstanding is well illustrated by the early histories of 100 children of school age (5 to 15 years) who have attended Brixton Child Guidance Unit. These case histories were selected only to the extent that children who had been in institutions from infancy were excluded, or in whom for some reason

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details of infancy and early childhood were unobtainable. It was found that 39 per cent. of these patients have shown symptoms indicative of emotional disturbance in their first year of life and 74 per cent. of them in the first five years of life. Such symptoms covered the whole range of childhood behaviour and they included, for example, difficulties in feeding and weaning, excessive crying in infancy, undue dependence on the mother, disturbance of sleep, excretory dysfunction, and most common of all, manifestations of aggression.

Such common findings at so young an age again closely followed Gillespie's (1954) findings and point to the importance of psychiatric treatment early on; and a child guidance clinic, which serves a relatively small local area and which maintains a close contact with agencies responsible for pre-school children, will allow very young children in an early stage of psychiatric disturbance to be referred for treatment. Thus, it was also possible to examine a series of 50 pre-school children treated at Brixton child guidance unit over the same period, and to compare them with the older group. The age range in this series was 18 weeks to 4½ years; 29 (58 per cent.) were boys and 21 (42 per cent.) girls. The majority (68 per cent.) were referred by local child welfare clinics, a further 24 per cent. by general practitioners, and the remaining 8 per cent. by other sources.

It was characteristic of these very young children that almost every mother complained of a large number of symptoms at the initial interview, and in the course of ordinary history taking revealed a number more. This is shown in Table I, and it implied that without exception these children showed evidence of disturbance in most aspects of their behaviour and they again paralleled Gillespie's findings (1954).

TABLE I

Symptoms Found in 50 Pre-School Children (Under Age of 5)

	Symptoms Spontaneously Complained of by Mother in: (Children)	Other Symptoms Elicited in: (Children)	Total	Per cent.
Aggressive manifestations	26	14	40	80
Sleeping difficulties	15	25	40	80
Enuresis	15	6	21	42
Feeding difficulties	14	16	30	60
Overdependence and clinging to the mother	5	20	25	50
Encopresis	3	3	6	12
Speech difficulties	3	1	4	8
Masturbation	2	3	5	10
Fears	2	14	16	32
Eczema	2	—	2	4
Backwardness in development	1	—	1	2
Asthma	1	—	1	2
Overt jealousy of siblings	1	—	1	2
Regressive behaviour	1	—	1	2
Tics	—	1	1	2
Attention-seeking behaviour	—	3	3	6
Wandering	—	2	2	4

Seventy per cent. of these children had been considered "difficult" for one reason or another during the first year of life, a marked contrast to the older child of whom it was often recalled that he "could not have been a more perfect

baby". It is not suggested that older children with psychiatric disturbance did not show earlier difficulties, as the findings in the older group have shown that this was not the case; it is that mothers tend specifically not to recall and so not to complain of earlier problems. Such a repression is commonly seen in mothers who appear to find it impossible to accept their role in the production of the child's symptoms and so may concentrate on a relatively unimportant symptom which, they feel, can be attributed to external causes.

Further comparison of the clinical findings between the pre-school children and those referred at an older age showed more difficulties with breast feeding in the former. Fifty per cent. of the pre-school children had not been breast fed at all as opposed to 30 per cent. of the older group; a further 10 per cent. in each group had been weaned because of difficulties during the first three months. The causes for these failures to breast feed could not be accurately assessed in either age group. Most of the mothers adduced physical reasons, and very few were willing or able to talk about their emotional reactions to feeding except in conventional terms. From subsequent knowledge of the mothers' personalities, however, it seems likely that for a considerable number it had been a very disturbing experience.

The 50 mothers of the pre-school children formed an interesting group. Twenty-four were considered frankly neurotic, 20 more were over-anxious or mildly unstable and one was a certified defective. Of the 5 considered to be stable people, 2 were mothers of defective children. They all showed relatively more anxiety than the corresponding group of mothers of school age children and, it seemed, at this much earlier stage, more awareness of the unsatisfactory nature of the mother–child relationship. They did not seem to enjoy their children and felt they ought to do so, but had, as a whole, much more insight into their own part in the production of the difficulties. This may be because the mother and child, at this early stage, approach more to a symbiotic existence and the mother is perforce much more involved in the child's emotional development than during the latency period. This, not unnaturally, sometimes led to special difficulties in treatment, as the mother who finds that her child, who she says can never be left with strangers is, after a short time, quite happy for 30 to 40 minutes with a therapist may exhibit much jealousy and hostility as her own insecurity mounts.

Forty-one pre-school children were given systematic treatment; 3 further patients, including 2 children who were mentally defective, did not require it; 6 further mothers refused treatment. The immediate results are shown in Table II and compared with the immediate results in the series of 100 older children.

TABLE II

Immediate Result of Treatment in Percentages

	50 Children Aged under 5		100 Children Aged 5 to 15
	Per cent.	Patients	Per cent.
Symptom free	32	(16)	23
Improved	40	(20)	34
No change	24	(12)	38
Worse	4	(2)	5
	100	(50)	100

The most likely reason for these more favourable immediate results is the young age of the child. The position in regard to development is still fluid,

and it is hoped that by early treatment the child may be helped through critical phases in his development, and the mother enabled to give him security at a time when it is of such vital importance. There seem, however, to have been contributory factors. The parents of these young children tended themselves to be younger than the parents of older children under treatment, and therefore more often amenable to psychiatric guidance. Indeed, they nearly all had sought help of some kind from someone they considered an authority, whether general practitioner or welfare clinic. They may not at first have been anxious for psychiatric help, and a few found it very difficult to accept in the first place, but the group as a whole was in marked contrast to the parents of the school age referrals. Many of this latter group did not even consider the child a problem, or were unwilling to accept any responsibility for his behaviour and only brought the child to the clinic as a result of considerable pressure from some interested social agency. This distinction is further emphasized by comparing the numbers whose cases had to be closed as "unco-operative". These amounted to 26 per cent. of the group of pre-school children compared with 34 per cent. of the group of older children. They included a number who at once failed to attend; but if these are excluded, the comparative figures are 14 per cent. of the pre-school children and 29 per cent. of the older children.

The main cause of patients failing to attend or for breaking off treatment, and especially in the older age group, was that the parents appeared to have been over-persuaded by social agencies to attend the clinic, but still failed to recognize the need for psychiatric help. Other mothers found that psychiatric treatment meant the reawakening of disturbing factors in their lives and felt unable to face these so that treatment was broken off. A further difference between the two groups was that they tended to belong to rather different social groups. The two child welfare clinics from which a large number of the young children were referred, are in areas which contain a relatively high proportion of lower middle class families and a relatively small number of the near problem families who formed a significant proportion of the older referrals. It was also easier to contact the fathers of the younger children. Social factors were again important over this, but it may also have been because the marriage, though often unhappy, was like the child's problem, still in its relatively early stages, and had not crystallized into one of the hopeless marriages which were more likely to exist between the parents of nine or ten year olds.

The fact that psychiatric treatment of emotional disturbance in children in the pre-school phase on the whole led to encouraging results compared with that in older children, and also needed to be continued for a relatively shorter time, did not necessarily obviate the need for further help in the future. Amongst the present series it seemed clear that many of the children (and mothers) might need help at intervals throughout childhood, and it can be envisaged that such patients may need to keep contact with the child guidance clinic over a number of years with perhaps periods of more intensive treatment from time to time. Some mothers, for instance, who found it difficult to deal with the child's normal expression of aggression may well find in due course that a relatively minor degree of sibling jealousy is hard to accept; both mother and child may need help to work through this when it arises.

A Psychiatric Service in Maternity and Child Welfare Centres

Arising out of the encouraging clinical experiences illustrated by this series of pre-school children, it was decided, with the co-operation of the

Divisional Medical Officers and the clinics' staff concerned, that more might be achieved if a psychiatrist from the Brixton Child Guidance Unit attended regularly at one or more of the local Maternity and Child Welfare Centres; it seemed possible that there might be a further group of children attending there who were in a very early stage of psychiatric disturbance. It also seemed possible that the anxious and insecure mother who would not readily accept referral to a child guidance clinic, might accept psychiatric help in the child welfare centre itself, with the reassurance of familiar surroundings and personnel. This was found to be the case, so that three centres were visited more or less regularly over a period of twenty months. At first fortnightly visits were paid and on the whole this routine was continued in two centres, though at times the number of referrals lessened and attendance was cut down to once in every four to six weeks. In the third centre, regular visits were discontinued after a short time as it seemed more satisfactory for the doctor in charge of this centre to refer patients direct to the child guidance unit.

In the other two centres, where a regular psychiatric service continued, procedure varied with increasing experience. The medical officer in charge of the centre was normally responsible for referring patients for psychiatric assessment, when symptoms in the child or mother appeared to warrant it. A few were so referred at once while attending for routine examination, but the majority were asked to come later for a special examination. The fact that this was a psychiatric examination was not stressed. In addition, in one centre it was possible to "sit in" during the routine examination of infants, and so to explore with the doctor and health visitors the psychiatric aspects of management, or to facilitate the discovery of psychiatric disturbance when present. This was found to be most helpful and instructive both to the psychiatrist and to the centre personnel; it would probably have been even more helpful in a toddlers clinic (i.e. for children of 14 months upwards), but unfortunately lack of time prevented this.

A total of 34 cases were interviewed in these centres in 20 months. A further 3 patients refused the interview. The type of problem met varied a little with the clinic and ranged from the depressed and anxious mother of a very young baby who was concerned about her failure to breast feed, to the unstable and immature mother of the aggressive toddler who in no way differed from the ordinary run of pre-school referrals seen in the child guidance clinic. In one centre, where the doctor was particularly interested in the psychiatric symptoms to be seen in young children, any patients referred for psychiatric assessment tended to show overt disturbance in the child; in another centre, where most of the referrals were made on the instigation of the health visitor, the mothers tended to show more obvious inadequacy in dealing with normal stages of development in the child. However, in 6 of the cases seen, the mothers were found to be depressed, the children being relatively healthy; 4 of them could be classified as puerperal depression, of which 3 were clearing spontaneously. The other 2 mothers were severely neurotic people, one of whom had received prolonged psychotherapy in the past while the other was later referred to an adult psychiatric clinic for treatment.

After the preliminary assessment in these 34 cases, 12 were transferred to Brixton Child Guidance Unit, either because it was felt that the child needed such further investigations as psychological testing, or because the situation warranted prolonged treatment which could not be given in the child welfare centre for reasons of time and space. Of these 12 patients, 6 were taken on for formal psychiatric treatment on a weekly basis; the psychiatric social worker

then dealt with the mother while the psychiatrist continued to treat the child. A further child was proved to be of backward intelligence; no gross emotional problem was found and in due course a recommendation for ascertainment as Educationally Sub-normal was made. In 2 more patients, it was subsequently considered that no active treatment was necessary, but they were followed up at regular intervals in the child guidance unit and help could have thus been given at any time should it have been needed. In 2 other patients active treatment was advocated but in each case the mother refused it. In the last case, the mother later had to be referred elsewhere for psychiatric treatment in her own right. A further 3 patients were offered child guidance treatment but refused the initial appointment at the clinic.

Of the remaining 19 patients 9 were given supportive treatment in the child welfare centre itself for periods of between one and five months. These were all cases of anxious mothers of first children, who were either young and immature or elderly and rigid and for whom the advent of a child was a most disturbing occurrence. They were reacting with either over-anxiety and in most cases some depression to the normal difficulties associated with the child's increasing demands, and were helped by a relatively superficial discussion of their problems. In most, simple discussion of the management of a situation led to a change in the mother's handling with consequent improvement in the child. These mothers may need further support at intervals during the child's development, but it is probable that with increasing awareness by the health visitors concerned of the emotional factors operating in these cases, much of the support can be obtained from them. Two other mothers were offered similar supportive treatment, but did not avail themselves of it. Two more cases were referred elsewhere for treatment: one child with asthma was found to have no gross psychiatric symptoms and required physical investigation, and in another the mother was found to have a severe puerperal depression and was admitted to a mental hospital. The remaining 6 cases were not treated further after the preliminary interview; 4 because the symptoms complained of appeared to be clearing spontaneously, and in the other 2 it was the fathers who were seen but who were found to refuse any help that could be offered them. These fathers were both referred by the health visitors who had found them anxious, demanding and difficult people and did not know how to help them. Both were most unstable, one it transpired had made a suicidal attempt and later regularly attended a psychiatric clinic. They both came for interview with a long series of accusations against their wives and had invoked the help of numerous social agencies in the past. They neither expected nor would accept any help, but it reassured the health visitors to feel that they had been seen by someone with psychiatric experience.

Discussion

It is clear, judging by the experience gained in attending these child welfare centres, that useful psychiatric work can be done there, although much will depend on the building up of a co-operative relationship between the visiting psychiatrist and the clinic personnel. It was not possible, however, to assess what proportion of the population attending child welfare centres was emotionally disturbed, as only a very small fraction of the total was psychiatrically examined. For instance, the average attendance in any one infant clinic may be 40 to 50 a week, of which perhaps 15 may be seen by the medical officer. In a toddler clinic the attendance is approximately 15 to 20 patients a week. It seems

probable that the small number of 35 patients in 20 months who were referred for psychiatric examination by no means represented the total number who could have been so benefited.

The problem of deciding which patients were essentially "normal" in spite perhaps of minor upsets, and which should be regarded as psychiatrically disturbed, is one which has preoccupied the child welfare centre staffs. A psychiatrist, on the other hand, needs the experience of working with a large number of mothers and young children to appreciate how wide is the range of so-called "normal" childhood behaviour and how almost universal is some degree of anxiety on the part of the young mother of a first baby. Thus, continued contact by the psychiatrist with a child welfare centre and discussion of patients with the centre staff, has allowed clinical experience on these matters to be built up by the psychiatrist. At the same time, it has led to a greater awareness by the staff of emotional disorders in their patients. At first, much of the psychiatrist's work consisted of trying to pick out mothers and children in the early stage of psychiatric disturbance which, if overlooked, might have led to illness of greater severity. Increased awareness and experience by the centre staff in these matters might lead, however, to their undertaking such selection themselves. Such patients, if the centre staff felt they could not handle them themselves, could then be referred to the psychiatrist on the spot or to a local psychiatric clinic. The psychiatrist, apart from acting in a consultant capacity, would then be more free for instance to investigate the possibilities of mental health work with the centre patients.

It is a matter of speculation how far the doctor or health visitors on the staff of a child welfare centre can take psychiatric responsibilities. They are in a unique position in relation to mothers, and already do valuable work in physical supervision, education and in supporting anxious mothers. They have, however, no special training at present in these matters; they would need time to be set aside for such work, and their interests and the suitability of their personal qualities would be important factors. However, 11 of these 35 patients seen in these child welfare centres might have been successfully handled by a member of the centre's staff with the necessary skill, although the wide range and varying seriousness of the psychiatric problems met in these patients as a whole, stressed the need for skilled diagnosis and overall psychiatric supervision. How such training should be imparted would need careful consideration, but the shortage of psychiatric personnel precludes the sort of work outlined except in special circumstances.

In conclusion, "prophylactic" work such as described here, can only reach a limited number of mothers. Not all amongst regular attenders at the child welfare centres were found to be suitable patients for such an approach. Again, varying perhaps with the district, there are many mothers who do not come to child welfare centres, and amongst these are the less stable and the less intelligent mothers and also the mothers of problem families. It is probable that these latter form later on the hard core of perhaps intractable patients so often referred to child guidance clinics.

SUMMARY

The importance of dealing with children in an early stage of disturbance is emphasized by the examination of the early symptomatic history of 100 school age children referred to Brixton Child Guidance Unit. Fifty cases of pre-school children treated at Brixton are also examined with the results of treatment. Clinical work in Maternity and Child Welfare Centres is described. Established cases of early disturbance have been recognized and treated there and educative work with centre staffs carried out. A possible extension of prophylactic work is described.

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