PSYCHIATRY FOR THE BACKWARD CHILD

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Child psychiatry has to make a highly relevant contribution in the treatment of the backward child. Not only in those cases where backwardness has arisen from external factors, mainly environmental and scholastic, but also for children who are constitutionally retarded, especially in the higher grades of mental subnormality, whether they are cared for at home or attend a residential school for educationally subnormal children under the Education Authority.

The advantages of introducing the techniques of the Child Guidance Clinic into the hospital for retarded children by means of individual and group therapy, supported by social work with the parents and co-operation with the clinical psychologists, were stressed by F. J. S. Esher (1959). He recommended the use of play therapy with drawing, discussion on a childish level, and the exploitation of phantasy by model worlds on the sandtray, in the belief that the child's intellectual functioning will improve indirectly if his emotional difficulties are relieved. Lydia Mundy (1958) and A. Shapiro (1958) have described and adapted the different forms of individual play and group therapy of the Child Guidance Clinic for the use in hospitals, and Shapiro, independently from similar researches by O'Connor and Yonge (1955), has shown the positive value of such efforts, by comparison with controls. It is now over ten years ago that Dr. Burke, the late Medical Superintendent of Cell Barnes Hospital in St. Albans, invited me to experiment with an activity play group, of rather heterogenous ages and intelligence levels, when such ventures within the Mental Deficiency Colony with certified patients were still regarded with considerable scepticism by experienced colleagues.

The psychoanalytic school, which dominated therapeutic work with children before the War, had a stimulating influence on all other branches of psychiatry, but closed for many years the doors to any therapeutic efforts with backward children because of its insistence on the patient's intellectual co-operation in the spontaneous associations and his appreciation of the therapist's interpretations of psychodynamic relationships. But later followed a gradual emergence of modified and more superficial psychotherapeutic methods, and above all of group and social therapies, utilising non-verbal activity and situational approaches, and new and promising possibilities of treating the backward child opened up. K. O. Milner (1952) described the indications of selecting high-grade defectives for treatment in hospital and outlined a successful therapy which allowed considerably deeper penetration into problems and a more efficient catharsis on near-analytic lines than would have been considered possible before with subnormal patients. M. J. Craft *(1960 a, b) more recently applied and modified the methods of hospital group* therapy, as introduced originally by Maxwell Jones (1953) for the use with psychopathic patients, mostly dullards or young patients coming within the definition of "impairment," as advanced by the American Association on Mental Deficiency.

Apart from these psychiatric forms of approach to the problem one must mention all the indirect therapeutic procedures which are derived from the Child Guidance Clinic, e.g., the increasing use of team work between specialists in medical and non-medical, mainly sociological and psychological fields, and the acceptance of the concept of the clinical case conference in the hospital.

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I do not propose to discuss such intramural activities any further, because as a psychiatrist working mainly outside the hospital I am not competent to expand on what has already been described by others with first hand experience. I shall talk about some of the contributions the Child Guidance Team, within its clinic, can make in the treatment and rehabilitation of the backward child which remains at home.

The modern Child Guidance Clinic, as you know, is based on the now well tried team approach to a child's emotional and behaviour problems which was introduced over thirty years ago by Dr. Thoms at the Habit Clinic in Boston, U.S.A., and which spread, thanks to the Commonwealth Fund, in the late twenties to this country, where after gradual acceptance of the idea, the number of Child Guidance Clinics multiplied rapidly since the end of the War. While the diagnosis and the treatment of a child's emotional problems are the main purpose of these clinics, they also play a vital role in any national mental health programme by attempting to eradicate the trouble at its root and spreading information or advice to schools and homes about the normal and abnormal variations of mental development and behaviour in childhood and adolescence. The Child Psychiatrist, as the medical director of the clinic, aims at encouraging parents to bring their children for advice, with any major or minor behaviour problem that baffles them, and he, and his colleagues, are always more than happy when they can reassure an anxious parent or a frustrated teacher that there is no evidence of psychiatric disturbance. Far from attempting to find and reveal in every case a subconscious emotional conflict or a subtle deep-rooted disturbance in the parent-child relationship, he prefers to give commonsense explanations and practicable advice. Only in a comparatively small number of referrals is a diagnosis of more or less severe emotional disturbance made and treatment indicated. Independent assessment is made in each case by the medical, the social and the psychological expert of the child guidance team, to assure that the personal, environmental and scholastic aspects are investigated. Treatment, suited to age and intelligence, is only decided upon after the pooling of findings and ideas at the case conference. If psychotherapy is necessary it is arranged weekly or fortnightly at the clinic, while the child can and should continue with his normal time-table at home and in school.

The treatment of choice for young children is play therapy. It consists in encouraging the young patients to play in a room well equipped with toys and various play materials, among which the sandtray with its miniature world of animated and non-animated items is as important and indispensable for therapeutic exploration as is the proverbial couch in the adult clinic. The children are allowed to romp and let rip, according to the type of problem, either alone or in company of others, and while they are having the time of their life, they are unaware that the children's psychiatrist or trained psychotherapist, who is participating in their games, is observing and directing their activities to explore the working of their mind and to adjust their disturbed personal and social reactions. This indirect method of approach in treatment is necessary because children, unlike adults, will not readily reveal their emotional difficulties and freeze up when direct reference to them is made. Once it is clear to the therapist what is wrong he will allow the child in subsequent sessions to relax his tensions to release his pent-up emotions or to abreact his conflicts and externalise his anxieties. Unknown to him he is subtly guided into socially more acceptable and personally more healthy modes of behaviour.

Adolescents are treated like adults in the consulting room where they are encouraged to discuss their problems which are more or less deeply explored by analytical methods or relieved by discussion, suggestion and persuasion suited to their intelligence and experience. Naturally, one has to modify the adult approach somewhat to suit this delicate age of emotional turmoils and sensitive day dreams.

Transference is more important than with young children, where it hardly develops even if the therapist is temporarily invested with a halo of parental omnipotence.

However, no form of treatment in playroom or consulting room could be successful if one ignored the influence of home and school on the disturbed child. In this aspect child psychiatry differs radically from adult therapy, where the security of complete confidence and professional secrecy in the consulting room is essential to the therapeutic success. Dependence on adults and acceptance of life situations created by them is characteristic for childhood and to treat a child as an individual complete in itself would be ignoring the facts. There is no equivalent in an adult's life to the intimate relationship which exists between a child and his parents or their substitutes, nor to the forceful impressions of daily experiences in school, whether scholastic or social. His personality is in a constant state of flux, moulded by favourable and harmful experiences in his immediate environment, which have a powerful influence upon his acting and thinking. The psychiatrist dealing with a child therefore requires the close co-operation of the educational psychologist to explore the situation in school, and of the psychiatric social worker to deal with the home. These non-medical colleagues will have to participate actively with his treatment by securing the necessary modifications in the school or the re-education of the parents. Treatment of the personalities in the environment is in many cases more important than therapy with the child.

Having thus briefly outlined the approach and functions of the Child Guidance Clinic it remains to explain how far help can be given to the backward and retarded child. In doing this I shall not expand on the specialised function of the educational psychologist in such cases and will confine myself to the psychiatrist's role of treating the primary and secondary emotional disturbances associated with dullness.

Scanning through a long and varied list of conditions for which children are referred to my child guidance clinic I have not found a single emotional disturbance or behaviour problem which could be described as specific to, and occurring only, in the backward child. The most intelligent and backward child is liable to develop the same emotional difficulties, while the factors conducive to their precipitation are essentially the same for both. Nevertheless there is a considerable difference in the clinical picture and ultimate prognosis which depend on the child's level of intelligence. The emotional problems of retarded children are invariably unfavourably influenced through the limitations imposed by their endowment and they are handicapped in fighting against malicious influences or in taking advantage of therapeutic help. However, there is a mutual dependence between intelligence and emotional reaction which can be utilised in the therapeutic approach. Clarke and Clarke (1960) have shown that severe deprivation for various reasons in early childhood can influence the subsequent intellectual development, and accepting this together with Bowlby's theory of maternal deprivation, there is much to suggest that intellectual retardation and emotional maladjustment may be etiologically associated. It is perhaps less appreciated, as Sterling D. Gerrard and Julius B. Richmond (1957) have pointed out, that the intellectual limitations of a constitutionally defective child will a priori interfere with the formation of the healthy maternal-child relationship, which is necessary for satisfactory emotional development. Psychological disturbances due to maternal deprivation are therefore in the case of a retarded baby not matrogenic but infantogenic, if I may coin a term, which would lay the blame for the deprivation on the child's inability to respond to an attentive mother. Intellectual backwardness is therefore in many cases only one aspect of a generalised personality disturbance, which remains untreated if concentration is only directed towards the intellectual aspect. Psychotherapy for the development to promote a healthy personality is justified for the backward child, even if the deficiency cannot be improved. The feasability of such therapy

has been shown by the authors I quoted earlier and the experience of many psychiatrists in child guidance clinics. If the results have so far not been startling and the recorded successes cannot be statistically evaluated, it is not due to any inherent inaccessibility of the backward child, but, let us admit it, due to lack of time of hard pressed psychotherapists, who may be forgiven for giving preference for the more hopeful and socially important cases of more intelligent children.

Playtherapy is quite feasable for retarded children, especially in the older age range, if their mental age is continually kept in mind and any primary and secondary complications of an emotional nature are dealt with. I can see no reason at all why a child of 10 years cannot be treated according to his mental age of 6 or 7 years, as long as one makes allowance for incongruities of behaviour arising from the I.Q., and has the necessary patience to come down to his level of interest and appreciation. Verbal therapy should be largely replaced by activity methods, and I have found that some children of limited intelligence respond better to suitably modified group therapy than individual sessions. It is to their advantage and not to the detriment of the others if they can mix with brighter and more mature children. The therapist should, in such a group, remain on the lookout for those who need his special support to prop them up against the more alert, who may be inclined to take advantage of them. Improvement of emotional stability is achieved by allowing repeated self-assertion and adequate self-expression under controlled conditions until conditioned responses are achieved which maintain the dull child's social reactions at a personally satisfying and socially acceptable level of relative normality. During therapy special attention should always be paid to newly arising neurotic and quasi-psychotic symptoms because hysterical manifestations or schizophrenic overlay, Propf Schizophrenia, often complicate and obscure the clinical picture, and require special therapeutic attention.

Generalisations are too inaccurate to discuss therapeutic tactics in further detail, but if one keeps the few principles I have outlined in mind one can be quite successful with dull patients. I always have a few backward children under treatment at my clinic and I regard modified psychotherapy particularly indicated in a group of young adolescents of either sex who are dull but more likely suffering from a schizophrenic condition than a primary deficiency. I should like to refer to this group of patients as suffering from Delayed Childhood Schizophrenia, which must be distinguished from the classical early acquired forms of infantile schizophrenia or simple amentia. This condition is often found among educationally subnormal children in E.S.N. schools and should be suspected when emotional and social responses are not corresponding to the intelligence level and when sparks of temporary brightness or preoccupation with unusual interests singles them out from the group of ordinary backward children.

But child psychiatry is family psychiatry and parents' guidance and the Psychiatric Social Worker is often the most important therapist by her direct approach through the parents, who always present problems if they have a backward child. There are mutual tensions between child and parents, especially mother, which is continually ignored, tend to increase in intensity as time progresses and which may be the cause for secondary emotional problems between the parents and may lead even ultimately to a complete break of the marriage bond. Feelings of rejection acknowledged by the parents will in any case frequently prevent his full integration into the family and endanger the parents' own relationship. Kirk has pointed out how the diagnosis of mental deficiency arouses in the parents first shock and disbelief, which are later replaced by a denial of the truth and hope for a magic cure. When this fails, as it must, fear, frustration and guilt may overwhelm intelligent planning for the future. The parents will either dote on the child with unrealistic self-sacrificial devotion or the mother will fall into a state of continued

subacute depression. Projection of own guilt feelings will make parents blame each other and intimate relations will suffer permanent harm by the increasing misunderstanding and the inadequate sexual satisfaction from self-imposed contraceptual restrictions to prevent a further calamity in the family. The P.S.W. will find her work with such parents not easy but rewarding. Once the child has grown older she may have to protect him also from the parents' inconsistent and ambivalent handling which is due to their oscillations between overprotectiveness and rejection, which are more or less open. The child also suffers indirectly from his parents' mutual estrangement and directly by the restrictions they impose on his legitimate social outlets because of their fear of social or moral disgrace.

Summary

This paper has attempted to give the picture of the special set-up and approach of the child guidance team to the problems of the child patients and their parents. It also attempted to show why child psychiatry is a speciality which must differ in certain techniques and attitudes from the work with adults. Therapeutic work with backward children both in the child guidance clinic and the mental deficiency hospitals is not particularly frustrating, if one keeps in mind that the aim of any psychiatry with children is less the achievement of a particular level of stability or maturity, than to assure complete happiness for the young client and his acceptance without reserve by the community around him. It is necessary to view the backward child as creating a problem within a family setting. This will not be much different for the feeble-minded in a dullish home, the failure in grammar school with professional parents, or even a clever child of a scholarly family who fails to gain a university place or equivalent professional grade.

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