Round Table Discussion

PREVENTIVE PSYCHIATRY

SHERMAN LITTLE, M.D., Buffalo, N.Y., Chairman
ALVAH L. NEWCOMB, M.D., Winnetka, Ill., and KENNETH T. KNODE, M.D., South Bend, Ind., Secretaries

Chairman Little: This session has a title of "Preventive Psychiatry." I am not sure that it is an entirely correct or happy one. Psychiatry is still a bad word to a good many people, including some physicians, yet it has a real connection with the kind of thing in which we are all interested. What we will discuss is psychiatry in the sense that we are concerned in understanding and helping people, in this case, children. Yet it is not psychiatry in the sense that we are concerned with long term treatment of severe disturbances of adjustment. It is an application of psychiatric knowledge and skill by pediatricians within the framework of pediatric practice. The emphasis is on preventing disturbances in adjustment or on correcting early and relatively shallow-rooted ones.

For a long time many pediatricians have been giving a great deal more than good medical care to sick and well children. On their rounds and in their offices they have consciously and unconsciously helped many children through helping their parents. They help parents by supporting, encouraging and advising them in the difficult job of being parents, and in so doing, they indirectly but concretely help many children. It isn't easy to do this, at least I don't find it so. In the first place, we aren't trained for it. If we develop any skill at it, it comes from experience, which can be painful and slow, and from something that we call intuition. As a matter of fact, our medical training, at least that part of it concerned with our handling of the patient with a medical problem, is often a serious drawback. We are accustomed to telling people what to do. We say, "Take these pills every 4 hours; drink lots of water; stay in bed until I tell you to get out." The patient is relieved and happy. This is what he wants. We are trained to do this, and up to a point it is what we should do. We have been called in to tell people how to cope with something from outside themselves (outside themselves psychologically if not actually physically) which is attacking their physical body. Most of the time the patient feels no responsibility, no guilt in being ill. He doesn't feel defeated and inferior because he's caught a cold or has the flu. Of course if he has lues, he usually doesn't boast about it. The point I am trying to make is that he doesn't resent being told by the doctor what to do to make himself better. It is not a part of himself that is at fault, it is some external agent which is attacking him.

However, it is quite different when you are dealing with an individual with a problem of adjustment, or a parent of a child with behavior difficulties. They feel that this is something which concerns them, something for which they are responsible, something which indicates that they are at fault and in some way are failures in the job of being parents. It is not easy for people to change their thinking and behavior around things which do not touch them too closely and it is even more difficult when it is something which to them seriously questions their capabilities as parents.

Difficult as this is, this is not the major difficulty. The major difficulty is that out of their own past experience, particularly in childhood, they have acquired many concepts and attitudes, some of which are applicable and useful as parents and others which are inapplicable and perhaps basically unsound. It is these concepts and attitudes which largely guide and determine their behavior as parents. All of us do this to some extent even in the face of evidence which to others makes it obvious that what is being done isn't working.

In spite of education, advice and suggestions of others, parents are apt to persist in methods which will not work in their particular case and might not work in any. If you go into a situation of this kind and attempt to handle it authoritatively as you would a case of tonsillitis or pyelitis, you find yourself met with a considerably different reaction. Although the parent says he wants advice and help and you offer what seems to you to be very sound stuff, it either does not seem

to work in spite of earnest endeavor on the parents' part or to your surprise you find that they are not carrying out suggestions that you have made. This is at times apt to be annoying, and one's impulse frequently is to step in in an even more authoritative fashion. If, however, you stop for a moment to think what is going on, it may become clear why good advice is not working. There are several reasons why it may not be but the most important one is that basically you are suggesting to the parents that they modify a pattern of behavior which has been built up from early childhood. In other words you are asking the leopard to change his spots overnight. Furthermore, you are implicitly suggesting that his basis of operation as a parent is false and incorrect and that he give up what has seemed right and familiar to him and try to use something which is both unfamiliar and may from certain past experiences actually seem wrong to him, or at least very threatening. Of course there always is some possibility that what seems like good advice to you may actually not fit this particular parent and child because, as you know, behavior is not stereotyped. It is still true that there are a number of ways to skin a cat.

I have perhaps made enough of this point that one needs to use a different approach in dealing with problems of behavior than one does with a strictly medical problem. One needs to give up the authoritarian approach because it is inapplicable to this kind of situation. What then can one do that will be effective?

Various people, of course, have through experience worked out ways which are reasonably effective for them. Important and effective as this can be, it is even more important in the long run to define and understand clearly what one does and why it works or doesn't work. Only in this way can understanding and skills be improved and, to some extent, transmitted from one physician to another.

What is the kind of knowledge and skill which can be most effectively used by a practitioner of pediatrics? To my mind it is something that comes basically from psychiatry but has to be modified or changed to fit the setting of pediatric practice. I think it is useful for a moment to look at what another profession has done in a related area. I would like to speak for a moment about social workers because the field of social work has adapted psychiatric understanding and psychiatric skills to the professional job of social work.

I use social work as an example because I believe there are certain areas of professional practice in social work and in medicine which are very similar and at times even overlapping. This is in the area of helping with external problems which confront parents. The social worker may be dealing largely with problems of social nature, while the doctor helps the parent with the reality of being a parent dealing with children's reactions or the feelings which are stirred up by illness and operations. The area of responsibility is different but largely so in terms of knowledge and special conditions, not in basic skill.

To some, my use of the social worker as an example may seem inappropriate. There is still a hangover of associating social work with giving relief or with some of the negative reaction with which psychiatry has to deal. Unless you have had the good fortune of working closely with skillful social workers, you may not be aware of their professional and understanding competence in helping people with difficulties. By and large they confine themselves to helping with problems in the reality situation, in the situation or environment of the individual. Many people helped also have internalized problems of greater or less degree, but it is often gratifying and at times amazing how the individual is able to cope with his internalized problem as he is given understanding help with those problems which press upon him from without.

The social worker's most useful tool is the ability to conduct a skillful interview. The physician needs the same tool. Through this means parents can help to sort out and clarify the most pressing problem and to decide what are the possible contributing causes. Having been helped to achieve some order out of what has seemed to be baffling chaos, the possible approaches to the contributing causes are examined and the parent is encouraged to decide on a course of action. Through all this, the various conflicting feelings of the parent are calmly accepted as they are brought to light even though some of them may be a little surprising. It is this which gives the parent a feeling of acceptance and which often frees and encourages them to go ahead in some positive direction.

When the practicing physician has the necessary understanding of human nature and the skill in interview to do this with parents, a tremendous amount of emotional disturbance can be prevented. As a matter of fact, many seemingly serious situations would be helped without recourse to child psychiatrists or child guidance clinics. It is important to be clear when one has gone as far as one can and when to refer to specialists in child psychiatry. Perhaps this sounds as though
I were telling you to be psychiatrists and perhaps you think that to do this would take much time. I know from my own experience that what I have suggested can often be accomplished in 2 to 3 interviews. These do not need to be an hour long. Perhaps one at the beginning of a half to three quarters of an hour, and after that it can be done piecemeal following an initial clarification. A few minutes at the end of an office visit or a house call will often do the trick. Some of it can be done during your phone hour in the morning.

This will not prevent or solve all problems. If it would, psychiatry and child guidance clinics would have no function. There will probably always be a significant number of parents and children with severe internalized problems who will need the special skills of the trained child guidance clinic team. You can help to get these people to the help they need.

One other thought comes to me, and that is that you may be skeptical of the effect of this or the methods I’ve described. I can only say that it helps parents to help themselves.

There is nothing that licks frustration, discouragement and the unhealthful behavior which often accompanies these feelings like beginning to do something effective about a problem. If parents can get from their contact with the doctor a feeling of his acceptance and understanding of them as people, some skillful help in critically examining the possible causes for the difficulty and some support for their own plan of solution, they are often enabled in time to work through the difficulties in quite a satisfactory fashion. As a matter of fact, there is no sound solution of problems except in this way. No one can solve others’ problem for them, nor ever tell them much what to do, but you can help people to use their own knowledge and judgment. Neither the doctor nor the parent should be distressed that they do not completely understand all the cause of the problem. Understanding or insight, as it is commonly called, is a fairly feeble problem-solving tool. Much more important is the feeling of acceptance by others which gives us courage to try, some slight help in clarification, and the satisfaction in our own achievement which keeps us going. These are the kind of things which the doctor can give to parents.

Now as to evaluating the child himself. It is not always easy for us to do this because we get very little training in our formal pediatric training in being able to skillfully evaluate children. However, if you start with the observable behavior of a child and not just one small observation, you can get a good many clues as to what is going on. Children handle their feelings in different stages of development. You can observe this and combine this with your own knowledge of the parents and the history which they give and you can often be pretty accurate as to the amount of disturbance which is present.

One of the best of the observations which can be made is to notice how the child handles his feelings and to relate this to some rough standard in your own mind of the way a healthy and happy child of that age would handle feeling. Then you want to find out if his reactions are typical of his general reactions or if they merely represent a reaction to some fairly immediate experience. If what you see seems to be a fair sample of his behavior in general then it is significant.

For example, as you see his reactions to situations and thoughts which produce feeling you can note if he responds appropriately. Is he too cheerful under circumstances which would naturally bring out discouragement or anger? Does he dare to be friendly? Can he show appropriate disappointment? Naturally your own bias colors your observations, particularly if you feel that small children, especially boys, should always be brave little men and not cry when they skin their knees or should die fighting rather than temporarily accept defeat.

However, if you observe carefully and subject your judgments to critical examination, you ought to be reasonably correct. This helps because any child who does not on the whole handle his feelings appropriately is bound to have trouble. It may be obvious trouble or it may be trouble only in the sense that it is a sign of an inadequate and limited use of his total self. After all, we want children to be able to use all their abilities, physical, intellectual and emotional. Too many people are only partially functioning because some of their emotional life is not functioning in a full but controlled fashion.

Now a word about the specific way in which a pediatrician can be of help to a young mother—to make the situation clearer—a mother with her first baby. I want to emphasize this for 2 reasons. The first is that this first experience in being a mother and this first beginning relationship with her baby are very important times. The second reason is that for the past 40 years there has been accumulating pressure on mothers to make them feel less capable as mothers. First with the advent of scientific feeding the implication to mothers was that feeding was a science only for doctors and nutritionists to understand, not a mere mother.
Secondly, with the advent of modern psychology and psychiatry, we implicitly say to mothers, "Don't trust your natural, maternal impulses; beware of your own thinking about bringing up your children; child rearing is a science, needing great knowledge and fraught with many dangers. One must be a scientist to bring up children and obviously you are not that."

All of this has knocked the props out from under mother's confidence in themselves. It is perhaps an inevitable and painful stage in our development of genuine knowledge but it is mighty hard on mothers in the process. Gradually, as you are aware, we are recognizing that much of what mothers have done out of the living experience of the race is in many instances sound and "scientific." But we come to this slowly, we are skeptical and have to be convinced and meantime mothers are being put through the hoops.

From this, at least to me, it seems clear that young mothers need a lot of support and encouragement. They need someone to talk to, someone whom they respect and who respects them. Someone who has the patience to listen and the ability to set some limits so that the mother is helped to accept her own areas of responsibility; someone who can help her to think through the situation and get support for her own impulses and decisions.

I have stated my thoughts. I am interested to know what you do and what your thinking is.

New Speaker: One thing I have noticed in developing the responsibility of the mother and that is very often the mother will lean on you even though you try not to let her do so. There will be a relationship between you two of the understanding of the child with the father left out. It is more important and I try to do it in evening hours, to have the father come back with the mother. Get him as a team on the situation.

Chairman Little: This is an excellent point. It brings the father into the picture, brings the parents together as parents, helps the child and, not to be passed over lightly, helps you by putting the load where it belongs. Do any of you have any reaction to the situation in which the mother is inconsistent in dealing with the child and when the father comes home the kids jump and behave for him?

New Speaker: I don't think that is unusual, more of the normal family life. Part of the reaction to the father is also a reaction to fear.

Chairman Little: Do you think it represents in the father a superior ability to handle the situation?

New Speaker: He has a great perspective of the child by being away most of the day and also that way has more authority over the child.

New Speaker: I think a lot of the trouble develops with the mother expecting the child to behave beyond his years. It causes more unhappiness in those who are trying harder to do the job well. It seems to me as pediatricians we can do a lot of preventive work by telling the parents at each age group what is going to happen.

Chairman Little: Dr. Gesell's books are valuable in terms of an objective description of behavior at certain ages. This is helpful but the child and the forces around him are determining factors in the behavior which he shows. The feelings which go on inside and which relate to his external behavior have never been well stated.

New Speaker: Now no matter what book is written, it is not going to apply to everybody and may be misinterpreted, unless the mother has a chance to sit down and talk over with someone who knows that there are normal variations in the thing. The printed word is dangerous in one way. I think you read those things, take them at their face value and if your child doesn't go along right by the book then something terrible is wrong. It is much better to sit down and talk about it.

(A question was raised about the difference between what a psychiatrist does and what a pediatrician can do.)

Chairman Little: I see the job of the psychiatrist as a special job of treatment of the internalized problem of the child, where the child has developed certain patterns of reaction the reason for which he is not particularly clear about. They are ingrained in his way of reading. Even though you may change almost the total environment about him, he persists in going on with this method of behavior. There are a considerable number of problems of that kind, they do need the specialized help of the child psychiatrist, and at the same time, the parents need some help with their relationship with the child. There are, however, innumerable problems of children which in a sense are reactive. The child is reacting to certain things which are hitting him now, a particular set of circumstances in his particular environment. The pattern for the behavior may come from the past.
but the reason you see the behavior now is because of something happening now. If those particular circumstances can be modified in some way his behavior is going to pretty well take care of itself.

New Speaker: I think the line that is drawn depends a great deal on the individual. I come from a town of 100,000 where we have managed to get a team to work together. The social worker works with the parent and the psychiatrist works with the child. Our biggest difficulty right now is to get the child guidance clinic together with the pediatricians in town—to get the pediatricians to use them—and not only pediatricians but ministers and other people as well.

Chairman Little: Each discipline as does each individual has to learn out of its own experience its limitations. Some people in the practice of pediatrics can do an excellent job of psychotherapy. But it is not the kind of thing the average pediatrician has the time for, the interest in, or the training for. If he were primarily interested in that he would go into psychiatry.

New Speaker: One of the problems we have every day is the really spoiled child, the only child, the first child in the first year. What I would like to know is what you psychiatrists can do to educate the parents to unspoil the only child. What do you think of the idea of an educational film?

Chairman Little: Two things come to my mind around your remarks. One thing is the question of the use of educational material of that kind, which I think we might spend a minute or two on. The other thing is, what do you think spoils a child during the first year?

Speaker: Well, emotional feeling for this child is what spoils him; this child represents those feelings. The mother gives in to every whim of the child. On the problem of crying, one of the ways we get around it is to tell the mother the child has to cry a lot for the first few weeks to get good expansion of the lungs.

New Speaker: I think the help to the mother should start right in the hospital before she goes home; you can prevent a lot of those things from happening. I tell the mother that her baby is going to cry a lot during the first month. Now, during this period, especially at the beginning these cries are going to sound alike and they are all going to concern the mother so I advise her to go to the baby whenever she wants to. A little later, there is going to come a time when this baby is going to talk to the mother with these cries. Then, too, we have an hour in the morning when the mothers can report to us. That also relieves them when they know that they can report anything that concerns them.

If you ever intimate that a child is spoiled, then you are on the defensive. The mother becomes antagonistic when you use that term.

New Speaker: I think it would be an excellent idea for the obstetrician to talk to the mother during the prenatal period about these things. Also to have a psychiatrist talk to a group of mothers who are pregnant. Then a pediatrician to give a group talk too. The fathers should also be included and a pediatrician to contact the group before the mother delivers and then all along through to the meeting in the hospital; if, in that way we could develop a liaison between those three doctor groups, we would be doing a lot of preventive psychiatry.

Chairman Little: That is an important point. It is hard to achieve at the present time; very often it is hard to get obstetricians interested—why, I don't know, but I think it is. We are often going to be confronted with situations where that has not been done. Yet I think it is a very desirable kind of thing because mothers have a great deal of feeling as they go through pregnancy. feelings that are going to influence their reaction to their child after it is born. If some of those feelings can be met, if they can share them with somebody else, it helps a lot. The opportunity to share the feelings with another person who seems to know what we are talking about, who seems to be interested in us, can be very helpful.

Dr. Roy N. Andrews, Mankato, Minn.: It has occurred to me from these talks that every pediatrician has to do a certain amount of psychiatry. He knows the family, the mother and father; it is his duty to do a moderate amount of psychiatry and to call in the psychiatrist if the case is severe. One of the points mentioned that has been of help to me has been to bring the child in alone when he is older, that is, without the parents, and talk to him. There are many instances where you will get a lead you wouldn't get if the parents were there.

Chairman Little: That is an excellent point and one which I think a good many people do, but we often times forget to do it.

Dr. Gustavo Castaneda, Guatemala, Guatemala: Is it possible that it is unique to my experience that I have a good many children with the problem that they will not eat?
Chairman Little: It is by no means unique; I think we should bring that up for discussion a little later.

Do any of you have any strong feelings about what are the kind of things you want a mother to do in handling her child under 1 year of age?

New Speaker: Don't you think you should make the mother develop a sense of responsibility as early as possible to make it easier?

New Speaker: We have had too much of that; I think the mother should enjoy her child.

Chairman Little: I think as a rule the mother does have an adequate sense of responsibility. What do you think of saying to the mother when she raises certain questions with you, about the question of how often is she going to feed the child, for example—"What have you noticed about your child? How often does he seem to wake up? What seems to satisfy him?" Not as though you were gathering information but as though you were trying to clarify your own thinking. It helps her to realize the observations which she has made are fundamental and pretty important observations upon which good decisions can be made.

New Speaker: I wonder just how many of us do take the time to tell a mother that she is doing a good job with her child?

Chairman Little: A good point. I doubt if we do it enough although I don’t think we want to lay it on too thick.

Do you feel that it makes a whole lot of difference what you feed and in general what is done to a baby during the first year of life?

New Speaker: Many babies cry a great deal through the first year of life—and we sense that this is not due to formula or allergy but have our suspicions that there are tensions in the home which the baby has picked up. We suspect that the mother is quite nervous about the baby and that may be one of the reasons it is crying and we do everything we can to reassure her.

New Speaker: I think a practical thing to do when we have a very tense mother is to tell her to pick the baby up and love it only when it is quiet; then she is apt to be more relaxed in her handling of the child. Also I like to emphasize that the mother should try to relax and not bang things continually as most tense mothers do. If they can teach themselves to relax and be slow and easy in handling the baby, it will be better.

Chairman Little: Could you put it in terms of having fun with her child when it is quiet and when it is crying to do all she can to be sure the child is all right, then if the crying continues, put it down and if possible get out of earshot—although not too far away—for a period of time? This helps the mother and gives the child a chance to go to sleep.

What place does education have in preventive psychiatry? Do you find that educating the mother, reading discussions of feeding, etc., really help?

New Speaker: If we go into teaching these people we have to keep it very simple. We are dealing with people of so many types of education, stability, etc., that you can’t create just one pattern and try to teach on that scale. I think as a mother comes to you, problems will arise and can be handled at the time but I don’t think you should discuss problems that might arise. In some of those cases you can create hysteria. It is the anxious kind of person who is alert to any exaggeration.

New Speaker: I sometimes wonder if a little knowledge is a dangerous thing. I don’t personally advise them to buy Dr. Spock’s book or any of the other books. Unless the book you recommend is in full agreement with your practice it is better not to advise this.

Chairman Little: Isn’t that asking a lot of a book?

This question of education, to my mind, is very important. It has real value and it also has distinct limitations. It has to be used in terms of the individual because there are people who are anxious and who read into relatively simple things all sorts of ominous implications. It takes an awareness on our part of the people with whom we are dealing.

New Speaker: I think there is a tendency on the part of the doctor to make the mother too dependent upon him. So many of them call the doctor for every little thing instead of using good common sense.

New Speaker: I always feel that the baby is the mirror of the household. If there is a nervous mother, the child will be nervous and what you do is not so much to make the mother comfortable but to make the relationship between the mother and the baby such that the baby grows up a well adjusted child.
New Speaker: We have made a rule to allow the mother to come into our hospital and visit daily when a child is there for a length of time. When you think of it, it is cruel to take a sick child who needs his mother and put him in with strangers to perform all those tests on him. I think that is the most terrifying thing you can do to a child. Each child should be allowed to see his parents even if it does upset the routine of the ward.

New Speaker: We have instigated visiting hours in our hospitals every morning from 10 o'clock to 11 o'clock. We have found it considerable help—it relieves the nurses quite a bit; mothers help feed their children; the children are happier and quieter and the parents love it.

Chairman Little: It is my feeling that there are certain children whose parents have been tremendously protective and unnecessarily close to them and the child has a sense of relief when the parents are not there. However, there are a great many children, mostly under 6 years of age, where I think it is important for them to have frequent opportunity to see their parents. I know that those contacts will not always be satisfactory to the child, nor for the hospital personnel. It takes some understanding on the part of the nurses and the house staff of what is going on to make that contact with the parents a constructive one for the child. You have parents who are filled with all kinds of anxiety; they are going to project their difficulties on you, going to blame you for everything that is happening. They have to be directly and intelligently dealt with.

(A question was raised about preparing children for operations.)

Chairman Little: A child should be brought in about 24 hours before his operation to become accustomed to the situation, to get to know the other children and feel that this is a familiar place. With younger children—certainly those 4 years old and under—the mother should either stay with them if they are admitted very long before the operation or should bring the child in as prepared as possible just before the operation and stay with the child until he feels well or goes home.

New Speaker: One thing they have done recently at Children's Hospital in Chicago was to put the children who are not bed patients in shorts and jackets. They run around and seem a lot happier and a lot more normal. The children in bed are still in hospital gowns.

New Speaker: Does the hospital provide that or does the mother bring the clothes?

Answer: The hospital provides the outfit. They are very colorful, stripes, etc., and the children really love it.

(End of recorded material.)
Round Table Discussion: PREVENTIVE PSYCHIATRY
SHERMAN LITTLE, ALVAH L. NEWCOMB and KENNETH T. KNODE
Pediatrics 1952;10:68

Updated Information & Services
including high resolution figures, can be found at:
http://pediatrics.aappublications.org/content/10/1/68

Permissions & Licensing
Information about reproducing this article in parts (figures, tables) or in its entirety can be found online at:
https://shop.aap.org/licensing-permissions/

Reprints
Information about ordering reprints can be found online:
http://classic.pediatrics.aappublications.org/content/reprints
Round Table Discussion: PREVENTIVE PSYCHIATRY
SHERMAN LITTLE, ALVAH L. NEWCOMB and KENNETH T. KNODE

Pediatrics 1952;10;68

The online version of this article, along with updated information and services, is located on the World Wide Web at:
http://pediatrics.aappublications.org/content/10/1/68