

THE ROLE OF THE PEDIATRICIAN IN THE MENTAL HEALTH OF CHILDREN

Summary of Round Table Discussion

By Richard E. Wolf, M.D., and Hugo Dunlap Smith, M.D.

Children's Hospital, and Department of Pediatrics, University of Cincinnati, College of Medicine

THE DISCUSSION of the role of the pediatrician in promoting good mental health was introduced by Dr. Wolf with these questions: In the prevention of mental illness, where are we as pediatricians? What is our goal? To highlight the magnitude of the questions he pointed out that, according to statistics, of every 12 babies born today 1 will spend a portion of his life in a mental hospital. One-third of the nation's health bills are spent for mental illness. With the better training centers working at full capacity, there will not be enough psychiatrists to catch up with the case-load of mentally sick persons now existing. In the area of mental health we must do more than pay lip service to the prevention of mental illness. In medicine the sequence has always been: First, find out what is wrong (diagnosis), then correct this (treatment), and finally, prevent the malady (prophylaxis). The cardinal point is surely prevention. We must find ways of preventing mental breakdown and obviously the pediatrician having contact with children while personalities are forming must be a leader in promoting mental health.

There was active discussion of the pediatrician's role in mental health; of the ingredients of mental health; of the considerations in evaluating health and illness; and of the education of parents by pediatricians alert to developmental needs of children. The pediatrician must recognize that he has a key role to play in observing the manifestations of physical, psychological and emotional health. Each physician will

play his role in accordance with his special interests, be they in practice alone, in nursery school affiliations, in recreational, educational or treatment facilities. He can be expected to be asked for advice as someone well-qualified to survey these areas.

Most of the discussion revolved around several general areas: first, the opportunities of the pediatrician to handle anxiety in the child and in the parent. It was suggested that probably the best opportunity for establishing a relationship with the mother was during pregnancy, either before the birth of the child, or during the lying-in period. It was felt that spending more time during this period often avoided later difficulties and unnecessary calls, and several expressed the opinion that time was less a factor than inclination and ability to utilize an interview-situation properly.

During prenatal weeks one can learn much about the prospective parents, how they feel about having a baby, whether the baby has been planned and, if not, how to deal with mixed feelings. One can discuss with the mother the matter of breast-feeding, perhaps avoiding the difficulties which sometimes arise if she is unable or unwilling to breast-feed and thus avoid a sense of failure later. A mother is often troubled by the way she feels about the new baby, perhaps because of an exaggerated preconception about the strength and immediacy of "maternal instinct." She may feel inadequate and unsure of herself, or disappointed, and hence guilty, when the baby is not of the sex the couple had wanted. The pediatrician, through his un-

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Dr. Wolf is Director of the Pediatric Psychiatry Clinic. Dr. Smith is Medical Director of the Out-patient Clinic.

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derstanding of these feelings, his respect for the person, his experience and his confidence in himself as a doctor, is in a very good position to help the parent. He is able, through universalizing parents' feelings, to minimize guilt and anxiety. Through pointing out to the mother the healthy, positive aspects of growth, he can increase her interest and pleasure in her child and through his noncritical attitude, he can reassure her as to her capacity to deal with her child. Along these lines discussion was lively as to methods various pediatricians had found useful in helping mothers with their concerns about the "normal problems" of the first 3 years of childhood, particularly weaning, toilet-training and the setting of limits in the development of discipline. The benefits to be derived by a child of 3 to 5 who has a good nursery school experience was pointed out, as well as things that constitute a good nursery school.

Another opportunity presents itself in dealing with the reactions of the child toward physical examinations, painful medical procedures and hospitalization. Here the pediatrician may teach both the parent and the child how to handle anxiety. He must first try to understand the sources of these anxieties from the standpoint of the individual child—his level of development, his life experiences, his parents' adjustment and how much a child's anxiety may be related to parental attitudes. He must also examine his own attitude toward parents and child. In his role of doctor, he is in a position to be confident and firm in his knowledge of the wisdom and necessity of the procedure and, if his relationship to the child and to the parent is honest, warm and kindly, he will be able to reassure them and will have helped them to face painful and frightening experiences in a way which fosters strength and growth.

In discussing hospitalization, several questions were raised. The first had to do with separation from mother. The point was made that the period in the child's life at which he is hospitalized is of greater importance than the actual duration of the

hospitalization. It was emphasized that the time of greatest concern should be during the second year of life. The infant has not yet had the opportunity to learn much about his mother, whereas the child from 1 to 2 does know a great deal about his mother and father, but has not yet learned about other people who might act as substitutes. There has, in the past, been an overemphasis on the dangers of separation for the infant, and underemphasis for the 1- to 2-year-old. This point was illustrated by the report of a study of a group of children undergoing tonsillectomy. It was found that the 3-year-olds (the youngest group studied) suffered most, regardless of whether they had been prepared or unprepared. There followed some discussion as to how these observations might influence decisions on hospitalization for elective procedures, such as repairing of hernia, cleft palate, etc. It was brought out that this would also depend on other factors, such as the attitude of the surgeon, the hospital facilities, the danger of anesthesia in infants, etc. Also discussed were techniques of preparing for hospitalization. It was pointed out that too much preparation might mobilize greater anxiety and that the timing and the extent of the preparation should be determined by the needs and the developmental level of the individual child.

The question of separation for reasons other than hospitalization was then raised. What about parents leaving the child for a vacation? In this connection it was pointed out that the needs of parents must be respected. If the child is well and an adequate parent-substitute is provided, this can be an experience of growth. The parent may need to be encouraged to see this as something which is good for the child, as part of his learning independence.

About the working mother? It is important to know why she is working, what her motivation is to work, what she would be like if she were not working and whether she is providing an adequate substitute during her absence. The mother who feels

guilty about “neglecting her child” may overcompensate when she is with the child. This mother may need to be reassured and can often be relieved by the knowledge that sometimes 1 constructive hour spent with her child is of more value than a whole day of frustrations.

The father’s role was brought up at this point. There is the father who actually does not have enough time to spend with his child and needs to be reassured that it is not a matter of the amount of time, but rather what goes into the time he can give the child. There is also the father who avoids relationship because he is afraid of his child and so requires guidance in developing techniques for finding gratification. Then there is the father who is called upon to substitute for the mother, and here it was pointed out that this should be discouraged, if possible, as in our cultural pattern children need parent figures of opposite sexes with whom they can learn to identify.

Another general area covered during these discussions dealt with the pediatrician’s responsibility in counselling parents. What is his role in the family? How much can he do to guide and foster good parent-child relationships, to encourage healthy development? The importance of school was stressed, both as a setting in which children have some of their most constructive experiences and as a place where observations and impressions obtained by teachers can be very helpful to the pediatrician trying to interpret behavior to a parent, and assisting in attempts at its modification when necessary. The importance of the pediatrician retaining contact with school-age children so that he has as rich an understanding of normal physical and emotional growth in this period as he does in younger age groups was stressed. Perhaps pediatricians have not done all they can to make use of these older years of childhood in the promotion of mental health. A child of 10 years still has to grow considerably in both psychological and emotional aspects. Emphasis was placed upon the importance of know-

ing the family unit, observing and giving parents an opportunity to explore their feelings and to convey these feelings, if possible, to the doctor. When one is asked how to handle antisocial behavior, school problems, sleep disturbances, abnormal fears, speech disorders and sibling jealousy, it is essential first to try to understand the feelings which these symptoms are expressing; what there is within the family situation to which these manifestations may be a reaction.

One may then see that help is needed by parents who have become confused as to where one draws limits in permitting children freedom of expression. This may have resulted in behavioral difficulties, sleep disturbances and other maladjustments. Or, one may then be in a position to advise them in regards to whether or not their child should go to nursery school; how they should handle the child who refuses to go to school; whether the child’s speech problem requires speech training; etc.

There was considerable discussion of methods of making referrals to psychiatrists. How far does the pediatrician go in attempting to treat emotional problems? When does he try to handle such problems himself and how does he make the referral? When the pediatrician feels that there is no longer a chance for him to modify the situation, recognizing that this is an internalized problem requiring techniques of treatment which he does not have, then he must explain this to the parent. If he feels that a parent requires psychiatric treatment, he will try to help him or her to see that the child’s problem has to do with their interrelationships. As the parent begins to understand, the pediatrician can explain what the psychiatrist or guidance clinic can do, and what can be expected from such a referral.

A final general area of discussion had to do with the pediatrician’s role in the mental health of the community. This was touched upon in connection with several of the topics already discussed. The question of

finding mother-substitutes pointed up the need for adequate nursery schools and day-care centers. Hospitalization and the problem of separation brought out the need for examining hospital practices. The emphasis on the family as the key unit in mental health stressed the importance of recreational facilities and group activities within the community. Psychiatric help for children and families of children with serious emotional disorders requires, along with private psychiatrists, guidance clinics and family service agencies equipped to handle such problems. It appears, therefore, that it is a responsibility of the pediatrician to acquaint himself with existing facilities, to work with them and at the same time seek ways and means for their continued improvement.

In summarizing the trend of the Round Table discussions, Dr. Smith pointed out that discussion had progressed from questions of treatment to means for prevention of mental illness. In promoting mental health the pediatrician strives for balance within the family, an awareness of the needs of the individual child—his need to advance and, at times, to regress; and his need for authority and limitation, as well as freedom of expression. The pediatrician must also be able to evaluate the seriousness of a problem and be prepared to act in accordance with his evaluation, bringing other specifically trained professionals in as necessary. In addition to his role as educator and guide, he has a responsibility toward furthering the mental health of the community in which he practices.

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