THE TECHNIQUE OF CHILD PSYCHIATRY.*

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I ONCE knew a child psychiatrist who had two treatments: Boy Scouts for all symptoms except enuresis, for which he prescribed Sea Scouts; but that was before the war, when we had a seaboard.

There is great satisfaction to the human mind in reducing multiplicity to unity, diversity to simplicity, but this exercise can be carried too far, especially in dealing with such a complex creature as the child. In contrast there is the school of thought which believes in intensive analytic treatment, four to five sessions a week, for every child. How can one steer a middle course in a modern Child Guidance Clinic where numbers must be dealt with, without the sacrifice of the deeper approach, where short and long treatments must be fitted in, where diagnosis and consultations are essential, yet *treatment* must always be one of the fundamental aims?

The choice of treatment as to its probable duration and its type, for example deeper or more superficial methods, depends on—

(1) The diagnosis.

(2) The intelligence and insight of the child; intelligence may be high and insight poor; this quality of insight is just as variable in the child as in the adult.

(3) The degree of innate temperamental stability.

If longer and more intensive methods are reserved for a proportion of cases on this basis of selection, then it is possible even in a busy Clinic to make deeper analytic treatment an integral part of one's therapy for such children as need it and will benefit by it: for example, in obsessional and some anxiety states, withdrawn and depressive conditions and certain schizoid and characterological disorders. The deeper approach is not so much a question of time as of orientation, and with the collaboration of the experienced psychiatric social worker, treatments which aim at the exploration of the unconscious can be carried through successfully even with once-weekly visits.

The constitutionally unstable child with poor integrative potentialities is often difficult to recognize, and more so in the child than in the adult. Instability of course is a matter of degree. We need many more long-term studies of the psychopathology of such children, preferably into adult life, before we can make worthwhile prognoses or decide with any certainty the best type of treatment for them; but in my opinion these children on the whole do better with reinforcement of the ego than exploration of the id, and their elimination from the group for deeper treatment does relieve the congestion of the waiting list.

The assessment of emotional instability is one rarely missed by the mental hospital psychiatrist; it is not always believed in by the Harley Street analyst whose experience has not been in numbers. For that and other reasons, too, it seems important that the child psychiatrist should always base his training on a study of the fully developed psychoses in a Mental Hospital atmosphere. He learns from this experience to look for a continuity in the clinical expression of similar states in the child and the adult. He asks, for example, what is the connecting link between the depersonalization of the adult depressive and the unreality sensations and disturbances of body image of the child, expressed in the "funny feelings" of the expanding and contracting type in the "body thinking," kinaesthetic child, or in the mental sphere in persistent obsessive ruminations, such as I found some years ago in a boy of 12 who was constantly haunted by a sense of

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dissociation, and preoccupied with the recurrent question as he looked in the mirror, " Who am I ? " Much of his symptomatology had a depressive colouring.

Let it be clear, however, that experience amongst adult psychotics and neurotics, however enrichening, does not equip the psychiatrist to do child work ; this is a specialty in itself, and requires intensive study of child psychopathology as well as an acquaintance with the normal developmental phases of childhood.

Therapy makes use of suggestion, persuasion, re-education, catharsis ; all the shorter methods as well as deep and modified analysis. In placing the accent on deeper treatment in this paper, there is no intention of discrediting shorter methods nor environmental modifications in either Clinic or private work. Another factor favours the deeper orientation in child work, and that is the predominance of fantasy in the child's life. Fantasy in children is always so vivid and lively and accessible that whatever the type of treatment or choice of materials used, the therapist must be prepared for sudden incursions into the unconscious, and not be dismayed at the rapidity with which the child runs from one medium to another and from conscious to unconscious spheres, nor at his apparent disregard for direct questions, which is not always resistance, but often the child's more circuitous route to his central theme. For example :

Richard, aged 8. When the psychiatrist mentioned his misdemeanours, stealing, he took no apparent notice, but drew a tank—a British tank he said—with great care and absorption. He then camouflaged it with colours, and as the psychiatrist went on talking he covered it with swastikas and shouted triumphantly, " Ha ! that will fool the Germans." I suggested that he was fooling me and perhaps himself too. He looked at me directly then, and said, " It's not the stealing that makes me frightened ; but I have to go to boarding school, and what I'm really frightened of is that Mummie may be killed in an air raid and I won't be with her." In other words there is an element of deep treatment in all therapy in the child.

Now what is meant by *treatment* in the child ? What are the methods by which the psychiatrist studies and treats the child's personality problems and behaviour disorders ?

The child, like the adult, can be studied from two points of view :

(1) Objectively. His demeanour, manner (children are more natural and less conventional in these expressions of their personality than adults, therefore they show more, yet paradoxically hide more), his movements, style of talk, gesture or absence of it, gait, pitch of voice. One boy, for example, spoke in a gruff, muffled voice, saying, " I make it like that so you won't catch what I say." Will he remove his top coat, muffler and pixie-cap, or is he like some adults who sit gloved the first half-dozen interviews ? Is he stilted and over-controlled ? Is his apparently spontaneous but diffuse talk a screen to protect deeper feelings ? Will he look one in the eye or does he evade a direct glance ? Is the poverty of interest in toys due to depression and apathy, or to anxious inhibition ?

Apart from noting general behaviour, occasional remarks and comments on either significant details of behaviour or characteristic symptoms often call forth replies of astonishing insight from the child, valuable in both diagnosis and planning of treatment, and in the spotting of major mechanisms. Malcolm as an example of this showed a rapid maniacal output of vivid talk, fluent, exact and expressive. I suggested when he paused for breath that he might stop talking for a while. He held his head listening for a minute, then said almost in tears, " I have to go into silence at school ; I don't like it ; it's like a silent tunnel with demons (I spell it ' dimons ' so as not to be so nasty) ready to pop out." He was a boy full of neologisms. He looked afraid and said, " I don't like flatness, empty spaces or silence, it's then I feel I have offended people." This is an interesting commentary on hypomanic talk as a defence against depression, guilt and punishment, and aloneness. When I suggested bi-weekly interviews, he said, " Oh no, if I did you'd run me down and there would be nothing left to talk about."

Then there were two little boys of 5. When the psychiatrist mentioned dreams, one closed his eyes tight as an immediate response and said, " When I dream nasty dreams, I shut my eyes tight, like this, then I can't see them." He was a big, masculine, robust, realistic child. The other, a gentle, slim, silky-haired, imaginative child, responded to the same inquiry by opening his eyes wide. When I said, " Why do you do that ? " he replied, " When I dream I open my eyes big and look hard

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at the place between the blackout, then I keep awake and the lions go away." He was more afraid of his fantasy than of outer fears, and preferred the dark and its horrors to the imagery of his lively little mind. One knew that the first little boy would play out his problem with objects; the second was more likely to choose fantasy and dramatic play.

A description of outer behaviour, however, divorced from the underlying psychopathology tends to be merely photographic; it is of little value alone in promoting the understanding of mental processes. Perhaps this aspect is over-stressed by the psychiatrist without analytic training, but understressed by the lay therapist. To deepen and give more value to the meaning of outer demeanour and characteristic symptoms, one must relate them throughout treatment to both the structure of the general personality and the function of the psycho-pathological personality, which involves a study of the subjective aspects of the mind of the patient.

(2) How is this subjective orientation cultivated in the case of the child? This is a large subject, and it will be difficult for me not to lose myself in diversity at the expense of unity and simplicity.

The mind content is explored by many methods in modern treatment, the chief of which are talk, the investigation of dreams, drawings (a prolific source of information deserving of a paper in themselves), play with toys and materials of many kinds including sand and water, dolls and dolls' houses, plasticine, building blocks, guns, soldiers; and also fantasy and dramatic play which I personally find effective in therapy and fascinating as a study.

It should be emphasized here that the therapist should be conversant with all methods of treatment, and not confine himself to any one medium. There seems to be an odd belief prevalent that the doctor treats only older children through talk, and the "play-therapist," so-called, only toddlers through play treatment, and even that often restricted to a standardized type of material. Play is, in my opinion, part of every modern therapist's technique, and should be studied by everyone intending to do child work, otherwise he is likely to find the child under nine a closed book; but he should not concentrate on play to the neglect of that other very human medium of talk.

Here it is opportune to outline a few cases illustrating different approaches, beginning with that of talk. Talk with children to my mind should always be indirect and tentative, especially with suspicious or withdrawn children, and particularly in court cases or sexual offences. One never sits with paper on the desk and pen in hand "taking out a case history." The conversation darts rapidly back and forth from realism to fantasy, and one must be prepared to pick up the tempo from the child. I myself always put pencils and scribbling paper handy, as few children or young adolescents can sustain a conversation without supplementary aids, and drawings often reveal at the same time the undercurrent of the unconscious.

James was a case in point. He was a tall slouching lad of 12 who had suffered from faecal incontinence nightly since the age of 6 and intermittently by day; before that he was constipated. From 3 months to 4 years of age he was treated steadily with laxatives, suppositories, and later daily enemas by a visiting nurse. At school he is solitary and shunned by his companions. At home the family find him affectionate on the whole, but at times obstinate and bad-tempered, especially with his father. He is a restless sleeper; is the youngest of four with a big gap between him and the next child. Both parents had wanted him to be a girl.

He had been the round of the hospitals, where everything had been done from an EEG to a circumcision; every known laboratory test had been carried out, but no one had thought fit to explore his mind or his talk, which as later interviews proved, came readily from his rather facile tongue.

James was a naïve, ingenuous boy of poor intelligence (I.Q. only 76), so that some reservations as to his treatability had to be made. The first interview, however, produced many memories of his fancied ill-health and fears of a hypochondriacal nature, for example of being about to die when he was small—"They bathed me in olive oil to make me stronger; I was fed on Horlicks, Ovaltine and butter; the doctor made me crawl on the bare earth and in the muck with only a napkin on to make me grow up healthy." He remembered the suppositories, his interpretation being, "They used to bottle me up, but it was no good."

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When sex knowledge was mentioned he looked coy and said, " I'm far too young to know about those things." With encouragement, however, he produced a wealth of fantasy centering round anal birth, in which he still believed. When told the facts of birth and that " only ladies could have babies " he looked relieved, and then recalled a 6-year memory of wondering whether he had a baby inside him and fears of producing it in the lavatory. " I felt kind of funny but cruel thinking of it going down the sewage pipe and being drowned." He drew this obligingly and many similar drawings of a crude, expressive, realistic nature.

He then disclosed he would like to be a girl and have a baby of his own ; whenever he had a stomach-ache he imagined there was one inside him. He added that his Dad had wanted him to be a girl.

Another theory of birth was the Caesarian, and that fathers kill mothers by " cutting their tummies open " when they have babies. This had added further conflict and fears of losing his mother should she become pregnant, with increased hostility against his father. He produced a spate of drawings as he talked, all of " innards," gastric, intestinal and reproductive, illustrating his prolific fantasies and fears. Each week some of his talk centred round reproduction, cats having kittens, twins, triplets, theories of the navel (about which piece of anatomy most children are very curious), fresh theories of birth, and elaborations of his former belief in anal birth.

During treatment the incontinence gradually lessened and James became less hypochondriacal ; his interest shifted away from bodily fantasy to games and school friends. He no longer wished to be a girl, and it was a great day when he was promoted to long trousers. At the end of six months the symptoms completely cleared, with no recurrence in two years.

His symptom may be interpreted as a fixation at the anal-erotic level, or in Adlerian terms one might say his power drive was deviated into his viscera, with invalidism and constant maternal attention to compensate for his lack of masculinity. The feature of his treatment was his easy talk and rich fantasy which, however, was entirely self-centred and hypochrondriacal in content ; one expects this type of fantasy to diminish in treatment as this boy has little true imagination, and this did eventuate. Once or twice he played with the sand-tray, but his treatment was mainly through talk, drawings and paintings.

The progress of this case is an argument against Professor Valentine's theory in his recent book *The Psychology of Early Childhood*, that recovery in children can largely be ascribed to a process of maturation. James' mother would have no hesitation in stating that psycho-therapy can claim definite cures, although the story did go round the village where he lived, " You couldn't clean up a boy like that with only talk ; he must have had some medicine on the sly ! "

Drawings, dreams, choice of ages, what he will do when grown up, spontaneous wishes, etc., are all significant in disclosing the deeper levels of the mind. Andrew, for example, aged 8, was " backward," with an I.Q. of 135 ; he wanted to be an explorer " and make history to make it harder for other children at school " ! There is a great deal that could be said here, but time is short, and I want to give the rest of my attention to the subject of Play.

Play is the most useful method of treatment in younger children. Play is the most revealing of information regarding the young child's conscious and unconscious processes, but it must not be regarded as an isolated therapeutic entity, divorced from other methods of learning to know the child. I am deliberately avoiding the word " play-therapy," because as a separate and specific treatment it does not exist. We might as well use such elaborations as " conversation therapy " and " dream therapy " in adult treatment. Play *is* made use of in therapy, however, play being the tool or instrument of treatment, but it is merely one instrument of many.

The child comes into the room and sees a collection of all kinds of toys. The therapist observes carefully but casually :

I. *His choice of material.* Choice of material is useful in diagnosis as well as throughout therapy.

II. *Type and content of his play.*

I. *Choice of material.*—Examples :

(*a*) The obsessional child rejects dirty play, is bewildered as to choice

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of materials, is often compulsively driven to include all the toys in his " story."

(*b*) The anxious, over-tidy, " good " child spends the whole interview preparing and clearing up, and often asks at the end, "Am I your favourite patient ?"

(*c*) The over-sophisticated brought up on " reason " are scornful, especially of dolls, and to begin with avoid play of any kind.

(*d*) One boy was seriously waylaid, and could not start until he had eaten up any odd crumbs and small pieces of paper on the table. " They are like babies and must be protected."

II. *Type and content.*—The child may play on realistic or on symbolic planes, and he usually, especially the very young and the more imaginative, intersperses the whole with fantasy and dramatic play. Whatever the type of play, it is necessary in bi-weekly and still more in weekly interviews to guide the treatment by two criteria :

(*a*) the central emotional problem ; whether this be anxiety, guilt or other hurt suffered by the child,

(*b*) the symptoms, their meaning and their defences,

and although children bring more self-interpreting material than adults, yet many fantasies and much of their play requires interpretation. In the less frequent sessions of both clinic and present-day private practice this obviously needs careful handling.

The type and content can best be demonstrated by means of a case :

Patricia, aged 5½, *I.Q.* 132.

Symptoms on referral.—Unmanageable at school ; scratches and hits teachers and children, tears up books and smashes apparatus ; excluded temporarily.

Fits of temper at home the last two to three months ; prior to that described as a " little saint."

Masturbation. Severe constipation.

Phobias centering around bath plug and lavatory chain, with fear of the water gurgling out.

An only child. Mother over-anxious with some obsessional tendencies. Much discussion and dissension between parents regarding Patricia's upbringing.

Patricia is a lovely, clear-skinned child, well poised, graceful, with excellent language ability ; imaginative. She works in interviews with tremendous energy, her drawings are vivid and expressive (she produced a whole book of these), but is excessively tidy, neat, clean, exacting and precise in attitude and demeanour. Dislikes getting her hands dirty. Is over-active and tense. Throughout treatment, but gradually lessening, attacks of shuddering with pallor and tension, always in relation to anxiety, frustration, aggression.

During treatment she played with materials including every type of toy ; play was widely varied, and different types of play were intermingled at each interview.

These types of play were : A. She began, as might have been expected in a child with severe constipation and some obsessional tendencies, with lavatory play expressing the anxiety and curiosity which centres around her excretory functions :

(*a*) Of a reality type with dolls as babies in the process of habit training ; treating constipated baby by laxatives, etc., slapping if cannot defaecate ; babies refusing. This brings out her own fears regarding early illnesses when she had blood in the faeces and green faeces. A plasticine mother is brought into play ; the baby soils herself and mother had to clear it up.

(*b*) Of a fantasy type. A " china party " to which bathroom furniture and utensils all came, each talking his own language ; she gave all of them names. " Bush Ush," the wash basin, was the rebel of the party. He always ate too much at a feast, was disobedient, and washed the floor with milk instead of water. He appeared in play again and again.

B. Teacher and child game with psychiatrist. Patricia the teacher was harsh and depriving ; folded up even the carpets on the floor so that psychiatrist could not see the colours ; threatened to tie my hands if I couldn't keep still. (Expressing possibly her own anxiety at school regarding fantasying or looking away from her task.)

Her negative transference is expressed here in a play situation, but later shifts to the person of the psychiatrist with much ambivalence. In this she showed

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open aggression by blowing in my face, but called it " the dolls' house wind and thunder " (for which therefore she was not responsible). Later there were attempts at overt pinching and scratching, which psychiatrist preferred to divert towards inanimate objects! As treatment progressed the wind " blew " at psychiatrist, but Patricia kindly " turned it off."

She constantly scolded psychiatrist for expression of any " happy or contented noises," and as she did so showed severe anxiety tension with shuddering. She calls her shuddering " my excitement," and says it is of two kinds, nice and nasty. " The nasty one I call the 'Beastly Beast'; don't ever tell him not to do things or he just gets wild." When psychiatrist interpreted the " Beastly Beast " as her own anxiety-aggression, she responded, " There are two; one is black and white with rows and rows of teeth and no arms, and the other ' blue and gold ' with only two rows of teeth, but he hates soft skin." She adds, " There was a nice smiley person there and he killed her."

The interpretation of her play with materials released in a symbolic form her aggression repressed by her own superego and her mother's upbringing. This resulted in the release and diminution of her anxiety (the shuddering) and the verbalization of her ambivalence. When she had accepted her negative transference partially she went through—

C. A phase of regression expressed in baby play typical of a child of six months to three years old; lying on her back kicking, saying, " I'm at the kicky age," making crooning noises and talking baby talk (this in a child with a mature and well enunciated vocabulary), learning to walk, my helping her. At a later stage being pushed round in a baby chair. All this play was accompanied by much more positive feeling; it was relaxed and free from tension.

D. Eye testing play: this took us back to the bathroom set.

(*a*) With a group of " children " (dolls) having their eyes tested by a doctor.

(*b*) With bathroom utensils and fittings all wearing glasses made of plasticine. " Bush Ush " refused to wear his glasses and fell ill with pneumonia and tic dolorasma! She said, " He is a naughty boy; his eyes are very dim."

She then recalls that when she was three she had measles, her eyes were " dim," and she was very frightened of becoming blind. She drew all these scenes but psychiatrist was never allowed to look at them without permission, so she always did me a rough drawing first, " to keep you contented; something to look at so your eyes won't get *bad*." She showed much anxiety if ever psychiatrist took her glasses off, saying, " Glasses are like gloves, the eyes' clothes." One assumed this related to the taboo on looking at forbidden parts of the body in the bathroom. For example, she said, " What do you call the part you sit on? My Mummie calls it nothing." She then added that her mother said her eyes were for Mummie and Daddy alone.

E. The last phase of play was with sand and water of a type suitable to her age, in which she was much gayer, less exacting and free of tension.

Towards the end of treatment during the resolution of transference she showed keen interest in having her permanent teeth counted; she stood very still, quiet and smiling during the process, asking how many of her grown-up teeth were coming through, as though accepting her early biting aggressive wishes.

At the end of treatment (once weekly for 8 months) Patricia became more carefree, could splash paints, play with sand and water. At home she lost her fear of the lavatory chain and could put her toe on the bath plug. Her habit of tension and shuddering disappeared. She returned to school; could now play with children of her own age, and became less dependent on her mother.

This case illustrates the variety of play in the young child, his capacity for setting his own pace, and for making selections of materials and methods to suit his own needs on his own initiative.

During the whole of treatment one must constantly link up the two aspects, subjective and objective, described above. One should compare and contrast the content of play with the fluctuations of the child's symptoms and also with his realistic life, for example his relationship with his parents and siblings, as well as with his general behaviour at home and at school. It is here one finds indispensable the week by week consecutive work with the psychiatric social worker who checks

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up on the home situation. Unless one does make this comparison and evaluation there is the danger of losing oneself in the fascination of the material, its symbolism, and the emerging psycho-pathology, and forgetting the child who is the author of the play, and the victim of the symptomatology. Personally I do not believe in any set symbolism or rigid formal pattern of play, and I think that treatment progresses more rapidly and successfully with the minimum of play material, provided it is the right kind. Adherence to any specific rigid technique increases the child's tendency towards patterned modes of thinking, rather than releases him from his mental and emotional bondage.

As to interpretation of play, whether interpretation of the symbolism of material, or interpretation of interruptions, defences or resistances, this calls for the greatest skill and judgment in selecting the one vital situation out of the many possible, particularly when one is restricted to once-weekly interviews; while the handling and interpretation of transference requires subtle and sensitive understanding, and must not be forced into rule-of-thumb preconceptions. Again I would like to emphasize that play is the most intricate field of the child therapist's art; it is comparable to analytic work in the adult, and should never be attempted by the untrained doctor, however good his rapport with children, and however clever he is with the Hornby train at home.

The technique of child treatment then lies in a threefold study of the child:

(1) his temperamental make-up and basic pattern of personality,

(2) the psycho-neurotic superstructure, the psychopathological personality,

(3) the symptoms.

and through play, talk and other forms of exploration of his conscious and unconscious mind, determining which of the mechanisms, repression, regression, identification with parents, projection, etc., are represented by the symptom and his central emotional problem.

There is no magic in play treatment nor in the play materials themselves; the magic, if any, lies in the skill and experience of the therapist combined with certain essential personality qualities, his receptivity, his wisdom and his suppleness in interpretation. His attitude to the child is an active-passive one; he must be patient and willing to listen, be sympathetic yet not sentimental. He must be observant, take an intimate part, be able to play, live in and share for the moment the child's feeling life, using his instincts and intuition all the time, yet with his rational faculties keenly at work in judging and evaluating the substance not only of each interview but in piecing together the mosaic of several interviews. Many single interviews have little meaning alone, but a consecutive series reveals a clear-cut theme. I think *Technique* almost too bold a word for the title of this paper; child treatment is still in its infancy, and a technique has yet to be evolved.

In future work, what is needed is not a further elaboration of intricate toy material and play apparatus, so much as a deepening of the insight and imaginative vision of the therapist, and the enlargement of his knowledge through careful studies with individual children, and follow-up records of these children into adult life. Particularly I would like to stress the all-round training of the child-psychiatrist in all the known methods of access to the child mind.

Lastly I would advocate a better liaison between the Child Guidance Clinics and other branches of medicine, particularly paediatrics, mental deficiency, psychosomatic medicine, and last, but not least, adult psychiatry.

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