WHAT CAN PSYCHIATRY CONTRIBUTE TO MATERNAL AND CHILD WELFARE SERVICES?

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The aim of this article is to give some indication of how psychiatric knowledge can be incorporated in a municipal health department. It is a report on an 18-months' experiment in the maternal and child-welfare section of the Pretoria Health Department. The experiment was made possible by the cooperation of the Secretary for Health and the Medical Officer of Health, and it deals with problems of administration, allocation of time, the broad aspects of personnel training, and the results of treatment.

The fact that I was responsible for the administration and at the same time continued with some of the ordinary clinical work has considerable bearing on the findings. The work was confined to the European community, and the staff directly involved consisted of a full-time clinical medical officer and 11 health visitors. About half my time was spent on administrative duties and ordinary clinical work, and the rest on psychotherapeutic work.

The stimulus for this work arose from the recognition that many somatic complaints in childhood are psychologically determined or at least have very prominent psychological aspects. It was hoped to get some indication of the extent and nature of the psychological factors involved and also to what extent these could and should be dealt with within the framework of the existing public-health services — particularly the maternal and child welfare sections. The problems were the ordinary ones with which the mothers come to the clinics, such as feeding difficulties, sleep disturbances, excessive crying, and general management.

An attempt will be made to show what contribution a psychiatrist can make, where such special knowledge can be most rewardingly applied, and which aspects of psychiatric work do not rightly belong to a municipal department of health. The approach was analytical and directed at understanding the underlying emotional factors which brought the mothers to seek our help.

The psychotherapeutic work can be divided into four sections, viz.: (1) general and special training of personnel, (2) diagnostic work, (3) short-term therapeutic work, and (4) long-term therapeutic work.

1. General and Special Training of Personnel

The general training was done at staff meetings where an attempt was made to stimulate interest in this kind of approach, to increase awareness of emotional factors, and to gauge the reaction of staff members to what to them might be disturbing material. On the whole, psychological development and personal relationships were discussed on general lines, but sometimes specific cases were dealt with in greater detail.

The attendance at these discussions was on a voluntary basis, and no staff member was expected to attend or to contribute unless she felt like doing it. This approach was important because it was also the essence of what we considered our approach to the public had to be. No attempt was to be made to feed the public with psychological principles or to coerce them into accepting psychological treatment.

Apart from group discussions, more intensive and individual training was undertaken with those members of the staff who particularly desired it and showed special interest and aptitude. Their cases were discussed with them privately and they were left to deal with the mothers and infants in their own individual way.

2. Diagnostic Work

Patients were referred by health visitors, medical colleagues or social agencies when they suspected psychological problems or wanted advice on the handling or placement of a patient with an established diagnosis. The majority of patients were encountered at ordinary child welfare clinics. The mother usually complained of what appeared to be a physical condition. At the initial physical examination one of several factors, or a combination of factors, was revealed. In some cases the complaints were purely somatic. Often, however, the somatic condition was complicated by psychological factors in either the mother or the child, or the condition was entirely psychological. Because of the pressure of numbers at the clinics a reliable psychological diagnosis could only rarely be made and many of these patients were given appointments at what were called 'diagnostic sessions'. At some of these interviews a detailed history was taken; at others the interview was largely of an informal nature. The aim was always to get some knowledge of and insight into the underlying factors and also to appraise the extent to which the patient could be treated. The nature of the problem and the way it was proposed to deal with it was always to some extent discussed with the mother or both parents. The final decision about attending for psychological treatment was left to them.

A wider aspect of diagnostic work arose in those patients in whose cases the physical and psychological diagnosis was clear, but where planning for the future was the vital point. It concerned the physically, emotionally or intellectually handicapped child, his family, and the community resources. In these cases it was important to appraise the dynamic situation in the family, what it could itself do for the child, and how it could cooperate if assistance were offered. It was then necessary to assess carefully the present condition of the child and the degree of his possible future development or improvement, and whether community services were available or not. Much of this work was done in conjunction with the social agencies and the local branch of the mental health society.

3. Short-term Therapeutic Work

This constituted the bulk of the work. It was somewhat varied in character. Some of its clinical aspects have been reported on in an earlier paper.[1]

Occasionally it was possible to help a mother at her first visit to the ordinary baby clinic. Sometimes the more detailed diagnostic interview gave the mother sufficient insight to deal with the problem herself. In most of the cases, however, more elaborate measures were necessary. The subsequent treatment was conducted in the 'playroom', where the child could make free use of play material to express his preoccupations and the mother could talk freely about her difficulties. The ages of the children seen and treated varied from a few weeks to 6 years. Even if the problem concerned an infant the mother was still seen with the baby in the 'playroom'. It was felt that the free and easy atmosphere of this room was a real help because here a truer impression of the mother's attitude towards her baby could be got than in the formal setting of an office.

The following case histories illustrate some of the connections between the complaint and the nature of the problem in the family:

Case 1

R.d.J., a little girl of 2 years, was brought because of (1) a sleeping problem since birth — 'always wide-awake and very alive' (altyd baie wakker en lewendig), (2) not gaining weight, and (3) being very nervous and biting her nails. Up to date no treatment had made any difference to her. On examination she was underweight, nervous and timid, but otherwise physically healthy. The mother looked pale and depressed. A detailed history showed the following:

The firstborn son was electrocuted at a friend's house less than 4 months after the second son died of a kidney tumour. Seven months later the mother was delivered of a premature boy who only lived a few hours. This was followed by 'nervous breakdowns' in both parents, with marked feelings of guilt and being punished for their misdeeds. They decided not to have any more children, and the subsequent pregnancy which resulted in the birth of the little patient, was unwelcome and a source of much anxiety. The fear of losing this child haunted both parents. They could not bear to have her out of their sight and she had to give them constant evidence of the fact that she was alive. After 3 sessions the complaints had cleared up and they were contemplating another pregnancy.

Cases 2 and 3

J.G., a little boy of 3½ months, was brought because he always fussed when fed, often refused the bottle, vomited after feeds and slept poorly. The child looked peevish and the clinic card showed poor and irregular gains in weight. The mother was anxious, appeared rather immature, and complained of sleeping poorly herself. This was the parents' only child, and the pregnancy 3 months after marriage was unplanned and unwelcome. During this and the subsequent sessions the sexual problems of the parents were dealt with. The mother was an only child with a poor relationship to her mother who always warned her about men and the dangers of intercourse. She was also afraid of pregnancy, delivery and the responsibility of rearing children. She had never enjoyed intercourse, always kept her husband at a distance and, although she was frigid, she thought she could have an orgasm but she repressed it because she imagined it would lead to pregnancy and other nameless dangers to herself. She had always refused to read about sex and the idea of using contraceptives was repugnant to her. Both parents feared a second pregnancy and the husband had become impotent since the birth of the baby. As the sexual problem of the parents cleared up the feeding and sleeping difficulties of the infant disappeared.

In another case restlessness of a 2-month old baby with 'peculiar movements of legs and trunk' was related to the fear of poliomyelitis. During the puerperium the mother was visited by a little niece who developed poliomyelitis a few days later. As a 16-year-old girl, the mother herself had poliomyelitis with paralysis of both legs. She described it as the 'biggest thing in my life' and said that it took her 2 years of very hard work to overcome the defect.

The number of interviews varied from 1 to 14, the average being 5. The number of patients dealt with in this section was 130 and the results were as follows: Much improved 44, improved 48, unknown 18, and no change 20. The term 'cured' is not used because it does not seem applicable to this kind of work. Human relationships are dynamic and adjustment is always a challenge.

The 'much improved' group consisted of patients where the mother felt she had no more problems and the symptoms had disappeared, and the 'improved' group those where the mother felt that although all the symptoms had not disappeared she could now cope without undue strain or anxiety. The 'unknown' group consisted of patients we had lost track of and which could therefore not be followed up.

The 'no change' group was mixed. It included patients where the mother came for a few interviews and then stayed away; where treatment was interrupted by external circumstances; where the improvement was not lasting; and where after a few interviews it became clear that the original assessment was erroneous and treatment was discontinued. The errors were usually due to an underestimation of the mother's problems. The mothers with deep-rooted or widespread neurotic problems or extensive personality disorders could not be helped by this form of therapy.

4. Long-term Therapeutic Work

Nine patients were accepted for intensive individual psychotherapy; of these 3 were of pre-school age. These children were seen on their own for an hour once a week over periods varying from 6 to 15 months. This type of treatment was decided on when the child was so disturbed that he required treatment in his own right. The parents were only seen occasionally. This work was hampered by the lack of a psychiatric social worker. Like the children the parents were also seriously disturbed and required more intensive treatment than we could give.

The time spent on these 9 patients was about the same as that for the 130 short-term cases. With one exception they all improved. Two patients were discharged as sufficiently improved, but the treatment of the others was terminated by the end of the trial period.

DISCUSSION

In any service supported by public funds an important question is always whether it is worth the time and money. In this instance no statistics can be submitted, but some facts can be given.

Most of the 130 patients (group 3) were dealt with in cooperation with two health visitors. Both of them found that their work had become more interesting and rewarding. The number of attendances at their clinics had increased and the pattern of attendance had altered. More mothers attended, but they attended less regularly because they had become more self-reliant and less dependent on the weekly weighing and advice of the clinic personnel. Their increased confidence was reflected in a decrease of their anxiety and more relaxed handling of their children — hence a decrease in problems.

When the mothers did come for help they tended to discuss their problems in a more mature manner and to ask less for advice in a dependent way. This had a beneficial effect on both mothers and health visitors. The health visitors felt less burdened and found that they could do more work. In one of the areas it was possible to discontinue the help of a part-time health visitor.

The mothers were less inclined to ask for medicine, and the urge of the staff to give it was reduced — in the areas of both health visitors there was a noticeable decrease in the issue of medicines.

Saving of time and money in the homes was less directly observed, but was frequently commented on by the mothers. They often reported their surprise at finding how much more they could do for themselves and the rest of the family. For example, some found that instead of buying things ready-made they now had time to sew at home.

From the therapeutic point of view the results were satisfactory in 92 of the 130 patients (71%). The time devoted to these patients was roughly the same as that given to the 9 requiring intensive treatment, and the results were superior. The mothers, and often both parents, gained considerable understanding of their own feelings and also of their relationship to other children in the family.

The experience gained during this period indicates that this kind of mental health work rightly belongs to the maternal and child welfare services of a health department. Concern with this aspect of health work is reflected in many recent publications. Polack[2] concluded that behaviour problems in early infancy should be taken seriously and that their prevention and management should be in the hands of the maternal and child welfare services.

Another consideration in connection with a public service is the need of the community. This was convincingly proved by the experiment. Within a few months of starting, extra time had to be found to cope with the work, and still it was not possible to prevent the development of a long waiting list. As long waiting lists are felt to be most undesirable, certain

practical points in the running of such a service should be considered.

Public health services are specially concerned with preventive and promotive aspects, and in the field of mental health this policy need not be departed from.

During pregnancy and for a long time after delivery the mother's emotions are labile. The new baby acts as an activator of her emotional life as well as of that of the other members of the family. It is therefore a time when acute problems arise which must be dealt with promptly if the most satisfactory results are to be obtained. The longer they are left the more complex and chronic they become. The assistance must be in the nature of first aid. The staff members with special skills must be so organized that they are available when needed. An acutely distressed mother with a sleepless, crying or vomiting baby should not be put on a waiting list. Too rigid a programme with fixed sessions weeks in advance makes such arrangements impossible, though a set programme is necessary in the treatment of the more seriously disturbed children needing prolonged treatment. It is therefore felt that this latter type of case does not fit into the maternal and child welfare services.

Locality and rooms also play an important part. The early treatment of the mother and young child is without doubt best carried out at the clinic. The prejudice against psychological and psychiatric knowledge and treatment is still widespread and is sometimes a real barrier to early treatment. These services should be carried out as an integral and natural part of the child welfare work. It was felt that much of the success in the present series was due to just this fact. I was known to the mothers in the first instance as a 'clinic doctor' and only secondarily as a psychiatrist — many never even became aware of the latter function. If they had to be referred to a 'special doctor' at a special time and place some of them would have felt threatened and resistances would very likely have complicated treatment. Sandford,[3] working at a clinic in London, came to similar conclusions.

Close liaison between psychiatrist and health visitor, which is vital, should be encouraged. Free discussion and mutual consultation should be made as easy as possible. Therapy is much influenced by group feelings and tensions between staff members. This was demonstrated by Stanton and Schwartz[4] when they studied the tensions in the 'collective society' of a mental hospital. Caudill[5] showed how relationships between staff members could motivate their approach and treatment of patients. The relationship between myself and the health visitors undoubtedly played a role in the therapeutic results.

The training of personnel as a major aspect of this work has already received much publicity.[6-8] 'In-service' training is considered to be the best. With suitable training the usual personnel should be able to deal with the bulk of the psychological problems and the role of the psychiatrist would be largely supervisory and dealing with the more complex cases. Newby[9] makes an appeal for the training of the whole staff of the child welfare section 'from the doctors to the office workers'. I should like to endorse this; it was frequently found that office staff, especially the receptionist or secretary, played a significant role.

SUMMARY

1. The application of psychiatric knowledge to the work in a maternal and child welfare section of a municipal department over a trial period of 18 months is being reported on.

2. A municipal health department, with its positive health approach to the whole family, its long tradition, and its administrative facilities, is a suitable centre for the development of a parent and child guidance service for the less serious behaviour problems of infants and young children.

3. More seriously disturbed children and their parents can best be dealt with under a different set-up.

4. One of the most important functions of such a centre would be the training of personnel to enable them to recognize and deal with emotional problems in the families under their care.

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