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Managing the 'unmanageable': interwar child psychiatry at the Maudsley Hospital, London

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Abstract

When opened as a post-graduate teaching and research hospital in 1923, the Maudsley made virtually no provision for the treatment of children. Yet its children's department saw sustained growth during the interwar period. This expansion is explored in relation to novel behaviourist hypotheses and the forging of formal links with local government and charitable bodies. The recruitment of psychologists, educators and specialist social workers fostered a multidisciplinary approach through case conferences. This development would structure the theoretical origins of child psychiatry, in particular influencing the role and interpretation of psychoanalytic theory within it. William Moodie and Rosalie Lucas identified learned behaviour tied to social and familial circumstances as the crucial factor for both diagnosis and therapy. The theoretical orientation of child psychiatry and the practical treatment of children represented an area of dynamic change and innovation at a time when adult psychiatry struggled to discover effective treatments or achieve breakthroughs in causal understanding.

Keywords

behaviourism; child psychiatry; child psychology; child welfare; D. W. Dawson; educational psychology; Maudsley Hospital; mental deficiency; Mildred Creak; treatments

Introduction

When the Maudsley Hospital opened in February 1923, it contained a small department for the treatment of children under Dr D. W. Dawson assisted by the hospital almoner. At first, the clinic saw few cases but by the late 1920s children were referred in their hundreds by care committees, charities, education officers, probation services and local doctors. The exponential growth of child psychiatry was a significant feature of the hospital's interwar history but quite unforeseen by either Frederick Mott or Henry Maudsley who, when they set the institution's strategic goals in 1907, did not even consider that it could be used for the treatment of children (Jones and Rahman, 2008; Jones, Rahman and Woolven, 2007).

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The reasons for the growth of child psychiatric services, or the emergence of the discipline itself, have never been fully explained. General histories of psychiatry have hitherto attached little weight to the origins and development of this sub-speciality (Porter, 1990; Shorter, 1997). Works that have addressed child treatment in Britain have engaged more with the history of psychology (Rose, 1999), education and intelligence testing (Sutherland and Sharp, 1984), psychoanalysis (King and Steiner, 1991; Riley, 1983), child guidance (Thom, 1992), mental deficiency (Thomson, 1998), and the development of social work and child welfare services (Hendrick, 1994; Levene, 2006).

The writing of the history of child psychiatry in Britain has largely fallen to ex-practitioners (Cameron, 1956; Hersov, 1986; Kanner, 1959; Wardle, 1991; Warren, 1971), who have focused on the post-1945 period and have not fully explored the time when the discipline was undefined and developing rapidly. Targeting the inter-war years, this paper examines the reasons for the growth of child psychiatry and explores the way in which practice influenced both hypotheses and research. Surviving patient notes for the Maudsley Hospital together with management files have allowed us to explore the development of this novel service. By analysing the patient population, treatment initiatives and an ongoing debate about strategic goals, we have been able to test the extent to which the children's department was responsive to local needs, and was driven by the demands of research and teaching, and to what extent it raised the international status of the institution.

The origins of child psychiatry

The first physicians who worked in the children's department at the Maudsley employed a wide array of practical approaches to the treatment of mental illness in children. These ranged from dream interpretation and dietary supplements to drug treatment and sensory deprivation. The head of department, Dr D. W. Dawson, conceived of these treatments within a framework of mental evolution, drawing particularly from instinct theory. He explained his approach in 1924 in the form of a short book entitled *Aids to Psychiatry*. From the outset, Dawson made it clear that he considered psychiatry to be a continuation of psychology, ‘the study of behaviour of living organisms.’ Drawing on the work of Herbert Spencer, Alexander Bain and William McDougall, Dawson envisaged the human mind and its physiological functions as akin to an evolving organism, its responses to the environment progressing from primitive chemical reactions to reflex actions. The mind, he believed, gradually gained an awareness of these instinctive drives and responses until finally it was able to master purposive action or volition. Mental illness resulted from faults encountered by the purposive mind seeking to control the lower levels, in particular the instincts. This led to ‘much trouble and not infrequently disaster, together with … numerous abnormalities of behaviour’ (Dawson, 1924: 8).

On admission to the Maudsley, every child was given a physical examination in which they were checked for abnormalities or ‘stigmata’. First, the face, head and neck were studied, and physicians noted any deformities ranging from swollen glands and signs of injury to abnormal facial features. Possible symptoms of the nervous system were then noted, as were any signs which indicated deficiency diseases. Physicians next carried out a detailed study of the child's muscular tone and bodily movements. They tested their reflex reactions and noted any involuntary movements or tics which appeared to arise from lower or more primitive responses to stimuli. To investigate the cranial nerves, they observed the child's facial and mouth movements and tested vision, smell and hearing. Again, the aim was to find evidence of primitive or malfunctioning sensory-motor reflexes such as nystagmus (involuntary movements of the eye). Finally, they took an account of the child's early history particularly noting any traumas or shocks to the nervous system in the form of frights, major injuries or infections. Any signs of mental illness in relatives were also a cause for concern

due to the theory of hereditary transmission. In most cases, physicians also measured the child's intelligence using tests designed by Binet and Simon.

The search for ‘stigmata’ in children, and the systematic testing of their reflexes and intelligence, was not novel. This form of testing could be traced back to Francis Galton's tests of the 1880s, which had later been adopted and adapted by researchers such as Charles Spearman, Francis Warner and Cyril Burt (Wooldridge, 1994). However, they had focused on schoolchildren and did not attempt to integrate their findings with the study of adult mental pathology. What was unique about the Maudsley was that it used these tests to develop general hypotheses in psychiatry. As Edward Mapother, the Maudsley Hospital's first superintendent, put it, it was ‘hoped that study of these minor disturbances [in children] would at last produce records of the real start of what later becomes gross mental disorder’ (Mapother and Golla, 1932: 13).

Diagnostic labels applied to children at the Maudsley during its first three years of operation covered a relatively narrow range, namely chorea, epilepsy, hysteria, encephalitis lethargica (or its consequences), mental defect, neurosis, anxiety state, spasmodic tic and moral abnormality. Occasionally, they would be labelled as ‘backward’ or ‘nervous child’, though these diagnoses would usually appear in quotation marks to distinguish their colloquial form. Some were also diagnosed with endocrine disorders. Post-pubescent children could be diagnosed with other disorders such as depression, mania, dementia praecox and schizophrenic state.

Because the majority of disorders ascribed to young children were thought to result in nervous reflex actions, ‘fidgets’, tics and fits, Maudsley physicians regularly monitored movement and gait. For example, in September 1924 an 11-year-old girl was admitted under Dr Dawson and diagnosed with a ‘spasmodic tic’. She was described as having ‘facial play’ and movements in which she ‘fidgets generally like choric. Rubs and picks nose, bites nails, wriggles about and fairly frequently … gives a shake of her head’. The onset of these symptoms was traced by the family to a shock that the child had experienced several years earlier. However, Dawson identified the cause as ‘prolonged mental stress’. Environmental stimuli were thought to be the cause of the non-volitional reflex actions. As a result, treatment consisted of a small dose of parathyroid to stimulate blood calcium levels, accompanied by isolation and total bed-rest. After two weeks, physicians noted an improvement in the child's condition measured by the fact that her head shaking had almost ceased. However, they noted that she had become mildly depressed. She was then allowed up for short periods though sent back into isolation if she was found ‘grimacing’ or making any unusual movements. Eventually the movements ceased and the child was discharged. On returning home, her condition rapidly deteriorated. The anti-inflammatory drug salicin, usually used in choric cases, was prescribed and had some beneficial effects. After a total of six months' treatment, the case was abandoned when the mother was found ‘spoiling’ the child thereby encouraging her maladapted reflexes.[1]

Many children, even if not actually diagnosed with ‘chorea’, were described as having ‘choric movements’. These were thought to result from mental stress, anxiety and nervous shock. Diagnosis was problematic because chorics were sometimes judged to have experienced ‘hysterical fainting’, while children with neuroses presented with pseudo-epileptic fits. There were often few symptoms that enabled clinicians to distinguish between functional and organic disorders, which contributed to conceptual overlap. It was, for example, commonly believed that abnormal volitional movements and lower reflex actions indicated conflicting thoughts and desires.[2]

[1]CFM 004.221

Treatment depended on both symptoms and an assessment of intellectual capacity. Bromide and paraldehyde were used regularly as sedatives, while Luminal was prescribed for epileptic seizure. If there was evidence of choriform movements, Salicin was given and post-encephalitic patients received hyoscine, an antispasmodic. Children with nutritional deficiencies were prescribed cod liver oil, syrup of figs and malt, and those with thyroid deficiency were given replacement thyroid. Post-pubertal girls were occasionally found to have symptoms which correlated with their menstrual cycle. These girls would often be given thyro-ovarian treatments to regulate their periods and, by proxy, their nerves and emotional state.[3] Bed-rest and fresh air were common treatments for all ages, and were sometimes combined in the form of deck-chair rest in the garden. Baths, massages and douches of various types were also prescribed, usually to calm patients. For example, one 15-year-old girl diagnosed with ‘adolescent mania’ was given daily continuous baths to quell her manic activity.[4]

If a child were thought sufficiently intelligent, he could be engaged in therapeutic discussion of his symptoms and fears, often using the technique of free-association. Dr Mary Barkas, who worked under Dawson in the children's department, was well acquainted with Freudian theories about the unconscious phantasies of children.[5] She considered that adult psychosis represented a regression to an infantile state in which primitive bodily desires dominated the mind (Barkas, 1925). Dawson himself had studied Freud's work on the interpretation of dreams, free association, and had followed the debates between Freud and Jung over the sexual instinct, or life drive, and its role in the formation of neuroses. Regarding these theories as extensions of instinct theory, he categorized neurosis as an ‘outward and visible sign of an inward invisible conflict between certain innate tendencies and the precepts imposed upon the mind by education’ (Dawson, 1924: 67–8).

Psychoanalytic treatment was largely reserved for teenage children who were considered better able to discuss their thoughts and feelings. They were encouraged to recollect traumatic events and recount dreams and were asked for associated thoughts and feelings. For example, in 1923 a 15-year-old girl with anxiety neurosis was admitted as an inpatient and was referred to Dr Barkas, who saw the girl five times a week and asked her about her dreams and their associations. The girl related the fact that two years previously she had experienced a trauma in that a man had grabbed her in the street and she had run away in fear. She feared that she might be pregnant and had a recurring thought that she had harmed or killed babies. Barkas interpreted her anxieties and suggested that her ‘fear about injuring women and babies might be a projection of her own fear and wish to do away with her own pregnancy, and that the fear of men might be connected with the fear of pregnancy’.[6] According to the notes, the girl accepted this suggestion and asked to be discharged shortly afterwards.

Adolescents were sometimes treated with direct suggestion and hypnosis. In 1924, for example, a 13-year-old boy whose condition was tentatively diagnosed as ‘mental defect?’, ‘dementia precocissima?’ and ‘anxiety state?’ was seen twice weekly for intensive therapy. The boy's symptoms included fits of energy and restlessness and impulsive lying. He had previously been seen by Cyril Burt, who since 1913 had served as the ‘official psychologist’ the London County Council (LCC). Burt had unsuccessfully attempted to treat the boy by adapting his environmental surroundings. At the Maudsley, he was told to recall his dreams and was given light hypnosis. The therapist encouraged him to confront his fears and he was

[2] E.g., CFM 001.543
[3] E.g., CFM 004.504; CFM 018.718; CFM 019.654; CFM 021.845
[4] CFM 021.599
[5] E.g., CFM 006 719
[6] CFM 004.447

given ‘general suggestions and instruction concerning truth, honesty etc. and the danger of phantasy formation’.[7]

These approaches were tolerated at the Maudsley by senior staff such as Mapother, provided that they produced results. Physicians in the children's department did not think that psychoanalytic methods were in conflict with physical interventions which were used in the treatment of younger children. On the contrary, these were merely regarded as more sophisticated ways to intervene in the child's unconscious life. Physicians thought that sedatives and continuous baths could calm nerves and instinctive reflexes, while dream association and interpretation enabled the children to master unconscious impulses and drives.

The epidemic of encephalitis lethargica

In 1918 an epidemic of encephalitis lethargica, sleeping sickness, broke out in the UK. The number of reported cases rose rapidly, peaked in 1924 and continued to be reported until 1927 (Dourmashkin, 1997). Along with the epidemic came a growing awareness within medical circles of the bizarre mental changes which followed the illness, particularly if it was contracted in infancy or childhood. In January 1925 a discussion was held on this topic by members of the Royal Society of Medicine including Mapother and Dr F. C. Shrubsall who was an honorary lecturer on mental deficiency at the Maudsley Hospital and also the senior medical officer to the LCC. Shrubsall, who had been monitoring cases of encephalitis reported in London, described how post-encephalitic children were remarkable for their ‘state of irritability, lack of inhibition, and consequent impulsiveness’ (Cole *et al.*, 1925: 22). They were also excitable, noisy, restless and frequently destructive. Mapother believed that the moral sensibilities of these children were affected by the illness, rather than their intellectual capacity. In his words, there were ‘conative’ disturbances in the mind rather than cognitive disturbances (Cole *et al.*, 1925: 33–5). He claimed that post-encephalitic children develop a ‘defect of inhibition, so that a wish results in action without consideration of results.’ This was very different from the observed effects of dementia which also diminished intellectual capacity, and Mapother preferred to call it ‘demoralisation’. Dr Philip Cloake, who was conducting research into the illness for the Medical Research Council, explained that the disturbance seen in post-encephalitic children was probably caused by a toxic state brought about by the infection. Having a similar effect to alcohol, these toxins depressed ‘the highest psychic functions’ allowing ‘the freer play of partially uncontrolled instinctive activity’ (Cole *et al.*, 1925: 27). These symptoms continued to influence the patient after the illness had subsided because of brain damage and the destruction of pituitary gland which regulated the endocrine system. He also thought that ‘habit’ may play a part in prolonging the symptoms.

The encephalitis epidemic led to a growth in the referrals of such ‘demoralised’ children to the Maudsley. These children were notoriously difficult to treat, not only because of lack of knowledge about the illness and lack of effective medication, but also because of their behaviour. The nurses, in particular, found them mischievous and difficult to control. For example, one child had regular ‘bouts of violent temper in which she was quite uncontrollable … used bad language and at times attacked members of staff and other patients, creating considerable disturbance.’[8] Hyoscine was found to be effective in calming children down but had no lasting effect and children often relapsed after they left the hospital. Until Rosalie Evelyn Lucas began to develop alternative treatments in 1927, post-

[7]CFM 006 719; CFM 17.200
[8]CFM 030.972

encephalitic children were prescribed hyoscine and paraldehyde and were constantly monitored to check for possible side-effects.

Although the Maudsley partly functioned as a research institute, it was primarily funded by the LCC and had legal obligations to report any patients who were ‘mentally defective’ and required institutional care. Such cases were identified using intelligence tests. All children with intelligence levels below 70 were sent to Dr Shrubsall who certified them under the Mental Deficiency Act of 1913. Intelligence testing, a relatively straightforward process, allowed Maudsley staff to refer any children who were considered untreatable due to their ‘backwardness’, leaving the hospital free to focus on those with a good prognoses. Once identified, these children then became the responsibility of the Local Education Authority, as, unlike adults, they were catered for under the 1914 Elementary Education (Defective and Epileptic Children) Act. This act provided special schooling for such children (Sutherland and Sharp, 1984).

Although severely disturbed, post-encephalitic children did not fall into any recognized legal category. This posed problems for the early physicians who did not know which authority should be responsible for their care on discharge. Usually, both parents and LCC officials were simply informed that the child would be difficult to manage at home and would require long-term supervision and care.[9]

The rise in LCC referrals

During the interwar period, the Maudsley witnessed a sustained rise in referrals from LCC and charity agencies. In 1923 the majority of children were referred to the Maudsley by friends or private doctors. Only a small proportion of cases were sent by LCC agencies such as the Children's Care Committee. This number increased rapidly throughout the late 1920s and early 1930s. On the basis of surviving patient records, in 1924 just one in seven children had been referred by council agencies. In 1928 over one in three cases had been sent by this route and in 1937/38 well over half of all cases had been referred by LCC agencies, many others coming from charity organizations such as the Invalid Children's Aid Association or major London hospitals. By the late 1920s, the Maudsley accepted cases from Care Committees as far away as St Pancras, Kensington and Hackney, as well as from those in Streatham and Brixton which were nearer. This increase also reflected the dramatic expansion of the children's department. The total number of cases rose from 90 in 1924 to 432 in 1931 and almost doubled to 839 between 1931 and 1935.

The Children's Care Committees in London were founded as voluntary organizations. Their emergence coincided with the advent of compulsory schooling in 1870. Staffed by women, their work focused on the provision of food, clothes and other necessities for children whose parents were not supplying these themselves. After 1909 the LCC employed these volunteers as public servants responsible for ensuring that families received welfare benefits granted to them, and that they did not flout any laws of the Care and Protection of Children (Hendrick, 1994; Jennings, 1930). This initiative was part of a strategy to replace charitable services with fully coordinated agencies funded by the LCC. The scheme to co-ordinate welfare services had begun to receive LCC support after pioneering groups such as the Charity Organisation Society had claimed that systematic approaches to the provision of welfare would provide greater efficiency in the distribution of resources and thus ensure a healthier population (Owen, 1964; Stewart, 1997).

[9]E.g., CFM 003.585; CFM 014.059

Most of the children whom the Care Committees referred to the Maudsley came from working-class homes and many lived in squalid conditions. They were usually noted as being in poor general health and were often malnourished. A number of them were expected to carry out household tasks at home and, as a result, did not attend school regularly. Those who were at school were often well below the general school standards. In several cases, it was discovered that adults or older siblings who were supposed to be caring for the children had either violently or sexually assaulted them. Others were found to be 'illegitimate' or living with step-families in 'broken' homes. Growing referrals of severely disturbed and sick working-class children significantly increased the clinical caseload for Maudsley physicians who were only just beginning to manage their post-encephalitic patients.

As a result, the Maudsley enlisted the help of other agencies and professional groups. In particular, they turned to the Schools' Medical Service (SMS), which had been established in 1907 largely as a response to the Interdepartmental Committee on Physical Deterioration. The SMS was introduced to ensure that schools maintained strict levels of hygiene and to identify any diseased or 'defective' children who might threaten the health of their fellow schoolmates. Medical officers were put in charge of this process and 'special schools' were established for children who would be permanently removed because of epilepsy, 'defect' or 'feeblemindedness'. These special schools were usually residential institutions, sometimes referred to as 'colonies'. Any children who were regarded as a threat to the health of the public were sent there (Dwork, 1987; Harris, 1995).

The SMS was a useful ally to the Maudsley because it could provide education and care to the increasing numbers of difficult children being referred to the hospital. In return, Mausley physicians aided the SMS in deciding the best type of school to which these children should be sent. Residential schools, colonies and foster homes became increasingly specialized (Hendrick, 1994; Sutherland and Sharp, 1984) and knowledge of family conditions were thought especially important in the process of referral. The SMS started to rely heavily on the Maudsley to make the final judgement on whether or not cases might improve within their existing surroundings or whether they needed to be sent to special schools for the 'feebleminded', 'epileptic' or 'difficult'. For example, 'mental defectives' were often sent to the Fountain Hospital in Tooting or the Madonna school in Letchworth where they would receive institutional care and basic training for the rest of their lives. Other children were referred to foster homes where mothers specialized in bringing up particular types of children, such as the home at Caterham for 'difficult' children.

Mapother and the deputy medical superintendent, William Moodie, sent regular reports to Miss Morton of the Education Officer's Department, alerting her to those children they believed might require institutional care. All manner of information was forwarded about the child regarding their health, personality, sexual or criminal 'misdemeanours', bad habits, the way their parents appeared to discipline them, and whether or not they swore. For example, one boy was described as having 'violent temper tantrums in which he would hit and kick his parents. Twitching and jerky movements of hands and arms. Fussiness about food. Poor sleep. Nightmares. Awakes crying at night. Uses bad language and threatens to kill parents.'[10] However, he was also said to be 'a pleasant, friendly child though somewhat reticent. He admitted using bad words which, he said, had been taught him by another boy.'[11] As a result, he was considered morally deficient rather than mentally defective, and it was recommended that he be sent to a foster home to prevent any deterioration in his behaviour. Through work such as this, the Maudsley took on an important role within the

[10]CFM 033.698
[11]CFM 033.698

framework of local government. Children who would have previously been placed in custodial care under the poor law could now be referred to the Maudsley for an assessment.

The Maudsley also aided the SMS and the Care Committees by intervening in cases where a child's symptoms were the result of cruelty, violence or neglect. Although care committees had legal powers to intervene in such cases, these were difficult to enforce because of a lack of evidence and the fact that children's testimony was often disregarded in court. Instead of charging abusive families, Maudsley physicians usually recommended that the child should be removed from his or her home because it was bad ‘environment’. Both Care Committees and the SMS usually preferred this solution to legal proceedings. For example, in 1927 one Care Committee worker, Miss Morris, wrote a desperate letter to the hospital regarding a girl who was being severely beaten by her father leading to ‘hysterical symptoms’. Morris did not want the child to receive medical treatment but wished Maudsley doctors to recommend that the girl be removed from her home because, as she claimed, ‘the mother is unlikely to consent to placing except on medical advice’.[12]

Incorporating the study of behaviour into child psychiatry

It was only after the Maudsley children's department had begun working with the SMS and the care committees that they developed new conceptual frameworks for approaching psychological disorders in children. They sought to integrate classifications used by these groups and to incorporate their theories of child development. In the process, child psychiatrists began to abandon the principles of nineteenth-century sensory-motor psychophysiology and evolutionary theory on which child psychiatry had previously been based.

During the first three years of operation, Maudsley clinicians used a limited number of diagnoses to classify young children's disorders which described largely neurological abnormalities or disorders of physiological reflex, and which could be conceived within the framework of psychological evolution. In 1926–27 increasing numbers of children began to be diagnosed with moral disorders, or were merely listed as ‘difficult’ or ‘nervous’ children. In 1928 physicians started to use an entirely new diagnosis which had never been used in the previous three years. This was the classification of ‘behaviour disorder’. After 1928 the diagnoses behaviour disorder and behavioural problem were used as an alternative to all forms of ‘moral’ disorder. They rapidly became popular: of cases admitted in 1931, just over a quarter were diagnosed using behavioural categories. By the mid-1930s these diagnoses started to be used in conjunction with terms describing criminal activity and the child's ability to be ‘managed’ or ‘controlled’ by doctors, parents, teachers and carers. Of cases admitted in 1935, over one-third were diagnosed using a combination of ‘behaviour disorder’, ‘behaviour problem’, ‘unmanageable’ and ‘stealing’. This level was maintained until 1937/38 (Mapother and Golla, 1932, 1936). After 1930 no children were diagnosed with any form of ‘moral’ disorder.

The concept of behaviour had initially entered into the field of psychology through the work of C. Lloyd Morgan (1852–1936), a British experimental psychologist. He had rejected the concept of instinctive ‘drives’ and the ‘hormic’ theory of action, which had been advanced by psychologists such as McDougall. Morgan claimed that instinctive acts should not be conceived as the result of impulsive forces or powers. These forces were metaphysical entities and were not relevant to the field of psychology. He claimed that the concept of behaviour should be used to describe the actions of both humans and animals because it was more scientific and devoid of any metaphysical claims (Hearnshaw, 1964; Young, 1970). In

[12]CFM 033.224

the USA, ‘behaviorism’, as the support of behavioural concepts came to be known, was advanced most enthusiastically by J. B. Watson, also an experimental psychologist (Richards, 1996; Watson, 1913). Watson saw ‘behaviorism’ as a theory which discredited the theory of human instincts and in addition overturned the idea of hereditary transmission. In his opinion, all human behaviour was purely learnt behaviour.

Dawson took a different view. He originally considered behaviour to be an important descriptive concept, but nevertheless thought it crucial to retain theories of drive, power and motivation in order to understand children's actions. Drive theory was essential because it provided the backbone to theories of psychoanalysis, sensory motor psychophysiology and neurology, which were used therapeutically with children. When the links between the Maudsley and other agencies started to grow rapidly, however, the importance of retaining a concept of human motivation or drive gradually began to subside. Along with this subsidence came a gradual demolition of the edifice of nineteenth-century psychological theory which had originally supported both work and research in child psychiatry.

Towards the end of 1925, Dr Dawson was awarded a Rockefeller fellowship enabling him to study child psychiatry in the USA for several months. There the ‘mental hygiene’ movement was gaining popularity through the work of Adolf Meyer and Clifford Beers. Its goals were largely administrative: to integrate mental health services into society rather than restricting them to secluded institutions such as asylums. The Rockefeller Foundation supported this approach which appealed as much for its relevance to social welfare and government intervention as to new models of medical practice. On returning from America in 1926, Dawson sought to implement a similar programme by educating child-care workers and parents in the principles of psychology and enlisting general practitioners as ‘sympathetic agents’ within psychiatric services (Dawson, 1926).

In 1927 when Dawson took up a Professorship in Sydney, Australia, Dr Rosalie Evelyn Lucas took control of the children's department (Mapother and Golla, 1932: 11) and embarked on an ambitious plan to expand the boundaries of child psychiatry. However, Lucas was a junior member of staff, who had only qualified in medicine in 1925 (Anon., 1942: 184). She therefore worked closely with Moodie who assessed most of the children and supervised their treatment. Lucas was considered a good candidate for the job because she had already spent a year in the USA on a Rockefeller medical scholarship (Hodgson and Brown, 1927: 2). As soon as she was appointed she began giving regular lectures to Care Committee workers and parents about the psychological problems of children. Her aim was to explain the role that they could play in reducing these disorders, but also to reduce the managerial workload on Maudsley staff (Mapother and Golla, 1932).

Although Lucas and Moodie continued to employ many of the therapies that had been instituted by Dawson and Barkas, their work diverged from that of their predecessors in two key respects. First, they considered family intervention a major aspect of their work and gave regular advice to children and their parents. Lucas, in particular, often spoke to children and parents about how to ‘manage’ troublesome behaviour. She adopted a pedagogical role which had previously been absent within the clinic. In addition, Lucas and Moodie began to treat very young children using psychoanalytic theory, something which Barkas and Dawson had reserved for adolescent patients. They simplified psychoanalytic theory considerably in order to do this.

Secondly, by focusing on aberrant behaviour, Lucas and Moodie drew a distinction between that which was learnt and could be addressed through advice and teaching, and that which was the result of infection or physiological disorder. This division had never been employed

in Dawson's clinic, where all symptoms were seen to result from disturbed physiological and psychological processes in combination.

The case of an eight-year-old girl admitted to the Maudsley in June 1927 illustrates the new theoretical approach which was emerging in the hospital at this time. On first being observed at the clinic, she was given a diagnosis of ‘post-encephalitic moral defect’. On closer observation, Lucas and Moodie took note of the following symptoms:

> Alteration in behaviour since about February 1927. Violent temper tantrums, screaming, kicking and swearing. Extreme depression at times. Many suicidal and homicidal attempts. Aggressive towards other children. Some imaginative lying. Much nail biting, spasmodic antagonism to family, especially to mother and aunt, followed by extreme and prolonged sobbing. Restless sleep and somnambulism.[13]

They also noted that the girl had had ‘hallucinations’ of hearing since the age of five, and tantrums since the age of six.

Lucas and Moodie enquired further into the child's physical condition and home environment. They discovered that she had septic tonsils, an ear infection and what appeared to be rheumatism. Rather than treating the girl's physical and psychological condition in combination, they identified three distinct ‘factors’ which appeared to have a bearing on her present behaviour. Questioning both the child's mother and the girl herself, they discovered that she had, what they called, ‘an unusually strong and early developed maternal instinct’. The mother told them that her daughter was ‘mad on taking babies out’ and that she would ‘run out and hit’ other girls if she saw them wheeling toy prams. The girl was also very aggressive to the female members of her family but never to her father whom she wanted to ‘marry’. This factor was considered to be ‘the most important’ in eliciting the girl's recent behaviour. Her extreme jealousy of women, who had the capacity to have children, was seen as the cause for her aggression.

The second factor was an infection, which they presumed to be encephalitis. This, Lucas and Moodie assumed, had led to the girl's under achievement at school, though was not thought to be responsible for her aggressive outbursts. Because she was nervous and easily frightened, they characterized her as ‘introverted’, a Jungian term that referred to individuals who turned their drives inwards.

Lucas and Moodie took an educational and behavioural approach to the girl's treatment. The notes state that ‘with her mother's permission, a simple explanation of the facts of reproduction was given’. This was designed to help the girl to overcome her aggressive tendencies towards other women by alerting her to the fact that she could have her own children when she was older. This, they found, was the ‘turning point’ in the case. The girl, they claimed, then ceased all her aggressive behaviour and started to trust her mother, which also helped her to overcome her fears.[14]

This treatment, which purposely involved the child's mother and brought the pair into an educative programme of behavioural management, was markedly different from the individual treatment which had been employed previously in the clinic. In 1924, for example, a ‘post-encephalitic’ child, treated by Le Marquand, was referred elsewhere as soon as it was realized that the family played a part in the child's symptoms. While badly behaved children had previously been regarded as a nuisance at the clinic, under Lucas's direction they were positively encouraged to attend. In July 1927 Moodie wrote to Miss N.

[13]CFM 018.591
[14]CFM 018.591

C. Murray at the education officer's department stating that ‘we are very glad to see any cases of behaviour problems in children which you may care to refer to this clinic.’[15] This new approach to child psychiatry drew from the mental hygienist principles which sought to approach psychological problems at the social, rather than the individual, level. Children's aberrant behaviour then became a problem of family care and education. It could no longer be regarded solely as the consequence of an individual's malfunctioning instinctive drives.

Psychoanalytic theory of the time suggested neurotic behaviour in children was the result of unconscious fantasy about parental figures. Because these were not necessarily realistic representations of adults or actual events, treatment focused on releasing the repressed desires and wishes. In contrast, Moodie and Lucas placed learned behaviour that was tied to social and familial circumstances at the centre of any therapy. Their approach implied that they had abandoned evolutionary theory within psychology and its relation to unconscious mental processes. It enabled a practical approach to young children's disorders which could be employed en masse. Within this new model, Lucas and Moodie began to ascribe numerous causes for each child's condition, developing a model of causation which was broadened out to include many events in the family home. For example, the aetiology of one ‘delinquent’ child's condition was listed as ‘poverty, unhappy home life, [and] poor parental outlook’, that of a hysterical girl as ‘shock’, ‘spoiling at home’ and ‘subnormal intellect’, and that of a ‘difficult’ child as ‘jealousy of sister’, an ‘unwise parental attitude’ and ‘school difficulties’.[16] Forms of behaviour now took precedence over symptoms. For example, one girl was described as suffering from ‘hysterical habits’, and another was regarded as abnormal because she fainted regularly without there being any apparent organic cause for her low blood pressure.[17] Lucas took the opinion that if a symptom was related to family or ‘environmental’ problems then it could be categorized as a form of behaviour that was treatable through education.

Dr Thomas Tennent and the growth of psychiatric social work

In 1927 the Commonwealth Fund, founded in 1918 by Anna Harkness (wife of one of the original Standard Oil investors, Stephen Harkness), began to fund child guidance clinics in the UK. Child guidance was a new professional practice which was gaining ground in the USA. As with the mental hygiene movement, child guidance had no particular theoretical orientation. Clinics adopted diverse theoretical orientations and methods of practice (Thom, 1992). The overriding aim of the movement was to prevent delinquent activity and anti-social behaviour (Levy, 1951). It had emerged from a clinic set up to treat juvenile delinquents – namely Healy and Bronner's Judge Baker Clinic in Boston, established in 1917. In attempting to reform the young criminals who were referred to their clinic, Healy devised a professional mode of practice which sought to involve multiple agencies in curbing the criminal behaviour of children. On entering Healy's clinic, each child was assessed by a tripartite team consisting of a social worker, a psychologist and a physician. In the late 1920s the clinic started to extend its work to include the treatment of non-delinquent behaviour problems (meaning nascent criminal activity) as well as delinquency (Jones, 1999; Thom, 1992).

In 1928, with the support of the Commonwealth Fund, the Child Guidance Council established the Islington Child Guidance Clinic, a ‘demonstration’ clinic designed to educate others in the methods of preventing anti-social behaviour. In February, Moodie was appointed head of the clinic and Lucas joined him as assistant psychiatrist. One year later,

[15]CFM 009.87
[16]CFM 038.112; CFM 033.860; CFM 030.803; CFM 032.881; CFM 033.224
[17]CFM 033.224; CFM 031.377

the Commonwealth Fund established the Diploma in Mental Health course at the London School of Economics (LSE), the central training institution for social research in the UK. This course trained psychiatric social workers, many of whom received practical training at the Maudsley.

After the departure of Moodie and Lucas from the Maudsley, Dr Thomas Tennent took control of the children's department. Tennent had also received a Rockefeller fellowship and had travelled widely in the USA visiting the Child Guidance Clinic in Philadelphia, Dr H. E. Chamberlain's clinic in Minneapolis, Dr Adler's Institute of Juvenile Research in Chicago and Dr Shumaker's clinic in Cleveland. It was Tennent who introduced the diagnosis of behaviour disorder to the Maudsley, and the rapid uptake of this term was largely due to his efforts. Shortly after his appointment, the Child Guidance Council approved the Maudsley clinic and worked closely with Tennent to secure their goal of preventing social disorder. Within three months Dr Mildred Creak was appointed as his assistant (Mapother and Golla, 1932).

One month before Tennent became director, Miss Craggs, the clinic's first child social worker, was loaned to the clinic by the Child Guidance Council. Miss Craggs carried out detailed home assessments, which provided important evidence of how family circumstances impacted on children's conditions. As Mapother and Golla (1932: 17) put it, to determine ‘the causation of mental disorder …, there is really no dispute among those with practical knowledge as to the increase of accuracy which is obtainable through local enquiry by a social worker’. Just prior to Tennent's arrival, the hospital also took on the services of a voluntary psychologist, Miss Nevill, to conduct intelligence tests on the children, a task previously undertaken by clinicians.

Unlike Healy's Boston Clinic, the Maudsley Hospital was not linked primarily to the courts. As a result, most children referred to the hospital came with a medical rather than a forensic history. Nevertheless, when Tennent took up his post, there was already a full range of professional disciplines employed in the department, exactly as in Healy's clinic. In 1930, to strengthen the bonds between the Maudsley and other agencies, Tennent introduced weekly case conferences to which Care Committee members, school teachers and other interested professionals were invited, along with the social workers, psychologists and physicians at the Maudsley. He forged links with the courts and probation services. In June 1931 the children's department was recognized as a ‘school clinic’ by the LCC, ensuring the co-operation of local head-teachers whose pupils would not legally be missing lessons by attending the Maudsley.

Along with the growing interest in the social causes of mental disorder, and the employment of increasing numbers of non-medical professionals, came behavioural categorization and conceptualization. As mentioned earlier, Tennent introduced the diagnostic term ‘behaviour disorder’ to the Maudsley. From a sample of cases diagnosed as behavioural disorders by Tennent during 1930–31, it is clear that he perceived the term as encompassing a broad array of presentations. For example, it was applied in one case of vomiting, temper tantrums and refusal to wash; one case of obsessive swearing, sadism and destructiveness; one of enuresis (involuntary urination), sexual perversion and low intelligence; one of staying out late, lying and stealing; and one of masturbation.[18]

Treatments for these behaviour problems increasingly resembled social and group activities. Moodie and Lucas had offered advice on sex education and family relationships, while Tennent and Creak also recommended that children participate in sports, such as tennis, join

[18]CFM 066.415; CFM 067.278; CFM 071.438 ; CFM 074.349; CFM 074.460

the scouts or the girl guides, and, in one case, take up morris dancing.[19] Close co-operation with the various social agencies with which the Maudsley worked made it more likely that their management plans were observed. If not, they retained the power to recommend removal of a child from the home environment on medical grounds. The growth in social treatments also led to a reduction in the proportion of children treated with medication, in particular sedatives and hypnotics.

A consequence of this emphasis on social psychiatry was that less time was devoted to study of a child's individual condition and any attempt to explain it within a comprehensive theory of mind and evolutionary development. Tennent and Creak ceased to collect detailed information about the child's reflex actions, as Dawson and Barkas had done. They no longer observed the particular nature of the child's movements or finding out details about the minutiae of the child's unconscious psychic life. By the time Tennent took charge of the clinic, child psychiatrists had also abandoned the Galtonian aim of studying child variation in order to understand the phenomena of individual differences. In addition, they had abandoned the aim of psychological investigation in the tradition of Bain, Spencer and McDougall, which sought to understand the force of instinctive drives within psychology.

Driven by behavioural psychology, child psychiatrists at the Maudsley focused on co-ordinating multiple agencies, assessing increasing numbers of ‘difficult’ children, and conceived their problems in terms of social processes. The emphasis on behaviour, rather than on medical symptoms, enabled workers from disparate theoretical backgrounds to unite with a common aim of changing children's behaviour so that they could adapt to a ‘healthy’ model of society. While these changes clearly represented gains for diplomacy and integration, they brought about a marked loss in terms of maintaining theoretical coherence and accuracy within the developing field of child psychiatry.

Mildred Creak and the plans for child psychiatry

In 1931, when Tennent became deputy superintendent of the Maudsley, Mildred Creak (1898–1993) was appointed head of the children's department. She had trained in medicine at University College Hospital in London and had also gained membership of the Royal College of Physicians (Graham, 2004). Creak had worked for five years at the Retreat, a Quaker psychiatric hospital in York, before taking up her post at the Maudsley (Anon., 1993; Moncrieff, 1964). Under Creak's management, the contracting out of care to social workers and other non-medical groups continued to grow. She enlisted the voluntary services of a speech therapist, a teacher for children with reading disabilities and numerous play-group assistants. A ‘rhythm class’, under Miss K Taachi, was set up to re-educate ‘the large number of children who are habitually restless and poorly co-ordinated in their movements’ (Mapother and Golla, 1932: 23). With these services provided by other groups, the role of the physicians was transformed. Henceforth, they concentrated on diagnosis and deciding which social and educational treatments should be employed.

Because the Maudsley possessed the facilities to manage difficult cases, the clinic's reputation spread. By the time Creak took over, not only the Care Committees but also many of the London child guidance clinics were referring children who were not easily classified or found places in special schools or other institutions. For example, in 1934 Emanuel Miller of the East London Child Guidance Clinic sent a child whom he presumed to be ‘mentally defective’, but for whom his clinic could do nothing. In 1935 Margaret Lowenfield of the Institute of Child Psychology for the Treatment and Study of Nervous and Difficult Children, referred a 12-year-old boy to the Maudsley in 1935 stating that ‘his general

[19]CFM 066.415

attitude reveals an early paranoid of so outstanding a type that we are referring him to you for consideration'. Cases were also referred from Moodie's London Child Guidance Clinic, the Tavistock Clinic for Functional Nerve Cases and many others.[20]

In clinic, Creak continued to employ the selective psychoanalytical ideas which had first been used by Lucas and Moodie to treat young children. She used this model to inform other groups about the child's problems and to identify ways in which these could be approached. Her dominant role in case conferences was revealed in their notes: 'Dr Creak feels that the stepmother has created the circumstances and will manage to overcome them all successfully' or 'Dr Creak emphasised home difficulty…The child is manifestly jealous of the brother and has a sense of guilt about this.'[21] Creak began to think of disorders in child psychiatry in terms of 'emotional disturbance'. Treatment in these cases consisted of changing family or school circumstances, or talking to the child and discussing the anxieties and fears which were thought to be influencing its emotional state. In a telling transition, Creak ceased to use the word 'phantasy', taken from the translation of Freud, when discussing children's unconscious thoughts, and instead used the more neutral 'fantasy', which fused both conscious and unconscious thought processes (Creak, 1938). Instead of attempting to address any hypothetical unconscious mental processes, Creak made the identification and alteration of conscious emotional states the central goal in her treatment methods.

Not surprisingly, Creak often found it hard to differentiate between an 'emotional disturbance', which could be addressed through family dynamics, and a physical illness which could be treated with medication. For example, in 1935 a girl was admitted who had a limp arm and leg which occasionally produced spasmodic movements. Creak was not sure whether the girl had chorea or whether she had converted a psychological conflict into physical ailments. She interviewed the child and her mother, enquiring as to the girl's 'sexual inclinations' as well as her feelings and emotions. She also observed the movements, noting that 'some of the movements do look spontaneous others as if they might be hysterical'. Finally, she treated the girl with Nirvanol, a sedative, the success of which was taken as evidence against a psychoanalytic interpretation.[22] By contrast, a boy, who was treated for one year and three months for enuresis, was regarded as experiencing a psychological disorder, and his family conditions were fully investigated by the social worker. He was found to be an 'over-conscientious anxious child' who came from a motherless home. His anxieties were addressed through twice-weekly sessions on the Child Guidance model. Yet in the middle of this treatment the boy suddenly died, and it was discovered that he had contracted 'acute osteo-mylitis of the lumbar spine with septicaemia';[23] in a pre-antibiotic age, no effective medication existed, and the case illustrated how little physicians could do for seriously ill children.

The difficulty of distinguishing between psychological and physical effects continued to plague Creak's work, and she later became interested in the problem of diagnosis, and distinguishing between clinical types (Creak, 1937, 1938).

Although the influx of difficult cases from care agencies had transformed the theory and practice of child psychiatry at the Maudsley, Mapother still sought to use the sub-speciality to advance understanding of adult mental disorder. As a result, Creak was sent on a Rockefeller scholarship in 1932–33 to medical school clinics in the USA, where

[20]CFM 017.200; CFM 159.521; CFM 163.650; CFM 024.738
[21]CFM 167.1129; CFM 157 646; CFM 068.884; CFM 066.415
[22]CFM 161.1289
[23]CFM 162.645

experimental research was being conducted into children's disorders. These included Klopp's unit in Allentown, Potter's in New York, and Bradley's specialist neuropsychiatric clinic in Rhode Island, where work was being done on the effects of amphetamine on children's behaviour (Mapother and Golla, 1932: 22; Wardle, 1991: 56–7). Bradley's work is now well known for his pioneering use of stimulants in the treatment of hyperactivity (Singh, 2002). These clinics were distinct from child guidance clinics because they did not have the management obligations.

Mapother also secured funding from the LCC to build an inpatient department designed solely for children. Hitherto, children had been admitted to adult wards or sent to foster homes for observation. These options were considered unsatisfactory because, as Creak (1940: 396) wrote, ‘in the foster home expert observation could never be more than partial, and in the wards for adults the setting is too unlike a child's ordinary life to permit him to show his responses to familiar situations reproduced in a controlled environment’. The new department was designed to facilitate close observation. Children who were thought to require continual monitoring were to be kept on the first floor where nurses could watch them from a central ward. The inpatient department comprised dormitories, two self-contained units, four glass-fronted rooms for infectious children, a kitchen, a dining room, a schoolroom, a playroom and a walled-in playground which was open to the sky. On the roof there was a covered playground which had ample windows to allow in light and air (Creak, 1940).

However, Mapother's plans for child psychiatry were not easily achieved. The construction of the children's inpatient department was delayed because of economic difficulties and did not open until 14 July 1939, only to be evacuated two months later because of the threat of bombing (Creak, 1940). Most importantly, the practical changes which had taken place during the late 1920s and early 1930s had undermined any intellectual coherence that may have existed in the field. Although child psychiatrists had access to vast amounts of case material, they had yet to develop a central hypothesis that would form a basis for clinical research. Child psychiatry had come to represent so many things that it was difficult to know where any research programme would begin. Acutely aware of this shortcoming, Creak, in an article written with B. J. Shorting, a research fellow at the Maudsley, sought to summarize recent developments. This covered everything from research in normal child development to electro-encephalography (measurement of electrical charges in the brain), childhood psychosis, psychoanalysis, children's understanding of war, fantasy companions, stealing, brain damage, bed-wetting, sex play, parent-child relationships, drawing, homosexuality, and play therapy (Creak and Shorting, 1944).

Conclusion

The sustained growth of the children's department of the Maudsley Hospital was both opportunist and the product of novel thinking. During the 1920s, a significant gap existed in the provision of care for children suffering from abuse or mental illness. A number of charitable and local government initiatives had been set up to offer professional help but they lacked expertise in both medical and psychological assessment. Having been drawn fully into child psychiatry by infective encephalitis, Maudsley physicians sought to develop their expertise by studying the child guidance movement in the USA. Rockefeller fellowships allowed key members of staff to learn at first hand and led to the introduction of new behaviourist ideas. Moodie, Lucas and Creak identified clinical opportunities in this approach, which would also serve the Maudsley's strategic goal of attempting to find cures for mental illness. The child psychiatrists reasoned that if behaviour had been adopted as a result of family or other environmental influences, then it could be re-learned if the child were removed from these toxic circumstances and offered instruction and encouragement.

Disorders that had seemed intractable or chronic could plausibly be addressed at root before they had time to become established.

The introduction and spread of mental hygiene and child guidance practices in the second half of the 1920s provided the intellectual context for these developments. Before this, child psychiatry had used practical experience to further understanding of the nature of human instincts, sensory-motor physiology and hereditary transmission. The rise in Care Committee referrals, and the introduction of mental hygiene and child guidance administrative measures, led to a move away from these groundings and the growth of an interest into the social causes of children's psychiatric disorders. Behaviourist concepts enabled physicians, social workers and other health-care professionals to manage children's behaviour and emotions through consultation and environmental change, rather than through individual treatments.

During the interwar period, the Maudsley did much to establish child psychiatry as a sub-speciality in its own right. Although research and clinical study were delayed until after World War II, increasing numbers of clinicians began to specialize in this area. The development of the case conference, multidisciplinary teams and the emphasis of family and social context were significant practical innovations. However, these innovations were accompanied by a decrease of intellectual coherence within the field, brought about in large part by the neglect of evolutionary theory and sensory-motor psychophysiology which had previously provided the foundations for child psychology.

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