‘The dangerous age of childhood’: child guidance in Britain, c.1918-1955

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Executive Summary

- The present government seeks to support children and their parents during the early years. This includes attempts to ensure their emotional and psychological health.
- Such concerns are not new, as is witnessed by the history of the child guidance movement in Britain from the end of the First World War to the mid-20th century.
- Of particular concern to child guidance was the issue of maladjustment. This manifested itself externally in a range of behaviours and conditions, but was held to be symptomatic of deeper-rooted problems. For the most part, these were seen as deriving from a dysfunctional child-parent relationship.
- Maladjustment was a problem not only for the child, but also for its family and the wider society. Child guidance thus saw itself as a form of preventive medicine aimed at countering a threat to familial and social stability.
- Children suffering from maladjustment were seen at special clinics where they encountered a team led by a psychiatrist with the support of a psychologist and psychiatric social workers. The psychiatric approach adopted avoided controversial techniques such as psychoanalysis.
- British child guidance was initially supported financially by American, and to a lesser extent British, philanthropy. However the inter-war period saw increasing interest from the Board of Education and Local Education Authorities. The experience of the Second World War added impetus to demands for state-provided child guidance. It was embedded in the welfare state through the Education Acts of the mid-1940s and was thereby a part of the school medical service.
- Historical analyses of child guidance highlights issues and questions about the pathologising of childhood, the emphasis on the familial origins of child behaviour problems, the shift in focus in child welfare from the child to the parent, the role of the voluntary sector in advancing services such as child guidance, the way in which expert knowledge about child-rearing is spread and differences about the nature of expert knowledge and who is to apply it.
- Childhood is thus not simply a biological state, but socially and historically constructed, and child welfare a matter of debate and disagreement.

Introduction

The present Department for Education website contains, on various pages, the following statements: 'Sarah Teather, Minister of State for Children and Families, announced in October a universal parenting classes trial for mothers and fathers of children aged up to five in three local areas…'. The proposed classes were to be offered by a 'range of providers'. Citing with approval the United Nations Convention on the Human Rights of the Child it is noted that this gives children and young people over forty substantive rights, including that to 'grow up in an environment of happiness, love and understanding'. More specifically on the question of mental health, for children and young people this is deemed to involve 'coping and adjusting to the demands of growing up' which includes 'getting on with others, both peers and adults'. As to those workers providing children's services these should be 'skilled professionals' with working practices being integrated and showing 'a commitment to partnership'.

These concerns and aspirations are not new and here I examine a previous attempt to address them by way of an historical analysis of a form of child mental health care called child guidance. As will become apparent, this complex and contradictory history throws up a range of issues about children's emotional and psychological development which continute to have contemporary resonances.

Child guidance and maladjustment

Child guidance emerged first in the United States in the aftermath of The First World War, spreading to Britain and other parts of Europe shortly thereafter. One of its basic ideas was that even the most apparently 'normal' child might, in the course of his or her emotional and psychological development, experience 'maladjustment'. This meant that child guidance was, essentially, concerned with the whole child population, or at least that part of the child population which was not severely delinquent or, in the language of the time, mentally defective – in other words, the overwhelming majority of children. Child guidance sought to be a form of preventive medicine promoting children's mental well-being.

How might maladjustment manifest itself, why was it actually a problem, and how was it to be dealt with? An important starting point here is the idea of the normal child. It was an underlying principle of child guidance that even the most apparently normal child was at risk during his or her emotional and psychological development – during what one psychiatrist closely involved in the movement called the 'dangerous age of childhood'. Moreover, it was not the case that any given child was either maladjusted or not – rather, there was a spectrum of normalcy and the point at which any child might be located on this could change with time and circumstance. The symptoms of maladjustment covered a range of behaviours and issues from bed-wetting to much more ill-defined concerns such as timidity and shyness.

Emotional and psychological problems in childhood would lead to unhappiness and instability in the child both in the present and in the future. More than this, though, it would bring instability to the family and to the wider society. Maladjustment was thus a threat to social order. The wider context is important here. As noted, child guidance emerged in the aftermath of the First World War, of itself increasingly viewed as a conflict without rational cause or explanation and which thereby provided a boost to psychological theories stressing the unconscious and irrational basis of human behaviour. It grew as a movement in the inter-war era, characterised by instability in western capitalism; by developments in the natural

sciences which suggested that the universe itself was inherently unstable; and by the rise of political extremism. So it is revealing that one of the psychiatrist John Bowlby's major early publications was the co-authored book *Personal Aggressiveness and War*. This came out in 1939 and drew on his experience at the London Child Guidance Clinic. Child guidance became embedded in the welfare state at the end of the most destructive war in human history, the beginning of the Cold War, and the consequent aspiration in western democracies like Britain for social reconstruction and social security. Child guidance was thus to contribute to the stability of the key building block of British society, the family.

To return to maladjustment, what caused it? The word 'symptoms' was used earlier when discussing problems such as bed-wetting. For child guidance saw such matters as merely manifestations of much deeper-rooted problems, believed to derive primarily from the malfunctioning of the child's environment and, in particular, a dysfunction in the parent-child relationship - the emotional and psychological landscape of the family – rather than in material circumstances. This analysis had important implications to which I return below.

At the Clinic

The locus for treatment was the dedicated child guidance clinic. Here the child encountered members of three professions – psychiatry, psychology, and psychiatric social work. The psychiatric social worker gathered information about domestic circumstances and, in practice, carried out much of the treatment. The psychologist administered psychometric tests and possibly observed the child at play in the clinic's play room. Play was very important both as a diagnostic tool and as a form of treatment in British child guidance, and especially so for younger children whose verbal skills might not yet be fully developed.

The lead figure, though, was the psychiatrist who directed the clinic team. Much was made of teamwork in child guidance although in reality it was hierarchical teamwork, with the psychiatrist very much in charge. With the aid of psychological tests and social work reports as well as her or his own interviews, it was the psychiatrist's role to identify the underlying causes of the maladjustment and to prescribe treatment. This was, in short, a medicalised approach to psychological and emotional problems in childhood.

The language of child guidance was suffused with medical terminology, some of which we have already encountered. Children attending clinics were routinely referred to as patients while the overarching aim was to discover the aetiology of their problems. What this meant, when taken in conjunction with the idea that even the most normal child was at risk, was that childhood was being pathologised: it was inherently fragile, and always at risk.

As an indication of the age of the child patients, in 1938 the Notre Dame Clinic in Glasgow investigated nearly 200 patients ranging from eighteen months to eighteen years. Of these, around 12% were under 5, another 12% over 14, with the bulk, around three quarters, between 5 and 14. The number of boys and girls was generally pretty even. These sorts of patterns seem to have been fairly usual. Typically, the bulk of those seen at clinics were there because of problems such as bed-wetting and stammering, although much more clinically opaque and definitionally problematic conditions, such as shyness, might also see a child referred.

The psychiatric approach used in British child guidance had, for present purposes, two dimensions. First, the child's mind was deemed to be, again in contemporary terminology,

'plastic' in a way that was not the case for adults. It could be relatively easily influenced and adjusted and the sooner appropriate interventions (which, as we shall see, might in fact not directly involve the child) took place, the better for the child, the child's family, and the wider society. Second, since the child's mind was still in the process of formation, it was not advisable to use techniques such as psychoanalysis and this was especially true for younger children. Rather, for the most part all that was required was, as one psychiatrist put it, a common sense chat, although what he did not explain was why this required the services of someone trained in psychiatric medicine. This is not an entirely flippant point because child guidance was contested and challenged, not least for its clinical imprecision and lack of rigour.

Philanthropy and Local Government

But how did it come to be embedded in the welfare state? Key to the establishment of child guidance in America after 1918, both in financial terms and in terms of the promotion of the medical approach, was the philanthropic body the Commonwealth Fund of New York. Following an approach by British child guidance supporters in the mid-1920s, the Fund agreed to support the setting-up of the Child Guidance Council, its offshoot the London Child Guidance Clinic, and a training course at the London School of Economics for psychiatric social workers: the Diploma in Mental Health. In effect, the Commonwealth Fund, through its English Mental Hygiene Program, bankrolled British child guidance down to 1939.

However indigenous philanthropy also played its part. In Birmingham, for instance, an anonymous donation helped set up a clinic in the early 1930s. This was almost certainly from the Cadbury family and probably following the intervention of the local Medical Officer of Health, Dr Auden. There were even a couple of clinics in existence before the Commonwealth Fund intervention, for example the Jewish Child Guidance Clinic in the East End of London supported by the Jewish Board of Guardians and with the psychiatrist Emanuel Miller as its first Medical Director. Nonetheless, it is hard to see how child guidance could have taken off in this country without, at least initially, Commonwealth Fund monies.

This is not to say, though, that public sector bodies were not involved. The Board of Education became persuaded of the value of child guidance and in the mid-1930s amended its rules so that referral to a child guidance clinic could be counted as school attendance. This effectively allowed local authorities to set up their own clinics with financial support from the Board and thereby encouraged them to do so. There was thus, at this stage, a mixed economy of child guidance provision – part voluntary, part public sector.

War, Evacuation, and the Welfare State

The next important moment for child guidance came with the Second World War and in particular the experience of evacuation. Evacuation appeared to highlight the potentially traumatic effect, especially on infants and young children, of separation from their parents. This was revealed by the surveys which took place during and immediately after evacuation and it is notable that child guidance practitioners, for example the psychiatric social workers from the London Clinic, took part in these. One solution to the problems revealed was deemed to be expanded child guidance provision and demands for this began to mount, particularly from 1942 when serious discussion begins to take place about post-war social reconstruction. These demands came from voluntary bodies, especially women's organisations, from educational bodies, from local authorities and, of course, from child

guidance practitioners. Crucially, child guidance was also being promoted within the Board of Education itself by both civil servants and politicians. The papers of the Board's President, R.A. Butler, clearly show that he was committed both to legislating for child guidance and that this be done under the auspices of his department. Child guidance was thus to be part of the new social fabric and a contributor to familial and social stability.

Consequently, it became embedded in the welfare state under the Education Act, 1944 and the Education (Scotland) Act, 1945. In requiring special attention, the maladjusted child was for the first time placed in the same category as children with, for instance, physical disabilities, and thereby became part of the school medical service. Local education authorities could thus set up child guidance clinics and for the most part it was these bodies which became the providers.

The qualification here derives from the perception among contemporary psychiatrists and others that child guidance was, in principle, a mental health service and thus could also be seen as the responsibility of the NHS. In the late 1940s in particular there was endless confusion and wrangling about certain clinics and attempts by psychiatrists such as Bowlby to reclaim what they saw as lost territory. This is an illustration of the more general point that child welfare is often contested by various government departments, and often to its detriment.

In terms of growth, though, in the late 1920s there were two self-described child guidance clinics, both funded from charitable and voluntary sources. By the time the Ministry of Education's Committee on Maladjusted Children reported in 1955, there were some 300 in England and Wales with only a handful now run on a voluntary basis. This does not, though, necessarily tell the whole story. The voluntary body the National Association for Mental Health (later, MIND) continued to play a co-ordinating and pressure group role for increased and better child guidance facilities and number and qualifications of staff.

Impact and lessons

What analyses and lessons can be drawn from the early history of British child guidance? First, child guidance strongly contributed to the pathologising and medicalisation of childhood in the twentieth century. One implication of the idea that even the most normal child could experience maladjustment is that the total child population had to be constantly monitored and surveyed, both by parents and by professionals. This perception, which is still strongly influential even today, is socially and historically constructed and far from being the only way of seeing children and childhood.

Second, in the first instance child guidance was provided by philanthropy and voluntary effort – indeed it is difficult to see how it could have gained a foothold in Britain when it did without such non-state effort. In due course, though, this was more or less entirely supplanted by state provision, at least at the service level. However, the voluntary sector did not entirely disappear from the child guidance story, but it took on an adapted function.

Third, child guidance and its emphasis on the emotional and psychological environment at the expense of, most notably, the material environment had implications for welfare activities such as social work and family policy. This approach was also influential through the work and teachings of psychiatrists such as Bowlby whose early training included a period at the London Child Guidance Clinic. Bowlby is an especially important figure given his influence

on post-war British child-rearing practices. From a rather different perspective, the radical psychiatrist R.D. Laing, later famous for his critique of the family, was attached early in his career to the Notre Dame Child Guidance clinic in Glasgow where, among other activities, he held parenting classes.

Fourth, and leading on from the last point, if emphasis is placed on the emotional and psychological landscape of the family, then it is easy for diagnosis and treatment to shift from the child to its parents. Even before 1939 one leading child guidance psychiatrist was calling for a huge scheme of parental education. And here it is also worth noting the role of the psychiatric social worker. Notwithstanding that child guidance saw itself as a medical project, it was the social worker who had the most contact with the child and its family and gave advice to parents on how to adjust their own behaviour in order to cure their child of maladjustment. So while practitioners denied that they were blaming parents for their child's shortcomings, in practice responsibility - if not necessarily blame - was invariably ascribed to the parents, and especially to mothers.

Fifth, child guidance was, at least in principle, conducted via the clinic, but its message was more widely spread by other means. So, for example, practitioners contributed numerous articles to lay journals such as *Mother and Child*. These pieces often used case studies to get across the clear message that to, avoid the mistakes of these parents, readers should raise their own children in a better way. All this helped popularise and normalise the child guidance approach as well as placing considerable psychological and emotional pressure on parents.

Sixth, it seems clear that for a prolonged period child guidance was the predominant, and highly influential, way of thinking about the promotion of child mental well-being. But it was not uncontested. Within psychiatry, one of the few things that Anna Freud and Melanie Klein agreed on was a rejection of the child guidance approach, arguing instead that children, including very young children, had their own interior lives and so it was, at best, misplaced to locate their emotional and psychological problems with their parents.

Finally, another form of contestation came from outside psychiatry. Psychologists resented the subordinate place they had been allocated in the medical model of child guidance. This was on both status grounds and because they argued that maladjustment was a behavioural and not a medical issue. Like some psychiatrists, psychologists also pointed to the lack of clinical clarity which bedevilled child guidance psychiatry. This was true of reasons for referral, of diagnosis and of treatment. So, for instance, a child referred for shyness or timidity was de facto assumed to have a problem which in turn derived from deeper psychological causes and which needed some measure of psychiatric intervention. In passing, it is worth considering the way in which, in contemporary society, certain childhood conditions have been pathologised and medicalised and with what results.

Over time, psychology was going to win out, for three key reasons: first, the relative shortage of psychiatrists in the post-war era, and particularly of those willing to commit to child psychiatry – a supply side issue. Second, the argument against medically-oriented child guidance was bolstered by the Scottish experience, which had been dominated from the outset by educational psychology. During the war, a Board of Education delegation to Scotland had concluded that this approach was the way forward, and this clearly influenced official thinking, notwithstanding the vociferous opposition of psychiatrists and the medical profession in general. Third, the outcome of the two preceding points was that post-war child guidance was primarily provided by local education authorities which were often inclined, for

both pedagogical and economic reasons, to employ educational psychologists rather than more expensive and less professionally pliable psychiatrists. The irony was that the medicalisation of childhood ran alongside, ultimately, the de-medicalisation of child guidance. Whether this brought greater clinical rigour to child guidance is another matter, given that educational psychology too made claims to scientific and clinical precision which do not always stand up to close scrutiny.

Conclusion

I started by noting some present-day Department for Education concerns around parenting; who is to provide parenting classes, the right of children to an emotionally secure upbringing, how this is to be achieved and the role of professionals in helping with this process. As has been shown, these are by no means new issues. What has also been shown is the problematic nature of the emotional and psychological development of children and how contested this has been. If, for example, childhood is viewed as inherently problematic then this of itself raises significant policy issues. Similarly, the history of child guidance shows how different professional groups can lay claim to the field of child mental well-being and how, over time, different service providers can play a greater or lesser role. Most fundamentally of all, the history of child guidance shows how childhood itself is not simply a biological 'given' but also socially and historically constructed.

Further Reading/References

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