REFRESHER COURSE FOR GENERAL PRACTITIONERS

THE BACKWARD CHILD—I. PRE-SCHOOL AGE

BY

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Mental deficiency is not a clinical entity like diabetes mellitus. There is no simple method of arriving at the decision to class a particular child as mentally defective. There is no specific medical treatment for most of the conditions causing mental retardation. In fact backwardness is often more an educational or social problem than a strictly medical one. Nevertheless it is the duty of the medical officer of health and the school medical officer to ascertain cases of mental defect and ineducability, and the institutions in which some 55,000 persons certified as mental defectives are detained are classed as hospitals. Moreover, it is to the family doctor that the anxious parent turns when there is a delay in passing the first milestones.

Aetiology

There is no one major cause of inefficient functioning of the brain in a young child. There are hundreds. An exhaustive account of the pathology of mental deficiency would cover the whole of neurology. Children with grossly damaged brains are usually idiots (the severest grade of mental defect) or imbeciles (the medium grade). Some of these fall into easily recognizable clinical categories—for example, mongolism, hydrocephalus, microcephaly, gargoylism. In other cases the history assists in labelling the particular clinical condition—for example, rhesus incompatibility with a history of severe neonatal jaundice—in others there is a history of German measles in the first three months of pregnancy. Birth injury accounts for perhaps 5% of all cases labelled as mental defect. Very rarely nowadays is syphilis the cause of severe brain damage in the infant. Meningitis and encephalitis are more commonly to blame. In the rarer syndromes there may be a family history of brain pathology—for example, gargoylism and phenylketonuria, which are usually considered to have a recessive mode of inheritance, or epiloia (tuberous sclerosis with adenoma sebaceum), which is held to be a dominant character.

However, most children with a poorly functioning brain look much like other children. They are not distinguished by peculiar features as in mongolism or gargoylism, or by other so-called "stigmata" such as squint, abnormally shaped ears, or incurved little fingers. They are remarkable for their slowness of development. At necropsy it may be found that these unclassified idiots and imbeciles have all manner of defects of the brain—for example, porencephaly or microgyria—but the clinician can only recognize these conditions in life by elaborate methods such as air encephalography. In a few cases the diagnosis of a clinical condition—for example, mongolism—is a fair guide to prognosis.

Degree of Defect

None the less, the clinical diagnosis is of less immediate moment than the degree of defect. It is customary to attempt to measure this by means of some type of intelligence test. However, results so obtained should be treated with reserve. An intelligence quotient is much more liable to error than such a biological measurement as, for example, that of haemoglobin. There is no general agreement on the nature of intelligence, and tests which vary from those of an educational type like the Binet-Simon to those of social development like the Vineland scale often give very different

results in the same patient. Even so, attempts at an objective assessment of a child's performance represent an advance on the attitude common some years ago which paid much attention to the shape of the head and pinna, the set of the eyes, and other items of physiognomy which bear little relation to mental capacity. Those who are often consulted about backwardness in children should be familiar with the technique of the common tests, otherwise they may find themselves accepting as final a decision based on an arbitrary I.Q. In general, however, tests are even more unreliable when used by the medical practitioner who has only rare occasion for their use than when applied by the experienced psychologist.

Progress

The severe grades of mental deficiency are fortunately the least common. Idiocy is relatively rare. The practitioner is most likely to be consulted about children who are a little less forward than their brothers and sisters or the child next door. His main task may be to allay the undue anxiety of the parents. In any prognosis which he may make before the age of 5 he should state that it is only tentative and subject to revision. Definite predictions are always unwise and usually wrong.

In order to assess prognosis when a child is, for example, slow in getting on to his feet, one should remember that the brain will develop even if it is a faulty inferior organ. Even an idiot goes on developing mentally up to the age of 16 or over. It may not be much, it may be only to feed himself with a spoon, to be continent of urine and faeces, or to dress himself. None the less, that part of his brain which has escaped injury matures and develops at a rate parallel to, though below, that of the normal organ. Therefore the possibilities of development in any young child, no matter how behind he may seem, are considerable.

There are a few forms of mental deficiency in which the patient gets progressively worse. Fortunately all of these are rare—amaurotic family idiocy, Schilder's disease, juvenile G.P.I. Most general practitioners never see such a deteriorating case. They are the exception to the general rule, which is that severe mental defect is due to damage to the brain, occasionally hereditary, usually before birth—damage which leaves an inactive scar or defect.

Maladjustment

There are, however, many backward children, perhaps the majority, in whom the defect is functional and perhaps only temporary. The term "maladjusted" has come into fashion of late to describe children presenting a wide variety of signs of psychological disturbance ranging from normal naughtiness to severe mental illness. Not all maladjusted children are backward. Some may be found very forward but give their parents ground for anxiety in other respects. However, maladjustment may lead to backwardness. Maladjustment is a relative term. It means that the child does not fit into his particular environment. A minority of relatively bright children find their way into mental deficiency institutions, children who have sufficient capacity to have managed at school had their circumstances been more favourable. Most of these children are illegitimate, homeless, or, occasionally, from bad homes. They are thus emotionally deprived, to use another term in current vogue. They have been pigeon-holed as defective because of their difficulty in fitting into the very rigid standards laid down by institutions such as nurseries. An

appearance of lack of mental capacity is readily produced by any form of emotional disturbance. Simple shyness is the best and commonest example. The difficulty is not overcome by the application of standard tests, since, however tactful and charming the examiner, the child may be too inhibited in the presence of a stranger to co-operate.

Where emotional upset is suspected to be the cause of the delay in development, treatment should aim at an alteration of the environment. Play therapy, when practicable, achieves this by providing opportunities for personal contact and self-expression hitherto lacking. Loneliness and over-protection of an only child may lead to severe disturbances. This is most common in suburban type surroundings and can be best overcome by opportunities for mixing such as are provided in the day nursery or recreation ground. For the emotionally deprived child with no suitable home of his own, the foster-home is the best solution.

Infantile Psychosis

Severe emotional disturbances are rare in children, but a diagnosis of infantile schizophrenia is fashionable, especially in America at the present time. This is largely because parents with a severely handicapped child are reluctant to admit that the lesion is permanent and irreversible. Some idiots do remind one of adult schizophrenics, but there is no proof that the condition is due to similar factors. In any event there is no general agreement on the cause of adult schizophrenia. Cases of this type in children do no better than other mental defectives, and often do worse.

Special Defects

Backward children are not usually retarded in some particular faculty. They are commonly below par in every way, often physically as well as mentally. They are deficient in height and weight and look younger than their years. A severely affected child of 4-5, for example, may look like a baby of 18 months, just able to walk, but unsteadily, without speech, doubly incontinent, and barely able to use a spoon. Such a child seldom presents the bizarre features encountered in adult mental illnesses. Further, he is to all intents and purposes a child of 18 months. If he is treated as such difficulties seldom arise. Few mothers, however, can adjust with equanimity to the notion of such a perpetual Peter Pan. In mental defect, usually the motor, sensory, conceptual, and emotional accomplishments are all equally delayed. Thus, slowness in walking is accompanied by slowness in recognizing people, by slowness in understanding instructions, and by delay in forming strong emotional attachments to parents or others. An understanding of this fact will help us to pick out those children who are classed as mentally defective because of some specific defect. A good example is the partially deaf child. Such a child may learn to walk at the usual age, be quick, active, and show much ingenuity in his play. On the other hand, he will be slow in learning to speak and in understanding verbal instructions. His character may suffer from lack of appreciation of his difficulty and he will become solitary, preferring his own company to that of others. His deafness makes him difficult to control and rebuke, so that he acquires a reputation for being naughty, wilful, wayward, difficult, destructive, spiteful, and bad-tempered. He may then well be labelled intellectually dull if his auditory defect is not recognized. Partial deafness, particularly high-tone deafness, is, naturally, more apt to be missed than complete absence of hearing. If the defect is recognized early the harm can be undone by special methods of education and speech therapy appropriate to the deaf.

Defects of vision are less likely to cause confusion, but blind children who could have been educated by special methods are occasionally encountered among mental defectives. Even cleft-palate with attendant speech difficulties may lead to an underestimation of intelligence.

Perhaps the biggest group of children with special handicaps apt to be confused with general mental defect is that

suffering from cerebral palsy. Much publicity has recently been directed to this problem, and parents are often relatively well informed about it. However, much confusion still exists. Parents of a child who has perfectly normal or even subnormal muscle tone will cling to the belief that it is spastic and can be cured by physiotherapy. On the other hand, there are some hundreds of patients with spastic diplegia, athetosis, chorea, certified as ineducable at an early age, although potentially intelligent. This is not surprising, for the child with Little's disease looks like an idiot. He grins from ear to ear, drooling saliva, and his utterance is so thick that it is intelligible only to those who are willing to listen with patience and attention. If he walks, his gait is unsteady. Having failed a Binet type test because of his faulty articulation he also fails a performance test because of poor muscular control. Yet it is well known that a few individuals so affected are capable of considerable intellectual attainment. Others, even more remarkably, accomplish fine handiwork. Children with cerebral palsy are properly classed neither with the physically normal nor with the mentally handicapped. If of sufficient intelligence they need a specially designed curriculum in a special class. Existing provision is quite inadequate, though a few groups under pioneer workers have achieved outstanding success.

In mentioning these special defects it should not be assumed that all blind, deaf, or crippled children are of normal intelligence. The same process, whether it be environmental—for example, maternal rubella—or genetic—for example, cerebromacular degeneration—may, in addition to damaging the brain as a whole, also affect special organs—for example, the ear or eye. Thus a number of children have multiple defects and have both general mental deficiency and special handicaps. This consideration accounts for the fact that among cases of severe mental defect there is a somewhat greater proportion of physical abnormalities such as microphthalmia, malformed pinna, talipes, spina bifida, malformations of the digits, etc., than in the general population. Hence the term formerly in use of "stigmata of degeneration."

Caution in Diagnosis

A diagnosis of mental deficiency should never be made on the basis of one examination. In this respect the family doctor has a great advantage over the paediatrician, the medical officer of health, the psychiatrist, and others who may have very limited opportunities for observation of the child. Any decision should take into account the physical health of the patient—repeated physical illnesses may produce temporary mental dulling—and the family background. Since there is no specific treatment there is not the same virtue in making a diagnosis of mental deficiency as with specific medical entities. In borderline cases the diagnosis is better not made—at all events before the age of 5. There is no value in alarming the parents unnecessarily; and for many the words "mental deficiency" have a most disturbing effect. Many members of the public fail to distinguish between insanity and simple-mindedness, and not all members of the medical profession are clear about the difference between disorder of the mind with the unpredictability of behaviour which it involves on the one hand and failure of development of the mind on the other. Thus they are not always in a position to explain to a parent that a child affected by the latter condition will always be simple, childish, and easily led, but, apart from this, need not necessarily be more trouble than the normal child.

In the few cases in which physical deformity is obvious—for example, mongolism or microcephaly—the medical adviser may reach a decision on the presence of deficiency even at birth. There is no advantage, however, in prematurely informing the parents of the condition. They are likely to make a better adjustment if they are allowed gradually to discover the child's disabilities for themselves. Particularly in cases in which there is any doubt is delay in voicing an opinion desirable. The more normally the

child is treated the better are his chances of normal development. It should be recognized that mental deficiency, viewing the condition psychologically rather than legally, is very common. In fact most people with very limited intellectual capacity are not labelled as defectives but fit into the general community and remain as ordinary citizens. The Wood Report* put forward the view that some 300,000 should have been recognized rather than the existing figure, which has fluctuated around 100,000, only half of whom live in institutions. This suggestion was made on the supposition that it would be possible to provide a more adequate educational service for the educationally subnormal (E.S.N.), who were at that time certified as feeble-minded under the Mental Deficiency Acts. Unfortunately this hope has not yet been realized, and there are still some 25,000 E.S.N. children competing for 18,000 places. At the present time ascertainment as mentally defective is a definite disadvantage for a borderline case, since it implies exclusion from the educational system.

Certification

Certification as mentally defective is a very serious step, similar to certification as insane. In practice experience has shown that once a child has been certified as mentally defective he is quite likely to be confined in an institution for the remainder of his life. There is no provision for defectives similar to that under the Mental Treatment Act whereby treatment and assistance can be obtained on a voluntary basis without loss of civil rights and the other legal consequences of certification. In practice, then, at present, certification should be limited to those whose condition is such that it is impossible to deal with them through the other social agencies and who must be separated from society at large for the purpose of special supervision and treatment. The medical officer of health of the local health authority, which has the duty of ascertaining mental defectives, will usually be ready to give advice in cases of doubt or difficulty.

Admission to Hospital

Parents sometimes approach mental deficiency as they would any specific medical problem. This attitude may lead them to seek admission to hospital with a view to curing their child's deficiency by surgery, shock therapy, psycho-analysis, or by some other method which they imagine will remedy the condition. It is necessary for the doctor to explain that the most that can be got from an institution is training and education. In some parts of the country it is exceedingly difficult to obtain institutional care for mental defectives, though the provision in Britain is better than in many other countries. Institutions are handicapped by a grievous shortage of nursing and other staff. They perform an essential task in caring for those children who cannot possibly be looked after at home. It should, however, very seldom be represented to a mother that a child will progress better in a hospital for mental defectives than at home: In fact the reverse is the rule. At home the child normally receives a good deal of attention from the mother even if she has other children, whereas in an overcrowded and understaffed hospital the staff may find it difficult to do more than care for the child's immediate needs. Accordingly speech and other attainments usually progress more rapidly at home than in the limited institutional environment. Physically, too, a young child usually does better at home than in hospital. The hazards of infection are not so great, whilst a firm emotional attachment in most homes contrasts with the impersonal institutional atmosphere. This latter factor often leads to feeding difficulties and loss of weight when a child is first removed from home.

For these reasons, unless the home is unusually bad, admission to hospital for a young mentally defective child should only be sought in the interests of other members of

the family. The higher the income the easier it is to make provision for a mental defective at home. On the other hand, if a numerous family is living under overcrowded conditions, perhaps in one room, the difficulty of coping with a low-grade defective may be very great. If the mother is in poor health her task may be very difficult. The attitude of the parents is all-important (as is that of the neighbours). Many superstitions attach to mental defect as to insanity. Previous exaggeration of the role of syphilis may have been a factor in this. The same applies to alcohol. Guilt may be experienced by the parents in connexion with an attempt at abortion, though this is rarely a cause of mental defect. Sexual aberrations may also be blamed for the abnormality. Thus a strong sense of shame, mixed with resentment, is often experienced by parents. It is easy to understand why mutual recrimination leading to open rupture may develop between the parents. The advent of a defective child not uncommonly leads to the break-up of the family, a process which is hastened when the relations on either side take an active part in fault-finding, and a critical scrutiny of the genealogy. It is the duty of the medical adviser to explain that mental deficiency is due to disease of the brain for which neither parent is to blame and which is usually not simply inherited.

The degree of the defect is also important in deciding admission to hospital. It is unreasonable to expect a mother to nurse the grosser cases of hydrocephalus and microcephaly, but there is less often reason why a mongoloid baby should not be cared for at home, at least for the earlier part of its life.

Educability

Legally, the question of educability is one for medical opinion. The medical man is, however, ill advised to rely solely on his own judgment. The person who has to do the job of teaching is the teacher. It should therefore be very exceptional for a child to be certified as ineducable before the teacher has formed an opinion. Apart from exceptional cases the issuing of certificates of ineducability under the age of 5 is to be deprecated.

Ineducability is of course a very artificial notion. Even an idiot can learn something, and the majority of ineducable children are far from being idiots. Some are certified as feeble-minded on the basis that, although not imbeciles or idiots, they are incapable of being educated with others; there is usually a history of temper tantrums or aggressiveness in such cases. Most local authorities—whose responsibility the care of the defective child in the community is—have recognized the fact that the mental defective is educable after a fashion by setting up occupation centres which these children attend daily. The curriculum in these centres, which aim to have classes of not more than 15, is very similar to that in a special E.S.N. school which is attended by the educationally backward (children classed as feeble-minded before 1944). In the interests of the imbecile or feeble-minded child such an arrangement whereby he can live at home but attend daily at a centre is ideal. Unfortunately, in many cases there is no such centre or the existing one is too small.

If, then, the child with a medium degree of mental defect has the good fortune to have a suitable home and parents who are able to accept the fact of his disabilities with reasonable philosophy, there is no reason why he should not remain in the community to grow up with his more gifted brothers and sisters. Difficulties may arise at later stages, but these are similar in nature to the hazards which any child may encounter.

Part II will appear in our next issue.

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*Report of the Mental Deficiency Committee, 1929. H.M.S.O., London.