AFTER-RESULTS OF CHILD GUIDANCE**A FOLLOW-UP OF 500 CHILDREN TREATED
AT THE TAVISTOCK CLINIC, 1921-34**

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In comparison with other long-established methods of dealing with difficult and nervous children, child guidance is still very much in its infancy, and its effectiveness is open to doubt. The criterion of successful treatment should be lasting good health in the patient in subsequent years; but even where this is achieved, it is impossible to judge exactly the contribution made by other circumstances towards the patient's cure. The study of controls is a means of obtaining greater accuracy with regard to effects of treatment, but many factors prevent the proper functioning of untreated groups as controls, and a comparison of identical twins, which represents an ideal experiment, can only be made on relatively rare occasions.

In a study of 687 children in eight elementary schools, with the help of the head teachers and their associates, McFie (1934) attempted to discover whether children's problems tend to clear up without psychiatric treatment during their school career. Having presented a table of results, she writes: "After scanning these figures we can say that very few problems are cleared up completely, and that apparently in the bulk of cases no improvement can be detected in the child's school career. Beyond this we should not be prepared to go." This study of McFie's is the only attempt known to us in this country to obtain an untreated control group for comparison with the results of psychiatric treatment. Some additional support for McFie's conclusion is obtained from experience with adult patients. Neuroses are rarely found to have developed in adult life, but have their roots in childhood. The earlier troubles not only persist but become worse.

The Present Investigation

In the work now reported an attempt has been made to follow up all discharged patients (excluding those coming for consultation only) who have attended the children's department at the Tavistock Clinic between 1921 and 1934. After sending 1,330 inquiries, a group of 500 patients who had been discharged for at least three years was eventually obtained. In 102 cases relations or referring agencies were out of touch, 201 letters were returned "address unknown," eight patients had died, and the remaining 519 did not reply.

Any conclusions based on a study of 500 out of 1,330 cases are open to criticism on the grounds that there is special selection; that in those who do not reply treatment was the least effective. Luff and Garrod (1935), in their study of 500 adult cases, have suggested that this criticism may not be valid, by the observation that the percentage relieved, at the time of discharge from treatment, was similar in both the group that did and the group that did not reply. In the present study the percentage of cases relieved at discharge among the 830 untraceables was approximately the same as that in the group of 500 who were actually investigated. Although this difficulty arises in all follow-up investigations, it seemed advisable to attempt an additional check-up visit on a group of those who did not reply, ascertaining the reason in each case. For this purpose 150 cases were taken, selection being based upon arbitrarily chosen postal districts in London. To avoid any intentional evasion of the interview, no introductory letter was sent stating that a visit was to be made. In seventy cases it was found that the patient had moved, address unknown; in twenty-nine cases no reply could be

obtained at the door. Of the fifty-one cases who were seen, forty (78 per cent.) were found to be in the "relieved" group. The remaining eleven (22 per cent.) were either not relieved or had had further treatment. The reasons given by the fifty-one patients for not replying were: resentment over reference to the clinic or wishing to forget the past, twelve cases; that the questionnaire was not received, twenty-five cases; and indifference or illness ("had intended to reply"), fourteen cases. In two cases only was objection made to the visit. These results provide no evidence to suggest that the general conclusions of the present paper, based upon the 500 cases in which replies were obtained, are invalid. It would, however, be unwise to conclude that similar results need necessarily follow in all follow-up inquiries in this field.

The main investigation was made by sending out inquiries in the form of a questionnaire to the parents of the younger patients, and to the patients themselves if over 17, unless it seemed unsuitable, as in the case of certain delinquents. In a few cases the referring agency or someone known to be closely in touch with the patient was approached rather than the parents. The questions were composed with a view to obtaining as much information as was compatible with simplicity and the avoidance of ambiguity. "Yes" or "No," without further detail, was often received in reply to some questions; on the other hand, many answers threw light on more than one question.

Follow-up Inquiry

The following is an example of the form sent to parents:

1. Is he keeping better?
2. Have you had to see any other doctor about him? If so, for what reason and where?
3. Have there been any other difficulties or troubles?
4. Is he in good health?
5. What work is he doing, and how is he getting on? Have there been many changes of employment? If so, for what reason?
6. What does he like most to do in his spare time?
7. Have you anything special to tell us?

In order to obtain a check on the conclusions drawn from replies to the questionnaire, a group of 160 cases were specially investigated, selected entirely by geographical distribution. The majority were visited in their homes, while the others were seen at the clinic. In a questionnaire relating to children additional difficulty arises where the reply is sent by a parent. To quote from Gillespie and Lay (1936) in this connexion: "Symptoms are by definition what the patient complains of, but in children they are much more often what the adult complains of as appearing in the child." One case met with in our inquiry was that of a patient, now grown up, who complains of an "inferiority complex," "weeks of depression," and suicidal inclinations, although the last report from his mother gives a very different impression. This describes a complete cure of nervous tics and the procuring of a job. In spite of the many possible sources of error, the differences between the assessment of the patient's condition judged by the answers to the questionnaire and by visiting were so small as to suggest that the conclusions of a follow-up inquiry conducted solely by letter can be reasonably accurate (Table I).

Comparison between Questionary and Visiting Assessments

TABLE I

	Result of Treatment			Total Cases	Percentage Relieved
	Apparent Cure	Improved	Not Improved		
Questionary	36	87	37	160	78
Visiting	40	81	39	160	76

An analysis of the replies received to the questionnaire is given in Table II. The term "apparent cure" means that the patient no longer suffers from his original complaint; "improved," that the complaint continues to a modified degree and may still be a handicap to the patient. Under the latter heading are a large number of cases that report "better" but give no details. In all tables the term "relieved" denotes a degree of improvement in the patient's condition ranging from "cure" to "some improvement," and refers to the relief of the actual complaint for which the patient was referred.

Present Condition of Patients

TABLE II

	Result of Treatment			Total	Percentage Relieved
	Apparent Cure	Improved	Not Improved or Further Treatment		
No. of cases	111	242	147	500	71
Percentages	22	49	29		

A group of seventy-one cases listed under "further treatment" has been included in Table II with the seventy-six "not improved" cases because many of them do not appear to have received benefit from treatment here. We have reports of their present condition, however, and some of them have improved since. If the present condition of the patients is taken as the criterion, irrespective of any further treatment, the percentage relieved is 78. "Further treatment given" falls under the following headings:

Private or out-patient treatment elsewhere	28
Approved schools and Borstal institutions	16
Mental defective institutions	14
Mental hospitals (in-patients)	11
Epileptic colonies	2

Table III shows the condition, first, on discharge from the clinic and, secondly, at present, of a group of cases afterwards treated elsewhere. It indicates the difficulties in judging, except in the case of approved schools, to what extent further treatment and how far the original clinic treatment have been responsible for the improvement.

Results of Further Treatment

TABLE III

Treatment	Condition on Discharge		Present Condition	
	Relieved	Not Relieved	Relieved	Not Relieved
Private or out-patient	12	10	13	9
Approved schools	3	13	10	6*

* These six are still in approved schools.

The final group of 500 cases was subjected to exhaustive analysis in an attempt to determine whether the proportion of cases relieved was representative of the whole or an average concealing wide variations in differing conditions and under different circumstances. Here the question of further treatment has been ignored, and the figures are based on the present condition of the patient in all cases.

Present Condition of Patient in Relation to Complaint

Classification in terms of diagnosis, such as "behaviour disorders," "personality traits," and "hysterical states," is liable to serious misunderstanding in the present state of our knowledge of these conditions in children, and in this report cases have been grouped under headings of "symptoms complained of." These are largely self-explanatory (Table IV). Under "difficult to manage" are

included complaints of an aggressive nature (other than tempers)—disobedience, obstinacy, quarrelling, and refusal to eat—where the parents find their efforts at correction of no avail. General symptoms of anxiety include "nervousness," shyness, timidity, apprehensiveness, sleeplessness, and "highly strung condition." Specific fears, such as fear of noise or of the dark, have their own category and are not included under "nervousness." "Physical" symptoms include fits, asthma, and bodily complaints having no apparent physical cause.

TABLE IV

Complaint	No. of Cases	Relieved	Not Relieved	Percentage Relieved
(1) Stealing	87	77	10	88
(2) Backwardness and educational difficulties	62	37	25	60
(3) Difficult to manage	53	43	10	81
(4) Enuresis	45	33	12	73
(5) Speech difficulties	45	35	10	78
(6) General symptoms of anxiety	44	39	5	89
(7) Physical symptoms	33	24	9	72
(8) Tics, habit spasms, and nail-biting	31	18	13	58
(9) Tempers	27	23	4	85
(10) Fears	23	21	2	91
(11) Masturbation and sex difficulties	17	15	2	88
(12) Truancy and wandering	13	10	3	77
(13) Various	20			
Total	500			

This table was worked out in greater detail with regard to degrees of improvement, but nothing of significance was revealed except that stealing was the one complaint that showed over 50 per cent. apparent cures. This may be explained partly by the fact that stealing is a symptom about which there can be little doubt in the minds of parents as to its persistence or disappearance (in contrast to "fears," for instance), and partly by the fact that only twenty-four out of eighty-seven were court cases (which are more severe but often difficult to trace). The remaining sixty-three cases were for the most part minor, though often very persistent, thefts at home or at school. A number were stepchildren or adopted children showing definite maladjustment in their relationship to their step- or foster-parents. Sometimes the theft would appear to have been a self-assertive reaction, and it ceased after discussions with the parents as to discipline and outlets for initiative. It is worth noting that only five out of the forty-seven cases listed as cured on discharge had had any relapses since treatment, while four had developed other nervous symptoms. The relatively low percentage of relieved cases in the backward group can be partially explained by the inclusion of some mental defectives, these being accepted for treatment in the early days of the clinic. It was noticed that several children whose main treatment comprised coaching in arithmetic had made no headway in that subject although their general school adjustment had improved considerably after attending the clinic.

Sex Incidence

TABLE V

	Number of Cases	Percentage Relieved
Boys	298	78
Girls	202	78
Total	500	

Here our findings correspond in the main with those of Guy's Hospital (Hardcastle, 1934), both in the greater incidence of boys than girls referred and in the similar degree of improvement in the two sexes. This table was also worked out in greater detail, the only point emerging being a slightly higher percentage of apparent cures in the case of girls than of boys. When an attempt was also made to discover whether there was any difference in the relief of the various complaints as between boys and girls, the percentages showed a striking correspondence. The contrast in sex incidence between an adult and a children's group of patients was referred to in Luff and Garrod's follow-up study of adult patients (1935). Their 500 cases consisted of 39 per cent. men and 61 per cent. women, whereas ours contained 60 per cent. boys and 40 per cent. girls. We would agree with them in their comment:

"The preponderance of boys may, to some extent, be due to the fact that their psychoneurotic symptoms tend to take a more spectacular and socially difficult form than those of girls, so that parents and others in authority are more likely to realize the need for treatment among boys. . . . It is possible that the present form of social organization gives a better chance for boys who show neurotic symptoms to adjust as they grow up, whereas girls who may possess only a latent tendency to neurosis in childhood develop more definite symptoms in later life."

Age is analysed in Table VI, from which it appears that this is not an important factor in determining the success of the treatment.

Age Groups

TABLE VI

	No. of Cases	Percentage Relieved
0-5 years	81	80
6-11	226	76
12-14	126	80
Over 14	67	73

Position in Family

TABLE VII

	No. of Cases	Percentage Relieved
Eldest	141	80
Youngest	97	78
Having older and younger siblings	114	71
Only child	110	78

The position in the family was recorded in 462 cases, and there was no striking difference in the figures as between one position and another. No conclusion can be drawn from the high incidence of eldest children in our group, as the incidence in the general population is unknown. An investigation of the position in the family in relation to the different complaints revealed few striking variations with regard to results of treatment. Though the whole table is not reported in detail it is perhaps worth mentioning that the incidence of cases in Groups 3, 7, 9, and 10 (Table IV—"Difficult to manage," "Physical symptoms," "Temper," and "Fears") was relatively high among "only" children. This is true also of youngest children in relation to Groups 3 and 9. On the other hand, the incidence of patients in Groups 1 and 12 ("Stealing"; "Truancy and wandering") was relatively low for both "only" and youngest children. These findings are unlikely to cause surprise, and do not seem to call for further comment.

Intelligence Quotient

TABLE VIII

	No. of Cases	Percentage Relieved
Under 70	15	60
70-89	36	69
90-109	91	83
Over 109	83	76

In the early days of the clinic intelligence tests were not given in every case: they were recorded in 225 of the present series. Children of average intelligence show the highest percentage of relieved cases, followed by those of above average. If, however, one takes a group of thirty-eight children having high intelligence quotients (over 120) the percentage falls considerably, as thirteen were found to be making no improvement; for the most part this was not owing to lack of outlet for their abilities, but to the effect of an unfavourable home background upon highly sensitive children. It has been suggested that no satisfactory conclusion can be drawn from a study of intelligence quotients in relation to results, because the age of the patient affects the outcome of treatment more than does the intelligence quotient, so that a child of 14 responds better to treatment than a child of 6 with the same intelligence quotient. We can find little support for this suggestion in the material presented in Table IX.

TABLE IX.—Percentage of Patients Relieved in Relation to Intelligence Quotient and Age

	Intelligence Quotient			
	50-69	70-89	90-109	Over 109
0-8 years	66	66	85	82
9-12	60	58	86	82
13 and over	50	80	90	82

Length of Treatment

With children, treatment may consist of so much besides actual clinic attendances (social work, temporary placement, advice to parents, and the school, for example) that it is not possible to assess its amount numerically as between one patient and another in terms of the number of attendances. It may be said, however, that the records give no support to the view that superior results are necessarily obtained from long rather than short methods of treatment.

Continuance of Improvement through Adolescence

It was suggested at the last Inter-Clinic Conference of the Child Guidance Council that for the estimation of the success of any type of treatment a follow-up cannot be regarded as reliable unless the child has been followed through "the strains and stresses of adolescence." In order to test the truth of this statement, which suggests that success of treatment before adolescence may be followed by subsequent breakdown, we worked out the "relieved" rate among 121 patients in our group now aged 20 and over. The resulting figure is 77 per cent., corresponding almost exactly with that of the whole group. This is not to say that none of these suffered adolescent difficulties, but it does seem to show that the good results of treatment given before or during adolescence persist as well through that as through any other period.

Various Comments on Replies and on Cases Visited

tone of replies

On the whole the individual content and tone of the replies reflected that of the treatment records. There were exceptions, in that some uncooperative parents who had ceased bringing their children for treatment, or who had replied to previous inquiries in a disgruntled tone, completed this questionnaire in glowing terms, attributing improvement to clinic advice and offering to bring the children for inspection. This shows that broken treatment need not indicate a bad prognosis.

PARENTAL SITUATIONS

Note was made of the home situation in each case—for example, whether both parents lived in the home, whether there was a step-parent, or whether the child was adopted. Out of twenty-seven patients having either a stepfather or a stepmother, eleven were reported as “not improved,” and there was good reason to think in each case that the cause was to be found in the step-parent’s attitude.

GENERAL CONDITION OF PATIENTS

In certain symptomatic groups, especially in those of stammering and enuresis, the relief of the symptom does not necessarily indicate an adjusted personality. Several children whose stammers had cleared up were reported to be “unhappy,” “languid,” or “abnormally reserved”; and one older patient revealed an obsession in connexion with his general health though his bed-wetting was very much improved. In certain cases parents who reported a cure of incontinence in their children mentioned at the same time a special interest on the patient’s part in personal cleanliness and neatness. It was thought that this discrepancy between relief of the patient’s symptoms and improvement in his general condition might have rendered our results unreliable, since they are only concerned with the former. We therefore assessed the general condition, so far as was possible from the replies, and found that in only 7 per cent. of the cases was there a notable contrast between the two assessments. Table X may be compared with Table II and the similarity of results noted.

TABLE X.—General Conditions

	Result of Treatment			Total Cases	Percentage Relieved
	Apparent Cure	Improved	Not Improved or Further Treatment		
No. of cases	139	215	146	500	71
Percentages	28	43	29		

PARENTAL ATTITUDES

The large majority, among both patients and their parents, considered that they had received help, though few could say definitely in what way. At one visit the continual repetition of the phrase, “Of course I never worry about his difficulties now,” led us to suspect the opposite, particularly when mother and child were seen together. On the other hand, there were several parents who declared they had gained nothing by discussing their difficulties with the doctor or social worker, although their attitude belied this statement, and in the course of conversation they inadvertently quoted the doctor’s words to uphold their own theories. A definite attempt at theoretical understanding had often been made by the unbalanced parent, whose psychological insight appeared to have an adverse rather than a beneficial effect upon the problem. One father, after studying the writings of the leading psychologists over a period of years, came to the conclusion that he was utterly unfitted for parenthood: his intellectual understanding of the problem

seemed to have increased his anxiety until he was unable to allow any spontaneity in the relations between himself and his adolescent daughter.

In the group visited a subjective judgment was made of those cases in which patients had normal and apparently satisfactory parents and those cases in which the parent interviewed was definitely unbalanced or whose attitude was clearly detrimental to the child. The two subgroups were almost equal so far as numbers were concerned, but the unimproved cases were more than double in the latter. There were several cases in which social work with the parents had been carried on over a long period with apparently little effect at the time, but with eventual improvement in the child, traceable to a change in parental attitude. At the same time there were a large number of children who had made some improvement in spite of a persistently difficult parental attitude and who seemed likely to improve further as they got older. The intelligent adolescent who was beginning to grow away from his home and to find satisfactory interests outside was typical of this group. The three most neurotic parents (separate cases) visited were those of patients who had almost ceased to be problems. In each of these cases the child had good intelligence, and one was led to believe that the unvisited parent was a comparatively normal individual. Of the five unimproved patients with apparently well-adjusted parents, one was an epileptic, one a persistent enuretic, two were “nervous” children, one of whom had low intelligence and was continually trying to catch up with a successful and attractive older sister, and the fifth was a schizophrenic.

TYPE OF TREATMENT

Treatment had been very varied in type, ranging from simple advice to parents in a few interviews to lengthy treatment programmes involving, besides psychiatric interviews, play-therapy, coaching, social work, and foster-home placement: sometimes all these were applied to one case. It was not possible, therefore, to correlate type of treatment with results. Even if statistical evidence was in favour of one particular type, this would not preclude the use of other methods which happened to have been successful in a smaller number of cases.

SOCIAL STATUS AND GENERAL ENVIRONMENT

The majority of homes visited were comfortable and had no obvious signs of financial stress, but in many the attempt to live up to or above the standard of the neighbourhood caused great psychological strain. A “difficult” only child in a comfortable home was not allowed to mix with the neighbours’ children for fear of acquiring an accent. In another very good home the shame brought upon the family by the daughter’s small theft from school was reflected upon the child to an extent out of all proportion to the gravity of the crime, and the mother hardly dared leave the house for fear of meeting an acquaintance. On the other hand, in two of the poorest and most overcrowded homes, where the social environment was accepted, family relations were unstrained and the patient had ceased to present any serious problem. We are inclined to agree with Suttie (1935) when he says: “The incidence and importance of the nervous factor in illness is if anything less in the poor than in the rich.” This conclusion is supported by Neustatter (1938).

With regard to this question of environment, perhaps we may once more quote from Gillespie and Lay (1936): “We have been surprised to find how readily psychoneurotic conditions in children subside on a mere change of environment; how they may stay away so long as the environment remains suitable; and how, if properly handled, they need not necessarily relapse on the return to the family.” On the other hand, we have the experience of Healy and Bronner (1937), who lately carried out an extensive research in America, not on psycho-

neurosis in general but among delinquents: "We often regretted that, after foster-home placement or institutional life, a delinquent had to return to a home with the social pathology largely or entirely unaltered. All clinical observers inveigh against this; it presents so much essentially wasted effort, since so many cases then revert to their delinquent trends." In our visited group of cases we found examples corroborating each of these statements, and consider that they may both apply at times, not necessarily the one to psychoneurotic disturbances and the other to delinquency, but to almost any type of symptom. The children who seem to have derived lasting benefit from being sent away (and these were in the majority) all came from homes where relations had become strained to the point of creating an atmosphere thoroughly inimical to the child's recovery, but where the psychological environment was moderately healthy outside the sphere of the problem. The cases which relapsed soon after their return, though they had all improved during absence from home, came back to exactly the same aggravating atmosphere which they had left. In two of these, for instance, the mother had marked personality difficulties of her own, and in another the stepmother's attitude towards a delinquent boy prevented any chance of permanent recovery. The question then arises whether some attempt should be made to modify the environment during the child's absence and, if this is not possible, should the case be rejected from the first as unsuitable for treatment, thus leaving the time available for more hopeful cases? Healy and Bronner (1937), in the course of the research to which we have just alluded, divided their delinquents into three groups: in Group 1 are the "abnormal or the markedly neurotic personalities or those suffering from severe mental conflicts, and mental defectives"; in Group 2, "those where the social pathology was heavily weighted against successful treatment." The cases in these two groups, they concluded, were unsuitable for treatment. In Group 3 were "individuals whose personality or internal difficulties did not show extreme deviations and who came from conditions where the social pathology did not give evidence of greatly weighing against the chances of successful treatment. This does not mean that the cases were less severely delinquent or that none exhibited any signs of abnormality, neuroticism, and conflict, nor does it mean that there was no social pathology." Only in this group did they find cases which had justified to any extent the time and expense of clinic treatment.

A study of the unimproved cases in our follow-up group to a large extent upholds the truth of these findings. Again we are referring to all symptoms, not merely to delinquency. The obvious criticism, however, of this very careful selection of patients is that little progress can be made in methods of treatment if the more difficult cases are rejected, and that diagnosis is not such a simple matter as to enable cases to be neatly consigned to one group or the other. Some children recover in the face of apparently insuperable difficulties, and others retain their symptoms for reasons which often remain obscure.

Summary

A follow-up inquiry was carried out upon a group of 1,330 cases attending the Tavistock Clinic for treatment between 1921 and 1934; 500 replies were obtained and analysed.

Of those who did not reply 150 were visited to determine the reason for the lack of reply. The present condition of this group of patients was entirely comparable to that of those who did reply.

Of those who did reply a group of 160 cases were visited to verify the reliability of the written replies. No significant difference was found.

The inquiry showed that three years and more after cessation of treatment improvement in the condition for which the patient sought treatment is still present in over

77 per cent. of cases. If all the cases which received further treatment are excluded the figure is 70 per cent.

Little or no significant variation in the degree of improvement could be found as between the two sexes, in different complaints, or in relation to position in the family.

Those cases with average intelligence respond better than those above or those below average.

The proportion of cases relieved in a group of 121 patients who had passed through adolescence was the same as that for the whole group.

We wish to acknowledge the generous gift from an anonymous donor which enabled the investigation to be carried out.

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THE REMOTE EFFECTS OF PUERPERAL SEPSIS

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The far-reaching effects of childbirth and its complications in the causation of maternal morbidity are well known to the medical profession, and the difficulty of assessing the bearing of this morbidity on the patient's future health is fully appreciated. In recent years, however, more detailed investigation of the problem has been strongly advocated by such authorities as McIlroy (1935), MacLean (1935), and the Departmental Committee of the Ministry of Health (1932). In 1937 Kenny published the results of such an investigation in a series of 100 patients.

One of the chief causative factors of disability resulting from childbirth is puerperal sepsis. This condition is almost always regarded, by the lay public at least, as a very serious illness which either terminates fatally or leaves behind a train of crippling symptoms and much ill-health. Accordingly, those of us in the medical profession who have had to deal with "puerperal fever wards" cannot fail to have noticed the ever-present anxiety of the patient and her relatives, not only for her immediate recovery but for her future health. It would seem, therefore, that an investigation into the maternal morbidity following puerperal sepsis and an analysis of the disability caused thereby are desirable and essential. It was with these points in view that I began to study the remote effects of puerperal sepsis.

The Investigation

This was started in March, 1936, and the number of patients examined was 200. Invitations to attend at the hospital for examination were sent to all the patients who had been in the wards between certain dates with verified puerperal sepsis, until 200 replies had been received, by which time 710 invitations had been sent. All the patients who were examined had been admitted with