



**The
Dr Margaret Lowenfeld
Trust**

Child Psychotherapy in historical context: an introduction to the work of Margaret Lowenfeld

By Cathy Urwin

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The paper reprinted in this volume is one of the last pieces of work completed by Madeleine Davis. Madeleine was a close friend of Donald Winnicott and after his death edited his unpublished work in collaboration with Clare Winnicott and Ray Shepherd. After Clare Winnicott's death, her place was taken by Christopher Bollas. In addition in the numerous posthumous works of Winnicott which Madeleine Davis edited, she wrote, together with David Warbridge, *Boundary and Space: an introduction to the work of Donald Winnicott* (1981).

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Judging by publishers' lists, conference topics and some of the articles in this journal, psychoanalysis, psychotherapy and allied disciplines have begun to show an increasing interest in their own history. Though there are many reasons for this interest, it has clearly been fuelled by the political and social climate of the 1980s, as one aspect of a growing concern among many psychotherapists and other practitioners to place themselves and their work in a broader social context.

This concern also applies in psychotherapeutic work with children, where it is particularly obvious that the kinds of symptoms or presenting problems for which children are referred vary historically, both in incidence and in what are identified as forms of deviancy or problems of widespread social concern. At the present time one can think of the publicizing of child abuse, the recent concern over alcohol and drug addiction in young people, football hooliganism and the emphasis on violence towards teachers in schools. Paradoxically, public concern over these issues has been matched in some areas by a reduction in economic resources available to support child guidance clinics and similar agencies, with many direct and indirect effects on child psychotherapists working in the public sector.

As Dilys Davis (1987) has recently pointed out, child psychotherapy has always been a small and highly specialized profession, marginal in many respects to mainstream child psychiatry and child guidance work. As such it has probably always regarded itself as fighting a crusade. Nevertheless the current economic and political climate has prompted several initiatives aimed at promoting public awareness of the work done by child psychotherapists and its range of application, also raising many questions about appropriate ways forward for the discipline and the profession.

As in adult psychotherapy, some understanding of the state the art may be gained by looking historically at the emergence and development of child psychotherapy. But for present purposes, neither a self-congratulatory look at a past track record nor the kind of history that focuses on internal divisions and theoretical debates within the psychoanalytic tradition will be sufficient, even if these emphasize the politics of the psychoanalytic community. Rather, it is necessary to recognize the role of other professions and disciplines in producing the terrain, which child psychotherapists currently occupy. That is to say, internal forms of historical enquiry, or what John Forrester (1986) has described as "psychoanalytic histories", bypass what may be prior questions. How was it that a problem space could be carved out for child psychotherapy at all? How was it that a space was produced for identifying or offering treatment to children with 'emotional' difficulties? And how was it possible to begin to understand behavioural problems and even physical illness in terms of emotions, feelings or phantasies? How, too, is the emergence of the tradition related to the biography of its individual pioneers?

Very broadly, the creation of a problem space for child psychotherapy can be traced to various child protection and philanthropic movements of the last century, on the one hand, and the beginnings of the scientific study of child

development, on the other. The latter is said to have begun with Charles Darwin, whose autobiographical study of his own son provided something of a blueprint for later investigators (Darwin, 1877; Riley, 1983; Urwin, 1986). By the end of the century the child study movement had given rise to numerous societies, in this country, Europe and America, providing the beginnings of the developmental psychology of today.

Freud himself was greatly influenced by this movement (Urwin, 1986). But in the conditions of possibility for child psychotherapy, the First World War and the two decades following it stand out as particularly crucial. In the post-war reconstruction, a number of social and administrative changes brought the twentieth-century child into the centre of the study. These changes included developments in medicine and an expansion in welfare provision directed towards improving the health of infants and their mothers. Concern over high infant mortality rates, a declining birth rate and the poor state of health among a large proportion of the population had, in fact, begun in the last century (Dwork, 1987). But in the first decade of the twentieth century the urgency of the situation came to the government's attention as it was discovered that a large number of potential recruits for service in the Boer War had had to be turned down because of ill health (Lewis, 1980; Rose, 1985).

This concern was increased after the First World War when in addition to the considerable losses of young men sustained in the war, the national population was declining. This set of problems provided a point of purchase for the techniques and assumptions promulgated by the child study movement, paving the way for active research into infant feeding and nutrition, the introduction of 'mothercraft' classes and the instigation of a large number of epidemiological studies into social correlates of disease such as tuberculosis. These included questions of parental lifestyle and child management among the variables. Targeted here, of course, were not simply the infants and children, but the mothers of those children, responsible for providing adequate diet, nurturance and moral training. By 1920, the Dawson report was recommending a shift within medicine away from a model, which focused on the relation between the ill patient and the doctor, proposing instead a community-based medical service, which would prioritize prevention and early detection. This would be achieved by introducing a system of primary care. Although their recommendations were not brought into effect until after the Second World War, if then, they none the less indicated an expansion in what could be regarded as falling under the rubric of medicine, to encompass everyone's living habits and patterns of childcare.

During the same period, parallel changes were taking place in education. Though compulsory education was introduced in the last century, the 1918 Education Act promised further reforms and expansions. Since this occurred in the face of overcrowded conditions in schools and limited economic resources, school inspectors, teachers and welfare workers were directly confronted with the problem of how to deal with children who would not easily 'fit in', and who had earlier been described as the "potentially imbecile", the "potentially criminal" and the "potentially insane" (Warner, 1890; Keir, 1952). It was, of

course, in the context of the problem of identifying and possibly treating the child who did not fit that a foothold was found for the educational psychology promulgated by Cyril Burt, giving rise to the concepts of educational subnormality, delinquency and maladjustment (Keir, 1952; Rose, 1985).

Like concern over child health, the preoccupation with social adjustment and moral development contributed to the production of what have been described as sites of intervention within the family (Armstrong, 1983; Rose, 1985). It is the potential for producing and enhancing particular notions of normal development that underlies the policing functions of the so-called helping professions such as social work, psychiatry and branches of applied psychology. The creation of a space for psychodynamic forms of explanation and treatment in part arose through these same conditions; that is, with how to understand children who did not fit and with the pressure to make recommendations about normal upbringing.

The preoccupation with order or civil harmony in the 1920s, however, has to be understood in the context of the aftermath of the First World War. The acceleration of these developments occurred at a time when, for many individuals in the population, a major task was to "recover" from the disillusion and horrors which the war had produced. It was also a time when the implications of the Russian Revolution of 1917 were felt internationally. Although preoccupations with Empire and with problems of social control were clearly behind many government interventions, it was also a time of considerable rethinking and of potentially radical intervention, particularly in education. This was the 'New Era' in education, the era of experiments, of the foundation of Summerhill, Dartington Hall, Bedales and the Caldecott community, and the introduction of Montessori's methods. By 1933 the government-commissioned Hadow Report had gone so far as to endorse the 1918 Education Act's insistence on the need for widespread expansion in nursery education (*Consultative Committee of the Board of Education, 1933*). There were substantial differences in the positions of the new generation of 'progressive' educationalists. But what they shared was a commitment to moving away from old-style, rigid and autocratic teaching methods. A strong body of opinion associated these with Prussianism or the Germanic tradition, and saw them as playing a major role in influencing German consciousness and the instigation and course of the First World War (Selleck, 1972; Walkerdine, 1984). Within the progressive education movement, the concern was not simply with who could get taught, but what and how. Providing environments, which would foster emotional as well as intellectual growth became a priority. This was linked with explicitly libertarian or democratic political ideals, fuelled by a concern to promote world peace.

Many of the new progressives drew explicitly on psychoanalytic assumptions. One effect of this movement was to draw attention to the potential for 'child-centred' applications of psychoanalysis. However, though apparently radical, the idea of freeing children from oppression and repression was not entirely lost on a population who, over the first two decades of the twentieth century, had been increasingly exposed to discussions about 'nerves'. Indeed, by

1920 psychological ideas had to some extent become part of everyday parlance. Of particular importance in the British context was the relatively successful treatment of victims of shell-shock sustained during the war by, broadly speaking, psychodynamic methods (see Crichton-Miller, 1920). Some success had also been claimed in the elucidation of psychological concomitants to malingering - being reluctant to return to industrial work as well as to the front. In 1920 Hugh Crichton-Miller, a doctor and psychiatrist by training, established what later became the Tavistock Clinic, London, with the idea of expanding the possibilities of psychodynamic work in peacetime into the wider community. As Dicks (1970) has emphasized, one of the first patients treated in this clinic was, in fact, a child. A children's department was rapidly established, its development fuelled in part by the relative success that could be claimed in treating children exhibiting various forms of antisocial behaviour (Dicks, 1970). By 1927, the first experimental Child Guidance Council had been established in this country, and the National Child Guidance Council had been founded (Keir, 1952; Burke and Miller, 1929).

The work of Crichton-Miller and his colleagues and of the Child Guidance Council was theoretically eclectic. For example, many of Crichton-Miller's associates drew their ideas from the British dynamic psychology movement rather than from psychoanalysis *per se*. This movement reflected a shared commitment to the idea of 'deep' strata of the mind and the power of unconscious mental forces which, demanded expression, whether in adaptive behaviour or in symptomatology. The membership varied in how far they accepted Freud's tenets, such as the importance of infantile sexuality. Nevertheless, the foundation of the new clinics marked some degree of receptivity to psychoanalytic ideas. By 1926 Melanie Klein had established residence in London. Donald Winnicott began using psychoanalytic ideas within his paediatric practice at around the same time, and Anna Freud arrived in this country as a practising child psychoanalyst in 1938, shortly before the outbreak of the Second World War.

Though the names of these pioneers in child psychotherapy are well known, a much less well-known figure is the paediatrician and child psychiatrist Margaret Lowenfeld. Yet, in the history of child psychotherapy in the United Kingdom, her role was particularly interesting, if not of crucial significance. In the interwar years she was at the spearhead of many of the shifts of emphasis mentioned above, taking part in the initial discussions, which led to the information of the Child Guidance Council (Lowenfeld, 1969). Like Winnicott, she entered psychotherapeutic work through medicine and through this route was one of the first to make explicit links between emotional and physical processes as they emerge in the psychosomatic disorders of childhood (Lowenfeld, 1930). In general terms, opening up relations between mind and body was a major influence in widening the acceptance of the importance of psychological processes in the medical profession, contributing to changing the face of modern medicine and psychiatry (Armstrong, 1933; Dicks, 1970). It was while she was engaged in medical research that Lowenfeld began to make observations, which led her to recognize, like the psychoanalysts, the significance of children's play and the importance of nonverbal forms of thought and communication. Like

Susan Isaacs, she also drew on the work of the educationalists and other developmentalists, and actively contributed to the wide-spread acceptance of play in nursery education.

But, despite the parallels with other pioneers, Lowenfeld also always maintained a position that was interestingly tangential. This eventually allowed her to develop an approach to children's minds and a form of therapy, which remain unique and set apart from psychoanalysis, though she was strongly influenced by the 'New Psychology' associated with the shell-shock work mentioned previously. Rather, she came to understand the importance of phenomena identified by psychoanalysis through a different route, and in a different way. This itself was bound up with her own experience of war and her childhood before the war.

Margaret Lowenfeld was born in Lowndes Square, London, in 1890 as the younger of two sisters. Her childhood combined many of the benefits associated with affluence and social position with a good deal of emotional isolation and unhappiness. It was also an unusual one, in that it offered unparalleled opportunities for travel and cross-cultural experience. Margaret Lowenfeld's father Henry (ne Heinz) Lowenfeld was Polish, growing up himself on a family estate in Chrzanow, in what was then the Austrian part of Poland. His move to England had been precipitated by a crash in the family fortunes, obliging him to earn his own living and make his way. At this he proved extremely successful. He eventually amassed a small fortune through a range of businesses, which included the buying and selling of hotels and the management of theatres. Although he remained based in this country, this enabled him to restore the family estate and take over its management, entailing numerous and frequent trips to Poland. On many of these the two children would accompany him to keep in touch with their grandmother and other relatives still living there.

Margaret's mother Alice was British, a little younger than Henry, inexperienced and somewhat naive in the face of what emerged as the more flamboyant aspects of Henry's character. Although she enjoyed the round of social events and made space for Henry's collections, as years went by the marriage proved increasingly difficult and unsatisfactory. This contributed to a lack of contact between Margaret and her mother. As a small child Margaret was often ill, spending long hours alone or in the servants' charge. Her elder sister, Helena, appeared to have been more resilient as a child, and Margaret suffered from comparisons and a fairly unremitting sense of inferiority. Although she was strongly attached to her father, and took from him a lifelong interest in art and in collecting things and an acute sensitivity to visual form, their relationship was strained by increasingly frequent absences.

By the time the girls were in their teens, divorce proceedings had been initiated between Alice and Henry on the grounds of the latter's infidelity. The aftermath of the divorce lasted several years, not aided, of course, by the relative uncommonness of divorce among the upper middle classes at that time. There are general indications that the effects of the divorce on the daughters were far-reaching and traumatic, including, in Margaret's case, a break down in her

sixteenth year. However, some protection was provided by the steps Alice took to secure her daughters' education. Both children attended what is said to have been the first Froebel nursery to have been established in this country, and in their teens they went to Cheltenham Ladies College, at that time renowned for its insistence on the importance of educational opportunity for women. One of the products of this education was that Margaret, in particular, became very involved in the Student Christian Movement, throwing herself into it with typical adolescent zeal. The other was that both daughters decided to study medicine. Helena, apparently, had already made the decision as a small child. Eventually, as Helena Wright, she became well known as a gynaecologist and a pioneer in the birth control movement, and as a somewhat more controversial exponent of sexual satisfaction and freedom within marriage (Evans, 1984).

Margaret herself began her medical training shortly before the outbreak of the First World War at the London School of Medicine for Women, associated with the Royal Free Hospital. At that time this was the only medical training establishment in this country open to women wishing to be doctors. The war, however, rapidly increased the demands on, and demands for, women doctors, as their male colleagues were required for active service at the front. It also meant, of course, considerable experience with the war victims invalided home and a training period that was more than usually arduous and stressful. But for Margaret Lowenfeld, the impact of war work extended beyond the duration of the First World War itself. During November 1918, when Armistice was declared, she was staying in Cornwall, recovering from concussion sustained earlier that year. Later in the same month, a message arrived for her from the family village in Poland, a desperate plea for help from the people on the estate and in the surrounding locality, where the destitution and hardship caused by the war had been considerable. Lowenfeld responded to this challenge, entering Poland the following year by attaching herself to a League of Friends' Typhus Mission, having obtained this position both through her medical training and also through her experience in the Student Christian Movement which at that time was actively committed to the expansion of overseas aid. Travelling from Kracow to Chrzanow, the village from which the request had originally come, Lowenfeld met appalling dereliction and despondency. In addition to the damage caused by war itself, typhus and influenza ravaged the country. There were also political complications, as, following settlements made after the First World War, the Polish-Russian war broke out almost immediately.

Although she returned to England, ill herself, in the spring of 1920, she recovered and gathered more supplies and was back in Poland by September, working, on the one hand, as a medical officer based in Warsaw, in charge of sanitation and welfare work along the extensive battle front, and, on the other hand, as an officer in charge of an organization providing relief to thousands of Polish students who had been demobilized or rendered homeless.

By the summer of 1921, Lowenfeld had returned to England. One of her first responsibilities was to report on the activities of the student organization in Poland at the annual Student Christian Movement Conference held at Swanwick. To her distress and dismay, she found it virtually impossible to convey to her

audience the nature of the appalling atrocities she had seen and their impact on her. Later in her life, she would cite this experience as symptomatic of the inadequacy of verbal communication as a medium for expressing crucial aspects of human experience, thought and feeling, and the difficulty of transposing its specificity from one cultural location to another. But she also stressed the formative effect of these wartime experiences themselves, in moving her towards her theory and method of child psychotherapy.

One account, repeated in lectures to students after the Second World War, to my knowledge first appeared in a public context in a paper entitled 'On the nature of the primary system', which was delivered in 1948. Part of it was repeated in an unpublished history written in 1969. The account describes how, in the course of delivering supplies on behalf of the Polish government, Lowenfeld and her colleagues were required to visit a stone house which had been set up to receive refugee children. The children and my surviving family had been brought across the country crammed in cattle trucks, the dead being thrown out along the way. The house contained about forty boys, aged between ten and fourteen, who, as Lowenfeld understood the situation, "had lost everything a human child can have, language, nationality, family, 'roots' and anyone with whom to share childhood's experiences" (Lowenfeld, 1969, p. 1). This was one of many situations in which the competing demands of the work obliged Lowenfeld to move on. Some time later the house was again on her list. Retrospectively, she described with shock the discovery that the children had not only survived but organized themselves. She remembered a pleasant interior, the addition of furniture and a theatre, which the children had made themselves, with footlights, scenery and costumes; there was a cheerful sense of community. Without psychiatric experience at the time, it appeared to her after a day's observation, "unlikely as it seemed, that a substantial number of the boys I had been watching were cheerful and developing normally" (Lowenfeld, 1969, p. 2). Then she added as a question: "How could this have come about?"

In citing this question from 1948 onwards, Lowenfeld was, in part, attempting to comprehend her own history and the factors leading to her particular priorities and theoretical approach. In doing so she was following a basic tenet of the philosophy of the British philosopher Robin Collingwood, with whom she was involved intimately over a number of years and who had a profound effect on her thinking and theoretical development. A staunch critic of the realist tradition, which dominated much British philosophy in the first decades of the twentieth century, Collingwood (1933) insisted that the truth of a philosophical or theoretical proposition can be evaluated only through first establishing the question in the mind of the proposer to which he or she intended the proposition as an answer. In Lowenfeld's own writing, the phrasing of the question, "how could this have come about?", was intended to convey a sense of shock, due to a prior domination of a generally accepted view influence, she suggested, by psychoanalysis: that adverse early experiences have potentially devastating effects on psychic development. From her understanding of this thinking, she would have predicted that many of the children she observed would not have survived such traumatic experiences. This led ultimately to the question of what it is in the human psyche that promotes the

survival of the individual and/or social groups under environmental conditions, which under other circumstances promote death, fragmentation and despair.

Thus Margaret Lowenfeld appears to have been one of the many whose first interest in psychotherapy and in what could loosely be described as the personality of the child was precipitated by wartime experiences. However, her move into psychotherapy was not immediate. Her first commitment was to a medical training, which she had had to struggle to enter and complete, though she was now clear that she wanted to work with children. But she returned to England a good few years after the First World War, by which time most of the available clinical positions had already been filled by male doctors returning from the front. She opted instead for a research career. As a preliminary, in 1923 she was accepted as a postgraduate research student at the Mothercraft Training Centre, which existed explicitly to encourage the teaching and dissemination of scientific principles of infant management and mothercraft. The course was based on the work of Truby King, who had claimed considerable success for his methods in combating high infant mortality rates in his native New Zealand. By the end of that year she joined Professor Leonard Findlay at the Royal Hospital for Sick Children, Glasgow, to work on a study of acute rheumatism in children and its relation to home conditions. At that time rheumatic conditions in childhood were a major cause of school absence and a significant threat to child health. The aetiology was not well understood, though there were well-recognized relationships between the environmental conditions associated with poverty, rheumatic conditions in childhood and chronic heart disease in adulthood. Like tuberculosis, it thus had long-term consequences. This study was one of the first post-First World War surveys to concentrate particularly on aspects of child health and social conditions, and it was relatively ambitious in its scope and insistence on a scientific methodology. Since Lowenfeld was required to participate in the social side of the investigation as well as carrying out comprehensive clinical examinations, this gave her, as she later stressed, some insight into the lives and experiences of 200 families from the poorest parts of Glasgow (Lowenfeld, 1969, p. 2).

The general findings of the study, published in a monograph (*Social Conditions and Acute Rheumatism: MRC Child Life Investigations, No. 114*) in 1927, were in some respects disappointing. Apart from demonstrating the general relationships already suspected, it was unsuccessful in pinning down either heredity or more specific environmental factors conducive to rheumatic conditions. However, in many respects seeking the cause of the disease in specific environmental factors was not ultimately what interested Lowenfeld most. First, her own major published contribution (Lowenfeld, 1927) was concerned with demonstrating the effectiveness of a 'clinic' organization not simply in detecting illness but in promoting a holistic approach to treating children and their families. This model was ultimately central to the design of the children's clinic, which she set up a few years later. Second, in many respects the findings which most intrigued her were precisely those that did not easily fit into the research design and which ran contrary to predictions drawn from orthodox medicine, as she became impressed with curious anomalies that appeared in children's reactions to the same physical illness. As she put it later,

“From time to time during the clinical work carried out in the wards, I had been puzzled to observe that in some cases children with very severe cardiological conditions, who might reasonably be expected to die of these, recovered instead... On the other hand, the reverse also occurred, in that every now and then children whose prognosis was good would unexpectedly die.” (Lowenfeld, 1969, p. 3)

On completing her part of this project, Lowenfeld returned south and joined a second research project, this time in the Obstetric Unit at the Royal Free Hospital, London, on a project concerned with infant feeding and the function of the mammary glands, concentrating on the first ten days after birth. At that time women giving birth in hospital were largely from the poorer classes, and through her role as a researcher, unsurprisingly, she became involved informally with the mothers' side of infant feeding. Although the Truby King course had obviously provided assumptions about appropriate management, again Lowenfeld was struck by variations between the infants, and by the fact that something indigenous to particular infants could help them offset considerable disadvantages in maternal health and social conditions and vice versa.

Since the research project produced interesting findings it was continued for several more years. In the meantime, by 1926, Lowenfeld's experience had enabled her to open a private practice working in cooperation with obstetricians as an expert on infant feeding problems and as a consultant concerned with a wider range of problems specifically associated with illness in childhood.

But from the outset it appears that Lowenfeld was using the consultancy as a launching pad for furthering her major preoccupation which, broadly speaking, concerned the emotionality of the child. In October 1928 she opened what became her first clinic in two small rooms in Telford Road, London. Posters advertising the clinic as a 'children's clinic for the treatment and study of nervous and difficult children' were put up in shop windows in the immediate vicinity. The terms set by the poster proved effective in drawing in parents and children from the neighbourhood and sometimes just the children themselves. At that time a major focus was on observing what the children did and said, with no particular treatment planned in advance. The equipment provided was sparse: paints, a few toys, a bowl of water. From the beginning Lowenfeld aimed to combine her observations of children's psychological development with physical examinations. She was accompanied by an enthusiastic colleague, Miss Trew, a biochemist from Bedford College, London University, who carried out biochemical testing of urine samples in a washroom at the back. They were soon joined by a Miss Nixon, an official in a local charity organization who initially came to check on what exactly was happening in her neighbourhood, but who was sufficiently enthusiastic about the project to take on board a good deal of the interviewing of parents and the social work. It soon became obvious that this would be essential in order to maximize the children's opportunities for dealing with their own worries or emotional tangles.

By the end of that year the clinic could boast of an expansion in clientele and a sufficiently large number of satisfied customers to justify a move to bigger premises. It reopened in March 1929 at the Quest, Clarendon Road, London, now under the name of the 'Children's clinic for the treatment and study of nervous and delicate children'. The clinic acquired, at the same time, a constitutional structure and an increase in staff to support work with the parents as well as the children themselves. This included psychiatrists, social workers, ex-teachers and a psychologist. The move roughly paralleled expansions in the children's department at the Tavistock (Dicks, 1970) and the publication of a first report from the East London Child Guidance Clinic, started by Dr Emmanuel Miller and Mr Noel Burke under the auspices of the Jewish Health Organisation (Burke and Miller, 1929). The latter clinic was the first in this country to follow what became identifiable as the standard child guidance pattern involving collaborative work between psychiatrists, psychologists and social workers. Lowenfeld herself adopted a team approach, which was in some respects similar to this pattern. Later on, her techniques had a marked influence within the child guidance movement. However, she herself was not strictly speaking part of the child guidance movement. To begin with, since the movement initially drew impetus from the apparently successful work of Healey and his collaborators in the United States (Rose, 1985), she was sceptical about the importation of ideas and methods, which might prove inappropriate to this country. Secondly, in spite of the fact that the child guidance movement claimed to base itself on the scientific principles of child study (Burke and Miller, 1929), the model, which Lowenfeld had in mind was more research-orientated and involved a persistent commitment to expanding medicine to embrace the psychological. Within this framework the team's orientation was based less on a division of labour than on a holistic approach to the relations between mind, body and environment, a view which was based on the conviction that a child's illness or difficulty had to be understood as a response of the whole child to the whole of his or her circumstances (Lowenfeld, 1931). Thirdly, Lowenfeld resisted aspects of the child guidance philosophy, which, as she saw it, viewed adjustment to the environment in terms of the production of conformity. Such a viewpoint presupposed a satisfaction with current societal values and achievements, which for Lowenfeld, in the aftermath of the horrors of war and the clear evidence of the human capacity for cruelty, was untenable. Here Lowenfeld shared the view of a number of liberal thinkers in the post-war period that believed that the scientific and therapeutic investigation of human minds could be one contribution to understanding the causes of war and to ensuring that such devastation should not occur again. Here, consistent with the emphasis on a capacity for survival, which had persisted through her research, she insisted that harnessing processes *inherent in children themselves* was the most appropriate way of enabling children to find their own way of coping more adaptively with environmental stress. This emphasis allowed her to see the child who did not fit as a 'rebel' rather than a failure and to regard actions expressing 'maladaptation' as a cause for hope rather than necessarily of despair.

It was in this context that Lowenfeld aimed to create a therapeutic environment by providing ample opportunity for free expression and experimentation. Her commitment to the value of recording behaviour did not

preclude sensitive observations of emotional reactions. It was through observation that she came to view play not only as a medium by which children could work through or master emotional conflicts, as the child psychoanalysts were proposing, but also as a cognitive process, giving access to the ways in which children think. The emphasis was less on the emotional relationship between child and therapist than on enhancing the child's ability to organize and make sense of his or her own experience. Similarly, with the minimum of active intervention by adults, focusing on working with the transference, for instance, was positively discouraged although Lowenfeld recognized the pertinence of themes described by psychoanalysts. In interpreting symbolic material, Lowenfeld prioritized understanding the meaning from the point of view of the child currently producing it, and stressed the need to suppress pre-existing theoretical prejudices.

Lowenfeld's emphasis was related less to the idea that family dynamics or relationships were unimportant than to the belief that a solution to a child's predicament must be found within the child him or herself. Coupled with her war and research experience, this led her to the view that the possibility for creative expression was essential both to the health and development of individuals and to the survival and cohesion of cultural groups. But creative expression might also require materials, the availability of which depended crucially on the parental culture. Central to the development of Lowenfeld's theory and practice was the World Technique, in which children used a sandtray to make imaginary worlds with facsimiles of real life and/or fantasy objects, supplied by the therapist. First used in the late 1920s, this technique allowed for the exploration of both the inner world of the child and, simultaneously or on other occasions, the nature of his or her relation to a particular social reality; the children were seen to be attempting, through play, both to find harmony within themselves and to locate themselves in the social world in which they were growing up. This interest in the cultural location of psychological experience and symbolic functioning was present throughout Lowenfeld's work. But it is most obviously illustrated through the use made of the Lowenfeld Mosaic Test. Designed even before the World Technique, in the early 1920s, this consists of a set of coloured geometric shapes with which the individual child or adult is asked to make 'anything you like' on a flat board. It was used originally as a diagnostic and therapeutic tool in clinical contexts, but, after the Second World War, its value in cross-cultural research, as a means of exploring characteristic patterns of thought across cultures and historical epochs, was also recognized (Lowenfeld, 1954; Metraux, 1976; Metraux and Abel, 1957, 1975; Woodcock, 1986).

These techniques also contributed to distinctive theoretical contributions, including the identification of a primary form of thought, which she later called the 'proto-system'. This is a system of grouping and linking between experiences, giving rise to primitive thought structures which she called clusters. The proto-system exists before words, is multimodal and multidimensional, and cannot be translated into language. Lowenfeld linked this primitive thought to a fundamental drive to pattern, giving rise to a primitive aesthetic awareness. Later she added the Theory of E, a neutral force or energy, which gains in

strength and polarity according to its relation with the structures through which it flows (see Lowenfeld, 1979, pp. 271-2).

During the late 1920s and 1930s, as the psychoanalytic tradition became more firmly established in Britain, and the Tavistock and other child guidance centres were also expanding, Lowenfeld's clinic was far from unsuccessful, both in recruiting popular support and in demonstrating positive effects of treatment. In 1931, as the clinic shifted premises again to cope with an ever-increasing demand, its name was changed to the Institute of Child Psychology. By 1935, despite the financial difficulties of the Depression years and the beginnings of more overt rivalry within the psychoanalytic community, Lowenfeld and her colleagues had opened the first child psychotherapy training in this country. After the Second World War psychoanalytically orientated child psychotherapy trainings were mounted at the Tavistock Clinic and at Anna Freud's Hampstead Child Therapy Clinic. Though her own work had been considerably disrupted during the war, in the late 1940s Lowenfeld made a major contribution to establishing what is now the Association of Child Psychotherapists, the administrative and political organ of the profession. Since that time a Jungian training has been added and, more recently, a child psychotherapy training mounted under the auspices of the British Association of Psychotherapy. This training is also psychoanalytic in orientation.

Margaret Lowenfeld died in January 1973. Within six years of her death the Institute of Child Psychology was closed and the training, which she had mounted was discontinued. Today, remarkably little is known about a figure whose work and personality were once so central and influential in making the practice of child psychotherapy possible. She left behind her two published books, *Play in Childhood* (1935) and a volume on *The Lowenfeld Mosaic Test* (1954). She also left a manuscript on the World Technique itself, which was edited and published posthumously under the title *The World Technique* (1979), and a number of published and unpublished papers. A selection of her more theoretically orientated papers, edited by Cathy Urwin and John Hood-Williams, has now been published by Free Association Books under the title *Child Psychotherapy, War and the Normal Child*. The selection is intended to supplement, rather than replace, the account of her work and its development given in *The World Technique*, but it is accompanied by an extended introduction, which situates Lowenfeld's life and work and her intellectual journey within the social and historical context of the times. Part of that material has been reproduced here.

By way of an introduction to Lowenfeld's contribution and the challenges it poses for psychotherapists of all traditions, the following article by Madeleine Davis illustrates her approach by comparing her work as a clinician with that of Donald Winnicott. Though Winnicott was a psychoanalyst, the areas of similarity and overlap were considerable, as Madeleine Davis indicates. In particular, both foregrounded the problem of accounting for creativity, and they shared an emphasis on the therapeutic function of the process of playing itself, giving paramount importance to the individuality and idiosyncrasy, of each patient. They also introduced theories of symbol, formation and of what constitutes a

symbol, which were arguably considerably broader than were current in most psycho-analytic writing in the 1920s and 1930s.

These areas, of course, are among the most distinctive aspects of Winnicott's approach. His emphasis on enabling the patient to reach the point where playing is possible has had widespread effects on psychotherapeutic practice in many traditions, even where the response is critical. The overlap is in part accounted for by the fact that they shared a medical background and a strong commitment to developing children's medicine. As Winnicott noted in describing his route in the Preface to his collected papers *Through Paediatrics to Psychoanalysis*, 'It has been valuable for me to keep in touch with social pressure which I have had to meet as a physician at a children's hospital', stressing that 'I have never cut loose from paediatric practice which was my starting point' (Winnicott, 1956. p. ix). Although they disagreed on a number of substantive issues, shared priorities contributed to the regard in which Winnicott held Lowenfeld, and extended to tangible forms of support. For instance, he was involved in an advisory or consultant capacity at the ICP at several points, and contributed regularly to lecture series and discussions organized there. As to understanding the process of playing, eventually Winnicott explicitly acknowledged his debt to Margaret Lowenfeld (Winnicott, 1971).

It is thus particularly interesting that Winnicott's influential conceptualization of play partly originated in a movement outside psychoanalysis. Over the last decade there have been a number of other developments within psychoanalysis, which bring its priorities closer to Lowenfeld's. For example, there is a growing interest in the work of Bion (1962, 1967), whose emphasis on the processes of containment and link making, whereby primitive mental events and preconceptual thoughts are transformed into the process of thinking, has clear parallels with Lowenfeld's theory of the proto-system and the formation of clusters, as I show (Urwin, 1986). More recently, another area of congruence between Lowenfeld's work and this psychoanalytic tradition is to be found in a renewed interest in the possible origins of aesthetic awareness (Meltzer, 1987; Read, 1987). These developments indicate what may be a general resurgence of interest in the contribution of psychoanalysis as a theory of mind as well as of emotion, suggesting new possibilities of dialogue with the tradition forged by Margaret Lowenfeld. It is particularly ironical that this opening should come via the post-Kleinian tradition because, of all psychoanalytic groups in this country, it was by the Kleinian group, in the 1930s and 1940s, that Lowenfeld's approach was most strongly criticized.

But despite the many areas of correspondence, it is vital to recognize that distinctive differences remain. Like Winnicott, the psychoanalysts mentioned above locate the processes described within the emergent relation between the infant and parents. In Lowenfeld's theory, object relations are not given a theoretical priority, interpersonal relations being one aspect of the totality of the child's relation to the immediate environment, and beyond. It is worth repeating here one of Margaret Mead's observations on Lowenfeld's contribution, cited by Madeleine Davis: that her emphasis was inspired by the conviction that 'the

child's relation to himself and to the universe provides as important a key to human development as the exploration of interpersonal relationships within the family, which she had got from psychoanalysis' (Mead, 1974, p. 56). As Madeleine Davis shows, the clinical implications of this difference are particularly apparent in Lowenfeld's rejection of the transference as necessarily a fundamental psychotherapeutic tool. Of course Lowenfeld herself as a psychotherapist was far from passive, raising many questions about the nature and functions of the relationship between child and therapist in her approach. But if it is around the transference that the two approaches cease to dovetail or find areas of common ground, it is also around Lowenfeld's rejection of family relationships as necessarily the most appropriate locus of theory and practice that her approach takes off at a tangent, opening up areas ill charted by psychoanalysis, and possibly inaccessible to it. I will mention two points of emphasis here. The first is on how, from the outset, human infants necessarily create images and symbols to mediate their own relation to the animate and inanimate environment; that is, there is a fundamental drive to pattern and to seek after aesthetic expression which is as vital to human survival and psychic health as is achieving relationships with dependable objects. This view was formed through the circumstances of her own childhood and upbringing; by the way she drew on developmental psychology, philosophy and anthropology as well as on psychoanalysis, and by her own experience in medicine. As the late Dermot MacCarthy, a paediatrician, once wrote of her,

"She saw, she discovered for herself, that what determined whether a child died of heart failure or recovered was (in some cases) the hold the child retained on life through having what we observe in a child using the World Technique the capacity to *express* (with pleasure, with absorption, even with passion) what is his or her inner vision of things." (Dennod MacCarthy, personal correspondence to the late Kate MacSorley, 21 June 1980)

The second distinctive emphasis stems from a lifelong absorption in relations between cultural products and the minds of people using them: how culture can be both an impediment to development and an absolute necessity. Here, as in the emphasis on human beings as symbol-making instruments, she was influenced by her relationship with the philosopher Robin Collingwood, and later by the philosophy of Suzanne Langer (1942). Of all psychotherapeutic approaches, Lowenfeld's is perhaps one of the most explicitly sociohistorical. Throughout her work she foregrounded the social and historical conjuncture in which her theories, presuppositions and approach were grounded. By implication, this historical location also applied to her child patients. Winnicott (1971), following Lowenfeld, stressed the importance of accounting for the origins of the child's movement into culture. But in his account this emerges, like play, in the space between mother and child, as a capacity, which is timeless and repeats itself over endless generations. 'On the seashore of endless worlds, children play' (Tagore, cited in Winnicott, 1971, p. 112).

For Lowenfeld, on the other hand, it was not the timeless quality of cultural heritage, which most interested her. Nor were the symbols produced by

children using her technique simply contingent upon vicissitudes of individual biography. Rather, for Lowenfeld any symbolic product was locatable within particular social and historical processes. Whether children use sticks, stones, clockwork trains and Meccano, or transformers, Cindy dolls and video games in their play depends both on whatever comes to hand and on the particular artefacts and cultural products which the adults in the child's environment make available. In the developmental necessity to find means for representing experience to the self, and expressing it, the human mind demands meanings from the culture in order to locate itself. These transactions thus have a constitutive effect on the developing psyche; they are not grafted on afterwards.

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