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Development of specialties – Child psychiatry

Children have always had problems of behaviour and mental illnesses but these have been dealt with in different ways through the centuries. Behavioural disorders could be seen as moral problems deserving punishment. Failure to learn might lead to a marginal existence as a village idiot. Only rarely would childhood mental problems be dealt with by doctors. Changes came about for two reasons. One was concern about educational failure and new ideas about infant and childhood development (for example psychoanalytical theories). Child guidance clinics, sometimes associated with courts, were developed and some psychoanalysts treated children. A new discipline of child psychiatry was developed. Psychiatrists, paediatricians and psychoanalysts were all involved as well as psychologists and educationalists. Scientific study was much further advanced, particularly in the UK by the work of Michael Rutter. The RMPA had a committee dealing with child psychiatry which was developed into a faculty by the College.

Child psychiatry as we know it did not develop until after the First World War when August Hamberger established a psychiatric out-patient clinic at the University of Heidelberg. He might be considered the first all round, comprehensive child psychiatrist. Nevertheless at the end of the nineteenth century, all the components for a comprehensive assessment and advice service for children were to be found in the Western world. The need for a more positive preventive and remedial approach to juvenile delinquency had been recognised. The establishment in Britain of universal compulsory education had uncovered a surprisingly high proportion of children who could not cope with it. These problems were seen to need a multiprofessional approach, and experimental clinics existed in which doctors and psychologists worked together. Some psychiatrists were beginning to recognise that children and adolescents had different problems from adults, and needed separate services. The ground was set for new ways of thinking about behaviour – behavioural, psychodynamic and psychobiological. The application of the scientific method to

child study was leading to the development of objective methods for assessing ability, attainment, and behaviour problems. Despite successful pioneer projects, no comprehensive psychiatric treatment centres for children of normal intelligence existed, and treatment methods were tentative.

Child psychology was a late development in psychology itself. Animal psychology had a longer history, but human psychology had been consistently limited to the reason of the adult man instead of being treated genetically. Darwin had been a pioneer, setting the example of keeping a record of a child's development. The subject expanded into a large literature which was partly child-study, partly a division of genetic psychology and partly a product of educational psychology. The development of child psychology became a study of human behaviour from birth onwards. The behaviourist was interested in the reaction of the infant, whether they could be defined as mental or not. Educational psychology was concerned with children of school age and aimed to establish norms of achievement with a view to improved methods of training. Another major influence was concern about both education and delinquency. The latter helped to explain the early combination of social worker psychologist and psychiatrist. This would have been less likely if the study of the neuroses or psychoses of childhood had received the same attention as delinquency.

Most of Child Psychiatry as we know it today was developed in the twentieth century. The term itself was first used in the 1930s. Before the 1920s it did not exist as an organised specialty. Child psychiatry was a fusion of what were previously a

collection of scattered segments. Doctors had been aware of the possibility of mental illnesses in children and Henry Maudsley included a chapter 'Insanity of Early Life' in his *Physiology and Pathology of Mind* in 1867 attempting to correlate symptomatology with the patient's developmental status at the time of onset of the illness. Henry Maudsley in 1895 had pointed out some of the difficulties psychiatrists found which are not inappropriate for today. He asserted that 'he who distinguishes well teaches well' but was suspicious of uniform procedures. He wrote that for adequate strategies 'it would be necessary to have a full and exact knowledge of the characteristic of the individual mind as well as of the proper remedy: to know the particular character, the special fault of it, the kind of disorder to which the fault was prone to lead, and the exact conditions of life which would be the fit remedy: for different pursuits might wisely be used as so many remedies for different defects of character'.

The earlier classifications of childhood mental derangements tended to use the same classifications that were used for adults dividing them into illnesses with mental defect and illnesses without intellectual defect. There had been a tendency at one time to consider the feeble minded a homogeneous group though the relationship between endemic goitre and intellectual stunting was known. Langdon Down in 1866 described the condition known for many years as mongolism and now called Down syndrome. In the 1930s Penrose who was one of the four psychiatrists who were Fellows of the Royal Society in the 20th century clarified many of the conditions associated with mental impairment.

A further development leading to present day child psychiatry was in education. When compulsory school attendance had become an established institution education became increasingly concerned about the problems of learning and conduct among their pupils. They developed remedial education leading to practical arrangements for the special education of the intellectually, sensory, neuro-orthopaedically and neurotically handicapped children.

Criminology and the crimes committed by children led to other developments and there was a change from a retaliatory attitude to young offenders (which was possibly detrimental to their development). Children began to be treated differently to adult offenders with the development of juvenile courts often assisted by a staff of social workers, psychologists, paediatricians and psychiatrists. Re-education and rehabilitation of the more severe offenders began to be channelled through special units such as reformatories, borstals, correctional or training schools.

Psychologists had also been concerned with children, particularly with comparison of individuals with regard to certain areas of their functioning. This led to examinations and recordings of the gradual emergence of motor, perceptual, conceptual, linguistic and social behaviour (developmental psychology). Psychoanalysis also made significant contributions to the observation and treatment of children. Unfortunately a mixture of probabilities, possibilities, assumptions, beliefs, opinions, conjectures, impressions and analogies which had not been validated by dispassionate scrutiny hardened into certainties and decreed truths which for a time formed the foundation of an all-embracing credo enveloping all aetiology and therapy. Immediately after

World War Two there were uncertainties in the training of child psychiatrists. Some psychiatrists considered that training in child psychiatry should be preceded by an adequate training in general psychiatry while others thought that a training in paediatrics coupled with psychoanalytic training was an adequate preparation to practice child psychiatry. This view was strongly propounded by David Winnicott who himself was a paediatrician who had trained also as a psychoanalyst. Winnicott deplored the departure of physical paediatrics from psychology and the loss that child psychiatry had sustained by its divorce from paediatrics.

Another development was that of child guidance clinics which was a name given to a certain way of approaching problem behaviour in children. It was initially developed to deal with juvenile delinquency but later extended to cover other kinds of difficult or neurotic behaviour. Causes were sought for the psychological pressures that had complex social, emotional and cognitive components. Those in the Child Guidance movement believed that prevention required emotionally upset children to receive treatment for what was currently bothering them and that benefit would be derived from dealing effectively with the everyday problems of the everyday child. They were concerned with the factors which did things to children shaping their feelings and resulting demeanour. This led to investigation of inter-personal relationships at home and in school and motivating factors. To unravel the tangle a group of specialists, who would pool their expertise and come up with solutions came into being. This was the origin of the basic child guidance team of medical psychologist (psychiatrist) educational psychologist and psychiatric social worker. Their provenance lay between medicine and schooling. The original arrangements at one

time became frozen into a rigid system which came to regard itself as a complete self contained unit. A landmark in the UK was the opening of the East London Child Guidance Clinic under the Honorary Directorship of Dr Emanuel Miller one of the founders of the Association of Child Psychology and Psychiatry and allied disciplines. He recognised that children's conditions almost inevitably called for treatment of the parents' difficulties from which they could rarely be distinguished as individual illnesses.

Kenneth Cameron at the Maudsley Hospital developed the approach to the child as socio-psychobiological following the ideas of Adolph Meyer. This approach saw as the subject of child psychiatry the whole individual in body and mind and employed everyday methods in their therapy including psychotherapy that would modify stress of body or mind. The responsibility of the discipline was to all who needed help, to the dull and disturbed as much as to the intelligent and neurotic.

Paediatricians were sceptical about psychiatry worrying about over popularisation and over sentimentalisation of child psychology, the over evaluation of some standardised tests and conflicting claims of speculative vociferous and dogmatic 'schools'. In 1939 the Faversham Committee reviewed the Mental Health services in Britain including those for children and for the first time drew attention to the issue of separate premises for child psychiatric outpatients in hospitals away from adults.

The goal of treatment in child psychiatry remains the sum total of efforts spent to help children attain their optimal condition of comfort and smoothness of

functioning. This recognises that the wide variety of conditions the optimum differs with each individual's somatic, intellectual and socio-cultural propensities which should have been investigated carefully before a plan for treatment is outlined. This may involve parent counselling, psychotherapy with the child, the correction of impaired vision, adequate classroom placement, the supply of sufficient food and clothes and other arrangements in keeping with special needs.

Since the inception of the Royal College of Psychiatrists there have been further changes. Classification systems were replaced by more reliable and valid systems which meant that a 'case' could be reliably distinguished from a 'non-case' which led to epidemiological investigations. A major study in the Isle of Wight in the late 1960s had broken new ground. The study included investigation of physical, social, intellectual and educational data using questionnaires and interviews of known validity and a 5-year follow-up enabled the (medium term) prognosis of disorder to be established. There were also major longitudinal studies of psychiatric disorders first diagnosed in childhood in a child guidance clinic. Anti-social problems had a poor outcome while those with emotional disorders were similar to those with no problems. Quantitative studies extended reliability. Molecular genetic techniques found two genes linked to hyperactivity. Brain dysfunction was found to play a significant part in the aetiology of psychiatric disturbance in some children with neurological disorders and that less obvious brain disorder was important in apparently physically normal children. Structural and functional abnormalities could be linked to behavioural disorder. There has been an increase in the number of trials of medication in this period with a move towards greater use of medication combined

with psychotherapy. Cognitive behavioural therapy which has become part of a group of interventions for obsessive compulsive disorders in childhood is often improved if combined with medication. The synthesis of opposing schools of psychoanalysis and behaviourism has been partially successful. There has however been a substantial rise in the psychosocial disorders of youth and a concomitant increase in the level of child and adolescent mental health services. There is now a better diagnostic classification system and a clearer idea of the prevalence of the different disorders. Treatments also are more often evidence based. It remains unclear however why populations vary over time in their prevalence of disorders. Rational prevention remains problematic though rational prevention is plainly needed. Many recent developments owe much to the work of Michael Rutter who was one of the four psychiatrists elected in the twentieth century to the Royal Society for his 'invention of child psychology'. As the first Professor of Child Psychiatry in Great Britain he became the acknowledged leader in the discipline. His influence has been immense in both practice and research into autism, classification, temperament, school influences, psychiatric epidemiology and an international authority of developmental psychopathology. A landmark in the 1970s was his epidemiological study on the Isle of Wight, the first of its kind in the UK and a yardstick for subsequent epidemiological research in the field. It provided much information on the prevalence of serious disorders, the development of new measures and a basis for planning services.

FACULTY OF CHILD PSYCHIATRY

The Faculty had its beginnings in 1942 when The Royal Medico-Psychological Association set up a Child Guidance Sub-Committee in July 1941. It was renamed the Child Psychiatry Sub-Committee in March 1943 and became a Section in 1946. It was sometimes called the Children's Section in early minutes and was called Child and Adolescent Psychiatry Section from the early 1980s until 1997 when it was renamed the Faculty of Child and Adolescent Psychiatry.

The College sections and faculties developed from the original Research Committee, which was first established in 1914 and which became a Standing Committee in 1927. Although it had sub-committees from the first, child psychiatry does not seem to have been among them. There are some references in Council early minutes to children (behaviour of delinquents and asylums with children for example) but these are not very frequent. However, in the 1930s the RMPA seemed to have become more aware of the needs of children and, for example, an Association representative was appointed to a Government committee on mentally defective children and it may be this awareness that led to the formation of the Section.

The Faculty is now very active, with over 1900 members. It has an unusually large number of members who are interested in the subject without directly working in the speciality. The academic programme is strong with a specific day in the College Annual General Meeting and a three-day residential conference each autumn. The Faculty averages some 300–400 attendees and it is one of the largest faculty residential conferences. There are also two CPD (continuing professional

development) institutes most years; one after the Annual General Meeting in the summer and the second in the following January or February. These are skills-based training days with numbers limited to 40–60 attendees. Topics include motivational interviewing, cognitive behavioural therapy and child care court work.

The Faculty also has a strong and fruitful link with FOCUS. Launched in 1997 FOCUS promotes clinical and organisational effectiveness in child and adolescent mental health services, with an emphasis on incorporating evidence-based research into everyday practice. FOCUS is funded by a grant from the Gatsby Charitable Foundation and from Section 64 funding from the Department of Health. It is a project based at the Royal College of Psychiatrists' Research Unit and has published a number of books with the Royal College.

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