SOME RELATIONSHIPS BETWEEN THE PSYCHIATRY OF CHILDREN AND OF ADULTS*

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For the Chairman's Address to the Child Psychiatry Section in 1955, Cameron (5) decided to survey the scene of Child Psychiatry. His survey was historical and he described the various influences that have in turn borne on and helped to shape the practice of Child Psychiatry as it is today. Kanner (9), in the Maudsley Lecture of 1958, took the same theme and elaborated on it further. It is significant that they both felt that the time had come to do this for a young speciality and, indeed, their lectures were of considerable interest and use to those of us who have not lived through—in Child Psychiatry—the times described. However, Child Psychiatry has not become static; the scene will continue to change and to enlarge as more new influences come to bear. It seems that we who are engaged in its active practice now, and in the future, have need to watch where we are going; especially, as comparative success has brought some rewards and we foresee the likelihood of further rapid expansion in the speciality, with the need to recruit more child psychiatrists. Again, the joint or liaison committees that have sprung up with other medical professional bodies are in a sense a recognition of our significance; they are also a responsibility and may be a test of our loyalty to psychiatry as a whole.

Cameron and Kanner both touched on the relationship of the psychiatry of adults to that of children and described how, early on, psychiatrists working in the adult field tried to apply their knowledge of adult patients to children. Kanner, almost apologetically, took Ziehen (18) as an example who, in writing his treatise on the mental diseases of childhood, as late as 1925, must, Kanner (9) felt, have proceeded in the following manner: "My readers are, of course, familiar with paranoia, melancholia, hebephrenia, stupor, hysteria, etc., in adults; now let us see how frequently these things are seen in children and how similarly or dissimilarly they manifest themselves." Both lecturers quickly went on to spend much more time on the important funds of knowledge that other disciplines, mostly outside psychiatry, have contributed to the practice of Child Psychiatry as it is today. It has become a dynamic subject, dealing as it does with the growing child; and, enriched by the psychodynamic approach and much else already outlined by Cameron and Kanner, it could only leave behind such seemingly sterile concepts as those of Ziehen.

On the other hand, both the psychopathologically orientated schools of thought and the psycho-biological approach of the Meyerian school have emphasized from their different viewpoints the continuity of Child Psychiatry

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with Adult Psychiatry. After all, "The child is father to the man" (Wordsworth). Psychiatry needs to be viewed as a whole; if some practise Child Psychiatry by choice, others may have to exclude practice with adult patients because of pressure of work. The total field of psychiatry has become too large and it has had to be divided. However, how far some child psychiatrists have shied away from the concepts used in the practice of clinical psychiatry with adults is illustrated by Winnicott (17) who has stated: "The harm done to Child Psychiatry would be consolidated should Child Psychiatry become part of Adult Psychiatry, a fate which it has so far avoided." It is not in fact likely that Child Psychiatry can become part of Adult Psychiatry in the way that Winnicott fears, but this Children's Section is significantly a Section of the Royal Medico-Psychological Association, a position that has enriched the former in many ways. Winnicott went on to say: "Child Psychiatry has more to offer to Adult Psychiatry than the latter has to the former." This may up to a point be true if psychopathology is under consideration. It may become true as far as descriptive psychiatry is concerned at some future date, but up to the present it is likely that colleagues working in the field of Adult Psychiatry have not gained from Child Psychiatry as much as they may have hoped to do.

Child psychiatrists are pre-occupied with the assessment and treatment of the immediate and pressing problems that children present. They may also pay attention to what can be done to prevent their development in the first place. They are on reasonably firm ground in their predictions for the near future of their patients. There can as yet only be speculation as to what sort of adults they will become. Few such patients have been followed up into adulthood and certainly not in sufficient numbers to allow any worthwhile conclusions to be drawn. The practice of Child Psychiatry has been too recently established and the war years have intervened. There are, of course, important studies under way; for instance, that of the University of London, Institute of Education and Child Health, Child Study Centre (Moore *et al.*, 12). Detailed as this is, it involves comparatively small numbers of potentially healthy children; it is not primarily concerned with disease processes.

On the whole, it seems that patients as they mature may often be viewed in cross section rather than in longitudinal section. Child psychiatrists naturally have ample clinical experience of children of all ages. Then, somehow, there are adult patients with their clinical characteristics, sometimes viewed by the child psychiatrist in a sense at secondhand, as parents. There is an ill-defined gap between the two, with adolescent patients placed uneasily somewhere in it, rather unhappily dealt with either by the adult psychiatrist or by the child psychiatrist. An adult patient naturally has a past history of childhood, but there is seldom opportunity to view this through the eyes of a child psychiatrist and memory is usually too short for accurate recall. In other words, knowledge of the phenomena showing in psychiatric ill health, as it stretches through childhood into adulthood, is on the whole rudimentary. It is more meagre, perhaps in the neuroses and character disorders than in the psychoses. Child psychiatrists, however, need such knowledge for long-term prognosis. Adult psychiatrists may be helped by child psychiatrists having traced forward more accurately, not in this connection in the psychopathological sense, the phenomena to be found in psychiatric ill health through earlier age levels; the natural history of mental ill health. This is a way of looking at Child Psychiatry and its relationship to Adult Psychiatry, which is the opposite to that of Ziehen.

The lack of opportunity to carry out long-term studies in Child Psychiatry into adulthood has left a hiatus, which has not been filled by psychopathological

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theories of aetiology. Mayer-Gross and Slater (11), in the chapter on "Child Psychiatry" in their textbook, it seems had this in mind, when they expressed criticism of facile optimism sometimes expressed by child psychiatrists, when judging the long-term value of their work: "The hope of preventing by psychiatric supervision or treatment in early life a large part of adult maladjustment or illness is even less substantiated (—than that the origin of neurotic and psychotic illness of adult life is to be found in the experiences of early childhood). All that the present state of our knowledge justifies is the hope that in some cases, which we may eventually learn to identify, the chances of illness or abnormality would be materially reduced by sane and healthy upbringing." They emphasize that the psychoses are found to be quite uninfluenced by early upbringing, home life and childhood experience. Are child psychiatrists in a position to refute this? Again, they point out that the more serious psychoses of adulthood, or severe neuroses based on constitutional psychopathic abnormalities, are rarely seen in children, or develop at that time of life to a stage where recognition is easy. May not long-term studies of child patients with psychiatric disturbance, followed up into adulthood, shed further light on these?

Many of the psychiatric disturbances of childhood, perhaps largely reactive to the environment, tend to settle down with suitable handling or sometimes without special treatment, and so allow healthy development to proceed. Other disorders, however, having started at some age or other in the first or second decade, seem to continue, sometimes unperceived or perhaps with intermissions; and, in spite of all efforts to treat them in childhood, develop into the well-known psychiatric disorders of adulthood. How far can these cases be picked out and how can they be better understood? Curran (7) in his presidential address to the Section of Psychiatry of the Royal Society of Medicine in 1951, pointed out that clinical studies are essential for the solution of the clinical problems of diagnosis, prognosis and treatment, and asked who could doubt our ignorance of the natural history of many disease groups. Have we, in fact, got much beyond Hector Cameron (3), who in 1919 wrote: "In children beyond earliest infancy we recognize a gradual approach to the conditions of adult life. Fractiousness and naughtiness, ungovernable fits of temper, uncontrollable weeping and inexplicable fears should disappear with early childhood even if management has not been perfect. If they persist to older childhood we shall find in an increasing percentage of cases evidence of definite neuropathic tendencies, which urgently call for investigation and for a precise appreciation of the nature of the abnormality."

It is now proposed to indulge in speculation, using clinical material as anecdotes to try and illustrate some of the links between the psychiatry of childhood and that of adulthood. Such are well known, but how far have they been studied prospectively as opposed to retrospectively?

It happens that follow-up material is now available from the in-patient unit for adolescents established in 1949 at Bethlem Royal Hospital and which has been described elsewhere (Cameron, 4; Warren, 16). This material consists of 187 patients, of whom 157 were followed up, discharged, aged 12 to 17 years old, between 1949 and 1953, and who have now mostly reached the early twenties. These patients were under the care of Dr. Kenneth Cameron or myself; and it is hoped that this follow-up material, which is being statistically analysed by Dr. Lilli Stein and myself, will be produced elsewhere. It has been collected from up-to-date reports and, in a majority, from follow-up interviews of relatives by psychiatric social worker colleagues, and of some of the ex-patients

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by myself. The data so obtained from the case notes and follow-up information require careful and uniform classification and statistical evaluation; and although such classification loses some of the individual "life" of each patient, this is the only way to evaluate the group-characteristics of each diagnostic category and to examine their common features and relationships. In the present paper, however, some of this material is being used to provide illustrations in terms of individual cases.

An advantage of adolescent patients is that a fairly recent account of their earlier childhood can be obtained, although even then recall of infant years by parents is not always accurate and occasionally not available at all. Their follow up six to ten years later meant that they had, or nearly had, reached adulthood. Even so, only the first few chapters of their lives have been written and much can happen later on. Nevertheless, the "plots" of their life stories have sometimes now been revealed.

Such material is most heterogeneous, including the psychoses, not to be considered here, a wide range of neurotic disorders, behaviour and conduct disorders and disturbances of personality. Some patients' illnesses were typical of the familiar childhood syndromes to be met in the practice of Child Psychiatry, others were more adult in form. A small proportion only can be used here, but it should be emphasized that when the material is examined as a whole, its outstanding characteristic is the overlap that occurs between the symptom-complexes and syndromes shown by these patients, including often the psychoses; they shade imperceptibly one into another, as do their personality structures. Certain groups can be picked out with outstanding features common to them, but there is usually no clear-cut division separating such groups from other patients. This is typical of the adolescent period of life, when all is, in any case, in a state of flux.

It is proposed here to make use of three groups of patients, whose subsequent careers often happen to appear rather discouraging to the earlier efforts of the child psychiatrist. To reassure ourselves, however, many others with various kinds of disturbance and who achieved stability, could have been picked out; they would not have been suitable to use for the present proposition.

Phobic States, Including School Phobia

At the N.A.M.H. Child Guidance Inter-Clinic Conference of 1959, the subject of "School Phobia" was discussed. Inevitably, much time was spent on the nature and aetiology of the underlying condition and how to treat here and now these children, who have such a troublesome presenting symptom. The accent was on the present rather than on the future. However, Burns (2), when summing up the conference, quoted Johnsen (8), who stated in 1941 that school phobia was "in line with other phobias and we need not think it stops with childhood, it can go on to the age of 50". Burns asked if school phobia was allied to the crippling disease of agoraphobia and also quoted a case he had followed up, who had later sought help for neurotic symptoms when a young adult, after an interim period of stability. He postulated sometimes a constitutional element in these cases, which he thought rather important and sometimes rather neglected.

As far as our experience is concerned, 16 patients, aged 12 to 16 years (7 boys and 9 girls), were admitted to the adolescent unit because of continued refusal to go to school, who had failed to respond mostly to treatment in child guidance clinics. There were 7 others where the school refusal was associated

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with a severe neurosis, or in 1 case an early psychosis, which in fact made them unfit to go to school. The histories and clinical conditions of the 16 relatively uncomplicated cases did not appear to differ much from the many cases dealt with by other means, elsewhere; their admission was perhaps somewhat fortuitous. Their hospitalization did not necessarily mean they were more ill. They were all treated with varying success as regards their underlying condition and getting them back to school, but follow up shows that of these 16 patients, now aged between 18 and 22 years, 1 should be in hospital for a severe phobic state, 3 are severely handicapped by a phobic state, 3 live somewhat limited lives because of phobic symptoms and 3 more have shown since discharge other kinds of neurotic difficulties, but which appear to be settling. Six (under one-half) now appear to be quite well.

Five of these patients with refusal to go to school had at the time shown phobic symptoms apart from this presenting symptom. To these can be added three more phobics who, however, did not show school phobia. Of these 8 latter patients on follow-up, 1 has been leucotomized for continued phobic symptoms, 1 is in hospital and another should be with severe phobic states, 2 more are severely handicapped and 2 mildly handicapped by phobic symptoms. Only 1 patient can now be considered normal. It seems in this small group that the outlook was worse when school phobia was accompanied by other phobic symptoms.

Looked at in this way, there seems to be considerable overlap in adolescence between phobic states in general and school phobia in particular. Is this sufficiently recognized by child psychiatrists, with the prognostic implications for the former condition? Further, 3 of these patients also showed obsessional ruminations and it is believed that some of these cases shade off imperceptibly into the obsessive compulsive states. Others showed well-marked hysterical traits and so on. All these have implications for adult life, if they persist. During the time of admission, these adolescents' likely future psychiatric state as young adults was not always appreciated. In the first decade of their lives, they had mostly not had any particular symptoms, to forewarn of future adult ill health; in the second decade their illnesses were in fact unfolding in some of them. Here are some examples, in brief outline, which perhaps give further a different slant to the day-to-day clinical problems met in the second decade. To study larger groups of patients of this type in detail, might be enlightening in helping to trace out the early stages of such a crippling condition as the phobic states can be later on:

Emergence of a Severe Phobic State

1. *Douglas*. Admitted, aged 15 years, after 16 months previous treatment in another mental hospital. His father had early on been killed in action; his mother was an anxious, neurotic woman. Douglas was of average intelligence. He was always shy and sensitive and with tempers if frustrated. However, he was happy until sent to a Royal Navy boarding school at the age of 11 years. He became anxious, hypochondriacal and was further acutely upset by anaesthetics for appendicitis and a fracture. Acute panic attacks developed and he was sent home. He then became afraid to go out and was admitted to the first hospital, aged 14 years, and thence to us. It seems that he might have been a school phobic had he not been at boarding school. He made little progress in the adolescent unit, in spite of intensive psychotherapy and, after nearly 2 years, was transferred to his local mental hospital. He did not like it and went home. Here he remained unable to go out. He was sent to relatives for 2 years and then returned to his mother. He remained more or less confined to the house for 3 more years and had out-patient psychotherapy. He was then admitted to hospital again, aged 23, for more intensive therapy and to get him away from his mother. There he remains for the present. He has a severe phobic state. He cannot go out without acute anxiety.

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School Refusal with Later the Emergence of a Severe Phobic State

2. *Raymond.* Admitted, aged 14 years, with a 9-months history of increasing refusal to go to school and tempers with his family. He had always been reserved, mixed poorly, quick tempered and had never shown affection. He had early on been frightened by air raids. His father was morose and lacked understanding; his mother ineffective; the marriage unhappy and home circumstances poor. He was of low average intelligence.

He remained in hospital for 11 months. He alternated between days of brooding or over-activity, but appeared to improve and become more outgoing. Psychotherapy was on the whole resisted.

After discharge, he seemed a good deal better. Within months he deteriorated and was charged as out of control and placed in an approved school. He failed to adjust and absconded. Aged 16, he returned home and became more solitary. At 17, he was admitted to a mental hospital for a few weeks and was given E.C.T. with some improvement. However, from this time until now aged 22, he has remained in his room, except for meals and to watch television. He has become passive, withdrawn, with vague fears and feelings of having committed a crime, if he meets people. The only job he attempted in a factory, he left as distressed by the crowds of people. He entertains himself with records, drawing and reading. He is having no treatment.

School Refusal, with Continued Minor Neurotic Illhealth and with Mild Phobias

3. *Pauline.* Admitted, aged 13 years, with a year's history of anxiety attacks, hypochondriasis and latterly refusal to go to school, following several months in hospital with rheumatic fever. She had previously been a happy and sensible girl, but always nervous, timid and over-dependent on her mother. Her father had paranoid schizophrenia and was separated from her mother, a very anxious woman. Pauline was of average intelligence.

She settled in hospital, soon became quite a tomboy and showed some bad behaviour. In psychotherapy she expressed hostility to her mother. She settled down and was discharged after 3 months. However, she relapsed and again refused to go to school and was readmitted for 6 months. She responded well and was discharged to go out to work.

She had a number of jobs, mostly in offices, and often stayed at home. She married at 19 years after 2 years courtship. She still lives with her mother and also her husband and baby, born when she was 20 years. She has had a number of minor ailments and fears to travel. With her husband, however, she had developed an enjoyable social life with a number of friends. She still suffers from attacks of nerves. She was sick through pregnancy and had a difficult delivery. After the birth, she again developed a vague illness called "rheumatic fever" and was in bed under the care of her own doctor. She is still very dependent on her mother.

School Refusal in a Boy of Dull Intelligence and with Continued Inadequacy

4. *Derek.* Admitted, aged 14 years, after several months refusal to go to school, after moving from the provinces to London and which led to a Court charge. He was sleeping badly and had temper outbursts. A shy, sensitive boy, always anxious and afraid of the dark. His father was away in the Army when he was young and subsequently took little interest in the family. His mother was inclined to depression and to be over-protective. An older sister had had a phobic illness for several years. Three other siblings were stable. Derek had had a number of physical illnesses, had been evacuated at the age of 2½ years, with a number of moves and probable neglect. He was of dull intelligence and had an inguinal hernia.

He settled down well in hospital, made friends and took an active part in everything. Much attention was paid to the mother, towards helping herself and her attitude to the boy.

Since discharge, the family has moved backwards and forwards to the provinces and is now settled in London. Father is in ill health and has not worked for 4 years. Family interrelationships are poor. Derek has had countless jobs as a labourer. He has lost a number by failing to go. He has one or two friends and goes to dance halls to watch dancing. He has never had a girl friend. He still has his hernia and will not have it treated. He is immature and lacks initiative. He spends a lot of his spare time in bed. He is undoubtedly handicapped by his dull intelligence and lack of education. He is now aged 20 years.

In Contrast: School Refusal with a Subsequently Normal History

5. *Bevan.* Admitted, aged 12 years, for refusal to attend school for 9 months, following a minor illness. A child guidance clinic had been unable to solve the problem. Both parents were overanxious, but the home was otherwise satisfactory. He had always been over-protected; a happy, sensible, but strong-willed boy. He was of average intelligence.

He settled down well and appeared to be free from disturbance. After 3 months he was discharged to a boarding hostel for maladjusted boys, and while there he attended a secondary modern school. He seemed normal and made good progress. There was no further trouble; he completed 2 years National Service in the R.A.F. and has joined the G.P.O. as a technician; a job with prospects. He is now aged 20 years. His parents now ascribe his trouble over school to a certain teacher there.

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The Obsessive Compulsive States

Obsessive Compulsive states, below the age of 10 years are uncommon, although children often and normally indulge in repetitive acts. In the same way, mild phobias are common early on; phobic states seem to be rare in the first decade. A young child is not yet a clinical entity in these respects; he is part of a family who are usually involved in such symptoms. A number of authors have touched on obsessional conditions in childhood; Pollitt (13), however, speaking on the natural history of Obsessive Compulsive states, analysed 150 cases retrospectively and showed that about 22 per cent. had had obsessional symptoms, as distinct from the present illness in adulthood, before the age of 10 years; 25 per cent. before the age of 15 years and 27 per cent. before the age of 20 years. As far as the present illness in adulthood was concerned, in 5 per cent. it had dated back to before the age of 10 years; in 12 per cent. to before 15 years; and in over 20 per cent. to before 20 years. The illness as a whole was phasic and tended to occur in bouts in childhood, adolescence and in adulthood.

In our experience, 15 patients were admitted between 1949 and 1953 with obsessive compulsive conditions, aged between 12 and 17 years, and followed up between the ages of 19 and 24 years. Five of these had also shown phobic symptoms at some time, and many in varying degree some of the mixed bag of symptoms indicative of disturbance early in childhood, familiar to child psychiatrists. In addition, there were 14 others who showed obsessional symptoms as part of some other psychotic or neurotic condition. However, of the 15 patients with a definite obsessive compulsive state, in 1 the illness began at 4 years, in 3 at 8 years and in 5 at between 9 and 10 years. In the rest, the illness was of fairly recent onset. On follow up, 1 has been leucotomized, 1 is in hospital with obsessional neurosis and 1 should be, but refuses treatment. Two more are severely handicapped by obsessional symptoms and 4 others somewhat handicapped. Four have a tendency to mild obsessional symptoms under stress. Two only are quite normal. Some of these patients can be said to have personality disorders with obsessional features; such could not, however, be readily separated from the rest of the group. Here are some examples, whose further histories will be of interest:

Continuing Marked Obsessive Compulsive State

6. *Donald.* Admitted, aged 15 years, with a long history of obsessional symptoms and phobias back to the age of 4 years. His father, a riddle maker, was critical and the patient had never got on with him; his mother, timid and with a history of Graves' Disease. One sister, 4 years younger, was normal; another died when he was 4. Always timid, obstinate and attached to his mother, he developed phobias and obsessional rituals at 4, after the birth of one sister and the previous death of the other. His legs were also in irons for 2 years at this time. He refused to go out for 6 months. He improved, but the rituals remained. They became worse at 9, and at 14, after slipping on some blood in the road, he became very much worse. He was of average intelligence.

During a year in hospital, he gradually improved and appeared to respond well to a psychotherapeutic approach. After discharge, he returned home and having to work in his father's business, his compulsions gradually returned. He moved away and improved, but his family joined him. Then, at the age of 22 years, he was again hospitalized for obsessional neurosis for some months and improved with largactil. He returned home, but was still unable to work. At 23 years he went to a Rehabilitation Unit. He could not cope and left. He remained at home and finally at 24 came to London and for a year he alternated between being a porter, a circus hand and a transport driver's mate. He has marked rituals, which he manages to hide. He feels freer and happier on the move. He would like to marry, but his illness, he feels, will prevent any girl getting fond of him.

Personality Disorder with Marked Obsessional Features

7. *Alan.* Admitted, aged 16 years, because of considerable withdrawal, inability to hold a job and a preoccupation with Underground train routes. His father had a history of

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depressive breakdown; his mother, kind, dull and tenacious. Three younger siblings were normal. His early development was normal, except toilet training was not completed to 4 years of age. At school he was a poor mixer and was bullied. He was short-sighted, clumsy with his hands, and stuttered at one time. He was always slow and dreamy and his main joy was timetables and riding in buses and trains. He spoilt his work by attention to irrelevant details. He had been under the observation of a child guidance clinic from the age of 11 years. Latterly, he had been lying about and failed to make friends. He was of average intelligence.

He stayed in hospital for 6 months and became a bit more sociable. He resisted strenuous efforts in psychotherapy and remained preoccupied with abstruse geographical details. On follow-up, now aged 21 years, he has remained at home. Exceptional efforts had been made to get him to work, including a Social Rehabilitation Unit, without success. He has at last settled down in his uncle's firm, spraying and blocking hats. He mixes with no one, but goes to an art class. He has shown no interest in girls. He spends all his spare time in reference libraries, studying buses and trains. He collects maps and timetables and knows the routes and times of trains to anywhere. He is content and has no complaints.

Obsessive Compulsive State, with a Continuing Mild Tendency to Obsessional Rituals

8. *Pamela.* Admitted, aged 12 years, with a 2 years history, following her mother's miscarriage, of attacks of screaming and hostility to her mother. She became very slow, spent a long time in the lavatory and was difficult to get to dress or to undress. She had previously been treated in a child guidance clinic. Both parents were over-anxious and over-solicitous of this only child. She had shown no difficulties until her present illness. She was of low average intelligence.

In hospital, she had obvious obsessional rituals and she was timid and anxious. She improved, showed more initiative, mixed better and was for a time rather aggressive. She gained some insight in therapy into her relationship with her mother. She was discharged after 8 months, apparently free from symptoms.

At 19 years, she is a pretty and pleasant girl, still very attached to her parents. She has worked for 3 years in a drapery shop run by two maiden ladies. She spends her spare time bellringing, square dancing, with music lessons and churchgoing. She has made no real friends and refused the only boy who asked her out. She is rigid and noticeably mean. She is meticulous and has a very orderly life. If tense, for instance before her periods, she gets fidgety and opens and shuts drawers.

Obsessional Compulsive State with a Subsequent Normal History

9. *Graham.* Admitted, aged 12 years, with severe compulsive symptoms and ruminations of a year's duration, after being beaten up by a friend at school. His father had obsessional traits, his mother impatient and tense. A younger stable sister was mother's favourite. As a baby, he was a slow feeder and was clean and dry by 3 years. He cried a lot and thumbsucked up to 5 years. He was shy, a poor mixer, obstinate, overclean and tidy and very jealous of his sister. He was of average intelligence.

In hospital he gradually improved, and in psychotherapy he appeared to work through a good many of his difficulties. He was discharged after 17 months.

At 20, he still lives with his parents and there is now no disharmony with his sister. He remained at school to 15 and then became an apprenticed pastrycook, did well, specialized in decoration and won prizes. He is now in a job in Dusseldorf for a few months. He was rejected for National Service. He mixes well and has had one girl friend and now another. He is very clean and particular, but has had no further overt obsessional symptoms. A quiet and studious young man, who gets a bit concerned over minor ailments.

It seems from others' retrospective studies and from our small experience, that obsessional neurosis often starts in childhood or in adolescence. It tends to continue or to recur and there is also the question of the "obsessional personality". Is enough attention paid to prognostic implications in the study of these cases at an early stage by child psychiatrists?

Psychopathic Personality

Children and adolescents with disorders of conduct, with or without accompanying neurotic disturbance are well known to child psychiatrists and to all other agents who deal with them. Most settle down as they grow up. Some do not, and child psychiatrists sometimes wonder which of these will later qualify for the title "Psychopathic Personality"? Much has been written about this term, but as time goes on there seems to be more uncertainty as to its nature. As Scott and Gibbens (14) have recently stated, "the main source of

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difficulty in proposing a plan for dealing with the problem of the psychopath is the lack of knowledge—in definition, distribution, prognosis and treatment. We do not know enough about the nature of psychopathic personality to agree about a definition". This is not the place to dwell further on these difficulties. Most psychiatric discussion has revolved round adult psychopaths with their life histories in retrospect. At the other end, there is such valuable work as Bowlby's (1), on maternal deprivation and the concept of the "affectionless" child, and there has been the recent publication of a series of symposia held by the American Orthopsychiatric Association (10), in which an attempt was made to delimit the "psychopathic" child from other behavioural and neurotic disorders. The conclusions reached, however, by the participants were somewhat indefinite, and, as elsewhere, there was little attempt to link it up with the concept of "psychopathic personality" in adults. It seems that there is again much need for long-term studies of children into adulthood.

Many adolescents have been admitted to the Unit, boys more than girls, showing antisocial behaviour; and some severely delinquent. Admission was sought for a number of reasons; some required psychiatric investigation, others also showed neurotic symptoms or for some other reasons they were thought likely to be amenable to psychiatric in-patient treatment. Their symptoms, including the length of history back into childhood, and the 'problems that they presented, were most varied. As a group, they did not stand alone; they graded imperceptibly into those admitted because of neurotic syndromes. There was considerable overlap. Again, in personality, those with conduct disorders as a whole, when compared with neurotic children, did not appear to be more aggressive. One could not in any of them diagnose "Psychopathic Personality". In any case, much of adolescent misbehaviour is "psychopathic" or would be if it occurred in adults.

Fourteen patients (12 boys and 2 girls) aged between 12 and 16 years, had subsequently, by follow-up, aged 19 to 24 years, earned the title of Psychopathic Personality, bestowed on them in due course by one or more psychiatrists or prison medical officers. It is not proposed to discuss here the merits or demerits of this title in their cases. Such a diagnosis may have been correct, but its use appeared rather haphazard. Is this one reason why the term is so nebulous?

Be this as it may, examination of their records underlines that they were, as children and adolescents, a very mixed group. Ten other patients (6 boys and 4 girls) had in fact similar subsequent bad antisocial records, but they have not yet, as far as is known, been diagnosed as Psychopaths.

Examination of the records of the 14 so-called psychopaths shows that 1 boy was admitted with a neurotic condition. His antisocial behaviour supervened after discharge. Six others during admission showed neurotic conditions as well as conduct disorders. The other 7 were admitted with conduct disorders only; but some of them showed neurotic traits. During the first decade of the lives of this "psychopathic" group no clear-cut features distinguished them. However, an impression was gained that they were, as were the others with serious antisocial conduct, amongst those patients with the more unstable and disturbed family histories; they had suffered on the whole more than most patients from environmental disturbances in early childhood, but not particularly from maternal deprivation. By the second decade, they had become on the whole amongst the more incorrigible in their conduct and those most difficult for outside agents to handle. In the unit, most had relative difficulty in making positive relationships with the therapist or with other patients, but few

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could be called "affectionless". Some appeared to settle down and to derive temporary benefit. On the whole, they were amongst the most awkward patients, although this was a matter of degree. In the majority, their antisocial behaviour continued and perhaps increased afterwards. There were, however, in contrast, at least 4 others, who, indistinguishable at the time of admission, had settled down and become more stable by the time of follow up. How many more will stabilize with increasing maturity? Here are some clinical examples:

Psychopathic Personality

10. *Keith*. Admitted, aged 16 years, following a charge of indecent interference with small girls. Both parents were strict and unaffectionate, there were 2 younger normal children. His early development was normal, but from 5 to 8 years he was evacuated to a strict family. He was always quiet and solitary and latterly he had been sullen, bad tempered and seldom went out. The sexual interference then occurred. He had been masturbating excessively.

A shambling, miserable and guilty youth of high average intelligence and with a normal EEG, he was passive and unco-operative in psychotherapy. After 2 months, he repeatedly absconded and finally stole a motor cycle, which led to committal to an approved school. He appeared to seek punishment and stated he would rather be in Borstal than talk of his sexuality.

He went on to abscond repeatedly from the approved school and was again apprehended for sexual interference with girls and sentenced to 18 months imprisonment. After discharge, he returned home, now aged 20 years, and was at once sentenced to 4 years for raping a girl. After discharge, he was again sentenced to 4 years for attempting to rape a 57-year old woman and for possessing an offensive weapon. He is regarded as a psychopath and castration has been requested by him and advocated by psychiatrists.

Psychopathic Personality

11. *William*. Admitted, aged 12 years, because of violent tempers since the age of 7 years, for which he had attended a child guidance clinic and then been admitted as maladjusted to two schools, but had absconded. He had had an eye removed at the age of 1 month and was very conscious of his glass eye. The father was an anxious disciplinarian, with many somatic complaints; the mother anxious and emotional. Both were over-protective, upset about his eye and feared to have another child. His early development was normal, but lately he had been having nightmares. He was of dull intelligence and had an unspecific, abnormal EEG.

In hospital he was superficially co-operative, but seemed actively afraid of failure and generally resentful. There was a strong undercurrent of hostility. Strenuous efforts were made to deal with his problems in psychotherapy, but he repeatedly absconded and finally got himself arrested and charged as beyond control and committed to an approved school. He was later discharged as unlikely to benefit from training. Aged 18 years, he was placed on probation for stealing and a few months later he was in Court for being drunk and disorderly and again for throwing milk bottles. He had had many jobs or avoided work. His tempers were severe and his parents in terror of them. Again, he was in Court for inflicting grievous bodily harm and admitted to a mental hospital. Here he was diagnosed as a psychopath. He settled down for a time and then became restless and was discharged. He had by now got his girl friend pregnant. This is his career up to date. Further details of his symptoms and personality are not known.

Psychopathic Personality

12. *Peter*. Admitted, aged 13 years, for truancy, stealing and stammering. His mother was inadequate, anxious and asthmatic; with minor fits in the past and a history of hospital treatment for recurrent depression. Peter was illegitimate. The stepfather "picked on" the boy. They lived in a very restricted flat. A breech delivery after a long and difficult labour, he was bottle-fed and had much vomiting. He also had repeated convulsions. At 3, he reacted with nightmares and enuresis to his stepfather joining the Army. At 4, his home was bombed and he was evacuated to 6 billets in 2 years. At 5, stammering began and also wandering. At 6, he and his mother were trapped in a train that was bombed. He was very frightened and became disobedient and destructive. He was treated in a child guidance clinic. He improved, but his mother went to hospital and his stepfather returned. His symptoms recurred and he stole from his stepfather. He now attended the Maudsley Hospital Children's Department, on and off for 3 years until admitted. He was now also educationally retarded, aggressive and mischievous. He had an abnormal EEG focus in the temporal region. He was of average intelligence.

In the adolescent unit, he was active and mischievous. At first very anxious, he responded well to the hospital régime, a psychotherapeutic approach and amphetamine. After 7 months, he was sent to a residential school for maladjusted boys, where he remained until 16 years. He gave no particular trouble. He returned home to a more spacious new house, and did a number of unskilled jobs. He was now twice charged with larceny, put on probation and at

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18 years volunteered for the Army. He was discharged as a "psychopathic personality" after stealing, aged 20 years. He was next sentenced to Borstal for further stealing. Interviewed at 22, he was a good-looking, plausible young man with a slight stammer. He was free from neurotic symptoms and his EEG was now normal. He had girl friends and liked the good things of life. He intended to settle down and make good. A month later he was again charged with stealing.

Severe Behaviour Disorders in Childhood, which Settled Down

13. *James*, Admitted, aged 16 years, because of inability to hold a job, truancy, petty thieving, temper outbursts and lying. His father had a duodenal ulcer; his mother, an aggressive, voluble woman had little affection for James. A number of relatives were unstable. His two younger brothers, however, were stable. He suffered a birth injury and was cyanosed for 2 days and then developed septicaemia. A troublesome babyhood, with vomiting, failure to gain weight and much crying. After his brother's birth he became, according to his mother, "the biggest devil". He was aggressive, disobedient and a liar. At 8, he attended a child guidance clinic for a time for fidgeting, stammering and disturbed sleep. Later he attended another child guidance clinic. He went to 6 schools, got on badly with lessons, had few friends and was often in trouble. He then held 6 jobs in 2 years, joined the Army and deserted. He was already diagnosed by some as a psychopath. He was admitted because he had walked into a river.

He was found to be of average intelligence and an EEG was mildly abnormal. He stayed in hospital for 5 months and remained childish, unstable, mischievous and without persistence. He was tense and hypochondriacal. He improved somewhat with psychotherapy directed towards sorting out his family inter-relationships.

After discharge, he quickly reverted to his previous state and a year later was admitted to a mental hospital twice for some months. He was diagnosed as a schizoid psychopath. He remained childish and aggressive. At 19, he was committed to Borstal for breaking and entering. He was discharged, aged 21, and settled down in a regular job. He is now aged 23, belongs to a club, has a full social life and is interested in singing. He has many friends and has been engaged. He appears to have entirely changed and while at Borstal saved the life of an officer. He is symptom-free.

Severe Conduct Disorders in Childhood, which May Now be Settling

14. *Richard.* Admitted, aged 13 years, for stealing and aggressive behaviour, which led to his exclusion from a residential school for maladjusted children. His father was a martinet and his mother anxious. Neither could control their 6 children; 3 of whom had attended child guidance clinics or been in Court. His early development was normal, but after his return from evacuation, aged 6, he was showing night terrors, sleep-walking and a number of neurotic traits, including enuresis. So disturbed was he that he was admitted for 9 months to the Children's In-patient Department of the Maudsley Hospital. He improved, returned home and soon showed acute conduct disorders with 3 Court charges and with increasing educational retardation. He again attended a child guidance clinic. He then went to a boarding school for maladjusted boys for 2 years until excluded. He was of average intelligence and his EEG was normal.

In hospital, he settled down well, but bullied the smaller boys. He was mischievous and destructive. After 2 months, he absconded, stole a motor cycle and was sent to an approved school, where he remained until 16 years old. His enuresis now cleared up. He had many casual jobs in the building trade.

He was charged a number of times for petty thieving and driving away cars. Aged 17 years, he was sentenced to Borstal and was discharged at 19 years. Soon after he was charged with loitering with intent, but this was dismissed.

At 19, he has no overt neurotic traits; he has kept one job for 3 months since leaving Borstal and is getting on better with his family. The other children have all settled down, although one is still in an approved school. He is not particularly interested in girls and enjoys a mild social life. He hopes to join the Army and drive army lorries. He is likeable and immature. He may be settling down and has not yet been diagnosed by any psychiatrist as a psychopath.

To sum up: it is apparent that nothing definite is here contributed towards the elucidation of the difficulties raised by the concept of Psychopathic Personality and its unfolding in the maturing child, although our experience points to its heterogeneity. Once again, it seems that prospective clinical studies of such children by child psychiatrists, who have detailed knowledge of their early lives and circumstances, may bring some reward.

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Conclusion

This address has kept deliberately to the sometimes neglected subject of clinical psychiatry in children. It has ignored psychopathological concepts and it has omitted the important ties that Child Psychiatry has with Paediatrics, with Psychology and so on. Time has not permitted discussion of many other threads which bind Child Psychiatry to the fabric of Psychiatry as a whole. However, it is of interest that Mayer-Gross and Slater (11) in their textbook *Clinical Psychiatry*, now include together in one chapter "Psychopathic Personality and Neurotic Reactions". How far their inclusive approach is acceptable is a matter of conjecture; it is certainly appropriate and a relief to apply their concepts to the very mixed syndromes to be seen during the second decade.

Finally, the training of child psychiatrists is at present under consideration, with an emphasis on recruitment. Creak (6), in the Charles West Lecture of 1958, dwelt on the pressing need of paediatricians for knowledge and training in the psychiatry of children and discussed the means by which they can get this or sometimes turn over to become child psychiatrists. Recently, Tizard and others (15) wrote on the same theme. Such is welcome, although this follow-up material demonstrates, if it does nothing else, that adequate knowledge of the clinical psychiatry of adults is most necessary for an appreciation of the long-term implications of psychiatric ill health in children; and this is apart from the proper understanding of the psychiatric ill health of parents, who are also the concern of the child psychiatrist. It would thus seem important that the training of the child psychiatrist should continue to provide for this aspect of their work and that it should also not be ignored by paediatricians.

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