

**WITNESS SEMINAR  
CENTRE FOR THE HISTORY OF MEDICINE  
UNIVERSITY OF GLASGOW**

**THE DEVELOPMENT OF CHILD AND ADOLESCENT PSYCHIATRY  
FROM 1960 UNTIL 1990**

**12 May 2009**

**Organisers**

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Front row: Ian Berg, Dora Black, Lionel Hersov, Bryan Lask, Philip Graham  
Second row: Arnon Bentovim, William Yule, Sebastian Kraemer  
Back row: Bob Jezzard, Michael Rutter, Malcolm Nicolson, Hugh Morton

## Introduction

**Philip Graham, Emeritus Professor of Child Psychiatry, Institute of Child Health, London**

The specialty of child and adolescent psychiatry began in Britain in the 1920s.<sup>1</sup> The period from the 1960s to the present time has been exceptionally rapid both in academic and service development.

We decided that a project was needed to capture the oral history memories of some of those who participated in the earlier part of this period from 1960 to 1990. Witness seminars are features of academic contemporary history research, and have for several years been used in the exploration of medical history by the Wellcome Trust at University College London.<sup>2</sup> Our seminar was hosted by the Centre for the History of Medicine at the University of Glasgow in May 2009.

“Witnesses” were selected on the basis of their contributions to different spheres of the specialty. Because of time constraints it was not possible to invite all of those who had played a significant part. Speakers were invited to recount their own experiences of the history of child and adolescent psychiatry and introduce topics for discussion between themselves and by the audience. The seminar was advertised in the Newsletter of the Faculty of Child and Adolescent Psychiatry of the Royal College of Psychiatrists, through the Centre for the History of Medicine, University of Glasgow, and by word of mouth.

The sound recording of the meeting has been transcribed and footnotes added. More details of the format of the seminar are given in the main transcript in the introduction given at the seminar. The participants included several leading members of the specialty – academics, chairmen and secretaries of relevant organisations and those who had pioneered service developments. They had all played a major role in extending knowledge and in shaping and developing the specialty in Britain. Biographical information provided by the witnesses and other biographical information is provided in an Appendix.

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1 Parry-Jones WL. ‘History of child and adolescent psychiatry’ in *Child and Adolescent Psychiatry* (3<sup>rd</sup> edn), Rutter M, Taylor E & Hersov L. (eds) (Oxford, Blackwell Scientific Publishing, 1994): 794-812.

2 Wellcome Trust Centre for the History of Medicine at UCL  
[http://www.ucl.ac.uk/histmed/publications/wellcome\\_witnesses](http://www.ucl.ac.uk/histmed/publications/wellcome_witnesses) accessed 9.9.08

The transcript should be of particular interest to all child and adolescent mental health professionals, as well as others interested in the history of child and adolescent psychiatry, child health and medicine more generally.<sup>3</sup> Much British academic research in the field has had a major impact internationally so the record of this event may also have interest for those in the field working in other countries.

## **Acknowledgement**

The organisers wish gratefully to acknowledge the financial support of the Wellcome Trust, which made this event possible

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<sup>3</sup> Child mental health professionals are drawn from many disciplines apart from psychiatry, including psychology, social work, psychotherapy and nursing. Many of these played a significant part in the development of the specialty, but, apart from one psychologist, time constraints prevented their inclusion.

## Seminar Programme

### List of speakers introducing topics for discussion

Philip Graham	Introduction
Malcolm Nicolson	Welcome
Hugh Morton	Child psychiatry in Scotland, 1965-1990
Lionel Hersov	Academic child psychiatry in the 1960s from the perspective of an editor: The Association of Child Psychology (ACPP) and its journal ( <i>JCPP</i> )
Michael Rutter	Scientific advances in the 1960s and 1970s
Ian Berg	Research and clinical developments outside London: The Child Psychiatry Research Society
Dora Black	From child guidance clinic to teaching hospital department: the role of part-time consultants
William Yule	Therapeutic developments in child psychology: behaviour therapy to cognitive behaviour therapy
Sebastian Kraemer	Developments in psychoanalysis: attachment theory, paediatric liaison services.
Bryan Lask	Growth of family therapy
Michael Rutter	Further scientific advances in the 1980s
Bob Jezzard	Adolescent psychiatry
Arnon Bentovim	Development of abuse services
Philip Graham	Academic developments in the UK and abroad: child psychiatric contributions to UK health, social and educational policy

## **Transcript of Proceedings**

**Malcolm Nicolson, Director, Centre for the History of Medicine, University of Glasgow:**

I would like to welcome you all to this afternoon's Witness Seminar, the third of these events that the Centre for the History of Medicine has organised. These seminars have now become an annual fixture in our academic calendar. I must say that I have been gratified by the interest shown in today's event and am very pleased to see such an impressive turnout. I have no doubt that this interest have been generated by the very impressive line-up of speakers that Philip has assembled and I look forward to hearing what they have to say.

I hope all the speakers will keep to time and be as brief as they can, and that applies to us in the audience as well, to be as concise with our points and our questions as we can - without it affecting what I hope will be an informal and conversational afternoon. At the end of the proceedings we will be serving wine in the Centre for the History of Medicine which is across the car park in Lilybank House and I hope you will join us. Thanks again for coming along.

**Philip Graham:**

Thank you very much, Malcolm. First can I add my welcome to everybody, particularly the speakers who've agreed to take part. You will hear who we are because we're all going to introduce ourselves. Maybe I could begin by asking the audience to introduce themselves. Who are you, how many child and adolescent psychiatrists are there in the audience? So, 12 or 15. How many historians are there in the audience? Three or four. And how many psychologists? Two. How many paediatricians? One. How many psychotherapists? None. One epidemiologist. Any other disciplines? Nurses! Two adult psychiatrists - welcome! A social worker, right! A perinatal psychiatrist - all these are very important links. Welcome to all of you. I think you all know that child and adolescent psychiatry is a medical specialty concerned with the behavioural and emotional disorders of children. Now

there were enormous changes in this subject during the period in question and our aim in this Witness Seminar is to provide through this transcript a record which historians and others interested in the subject can use in the future. So this is a serious attempt to recapitulate those events that led to the advance of the specialty.

We're not taking interruptions during the initial presentations but after that I hope we will have a very free discussion. All the speakers have been given ten minutes. I will start to cough when you've got one minute to go and when you're one minute over I will fall senseless over this makeshift desk. If you choose to continue with an unconscious, comatose Chairman you are welcome to do so, but most people haven't take that offer up in the past! So without more ado and a minute ahead of time, I'm going to introduce Hugh Morton. It seemed appropriate to begin in Scotland. Hugh is going to talk about developments in Scotland over this period of time. Hugh is a retired Consultant in Child and Adolescent Psychiatry and if he seems a bit distraught, it's because he had a grand-child born at seven o'clock this morning, Hugh -

**Hugh Morton, retired consultant in child and adolescent psychiatry, Dundee:**

Ladies and Gentlemen, there were a number of child guidance clinics in Scotland in 1960, but apart from the Notre Dame Clinic here in Glasgow, they didn't correspond in organisation to the English model, which as you know, had been pioneered by Emmanuel Miller and others. There was a child psychiatrist, a Dr MacCalman involved in Notre Dame from its beginnings in 1931, but he moved to Aberdeen as a lecturer in Psychiatry before the war, and for that and possibly other reasons child guidance clinics in Scotland were, and indeed are, staffed by Educational Psychologists.<sup>4</sup> (MacCalman, incidentally, was later to hold the chair of psychiatry in Aberdeen for a few years before he moved south to Leeds.) So child psychiatrists from 1960 have generally been based in hospital settings and this has perhaps made them rather less isolated from their medical contemporaries than those child psychiatrists working south of the border.<sup>5,6</sup>

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4 Stewart JW. 'Child guidance in interwar Scotland: international influences and domestic concerns' *Bulletin of the History of Medicine* (2006) 80, 3: 513-39.

5 Methven MM. 'The history of child psychiatry in Scotland' *Acta Paedopsychiatrica* (1966) 33:

In 1960 Fred Stone had been in post as a consultant here in Glasgow for six years but it was Margaret Methven in Edinburgh who was the doyenne of Scottish child psychiatry and she was a major early influence.<sup>7</sup> I'm particularly glad that Ian Berg is here today and will be able, perhaps, to give us one or two personal recollections of her – as will Sula Wolff.

James Rogers had, from the mid-fifties, been pioneering in-patient treatment at the Crichton Royal Hospital in Dumfries. He later moved to Edinburgh, where, by the later '60s, the lead Consultant there was Sula Wolff - she had trained at the Maudsley. There were in-patient beds in Edinburgh from, I think, 1967 at Forteviot House and in Glasgow from 1971 at the Royal Hospital for Sick Children at Yorkhill. Isobel Sutherland had joined Fred Stone in 1962. In Dundee in 1960 the service was provided on one afternoon a week by the general psychiatrist, James McHarg. Philip Barker was appointed as a full-time child psychiatrist in 1962 and he opened an in-patient unit at the Liff House unit in Dundee and also a purpose-built out-patient clinic at the Royal Infirmary. And I remember, I think I must have been in my final year as an undergraduate, Philip Barker demonstrating with some pride his new one-way mirror in the Liff House Unit. He moved South eventually to the Charles Burns clinic in Birmingham and Helen Mathewson (later Nicolson) and Ian Menzies took the Dundee service forward. The Dumfries service was joined by Joan Currah. In Aberdeen, Ian Lowit had been in charge from 1961 and there was an out-patient service at the Royal Aberdeen Children's Hospital, and later in 1965, in-patient beds too. There were also services at Bangour Hospital in West Lothian where a Dr Betty Magill ran a small in-patient unit and at Woodilee Hospital a large psychiatric hospital outside Glasgow where Dr Swinney had an in-patient unit for 11- to 15-year olds. There was a service in Inverness from 1964 although I've been unable to establish how long Dr McIntyre, who started that, remained there.

As the specialised services for adolescents began to develop further, John

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187-94.

<sup>6</sup> *Department of Health Fit for the Future: Report of the Committee on Child Health Services* (Cmnd. 6684) (London, HMSO, 1976).

<sup>7</sup> Margaret Methven (1910-1982), consultant child psychiatrist, Royal Hospital for Sick Children, Edinburgh.

Evans who had been in post from 1965 led the development of the young people's units which opened three years later at the Royal Edinburgh Hospital.<sup>8</sup> There were also developments in Fife at Stratheden Hospital in Coupar, where Douglas Haldane opened a children's unit in 1960 and an adolescent unit in the purpose-built Playfield House in 1968.<sup>9</sup> It's also worth noting that another consultant at the Fife service was Simon Lindsay who'd been a trainee of Melanie Klein and to my knowledge was the only Kleinian child psychiatrist in Scotland. There were problems with the Sick Children's Hospital in Glasgow from the start - it had to be pulled down and rebuilt but by 1971 the new rebuilt hospital had two eight-bedded in-patient units and also four mother-and-child rooms, although David James tells me that the operation of that facility proved rather problematic, to say the least. Later in Glasgow, Sandy Cheyne ran a ward for adolescents at Gartnavel Hospital.

The Glasgow and Edinburgh adolescent units were relatively detached from the neighbouring Child Psychiatry services and this may not have been to the ultimate benefit of either. Throughout the three decades which we're thinking about this afternoon, this, I think, has continued to have a detrimental affect particularly on the development of what you might term the critical mass known as desirable in stimulating research.

In the '60s most mentally handicapped child and adolescent patients were still in large long-stay hospitals and there was no significant input to mental handicap services from child psychiatrists except for Bill Fraser in Fife who was essentially a mental handicap specialist but had one foot, definitely, in the child psychiatry camp. One of the important influences of the late-60s and early-70s was the Scottish Institute of Human Relations - the MacTavi as we cheekily, but affectionately, referred to it. The Institute provided a focus outwith the health service for clinical discussions and also for research. By the mid-70s a number of new consultants were being appointed in Scotland, some of them from south of the border. They brought a particularly fresh look to the Scottish scene. The consultant appointed in the mid-70s found himself, or herself, essentially expected to bear the heat and burden of

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<sup>8</sup> Evans J. *Adolescent and Pre-Adolescent Psychiatry* (London, Academic Press, 1982).

<sup>9</sup> Haldane JD & McInnes D. 'New psychiatric inpatient unit for adolescents' *British Medical Journal* (1968) iii: 243-5.

the day. Demands on services were increasing substantially, not just from a clinical point of view, but also for teaching; and the development of rotational training in psychiatry meant that registrars were coming through our departments. There was, at that time, a modest increase in the number of senior registrars training in Scotland.

Fred Stone, as I mentioned, had been the senior consultant in Glasgow from 1954.<sup>10</sup> He was appointed to the Chair of Child and Adolescent Psychiatry here in 1977. The Chair had actually been set up three or four years earlier. He was secretary-general of IACAPAP (International Association of Child Psychology and Psychiatry) from 1962 to 66 and I think, probably, it was the meeting of that organisation in Edinburgh in 1966 which was particularly successful from a financial point of view and set up ACPP financially for a considerable period. Fred Stone's contribution, not just to child psychiatry but to Scottish life, has been very considerable. In fact it's impossible to overstate his importance; he was a member of the Kilbrandon Committee which reported in 1964 - the recommendations of this, in essence, led to the abandonment, in Scotland, of the juvenile court system and its replacement by a system of Children's Hearings.<sup>11</sup> The point about Fred's contribution was that the Children's Hearing system is fundamentally developmental and potentially therapeutic. It's a development which aroused world-wide interest at its inception and has continued to do so. Fred was also, a little earlier, a member of the Houghton Committee on Adoption.<sup>12</sup> When Fred retired in 1986, the Chair was taken in due course by William Parry-Jones.

Much research work was done in Edinburgh although there was no Chair. Sula Wolff and others made very important contributions – Sula early on with her work on the behavioural characteristics of children referred to a psychiatric clinic and the characteristics of their parents and later, of course,

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10 Fred Stone (1921-2009). Professor Stone died on 21 June 2009, five weeks after the Witness Seminar. He was the first Professor of Child and Adolescent Psychiatry, Glasgow University. His son was in the audience of this seminar, and sent Fred's good wishes. He was too ill to attend and died a few weeks later.

[http://www.theherald.co.uk/features/obituaries/display.var.2517415.0.professor\\_frederick\\_hope\\_stone.php](http://www.theherald.co.uk/features/obituaries/display.var.2517415.0.professor_frederick_hope_stone.php) accessed June 2010.

11 *Report on Children and Young Persons – Scotland* (Edinburgh, HMSO, 1964).

12 *Report of the Departmental Committee on the Adoption of Children* (Cmnd. 5107) (Home Office, Scottish Education Department, HMSO, 1972).

with her long-continued studies into schizoid disorder and Asperger's Syndrome.<sup>13</sup>

Later work in Edinburgh, from the Young People's Unit base, involved collaboration across Scotland in a multi-centred in-patient unit study. Sula Wolff's classic book *Children Under Stress* is internationally known.<sup>14</sup> Fred Stone was author of *Psychiatry and the Paediatrician* which reflected his ground-breaking paediatric-liaison work at the Sick Children's Hospital in Glasgow - work later taken on by David James in the Yorkhill Renal Unit.<sup>15,16</sup> John Evans wrote *Adolescent and Pre-adolescent Psychiatry* – the fruit of his long experience and work with adolescents, and David Will and Rob Wrate co-authored *Integrated Family Therapy*.<sup>17</sup>

By the time the '60s were coming to an end, even into the mid-'70s most child psychiatrists felt themselves really struggling. There were problems with obtaining adequate staff and the old relationships with social work, with educational psychology, and with clinical psychology were tending to break down.<sup>18</sup> Moreover there were doubts about the effectiveness of in-patient units and they started to decline. This had serious consequences for the small numbers of children and teenagers requiring in-patient treatment. However the development of family therapy and particularly the multi-centred training pioneered by Rob Wrate and his colleagues was an important counterweight at that time.

By 1990 there were more than forty practising child and adolescent psychiatrists in Scotland and some ten senior registrars – a vast increase on the select few who showed the way in 1960. But the service by 1990 was still undergoing major change.<sup>19</sup> Thank you very much.

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13 Dr. Sula Wolff (1924-2009). Dr. Wolff was present at the Witness Seminar, but died on 21 September 2009. <http://www.guardian.co.uk/society/2009/oct/22/sula-wolff-obituary>.

14 Wolff S. *Children Under Stress* (London, Penguin, 1969).

15 Stone F. *Psychiatry and the Paediatrician*, Postgraduate Paediatric Series, Apley, J. (ed.) (Edinburgh, Butterworths, 1976).

16 Stone F & Koupernik C. *Child Psychiatry for Students* (2<sup>nd</sup> edn) (Edinburgh, Churchill Livingstone, 1978).

17 Will D & Wrate R. *Integrated Family Therapy* (London, Tavistock, 1985).

18 *Report by the Committee on Local Authority and Allied Social Services* (HMSO, 1968).

19 *Crossing the Boundaries: New Directions in the Mental Health Services for Children and Young People in Scotland: Report of a Working Group* (Scottish Home and Health Department, Scottish Health Service Planning Council, and Advisory Council on Social Work of the Scottish Education

**Philip Graham:**

Firstly, thank you very much, Hugh, for a very good start to this afternoon - a lot of information I certainly didn't know. When speakers refer to others, please could they use both the first and the second name because otherwise there will be those in the audience who don't know who we are talking about.

I'm going to ask two people to contribute to a discussion of the Scottish scene and then open to general discussion. I want to ask, first, David Stone, who is Fred Stone's son. Unfortunately Fred himself is too unwell to attend, but his son David is here and I just wonder if he would like to contribute. And then I'm going to ask Sula Wolff if she has anything to add to Hugh Morton's presentation. So, David Stone -

**David Stone, Director, Paediatric Epidemiology and Community Health Unit, Yorkhill Hospital, Glasgow University:**

Thank you, Phillip. I should say that my field is epidemiology and public health. I usually see this as a different field from my father but as time goes on it becomes increasingly obvious that in fact they are the same. The child mental health and public health fields are converging very rapidly as we speak. I am very sorry my father can't be with us today; he's very ill, unfortunately, but he knows about this event and I will report back to him in detail, what has happened, what was said, who was here, so I'm sure he'll be greatly appreciative of the kind words that Hugh Morton has already uttered and will be very interested to hear some of the other contributions as well. I didn't want to prolong this statement other than to say that as I was growing up I was privileged to meet some of the big names of child psychiatry and general psychiatry and my memories of them as seen through the eyes of a child were probably rather different from the way that they were perceived by many of the people in this room. I wouldn't dream of entering into any reminiscences at this point, but perhaps over a cup of tea I might be persuaded to reveal some interesting little reminiscences. Thank you very much.

**Sula Wolff, retired consultant psychiatrist, Royal Hospital for Sick Children, Edinburgh:**

Well, I don't think I've got anything to add really, other than to say how sad I am that Fred's not here because I think Fred made a major contribution to child psychiatry in Scotland; he's a wonderful human being with a real soul. I'm not sure that I've got anything to add other than perhaps that Margaret Methven was in many ways an extraordinary lady, a terrific organiser who was particularly good (as I came to realise when I was doing some research) at fostering the careers and training of social workers and organising a record-keeping system at the Royal Hospital for Sick Children in Edinburgh, that was really superb. When I came to do my first research study and looked at some of those notes, everything was there and documented, it was terrific. That's really all I want to say.

**Philip Graham:**

Thank you very much, Sula. Obviously Margaret Methven was a very important influence. I can't remember if you mentioned Issie Kolvin as another of her Registrars who came up here to train and then went down to Oxford to work with Christopher (Kit) Ounsted in 1960.<sup>20</sup> Sadly, Issie Kolvin, who we'll probably talk about in some more detail later, died in 2002, but his influence was very great and his roots were very much in Edinburgh Child Psychiatry to begin with.

Now I should like to open up to both speakers and other members of the audience, who would like to add to information about Scottish Child Psychiatry. Ken Fraser –

**Ken Fraser:**

Thank you - Ken Fraser, primarily Liverpool and then later in South-East Thames. I only contribute here because Fred Stone's cousin, Philip Pinkerton, trained me when I was a Senior Registrar. Isobel Sutherland and I were paediatric registrars together in Alder Hey before we diverged, or

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<sup>20</sup> Professor Israel (Issie) Kolvin (1929-2002), consultant and then Professor of Child Psychiatry, Newcastle (1964-1990), Professor of Child Psychiatry, Royal Free Hospital Medical School, Tavistock Clinic (1990-1994).

increased our interest, shall we say. That's all I think I should say - Oh, Philip Barker as well was a senior registrar with me at the same time. So at that time there were only four senior registrars, I think, in the periphery of England and Wales; perhaps there were a couple in the Maudsley, and I don't know how many at the Tavi, and I thought just only one in Scotland, but perhaps there were more than that. But certainly in 1958 and '60 there were only very few senior registrars in training. Thank you.

**Philip Graham:**

Yes, Philip Barker's been mentioned earlier. He emigrated from the Charles Burns Clinic to Canada, eventually to Calgary - and I think we should mention his basic text books in the subject which were extremely popular and went through many editions - *Basic Child Psychiatry* and *Basic Family Therapy*. These were really very widely read and much appreciated and his roots were also in Scottish child psychiatry as I recollect.<sup>21</sup>

**Hugh Morton:**

I think that's true. I didn't mention his two books, *Basic Child Psychiatry* of course was very influential. I don't think he wrote that until he went back to the Charles Burns Clinic.

**Philip Graham:**

No, but I think Scotland ought to claim credit for things that happened afterwards to people who trained there.

**Forrester Cockburn, retired paediatrician, former Samson Gemmell Chair of Child Health, University of Glasgow:**

Forrester Cockburn, paediatrician in Glasgow at one time. Fred and I were appointed in the same year to professorships in Glasgow. He had obviously been here a long time and I arrived in '77. He was a great support to the paediatric team and that makes me reflect back to Margaret Methven because Fred Stone and Margaret Methven between them managed to insinuate psychiatry into the paediatric examination system in Scotland - The

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<sup>21</sup> Barker P. *Basic Child Psychiatry* (London, Crosby Lockwood Staples, 1976); Barker P. *Basic Family Therapy* (London, Granada, 1981).

Diploma in Child Health. There was a requirement to attend a week of instruction before you could sit the Diploma in Child Health in Glasgow and Margaret, I remember being on her course, early on in Edinburgh when I worked there, and getting a real interest in child psychiatry at that time.

**Philip Graham:**

Any other – I think we have time for one more contribution from -

**David James, retired child psychiatrist, Yorkhill Hospital, Glasgow University:**

David James, retired child psychiatrist from Yorkhill. I just want to also add a little note of affection and respect for Fred Stone. I was the third junior of the consultants when the new Yorkhill opened in '71. He was an astonishingly shrewd person and obviously he'd been in paediatrics for some time. The liaison work for which now Dr Mike Morton has developed a team has always been important. We were always asked in at the diagnostic stage, not just to write notes and shove off. This attitude, I think, has pervaded Glasgow paediatrics ever since. I also want to pay my respects to Sula Wolff in Edinburgh who also helped to nurture me and teach me things when I came in '71. There was a lot of fine research done here at that time.

**Philip Graham:**

Thank you very much, David. Now we move on, again, a minute in advance of time. I'm going to ask Lionel Hersov - everybody here's got an impossible task - Lionel's task, perhaps more impossible than most, to talk about academic child psychiatry in the 1960s from the perspective of an editor as well as the Association of Child Psychology and its journal in ten minutes. Lionel, best known, I think, for being joint editor of the text book *Modern Child Psychiatry* with Michael Rutter and a Consultant Child and Adolescent Psychiatrist at the Maudsley Hospital, though he worked in many other places. Lionel -

**Lionel Hersov, retired Professor of Psychiatry and Pediatrics at the University of Massachusetts Medical School and Medical Center, Honorary Distinguished Visiting Scientist at the Tavistock Clinic:**

Thank you, Philip. History was my best subject at school, but I'm not a historian; all I am is a witness to history. Now I'm going to start in the 1950s because I think that's when academic child psychiatry began to develop. There was research at the Maudsley Hospital Children's Department where I was training - it was called "The Psychotic Survey". In those days we didn't use the term *autism* as we do today. We talked about *psychotic* or *schizophrenic* children. It was headed by James Anthony, Senior Lecturer. The children were admitted to the in-patient unit for assessment and psychological tests and full investigation. Nothing was published about that survey because James Anthony moved to the USA. There are some Maudsley Child Psychiatrists who have the habit of moving to America. It was left, as you might expect, to Mike Rutter, then Senior Lecturer, to analyse the data of that survey and write two excellent papers about it. That was the first I knew of Mike, but I've got to know him a lot better since. There were other developments in the '50s which had to do with academic psychiatry and surprisingly enough the first was the ACPP - The Association of Child Psychology, Psychiatry and Allied Disciplines. The protagonist and driving force of that organisation, Dr Emmanuel Miller, had the vision of a learned society with an international journal, modelled on the Royal Society in London. Now I can't think of anything more academic than the Royal Society, so he had the right idea. And therefore, the ACPP and the *JCPP* (*Journal of Child Psychology and Psychiatry and Allied Disciplines*) have, ever since, tried to live up to that vision. And the scientific meetings which were held six times a year at the Royal Society of Medicine were examples of that. These meetings came in response to calls for workers in the field for a forum where they could hear the leading researchers and clinicians speak and exchange ideas. That was also, I think, an academic activity.

The *JCPP* began its first issue in 1960 as it took some time in finding a publisher. The egregious Robert Maxwell agreed to do so and really was an enormous help – he had a wide distribution network, he was very interested.

He gave wild parties at Headington Hall to which the editors were invited, so we had a jolly good time when he was around, before he fell off his boat!

The journal had a rough time for the first six years. It was a quarterly journal which only came out three times a year! *[laughter]* because we couldn't get enough papers! I am extremely thankful to Sula because two of her first research papers made a difference. You may or may not remember, Sula, but you did help us at the time because they were the only two child psychiatry research papers that were submitted. Most of the submissions were by psychologists and they had to do with child development. There were some very interesting papers and they were centred around maternal deprivation because that was the time when John Bowlby was expounding his views. They were either for or against it, depending on where they stood. With the lack of papers we had to pad out the issues, each issue, with a lot of book reviews and I must say, looking back over the past issues - there were some very, very important people who helped us out with that. I became an editor in 1963, joining Colin Hindley, who was one of the three original editors. It was a very difficult time. The papers we got were very poor. Looking through the earliest editions in those first ten years, the largest numbers of papers were on child development and they came from child psychologist researchers. The second largest number were on treatment by child psychotherapists, dynamic psychotherapy, and later on by child psychologists on behaviour therapy. And the third largest group was autism, in those days it was called either schizophrenia or childhood psychosis. One of the first papers was by Mildred Creak from Great Ormond Street in which she did a study of the mothers of psychotic children.<sup>22</sup> She also started a working party on diagnostic criteria for childhood psychosis at the time.

Then as we went on into the mid-'60s I joined Rodney Maliphant when Colin retired. We changed the aims to some extent. I felt very strongly that the journal should be a means for communicating research information of use and relevance to clinical work. Now if you look at the latest edition of the *JCPP*, even I can't find anything there which I could think makes a jot of

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22 Creak M & Ini S. 'Families of psychotic children' *Journal of Child Psychology and Psychiatry and Allied Professions* (1960) 1: 156-75.

difference to what the clinician does. Now that's not a criticism of the research because I'm going to go on to research which made a great difference. That of course was in the second half of the 1960s and the gentleman concerned [Michael Rutter] is sitting at the end of the first row. One of his first papers was on "Concepts of Autism" and was a masterly review of the knowledge of the time.<sup>23</sup> Now you notice the term "Autism Spectrum Disorder" is now being used; it's no longer psychosis or schizophrenia so there had been a change in name – there also had been a change in how you reach a diagnosis, so that is very important too. Then for the first time we got a paper in animal behaviour from Harry Harlow's Group in Wisconsin, which had to do with separation of rhesus monkeys from their mothers and their observations on it.<sup>24</sup> And if any of you were at the ACAMH conference at which Steven Suomi spoke last year, you will remember how fascinating that whole event was. The second paper we received was later on from Spencer-Booth and Robert Hinde in Cambridge, who also worked with rhesus monkeys and reported research on separation effects.<sup>25</sup> So if you look at the first six years it was tough going, not enough papers and then ultimately we received recognition, importantly by American clinicians, as well as by leading figures in this country. The Journal began to take off. Among the highlights was a paper, an unusual paper, by our Chairman, Philip Graham, which had to do with psychiatric disorder in the children of West Indian immigrants, the only study that I know of on this subject, when he was working at the Brixton Child Guidance Clinic where he was able to have access to families and case notes to carry out that study.<sup>26</sup> It is a very important piece of work.

Of course Mike Rutter did some excellent things for us too. He submitted a paper which he gave in Venezuela, on Classification.<sup>27</sup> It was the first of its

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23 Rutter M. 'Concepts of autism: a review of research' *Journal of Child Psychology and Psychiatry* (1969) 9: 1-25.

24 Seay B, Hansen E & Harlow HF. 'Mother infant separation in monkeys' *Journal of Child Psychology and Psychiatry* (1963) 3: 123-32.

25 Spencer-Booth Y & Hinde RA. 'The effects of separating rhesus monkey infants from their monkeys for six days' *Journal of Child Psychology and Psychiatry* (1967) 7: 179-97.

26 Graham P & Meadows CE. 'Psychiatric disorder in children of West Indian immigrants' *Journal of Child Psychology and Psychiatry* (1968) 8: 105-16. This was, in fact, followed by more substantial psychiatric papers on West Indian children from the Institute of Psychiatry.

27 Rutter M. 'Classification and categorization in child psychiatry' *Journal of Child Psychology and*

sort which challenged the current system that existed in the USA. Later on, there was the famous paper on a Tri-axial Classification arising from an international study group in Paris with a wide range of contributors including our corresponding editor in the USA, Leon Eisenberg.<sup>28</sup> What he told me at the time, it was impossible to resolve differences with French child psychiatrists on what the classifications should be. What Michael Rutter was putting forward was an excellent compromise because it was a system that the ordinary clinician could use. It also met the aims of the Journal.

So you can see how things were going. The only one thing I want to mention because it's slightly personal is that in the first volume there were two papers, one by James Anthony and Peter Scott on 'Manic-Depressive Psychosis in a Young Child'<sup>29</sup>, and later two papers, on 'Persistent Non-Attendance' and 'School Refusal'.<sup>30</sup> Believe it or not, the three papers are still cited today! On that happy note, I will stop, Philip. [Applause]

**Philip Graham:**

Not everyone will know by that modest reference to his own work that Lionel Hersov carried out pioneering studies in school refusal that are cited to this day. Lionel, you were the editor of the *Journal of Child Psychology and Psychiatry* - an outstanding journal, from 1963 to 1983, so for twenty years. And now there is a lot to say about the *JCPP* and about the *ACPP* that hasn't been said. Who would like to begin the discussion?

**Dora Black, retired consultant child and adolescent psychiatrist, Royal Free Hospital, London:**

I would just like to say for the record that of course it's not called that any more and I think that for the younger members of our audience, we ought to actually say what the Association is now called.

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*Psychiatry* (1965) 6: 71-83.

28 Rutter M, Lebovici L, Eisenberg L, Sneznevskij A, Sadoun R, Brooke E & Lin T. 'A tri-axial classification of mental disorders in childhood' *Journal of Child Psychology and Psychiatry* (1969) 10: 41-61.

29 Anthony J & Scott P. 'Manic depressive psychosis in childhood' *Journal of Child Psychology and Psychiatry* (1960) 1: 53-72.

30 Hersov LA. 'Persistent non-attendance at school' *Journal of Child Psychology and Psychiatry* (1960) 1: 130-6; Hersov LA. 'Refusal to go to school' *Journal of Child Psychology and Psychiatry* (1960) 1: 137-45.

**Lionel Hersov:**

It's now called "The Association for Child and Adolescent Mental Health". I forgot that because my unconscious got in the way or it may have been a Senior Moment – I didn't want it to be called that!

**Dora Black:**

And the journal is now called ...?

**Lionel Hersov:**

*The Journal of Child Psychology and Psychiatry* and they've left out the allied disciplines. I was also against that but I was voted down.

**Philip Graham:**

Thank you Dora. Hold on, there's a comment over here. Sebastian Kraemer -

**Sebastian Kraemer, retired consultant, Tavistock Clinic and Whittington Hospital:**

Just to note that one of the earlier Chairs of the ACPP was a paediatrician, I think Ronald MacKeith was the third Chair after John Bowlby and Emmanuel Miller, have I got it right? Just wanted to mention that. I don't think paediatricians would now be Chairs of ACPP.

**Philip Graham:**

Can I just say I think the ACPP was a model of a multi-disciplinary organisation? There was, and I think there still is, a real attempt to share the senior positions between the child mental health specialities. I can certainly think of two other paediatricians, Roy Meadow and Martin Bax, who've been Chairs of the ACPP, as it then was. With two adult psychiatrists in the back I have to be careful what I say but I don't think there is an organisation within general psychiatry where psychologists, psychiatrists, and other people interested in the field can talk in such a free and easy way and discuss academic issues; it's been a real advantage for Child and Adolescent Psychiatry that this organisation existed. Further comments please.

**Lionel Hersov:**

One minute of your time, Philip. Can I just say about Ronnie MacKeith that he promoted the symposium on Training in Child Psychiatry held in 1961 with Aubrey Lewis speaking, with that charismatic, but controversial psycho-analyst, Donald Winnicott, taking a different view?<sup>31</sup> I've read the published version of that debate over and over again because it really is a very interesting statement of polar opposites. Lewis didn't believe that specialities were a good thing and he thought that a general psychiatry training was all that a child psychiatrist needed to work effectively. Winnicott, of course, said "You either have to be analysed by a Freudian analyst or by a Jungian analyst, otherwise you couldn't do good."

**Philip Graham:**

Michael Rutter has a different perspective. Can we pass the microphone?

**Michael Rutter, retired Professor of Developmental Psychopathology at the Institute of Psychiatry, Kings College, London, Director of the MRC Child Psychiatry Research Unit, Fellow of the Royal Society:**

Aubrey Lewis, in contrast to what you said, actually was a firm supporter of the independence of child psychiatry and the need for special training.<sup>32</sup> Thus, he made it a condition for my career that I go to the USA for a year's training in child development in order to prepare myself for academic child psychiatry. He was also firmly supportive of both Philip and myself being academically independent. In the debate that you refer to, he argued that "Child psychiatry has the same relation to psychiatry as paediatrics does to medicine." He didn't go on to discuss training programmes as such because they weren't in existence at that time. His point was that the initial basis for child psychiatry training had to lie in general psychiatry, rather than in paediatrics and a personal analysis. His parallel between child psychiatry and paediatrics vis á vis their broader basis was surely correct.

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31 Dr Donald W Winnicott (1896-1971). Dr Winnicott was an English paediatrician who became a child psychiatrist and the most widely known member of the Independent Group of psychoanalysts.

32 Lewis A. 'Symposium: training for child psychiatry' *Journal of Child Psychology and Psychiatry* (1963) 4: 75-84.

**Lionel Hersov:**

I'm very glad you said that; I agree.

**Dora Black:**

Can I just add to that? In the famous debate between Aubrey Lewis and Donald Winnicott about training in child psychiatry, Winnicott thought that paediatricians should be trained as child psychiatrists mainly by having a child psychoanalysis and Aubrey Lewis thought that child psychiatrists should initially train as child psychiatrists. The interesting thing was that Aubrey Lewis really won that debate because that's the way we train child psychiatrists today - *But* - only this week or this month there's been a new training set up by the College of Paediatrics and Child Health to train paediatricians in mental health in which some of us are taking part and I think that's an interesting development. So Winnicott's winning now!

**Arnon Bentovim, retired consultant Great Ormond Street and the Tavistock Clinic:**

I just wanted to add to this discussion of course that a further debate, which was very important, not long afterwards, was over whether adolescent psychiatry and child psychiatry were separate or should be seen as one discipline. I would guess that the joint training won out from that as well although maybe in Scotland, I suspect, the separate adolescent psychiatry tradition has been a very strong one.

**Philip Graham:**

Perhaps I should just add, I think paediatricians have always been - we're going to talk in more detail and I don't want to pre-empt anything that Sebastian's going to say - but I think paediatricians have in general - not all of them, but a considerable number - been very supportive to child psychiatry. In around 1976 (I can't find the exact year) I was asked to start a Paediatric Psychiatry and Psychology group in the British Paediatric Association. That still exists under the name, Child and Adolescent Mental Health Group. It has an annual meeting and a contribution at the annual conference of what is now called the Royal College of Paediatrics and Child Health. But we're going to talk more, later, about paediatrics and child

psychiatry. We've got time for one or two more contributions? No? Well, just another word about the *JCPP*. The way the article of mine that you mentioned was treated, Lionel, reflects the differences between then and now in terms of the feed-back of referees' comments. I submitted the paper and it was sent back with two scribbled comments in the margin in the recognisable hand-writing of Wilfred Warren, with a covering letter from the editor saying "Please could you deal with these matters and then we will accept your paper." And in terms of the reams of stuff one would now get back, provisionally accepting your paper, providing you deal with perhaps fourteen pages of comments, there is a very stark difference in refereeing style. Now we move on.

**Lionel Hersov:**

Wilfred was a man of very few words!

**Philip Graham:**

Referees, generally, were men of few words in those days. We now move on to Michael Rutter. In introducing Mike Rutter I just have to say this - scientific child psychiatry, its foundation, owes everything to Michael Rutter. As just one index of his pre-eminence, I would remind you that he was the first psychiatrist, never mind child psychiatrist, to be elected a Fellow of the Royal Society since Sigmund Freud. Now that is such a mark of distinction we must acknowledge its significance. It's a great privilege for us that he's here. He's not just a Witness; he virtually created the subject he's now going to talk about. First, he is going to describe research in the 1960s and '70s and in acknowledgement of his contribution he has been given fifteen minutes to do this.

**Michael Rutter:**

The history of child psychiatry extends well before 1960.<sup>33,34,35,36</sup> Kanner's

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33 Parry-Jones 'History of child and adolescent psychiatry' (1994).

34 Neve M & Turner T. 'History of child and adolescent psychiatry' in *Child and Adolescent Psychiatry* (4<sup>th</sup> edn), Rutter M & Taylor E (eds) (Oxford, Blackwell Scientific Publishing, 2002): 382-95.

35 Eisenberg L. 'The past 50 years of child and adolescent psychiatry: a personal memoir' *Journal of American Academy of Child & Adolescent Psychiatry* (2001) 40: 743-8.

36 Rutter M & Stevenson J. 'Developments in child and adolescent psychiatry over the last 50 years'

textbook, published in 1935 provided the first systematic, evidence-based approach.<sup>37</sup> His 1943 paper outlining the syndrome of autism opened up a new field of research and his systematic studies, with his colleague Eisenberg, did much to increase understanding of this syndrome.<sup>38,39</sup> Although randomised controlled trials had their origin in the UK in 1948, Eisenberg and Connors were the first to apply the method in the field of child psychiatry.<sup>40</sup>

Levy's study of maternal over-protection was pioneering in showing complex patterns of factors influencing parental behaviour, the implications for effects on the offspring.<sup>41</sup> Bowlby's WHO monograph on maternal deprivation was highly influential in its arguments about the importance of early parent-child relationships and the damage done by institutional care.<sup>42</sup> During the 1950s there had also been innovatory clinical studies. Within the UK, Hersov's study of school refusal, and Anthony's studies of encopresis, and of infantile psychoses, would be representative examples.<sup>43,44,45</sup>

What there had not been, prior to the 1960's, was interdisciplinary research programmes or units dedicated to research into child psychiatric disorders. The person who was most influential in changing all of that was Lewis, then the Head of the Institute of Psychiatry. He set up the MRC Social Psychiatry Unit, which is the setting that provided my initial training in research.<sup>46</sup> I came to the Maudsley Hospital without any intention of becoming a researcher and certainly without any interest in becoming a child psychiatrist. However, Lewis knew me better than I knew myself and he

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in Rutter's *Child and Adolescent Psychiatry* (5th edn.), Rutter M, Bishop D, Pine D, Scott S, Stevenson J, Taylor E & Thapar A (eds) (Oxford, Blackwell, 2008): 3-17.

37 Kanner L. *Child Psychiatry* (Springfield Illinois, Charles C Thomas, 1935).

38 Kanner L. 'Autistic disturbances of affective contact' *Nervous Child* (1943) 2: 217-50.

39 Eisenberg L. 'The autistic child in adolescence' *American Journal of Psychiatry* (1956) 112: 607-12.

40 Lipman RS. 'NIMH—PRB-support of research in minimal brain dysfunction in children' in *Clinical Use of Stimulant Drugs in Children*, Connors, CK (ed) (Amsterdam, Excerpta Medica, 1974): 202-13.

41 Levy DM. *Maternal Overprotection* (New York, Columbia University Press, 1943).

42 Bowlby J. *Maternal Care and Mental Health* (Geneva, World Health Organization, 1951).

43 Hersov, 'Persistent non-attendance at school' (1960), 'Refusal to go to school' (1960).

44 Anthony EJ. 'An experimental approach to the psychopathology of childhood encopresis' *British Journal of Medical Psychology* (1957) 30: 146-75.

45 Anthony EJ. 'An experimental approach to the psychopathology of childhood autism' *British Journal of Medical Psychology* (1958) 31: 211-25.

46 Shepherd M & Davies DL. *Studies in Psychiatry* (London, Oxford University Press, 1968).

decided that I should become an academic child psychiatrist and, moreover, he expected me to provide some leadership in that field. At first I was a bit reluctant, but I said that I would give it a go. He made two requirements of me: the first was that I should receive systematic training in child development and that I should go to the United States to receive that (which I welcomed); the surprising second was that I should not receive any training in child psychiatry on the grounds that the training at that time was not very good and, particularly, that it was of a kind that was likely to inhibit creative thinking and research innovation. And I never have been trained in child psychiatry (at least not in a formal sense).

The Social Psychiatry Unit was a very special place with its emphasis on iconoclastic approaches, on inter-disciplinary collaboration, on developmental concepts and research strategies, and on the spanning of the normal and the abnormal. O'Connor and Hermelin, both psychologists, undertook pioneering studies into autism during the 1960s - with findings emphasizing the importance of underlying cognitive deficits of a rather particular kind and showing that supposedly untestable children could be tested in a meaningful way with the appropriate use of well-thought out methods.<sup>47</sup> Although I never collaborated directly with them, Hermelin's thinking influenced me enormously. I did work closely, however, with Brown, an innovative medical sociologist, and together we developed systematic methods of good reliability and validity for studying family features, including negative expressed emotion.<sup>48,49</sup> I also worked closely with Tizard, who was then particularly concerned with research into intellectual disability, our interests especially converged in the planning and undertaking of the Isle of Wight epidemiological studies.<sup>50</sup> Lewis was always on the lookout for unusually talented trainees and it was he who drew my attention to Graham as someone interested in doing child psychiatry and

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47 Hermelin NB & O'Connor N. *Psychological Experiments with Autistic Children* (Oxford, Pergamon Press, 1970).

48 Rutter M & Brown GW. 'The reliability and validity of measures of family life and relationships in families containing a psychiatric patient' *Social Psychiatry* (1966) 1: 38-53

49 Brown GW & Rutter M. 'The measurement of family activities and relationships: a methodological study' *Human Relations* (1966) 19: 241-63.

50 Clark ADB & Tizard B. (eds) *Child Development and Social Policy - the Life and Work of Jack Tizard* (Leicester, British Psychological Society, 1983).

who had the talents to make a major research contribution.

It was while I was at the unit, that I undertook my first systematic longitudinal study - into autism. It was meant as a “pot-boiler” study to be undertaken whilst I planned more ambitious studies of family functioning. In the event, however, it excited a major interest in autism that has continued throughout the rest of my career. The findings from the research undertaken with Lockyer showed the distinctiveness of autism as compared with other forms of psychopathology and also showed, for the first time, that autistic individuals with no known neurological dysfunction nevertheless developed epileptic seizures in about one fifth of the cases, the onset being particularly in late adolescence, providing the first evidence, along with the Hermelin/O’Connor’s experimental findings, to indicate that autism was likely to prove to be a neurodevelopmental disorder.<sup>51</sup>

Following Lewis’ stipulation, I obtained a Nuffield Medical Travelling Fellowship to work in New York with Birch, Chess and Thomas in the 1961/62 year.<sup>52</sup> This constituted a pivotal turning point in my career for several different reasons. Birch introduced me to what could be learned from animal models but also highlighted, as did Tizard, the need to integrate hard-headed science with implications for public health and public policy. Between them, Birch, Chess and Thomas seemed to have as personal friends almost all the international leaders in the fields of child development and child psychiatry. They put me in touch with Robins, the sociologist, who undertook the now classic long-term longitudinal study, which set the standards for all that was to follow.<sup>53</sup> I got to know her even better when I returned to the States a couple of year later, on a Belding scholarship. I learned an enormous amount from her about the value of longitudinal studies and of the methodological needs that are essential in undertaking this form of

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51 Rutter M. ‘Autistic children: infancy to adulthood’ *Seminars in Psychiatry* (1970) 2: 435-50.

52 For a more detailed account of his research career, see the interview with Professor Sir Michael Rutter, *Today’s Neuroscience, Tomorrow’s History* (Wellcome Trust, Video Archive Project, 2008) [http://www.ucl.ac.uk/histmed/downloads/hist\\_neuroscience\\_transcripts/rutter.pdf](http://www.ucl.ac.uk/histmed/downloads/hist_neuroscience_transcripts/rutter.pdf) accessed June 2010; Rutter M. ‘The emergence of developmental psychopathology’ in *Psychology in Britain: Historical Essays and Personal Reflections*, Bunn GC (ed) (Leicester, British Psychological Society, 2001): 422-32.

53 Robins LN. *Deviant Children Grown Up: A Sociological and Psychiatric Study of Sociopathic Personality* (Baltimore, Williams & Wilkins, 1966).

research. We became good friends and have remained in contact ever since.

The 1960s represented a time when much better understanding of longitudinal research came about, and in the late 1960s the life history research society was established, leading to a series of important and influential volumes.<sup>54</sup> Robins, together with the psychiatric epidemiologist, Gruenberg in New York, whom I got to know well, were instrumental in teaching me about epidemiological research methods. On my return to the UK in 1962, I collaborated with Birch in the Aberdeen epidemiological study, and then shortly after that became involved with Tizard in planning the Isle of Wight studies. Although paid as a trainee, I functioned as an autonomous, independent consultant psychiatrist, running my own clinical team, at that time. The children's department at the Maudsley Hospital was then strongly interdisciplinary and worked as a cohesive integrated group without paying attention as to whether any of us were university or NHS employees. I worked especially closely with the clinical psychologists: Rachman, Berger and Yule - and then Howlin and Hemsley. We set up a research group to investigate home-based approaches to the treatment of autistic children, bringing in psychiatric social workers such as Sussenwein and Holbrook as well.<sup>55</sup> At the same time, my own autism research group (with Bartak and Clarke) using experimental approaches to study cognitive functioning in autism and to investigate educational approaches to treatment.<sup>56</sup> The clinical department was run on inter-disciplinary lines with a rotating Chair. This approach (spanning research and clinical work) was particularly characteristic of the UK and was rather different from many otherwise comparable set-ups in other countries.

The Isle of Wight studies, led by Tizard, Whitmore and myself, but involving Yule and Graham as key partners, were distinctive and innovative in several key respects. To begin with, they were using epidemiology both to plan services and to understand risk and protective mechanisms for

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54 Maughan B & Farrington DP. 'Editorial' *Criminal Behaviour and Mental Health* (1997) 7: 261-4.

55 Howlin P, Rutter M, Berger M, Hemsley R, Hersov L & Yule W. *Treatment of Autistic Children* (Chichester, Wiley, 1987).

56 Rutter M. 'Language, cognition and autism' in *Congenital and Acquired Cognitive Disorders*, Katzmann R (ed) (New York, Raven Press, 1979): 247-64.

psychopathology.<sup>57,58</sup> Also, the standardised methods of interviewing and observation that were developed applied to clinical categories and not just behavioural traits. But perhaps most crucially, it included direct interviewing of children. Up to that time, it had rather been assumed that you could not interview children directly in the systematic way that you could with adults. The studies showed that that was a mistaken assumption. Richman and her colleagues were similarly instrumental in extending epidemiological methods to a younger age group through the innovative Waltham Forest Study.<sup>59</sup>

During the 1960s and 1970s, I was much involved with the World Health Organisation in their series of working parties, for the planning of ICD-9. These were very important in noting the somewhat artificial boundaries between some, supposedly established, diagnostic categories and they were also important in showing the value of multi-axial approaches in which the theoretical concepts of causation were kept separate from patterns of symptomatology.<sup>60</sup> This work was very valuable in bringing me into contact with a much wider international network involving a wide-range of disciplines, and with a focus that spanned both children's disorders and disorders in adult life.

During the 1960s the Spastic Society established a working party, which I chaired, that was focused on unusual disorders of communication.<sup>61</sup> Again, it was very inter-disciplinary. The approach spanned clinical and research considerations. It provided me with valuable insights on the range of language and communication difficulties that had some things in common with autism and yet which seemed different. It led to a systematic study undertaken by Bartak and myself, comparing boys of normal non-verbal IQ with so-called developmental disorders of receptive language or with

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57 Rutter M, Tizard J & Whitmore K. *Education, Health and Behaviour* (London, Longmans, 1970), (reprinted Melbourne, Krieger, 1981).

58 Rutter M, Graham R & Yule W. *A Neuropsychiatric Study in Childhood. Clinics in Developmental Medicine, 35/36* (London, SIMP with Heinemann, 1970).

59 Richman N, Stevenson J & Graham P. *Preschool to School: A Behavioural Study* (London, Academic Press, 1982).

60 Rutter M, Shaffer D & Shepherd M. *A Multi-axial Classification of Child Psychiatric Disorders* (Geneva, World Health Organisation, 1975).

61 Rutter M, & Martin JAM (eds.) *The Child with Delayed Speech. Clinics in Developmental Medicine, 43* (London, SIMP with Heinemann, 1972).

autism.<sup>62</sup> The research also gained much from the participation of Cantwell, who was spending a period of research in my department before returning to the USA.<sup>63</sup> We had quite a number of people from abroad who worked for a prolonged period in the UK. These included Folstein (in relation to the genetics of autism) and Mrazek (developing methods of observing children and families).<sup>64,65</sup> Because we sought to integrate research and clinical work, it was important to be able to set up research-driven clinics that could span the two in order to make use of two-way interplay.<sup>66</sup> In my case, these focused on autism, developmental language disorders, on acquired brain injuries, and on psychological implications of being a twin - to mention but a few examples.

Shaffer, who subsequently moved to New York, was a leader in the study of head injuries, but also set up a research clinic for nocturnal enuresis.<sup>67</sup> My interest in spanning research and clinical work also involved special educational approaches as applied to both autism and specific language impairment. Thus, for many years I was a consultant to the Sybil Elgar School for children with autism and for many years I have been a trustee of AFASIC, a charity concerned with language disorders. Both of these have involved close working together between professionals and parents and young people themselves.

During the 1960s, I led a study looking at the effects of parental mental illness on children.<sup>68,69</sup> With respect to environmental influences, I was also

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62 Bartak L, Rutter M & Cox A. 'A comparative study of infantile autism and specific developmental receptive language disorder I. The children' *British Journal of Psychiatry* (1975) 126: 127-45; Cox A, Bartak L & Rutter M. 'A comparative study of infantile autism and specific developmental receptive language disorder II. The families' *British Journal of Psychiatry* (1975) 126: 146-59.

63 Cantwell DP, Baker L & Rutter M. 'Families of autistic and dysphasic children I. Family life and interaction patterns' *Archive of General Psychiatry* (1979) 36: 682-7.

64 Folstein S & Rutter M. 'Genetic influences and infantile autism' *Nature* (1977) 265: 726-8;

Folstein S & Rutter M. 'Infantile autism: a genetic study of 21 twin pairs' *Journal of Child Psychology and Psychiatry* (1977) 18: 297-321.

65 Mrazek DA, Dowdney L, Rutter M & Quinton D. 'Mother and preschool child interaction: a sequential approach' *Journal of the American Academy of Child Psychiatry* (1982) 21: 453-64.

66 Rutter M. 'The Emanuel Miller Memorial Lecture 1998. Autism: two-way interplay between research and clinical work' *Journal of Child Psychology and Psychiatry* (1999) 40: 169-88.

67 Chadwick O, Rutter M, Thompson J & Shaffer D. 'Intellectual performance and reading skills after localized head injury in childhood' *Journal of Child Psychology and Psychiatry* (1981) 22: 117-39.

68 Quinton D, Gulliver L & Rutter M. 'A 15-20 year follow-up of adult psychiatric patients:

involved in an epidemiological/longitudinal study of secondary schools in London, focussing on the factors involved with school effectiveness.<sup>70</sup> The findings caused somewhat of a storm in the educational/academic establishment, who expressed doubt about the findings but later research showed that, if anything, we rather under-estimated the importance of school effects, rather than the reverse.<sup>71</sup> Both of these studies strengthened my interest in using epidemiological/longitudinal methods to examine hypotheses about causal processes. It is an interest that has grown even further over the years. Whilst working with Birch in New York, I undertook a small pilot twin study but the interest in genetics came more to the fore in the 1970s through a twin study of autism undertaken with Folstein. The findings showed that not only was there a high heritability but also one that extended beyond the traditional handicapping psychiatric category of autism.<sup>72</sup>

In 1979, I went to the Centre for Advanced Study in Behavioral Sciences in California for a year. We had a working group focussing on stress coping and development, with Garmezy (who spent a year in my department a few years earlier) and myself as leaders.<sup>73</sup> For me, this constituted another turning point experience that brought me into closer contact with some of the true pioneers in psychology, and it did much to stimulate my interest in the concept of resilience, which was taken further in the 1980s.

During the 1960s, I had a section of child psychiatry within the overall Department of Psychiatry led at that time by Hill. The arrangement worked well in bringing me into contact with colleagues in adult psychiatry from whom I could learn a lot, whilst being given a major degree of

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psychiatric disorder and social functioning' *British Journal of Psychiatry* (1995) 167: 315-23

69 Rutter M. 'Psychiatric disorder in parents as a risk factor in children' in *Prevention of Psychiatric Disorders in Child and Adolescent: The Project of the American Academy of Child and Adolescent Psychiatry*, Shaffer D, Philips I, Enver N, Silverman M & Anthony VQ (eds) (OSAP Prevention Monograph 2) (Rockville, Maryland, Office for Substance Abuse Prevention, US Department of Health and Human Services, 1989): 157-89.

70 Rutter M, Maughan B, Mortimore P, Ouston J & Smith A. *Fifteen Thousand Hours: Secondary Schools and their Effects on Children* (London, Open books and Cambridge, Harvard University Press, 1979) (reprinted London, Paul Chapman Publishers, 1994).

71 Rutter M & Maughan B. 'School effectiveness findings 1979-2002' *Journal of School Psychology* (2002) 40: 451-75.

72 Mrazek, et al, 'Mother and preschool child interaction' (1982).

73 Garmezy N & Rutter M. (eds) *Stress, Coping and Development* (New York, McGraw-Hill, 1983).

independence. However, the time was ripe for having an independent department of child psychiatry and that was set up in 1973. In keeping with the good relationships that I had had with adult psychiatry, I continued on Hill's teaching committee within adult psychiatry. A Chair at the IOP constituted the first Chair in academic child psychiatry within the UK, but it was soon followed by a Chair at the Institute of Child Health, linked to Great Ormond Street Children's Hospital, held by Graham, and then by a growing number of Chairs and separate departments in other medical schools around the country. Because it took time for academic child psychiatry to get established, a number of us pulled together to set up the Child Psychiatry Research Society in 1972, which constituted a kind of self-help group for child psychiatrists to discuss issues of mutual concern within a supportive setting.

As research was making a progressively greater impact on clinical child psychiatry, it was obviously important to try to do something to improve training standards throughout the country. The Royal College of Psychiatry was rather ahead of the other Royal Colleges in paying attention to this need and, within the College child psychiatry was one of the first to put together a set of standards and to develop ways of assessing the quality of trainees in centres throughout the country. It was also pioneering in involving trainers in the entire exercise.

The need to integrate research and clinical work was a matter of great importance to both Hersov and myself, and we served as editors for the first edition of *Child and Adolescent Psychiatry*, published in 1976.<sup>74</sup> The textbook is now in its fifth edition and, over the years, has brought a progressive integration between research and clinical work and has also become increasingly more inter-disciplinary and international in approach.<sup>75,76</sup> [Applause]

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74 Rutter M & Hersov L. (eds) *Child and Adolescent Psychiatry: Modern Approaches* (Oxford, Blackwell Scientific, and Baltimore, University Park Press, 1976).

75 Bishop D, Pine D, Rutter M, Scott S, Stevenson J, Taylor E & Thapar A. (eds.) *Rutter's Child and Adolescent Psychiatry* (5th edn) (Oxford, Blackwell, 2008).

76 Greener M. 'Interview with M. Rutter: advances and frustrations in paediatric psychiatry' *Progress in Neurology and Psychiatry* (2008) 12: 23-4.

**Philip Graham:**

I would like to interpolate a contribution from somebody who isn't here. Naomi Richman, who made a major contribution to research over the period Michael Rutter has been describing, would have been here but unfortunately has a very sore streptococcal sore throat, yesterday asked me to convey her good wishes to this meeting. I asked if she had a recollection from her time on the Isle of Wight she would like to share. She was very involved in the Isle of Wight study and led the Waltham Forest study to which Mike made reference. She described the opportunity in the Isle of Wight study to interview quite large numbers of normal children who had not presented to service - and hear what they had to say when asked about mood, anxiety, depression, their families, and so on. She described the experience as "fantastic" and for those of us who participated (there are a number here) it was indeed a wonderful experience because when we saw children in clinics it gave us the opportunity to compare the children we saw clinically with non-referred children in the general population. I think all of us felt that. She did have one anecdote she asked me to relate – she was one of the people who was involved in chasing up refusals. The research ethics in those days were very different. We just pursued people until in the end they gave up because we were more persistent than they were and at that time you could do that. She was interviewing a man who had sole charge of three children, who was a father, and she remembered interviewing him while he was milking cows in the byre. At the end of the interview which she conducted along normal lines otherwise except for the setting she said "Is there anything else you'd like to say?" He said "It would be wonderful if you could find me a wife." [Laughter] He'd been widowed and his three children were at school and Naomi added that it brought home to her, not just this experience but others, how hard it was to do research when you couldn't help the people whose problems you were eliciting. Obviously she would have liked to have arranged some support for this man who was finding life so difficult. It is hard, it was hard then, and it remains hard now. Who would like to add? Yes -

**Graham Bryce, child and adolescent psychiatrist, Glasgow:**

Two comments, really. One, just picking up your aside, Michael, about growing numbers of Chairs in Child and Adolescent Psychiatry, I think history would want to record that we don't actually have anyone in a Chair in Child and Adolescent Psychiatry in Scotland, nor have we since the untimely death of William Parry-Jones a number of years ago. And also that Edinburgh University has recently given up its senior lecturer in Child and Adolescent Psychiatry so we're at a very difficult time in that regard in Scotland. I think, it's just really, for the historical record that we should know that.

**Philip Graham:**

Yes, thank you very much. I don't think anybody's mentioned William Parry-Jones previously.<sup>77</sup> He succeeded Fred Stone, in 1987, and made a great contribution here, and it is particularly sad that he died so prematurely because he had a tremendous interest in medical history and wrote extensively on the history of child psychiatry, so we mourn his premature death even more than we otherwise would, at this particular event.

**Graham Bryce:**

I wanted to make a second point, if I may? And that is really to pay tribute to the tradition of child psychiatry and epidemiology that Michael Rutter began because it continues to be, I think, the single most influential strand of our research when we come to speak to government. The work that you've done and others, Robert Goodman, for example, and his colleagues have carried on, is probably the most influential thing that we have in trying to persuade the government of the importance of children's mental health.

**Philip Graham:**

Thank you very much. Hugh Morton -

**Hugh Morton:**

Thank you. Now just to add a note to what Graham has said about William

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<sup>77</sup> William Parry-Jones (1935-1997), Professor of Child and Adolescent Psychiatry, University of Glasgow, 1987-1997; Nicolson M. 'William Llywelyn Parry-Jones, 1935-1997' *Medical History* (1998) 42: 99-100.

Parry-Jones. The University of Glasgow was quite keen when Fred Stone retired that the Chair should go to the wall - if I can put it that way - and it was only the result of some very determined lobbying by the likes of Forrester Cockburn who is here today, at the time Professor of Child Health, and a man called Gemmell Morgan, who was actually a clinical pathologist and held the Chair of Clinical Biochemistry at Glasgow, but who had been a clinical biochemist at Yorkhill at the Sick Children's Hospital, that the Chair survived.

We really valued the direction that William took, certainly over the first few years of the short time that he was in post. Can I add a personal reminiscence of William? I was at an appointments committee at which he was the other national panellist, and the hapless candidate, who I don't think is present today - I hope not - the hapless candidate was dragged in and William demanded "Do you physically examine all your patients?" and the candidate stammered and stuttered. William pressed home his attack "Why not? Why not?" and I think it illustrates the rounded approach that William brought to child psychiatry. I know that he continues to be much missed, here in Scotland as well as south of the border, and as Philip has said, it's ironic that one of his main interests was in the history of psychiatry.

**Philip Graham:**

I think I'm going to have to draw this session to a close but I did just want to make one further comment. Your breath may have been taken away by the breadth of Michael Rutter's interests and achievements but in fact, for reasons of time, he has not mentioned a significant number of other studies he personally carried out. For example, the topic of his MD thesis, published as a Maudsley monograph, called *Children of Sick Parents*. As an indication of his influence, the reason why Eric Taylor can't be here today is that he's chairing a meeting of the Psychiatry Section of the Royal Society of Medicine on the impact of parental mental health on children, so that the continuity of Michael Rutter's interests has been very considerable. We'll be hearing more from him a little later on about later developments in research.

Now we move on to hear from Ian Berg, who's had a variety of research

interests.<sup>78</sup> School refusal and truancy have been major research interests of Ian Berg, who has contributed to a number of other research subjects. He's still very active in child psychiatry, much less retired than many of us, but most of the time he worked as a consultant in child and adolescent psychiatry in Leeds. Ian -

**Ian Berg, retired child and adolescent child psychiatrist, Leeds General Infirmary and elsewhere:**

Yes, well, the subject I was asked to talk about really is child psychiatry outside London and the subject is so enormous that I thought I'd better start by doing something much more confined - the Child Psychiatry Research Club - so I'll talk about that and if anybody wants to talk about other things that went on outside London, I'm very happy to do so in questions. There's been a lot of talk about particular individuals and when I was asked to do this I thought "Well, who was important in my area?" I suppose the person who was, perhaps, most significant was Jack Kahn, who was a GP and a psycho-analyst and ran the Harrogate Child Guidance Clinic with Jean Nursten, and wrote the book *Unwillingly to School*, but wherever you look around the country there have been significant figures, who are not here.<sup>79</sup> There was Lumsden Walker in Bristol, Philip Barker in Birmingham, but perhaps the most significant figure outside London was Issie Kolvin in Newcastle, who came to a provincial post and built up a wonderful research centre and clinical centre outside London. And of course there was John Howells in Ipswich, who was quite important in training occupational therapists to do play therapy when the social workers were taken away; outside of London there were very few child psycho-therapists. He wrote a great deal about family therapy.

Anyway, without rambling on too much, the idea of a research club devoted to child psychiatry was discussed by Philip Graham and myself at the Great Ormond Street dining club when it met on the 26th October 1971, at the Clothworkers Hall at Mincing Lane, in the City of London. I remember it as

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<sup>78</sup> Ian Berg sadly died on 18 September 2009. Graham P. 'Dr Ian Berg' *The Psychiatrist* (2010) 34: 308.

<sup>79</sup> Dr. Jack Kahn (1904-1989), consultant child psychiatrist, Newham; chairman, Child Psychiatry Section, Royal Medico-Psychological Association, 1967-1969.

Goldsmith's Hall, and I think Philip thought it was the Apothecary, but it was actually the Clothworkers Hall. As a result, a meeting of those we thought might be interested in an association of this kind took place at the children's department of the Maudsley Hospital on Thursday 18<sup>th</sup> May 1972. Seventeen child psychiatrists from the UK became founder members. I've passed round - I hope you've all got them - lists of the founder members and a list of the people who joined in the subsequent fifteen years. It was agreed at the first meeting to have twice-yearly gatherings. The membership would be formed by NHS consultants and academic counterparts, and there weren't many of those. There were no established university departments of child psychiatry at the time. Trainees in child psychiatry would not be excluded, non-psychiatric colleagues who were co-workers in research projects could help in making presentations, overseas visitors would be welcome to come to meetings, all members should be actively engaged in research. I think at some point we also discussed whether people should be thrown out of the society when they got to forty years of age because we thought they might not be as active in research as they should be! I think it was forty! New members would be recruited informally, by general agreement. No financial structures were envisaged. It was thought desirable to limit the number of members to less than thirty to encourage the active participation of all and to keep the club's activities as informal as possible. Presentations should be concerned not with completed research but projects that were in the process of being planned, or in the early stages of being carried out. The focus of papers and the discussion of them would be limited to methodology rather than findings. The officers of the club would be a Chairperson and a Secretary. Mike Rutter was elected Chairperson, I was elected Secretary. It was considered that three presentations at a meeting would suffice.

Over the next fifteen years, meetings took place in Spring and Autumn, twice a year, twelve of them out of London. About three-quarters of members came at any one time in London, but more like two thirds out of London, and on 12th May 1980 The Child Psychiatry Research Society was the new name adopted. Two of the UK founder members resigned, four emigrated, and there were still eleven of the founder members involved with

its activities fifteen years later, so it was a coherent group, who continued to meet and to busy themselves with research. Looking at the number of times the eleven remaining founder members had made presentations over fifteen years, it was on average two a session. The co-workers took up 62 slots at thirty meetings. A distinction was made between Associates - that is trainees - and Full Members. In 1986, after fifteen years, it was minuted there were 29 full and nine associate members. So it was a very small group of people, who were particularly concerned to find things out.

Distinguished visitors from abroad visited the Society, particularly in the first ten years. Various suggestions were made at business meetings of the society, held about lunch time every gathering, where just the members were allowed to be present. Several times it was suggested there should be links with other organisations with similar interests. These suggestions were always firmly resisted. There was never any support for the Society becoming involved on commenting on official documents about research in child psychiatry. I think at one meeting somebody suggested that we should have poster sessions. There was only one of those, by the person who suggested it, and they didn't happen after that. Officers of the Society changed about every five years. In 1977 I was the Chair, Naomi Richman was the elected Secretary. In 1982 Naomi Richman was the Chair and Gillian Forrest became Secretary. Another officer post was created alongside, a Treasurer, and Tony Cox was appointed. Towards the end of the first fifteen years, Sula Wolff was the Chair and David Skuse was Secretary/Treasurer to start in 1987. The procedure for bringing in new members remained informal until 1984, when it was made more of a formality since information had to be sent to the Chair before an application could be considered. In May 1980, it was decided to raise an annual subscription of £1, two years later this was increased to £5. Donations from pharmaceutical firms were gratefully received even though the drug trials were rarely, or ever, the subject of presentations, which meant that for most of the time there was plenty of money in the bank. People coming from a distance could have their expenses paid and generally it paid for lunches. There was a low point in 1986, when there was no cash in the bank, but soon

afterwards the Wellcome Trust came up with the goods and the Club was flush with funds from then on.

In 1980, an informal dinner was arranged the night before a meeting. Spouses and partners were not invited but one visitor per member was permitted five years later. On at least one occasion, in Oxford, people moved around between courses so they could talk to each other. At business meetings there was usually a lively discussion about presentations at the next few meetings. A lot of general topics were discussed (I'm rushing through it – and I'm nearly there). In 1986, the idea was to review the membership of associates after two years to see if they were still eligible to be members; there was a plea for those not actively engaged in research to leave. I don't think anybody ever did! In the next decade the character of the society underwent a few significant changes. Membership increased. In 1994, there were 53 full and 24 associate members. The atmosphere became less informal with a small group of committed participants, and more that of an audience for the presentation of research papers. Thank you.

**Philip Graham:**

Thank you very much, Ian. That was very helpful and systematic, and we're grateful for the data that you've brought to the session. Just for the record, because I think it's quite important, you're quite right that we did discuss the Child Psychiatry Research Society together, but I have a very clear recollection that it was your idea! We agreed that, in order to get the idea off the ground, it would be important to have Michael Rutter's support and, of course, this was readily forthcoming.

**Michael Rutter:**

I just want to make three quick points. Firstly I think we must pay tribute, Ian, to your work on truancy which was really innovative in several respects but particularly in persuading magistrates to allow a controlled trial to go ahead on the effectiveness of their sentencing procedures. I see that as one of the pioneering studies in our field.<sup>80,81</sup> On the Child Psychiatry Research

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80 Berg I, Consterdine M, Hullin R, McGuire R & Tyrer S. 'The effect of two randomly allocated court procedures on truancy' *British Journal of Criminology* (1978) 18: 323-44.

Society I think there are two things I'd like to say, the first is that throughout we have resisted appointing people because of their positions. Now that was easy when it first started but there have been temptations from time to time that if people held an academic appointment they would automatically become members and that has always been turned down. The third, just to sort of develop the point that you made, is that it is in my experience unique in not only discussing methodological issues but in having a sufficiently supportive setting to discuss failures. So I well remember one presentation of a study that had failed and this was very constructively discussed as to what lessons to learn from it. I know of no other group where that would be possible. It's very special. What is unusual - and it still makes me uneasy - is that it was important, initially, that only child psychiatrists could be members. I'm not sure that today that is justifiable, but there is a problem of numbers.

**Philip Graham:**

Helen Minnis -

**Helen Minnis, Senior Lecturer in Child and Adolescent Psychiatry, University of Glasgow:**

Hi! I just want to say, thank you very much to Ian Berg and Philip Graham for what I think was a very innovative idea in basically saying that presentations would be about research that was on-going and not about finished results. I was introduced to the Child Psychiatry Research Society as a research trainee and I found it very refreshing to be able to discuss a study that I was about to do and to have some crucial feed-back from the audience, literally, just before I was about to collect my data. That's an ethos that I tried to take forward in my own discussions about research with people who are new to research because I think it's a very good way of reducing the fear of research and just encourage people to ask questions before they start, so thanks for that.

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81 Berg I, Goodwin A, Hullin R, & McGuire R. 'Juvenile delinquency and failure to attend school' *Educational Research* (1984) 27: 226-9.

**Ken Fraser:**

I was very interested to hear you mention Jack Kahn, who was my mentor, but more interesting still was John Howells - he after all started the first residential weekend of getting psychiatrists together in 1958, I think. This carried on and became a college function which is still important.<sup>82</sup> I had the job of organising four of those weekends and I would like to share reminiscences of one where we had Dutch child psychiatrists across to meet us in - I think it was Southlands Training College in South London. I'd told them to make their own arrangements to get here and they were late, and we were waiting and waiting and waiting and finally they came in, laughing their heads off, because they'd been waiting at Heathrow for a coach, nothing came; then they saw a coach across the other side of the car park and went and enquired: "Yes he was waiting for child psychiatrists!" The Dutch people found this highly amusing, they brought with them large amounts of Dutch gin, which they'd started, so they were happy when they came and we had an eminently amusing evening that time.

**Philip Graham:**

The College has a record of all the residential meetings and you're absolutely right, it was 1958, Friday to Sunday, prayers were said before the meeting on Sunday morning, which was an unusual event.

**Ken Fraser:**

It wasn't continued.

**Philip Graham:**

No. I want to say one or two more words about those residential meetings because they provide a most useful record of events and the development of our specialty. Firstly, just to record that the college has all the programmes of all the residential and later one-day meetings. I think the science really started to come in round about 1965. Before that the presentations were mainly case-studies, with hardly any research discussed at all. In 1965 two of

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<sup>82</sup> The academic programmes and meetings of the Child and Adolescent Faculty (previously Section) of the Royal College of Psychiatrists (previously the Royal Medico-Psychological Association) are held in the Archive Department of the Royal College of Psychiatrists.

the speakers, Naomi Richman and Desmond Pond, gave what one could reasonably regard as scientific papers. Naomi we've already mentioned. Desmond Pond was both a child and an adolescent psychiatrist and there's a sense in which he too put child psychiatry on the map when he delivered the Goulstonian Lectures (highly prestigious Royal College of Physicians lectures) in 1959, on behaviour and childhood epilepsy.<sup>83</sup> These were published in the *BMJ*. He was a consultant at the Maudsley and at UCH, later becoming Professor of Psychiatry at the London Hospital. He was the third President of the Royal College of Psychiatrists and was important in my own career.

**Ken Fraser:**

... and Chief Scientist to the Ministry of Health at one time.

**Philip Graham:**

Other contributions, we've time for one or two more contributions on societies. Lionel Hersov -

**Lionel Hersov:**

I think at one of the meetings which Howells chaired he read *Under Milk Wood* by Dylan Thomas most beautifully. He was a Welshman with real brio. That's all I can remember about the meeting! [*Laughter*]

**Ken Fraser:**

I can certainly remember more about the meetings and that is - the first one that I went to was in Sussex and I think it was in 1960 or '61, and the next one was at Hoddeston Hall, out of London, and we had to share rooms and the person I shared with snored all night, that was really quite memorable! [*Laughter*]

**Philip Graham:**

Ken -

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83 Pond D. 'Psychiatric aspects of epileptic and brain-damaged children' *British Medical Journal* (1961) ii: 1378, 1454.

**Ken Fraser:**

It's quite true, research came into its own only in the 1970s or '80s, when the responsibility for arranging the whole weekend moved from the person who was hosting it to the college's committee. Ian Berg then produced the scientific part of the programme and only the social thing was done locally. The last one I did, we went to Boulogne for our dinner and that was quite special because we did get almost strip-searched by customs on the way back, but luckily we came clean!

**Philip Graham:**

Well, I think that's a good point to stop this particular session and move on to Dora Black who was Consultant Child and Adolescent Psychiatrist at ... was it Edgware General to begin with, or Barnet?

**Dora Black:**

Watford!

**Philip Graham:**

Watford! But finished up as Consultant Child and Adolescent Psychiatrist at the Royal Free Hospital and later developed other interests, particularly in children who'd been traumatised. She is going to talk about, what I think she was a bit surprised to be asked to talk about, "From Child Guidance Clinic to Teaching Hospital Department - the role of part-time consultants". Dora -

**Dora Black:**

Well, I'm here because of the biological differences between men and women and of course the part-time consultants that I'm going to talk about are not those maximum part-time consultants that were created by the NHS when it started in 1948, but the women consultants, or the part-time women doctors who had to find some way of reconciling their biological functions with their professional functions. And they were really the result of the government of the day in 1947 asking all medical schools to accept both sexes. Until then, certainly the London medical schools had not had women at all - I mean very few of the medical schools had any women medical students but they had to comply, although reluctantly. I remember an

interview at the Middlesex Hospital, with the Dean, when I was applying for medicine in which I was getting along famously, until he said “Your father is a doctor isn’t he?” He wasn’t! And I said he wasn’t - I mean he knew, he had my papers in front of him and he said “My dear woman, and you’re trying to get into medicine! Good day.” Anyway, Birmingham took me! And at that time Birmingham took 25% - 25% of our year were women – but that was very unusual, apart from the Royal Free, of course. Then the Royal Free reneged on women by taking 50% men! I qualified in 1955 from Birmingham and married my long-term sweetheart - we’d met at school, in the December of 1955. I knew I wanted children in due course and I wanted to work with children and virtually no medical specialities at that time offered part-time training or part-time consultant’s posts, compatible with child-care and housekeeping duties. But child psychiatry seemed a possibility so I spent a year full-time as an SHO at Napsbury Hospital, which was a large nineteenth-century mental hospital near London - there was a whole ring of them round London at the time - where there was little post-graduate training and one was used as a GP for chronic mental patients. I actually had 500 under my care at the time, with a consultant visiting the wards only to re-certify the patient at five-year intervals.

And it was while I was at Napsbury, in 1957, that the new psychotropic drugs became available and my senior registrar put the whole ward on Reserpine, with some dramatic results. I went from there to a full-time training post at the Maudsley, and stayed there until I became pregnant with my first child, born in March 1960, when I was 27 and a Registrar in child psychiatry. I’d done two years in child and adolescent psychiatry with Dr Kenneth Cameron and Wilfred Warren; Lionel Hersov, who’s here today, was my senior registrar at the time. I wanted a part-time post at senior registrar level, but there were none to be had in the London area where I had to live because of my husband’s work. Actually, I’ve just learned today that there were none anywhere else either! So I attached myself voluntarily for a few sessions a week to Sam Yudkin, a paediatrician at the Whittington Hospital, where I filled in the gaps in my paediatric knowledge. He found me useful to consult on child psychiatry as there was not a child psychiatrist

then at the Whittington - Sebastian Kraemer, who's here today, of course, is an illustrious follower. Indeed few non-teaching hospitals had child psychiatrists on the staff in the 1950s and '60s. Services were mainly based in local authority child guidance clinics - Scotland was different. There were great disadvantages to posts in these clinics. Most of the psychiatrists were not consultants but senior hospital medical officers, which is a non-consultant grade, and they'd been appointed as medical directors although they were employed by the NHS. The Clinic was administered and funded by - and most of the staff employed by the Local Authority, and this was a really difficult anomaly to get over.<sup>84,85,86</sup> The anomaly of having NHS medical directors heading these clinics was highlighted in a series of studies that were done mainly at the Clinic in which I then worked as medical director, by Brunel University in 1976 and '78.<sup>87,88</sup>

Well, back to my career. After doing a part-time locum at Luton Child Guidance Clinic, I managed to obtain a four-session SHMO post at Watford and St Albans. So you see, I never had training at Senior Registrar level in child psychiatry - a bit like Mike Rutter, of course - that was after the birth of my second child and I used to take him with me. I found a woman nearby who would look after him and I could pop out at lunch time and breast-feed him. And while I was at Watford I got involved with Cruse which was a bereavement charity at that time just for widows and their children.<sup>89</sup> They were just setting up a branch in Watford and I was detailed by our consultant to go and represent the clinic, and that really set me on my interest in bereaved children which I've had the whole of my professional career. Well, in 1966, they abolished SHMOs and every post had to be reconsidered: was it really a medical assistant or a clinical assistant post, in which case it would be downgraded, or were you really doing consultant work, in which case the

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84 Burck C. 'Study of families' expectations and experience of a child guidance clinic' *British Journal of Social Work* (1978) 8: 145-9.

85 Black D. 'Are child guidance clinics an anachronism?' *Archives of Disease in Childhood* (1983) 58: 644-5.

86 Black D. 'The future of child guidance' in *Progress in Child Health*, 3, Macfarlane JA. (ed.) (Edinburgh, Churchill Livingstone, 1986).

87 Brunel Institute of Organisation and Social Studies (BIOSS), *Future Organisation in Child Guidance and Allied Work* (Uxbridge, Brunel University, 1976).

88 BIOSS, *Organisation of Services for the Mentally Ill* (Uxbridge, Brunel University, 1978).

89 Richards S. (ed.) *Voices of Cruse, 1959-2009* (London, Cruse Bereavement Care, 2009).

post would be upgraded. But then you had to go before an appointments committee - to a full NHS appointments committee - for them to decide whether you were up to the job that you'd been doing all those years anyway! So I was upgraded to be a part-time consultant, and you know that was amazing, wasn't it, because there weren't any part-time consultants, and that was quite something. And two years later I was appointed to a newly created six-session consultant post nearer my home - I had three children by then - attached to a general hospital (Edgware General) and the newly opened Finchley and Barnet Child Guidance Clinics. I was able to rejoin medical colleagues in hospital after what seemed a long time in the wilderness of being a sole medical practitioner in a multi-disciplinary team. I was then able to develop a psychiatric liaison service to the paediatric and other departments, treating children and adolescents at the hospital. This I continued to do when I went to the Royal Free in 1984 - my children were grown up and I could take on a full-time job. Non-university hospitals did not have a post-graduate training function when I was at Edgware so there were no registrars or senior registrars to be trained or to assist me there. I believe it wasn't until 1985 that the senior registrar rotation schemes included non-university hospitals. By that time I'd brought up my children and I was ready for more challenges.

In 1972 a part-time clinical assistant post became available at Great Ormond Street Hospital. I was still at Edgware General Hospital and Finchley clinics. Philip Graham, then professor there, persuaded me when I was successful in gaining it that I shouldn't give up a consultant post but instead take a year's sabbatical from my consultant post to come to Great Ormond Street. So I did, continuing at EGH but getting a locum for the CGC. I never went back to the clinic - more sessions were found for me at EGH and I stayed on in an honorary consultant at GOSH, carrying out my bereavement research.<sup>90,91</sup> I had been very influenced by Bowlby's ideas on attachment and by the idea

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90 Black D & Urbanowicz M. 'Bereaved children: family intervention' in *Recent Research in Developmental Psychopathology*, Stevenson J (ed.) (Oxford, Pergamon, 1985).

91 Black D & Urbanowicz M. 'Family intervention with bereaved children' *Journal of Child Psychology and Psychiatry* (1987) 28: 467-76.

of the “Good Enough Mother”.<sup>92,93</sup> It did let us off the hook in a way that nobody else had - certainly Bowlby hadn’t. I had Bowlby come to lecture to our medical students at the Royal Free and he got a very poor reception because he told them all - and 50% of them, at least were women - that they should be looking after their children instead of doing medicine.

Anyway, Winnicott gave a series of seminars to child psychiatrists in, I think, the 1980s, and I was lucky enough to go to them. Another important influence on me was Robin Skynner, whose family therapy seminars I attended, and I then became very interested in family therapy and that was the basis of the bereavement research that I did.

Well, I applied for, and was successful in gaining, a full time consultant post at the Royal Free in 1984. Incidentally, two of my successors at the part-time clinical assistant post at Great Ormond Street, which Philip had established, were Jean Harris Hendriks and Danya Glaser, both of whom contributed substantially to the development of our profession. And maybe this is the place for one point that I want to make: one is never a part-time doctor; medicine is a profession, it’s part of you and you’re part of it. Even when I was employed part-time I was always available at the end of a phone when needed. Part-time doctors inevitably work more than their contracted hours, so the NHS gets a bargain. With my colleagues Freda Martin and Michael Black, I did a study in 1974, with a follow-up in 1982, looking at the use of consultant time in child psychiatry and we found that part-timers averaged 122% of their contracted hours, with some working nearly double their contracted hours on average.<sup>94,95</sup> Moreover because part-timers have other interests and duties, professional burn-out, I think, happens less often than with our full-time colleagues. I think that would be an interesting study for somebody to do if you’re looking for something to study.

Moving from a child guidance clinic to a medical environment and eventually to a more academic setting enabled me, and many like me, to

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92 Bowlby J. *Attachment and Loss*, vols. 1-3 (London, Hogarth Press, 1969, 1973, 1980).

93 Winnicott D. *The Family and Individual Development* (London, Tavistock, 1965).

94 Black D, Black M & Martin F. ‘A pilot study on the use of consultant time in child psychiatry’ *News and Notes* (September 1974): 3-5.

95 Black D & Black M. ‘The use of consultant time in child psychiatry, 7 years on’ *Bulletin of the Royal College of Psychiatrists* (July 1982): 116-7.

fulfil our academic potential, carry out a modest amount of original research, and contribute to the education of child psychiatrists, paediatricians and others. It was early recognised that such a valuable resource as women doctors should not be wasted, first by Rosemary Rue who created part-time training posts for married women doctors in the Oxford region as early as 1967, and then by the government - it's always later "by the government"! - who in 1972 created the Women Doctors Retainer Scheme, designed for women doctors who have family commitments, and there were other similar schemes set up.<sup>96,97</sup>

Well, as a result of my published research on bereaved children, I went on to take an interest in traumatised children where one parent had killed the other, and I founded the first clinic - I think - in this country for traumatised children in 1993.<sup>98,99</sup> I wanted to have a word about medical women's support groups but I think I'm running out of time, so I just want to end by telling you about a paper I wrote for medical women in the journal of the Medical Women's Federation called "Managing career and family: what about the children?"<sup>100</sup> I think child psychiatrists had a duty to try to think about the effect on children of women working. Philip Graham had done a paper on "Maternal employment" and the complexity of the issues that it involved.<sup>101</sup> I listed 15 points of advice to fellow working mothers - somebody told me the other day that it had changed her life - ending as follows, and I'm quoting: "Finally you need a lot of good luck, children who are not sick or disabled or who have a difficult temperament, who enjoy school and other activities, a partner who loves and supports you, a working environment that you can control (very important) and where you get satisfaction and a sense of achievement." But it is possible to have all that, I know because I had it. Medicine is a challenging, absorbing, exciting and very satisfying profession. Parenting is a challenging, absorbing, exciting

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96 Rue R. 'Employment of married women doctors in hospitals in the Oxford Region' *The Lancet* (1967) 10: 1267-8.

97 *NHS Women Doctors' Retainer Scheme*, DHSS (London, HMSO, 1972).

98 See footnotes 90 and 91.

99 Harris Hendriks J, Black D & Kaplan T. *When Father Kills Mother* (London, Routledge, 1993, 2000).

100 Black D. 'Managing career and family: what about the children?' *Medical Woman* (1991) 10: 11-4.

101 Graham P. 'Maternal employment' *Archives of Disease in Childhood* (1990) 65: 565-6.

and very satisfying occupation. To be able to do both is unbelievably fortunate. Thank you.<sup>102</sup>

**Philip Graham:**

Thank you very much, Dora. Open to discussion? Sula Wolff.

**Sula Wolff:**

Just to say I was very pleased you mentioned Sam Yudkin who was a very special paediatrician.<sup>103</sup> I trained with him for two years and I really thought he was wonderful and he died far too young. The other thing is, just to remind you that when I applied to go into medicine in 1942, Kings took seven women a year each and UCH also seven, so they did take a few women.

**Dora Black:**

They did but Guy's didn't, Bart's didn't, Thomas's didn't.

**Sula Wolff:**

No, those were the only two London schools.

**Philip Graham:**

Things have improved a little, Mildred Creak, my predecessor but one at Great Ormond Street, told me that she applied for 110 jobs after qualification before she was appointed to one.<sup>104</sup> That was in 1924 - but still it's a pretty horrific story. Things gradually got better and are a lot better now.

**Dora Black:**

Well now women outnumber men, I gather, in medicine.

**Philip Graham:**

Yes, but not in senior positions.

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102 Dora Black wishes to acknowledge the assistance of Sally Blake, librarian at the Royal College of Psychiatrists and Dr Fabre of the Medical Women's Federation, with the research for this paper.

103 Dr. Simon Yudkin, consultant paediatrician, Whittington Hospital, London (1914-1968).

104 Dr. Mildred Creak (1898-1993), consultant child psychiatrist, Hospital for Sick Children, Great Ormond Street, London.

**Dora Black:**

In applications - it takes time.

**Philip Graham:**

Other contributions? Yes, Harry Zeitlin -

**Harry Zeitlin, Emeritus Professor of Child and Adolescent Psychiatry, University College London:**

You mention your link, your move from local authority to NHS and then to teaching hospitals. I don't know if the important changes in the importance of child psychiatry in teaching hospitals is going to be referred to - that is, it wasn't a taught subject for doctors until, I think, Steven Wolkind who, I think, was the first academic appointee in a London teaching hospital, but he held a post in adult psychiatry, and the one at the Westminster Children's Hospital, which I was fortunate enough to hold myself, was specific to child psychiatry. We were charged with the job of actually creating a curriculum to teach to undergraduates and you'd be surprised at the opposition - "undergraduate students are not ready yet to learn about ..." - the fact that 20-25 percent of a general practitioner's work is in this field we had to persuade them. But there was a big change - there was then a curriculum and we secured about one-to-two percent of the undergraduate curriculum, but I thought because of your move and then the importance of teaching hospitals that ought to be referred to and I think our subject is now generally accepted as a necessary part of the undergraduate curriculum.

**Dora Black:**

You have to fight all the time for it. I mean it's amazing how if you're not there fighting your corner you lose it.

**Ken Fraser:**

Where I am I've seen it go from one-and-a half percent of the teaching time, now to less than half a percent - I'm not there to hit them any more.

**Philip Graham:**

Thank you very much, Harry, for reminding us of the importance of

undergraduate teaching because it was a subject we neglected. I'm going to ask Bob Jezzard because Ken, you contributed earlier.

**Bob Jezzard, retired consultant child psychiatrist, Guy's Hospital, former senior policy adviser in child and adolescent mental health at the Department of Health:**

Yes, I wasn't quite certain what point you were talking about, Harry, but I do remember getting child psychiatry sessional training when a medical student at Guys, from then it was Gerry Vaughan in 1965 or '66 and I don't know how much he'd been doing that before then, but I think Sebastian was before me - certainly we got child psychiatry training then.

**Dora Black:**

In the '60s yes.

**Philip Graham:**

There's somebody ... just hold on. Can you put your hand up high if you wish to speak because otherwise I can't see you?

**Elaine Lockhart, psychiatrist, Yorkhill Hospital, Glasgow:**

Some of us are challenged in the length of our arms! I'm Elaine Lockhart and a psychiatrist working here in Glasgow at the Sick Children's Hospital. I really enjoyed hearing your talk, Dora, and for representing women who blazed a trail in working in child and adolescent psychiatry. Recently we had a workforce assessment in Scotland and the CAMHS workforce in Scotland - at the last, I think a couple of years ago - was 80% female and I think that presents another challenge. It's a very difficult, tricky issue to discuss I think, but just for the record to say things have changed hugely and that's an issue I think for the children and young people we see about having the gender balance in teams.

**Dora Black:**

I just want to say that Carol Black when she was the President of the Royal College of Physicians was very concerned about the gender balance and she made an important point, which I think is right, and that is that men and women doctors are different - they have different priorities, they have

different views of life and of their work, and unless we have a reasonable number of men who are more aggressive than women, generally (there are exceptions), then the professional development, the pushing forward of the profession is going to suffer. You can see what happened in Russia when nearly all the doctors were women and medicine was then down-graded in its status, so I think we have to be very careful about it - or maybe women have to change, I'm not sure.

**Philip Graham:**

I think we have run out of time. Thank you very much, Dora. *[Applause]*

Bill Yule is Professor of Child Psychology at the Institute of Psychiatry. He worked with Mike and myself on the Isle of Wight and since then has made very significant contributions in a number of different areas in child psychology. He has the distinction of being the only psychologist amongst our speakers today and he's going to talk about "Therapeutic developments in child psychology: behaviour therapy to cognitive behavioural therapy".

Bill -

**Bill Yule, Professor of Applied Child Psychology, Institute of Psychiatry, King's College, London:**

Thank you, Philip. I follow Dora, in terms of being one of a minority here. I think what I want to do is illustrated by talking a bit about my own career, but I will stick to the subject. I'm one of the Scots who left Scotland. I went down to the Maudsley to get clinical psychology training, fully intending to return to Aberdeen to work with mentally ill adults - never got back. The course there really opened my eyes to all sorts of things, including the opportunity for research and I joined Jack Tizard to look at the effects of the abominable way in which children in mental handicap hospitals were being treated, when, by comparison, children in children's homes were treated better. We actually thought that children in group cottage homes of 400, being looked after by single women who had themselves been brought up in care, were treated better, but they weren't. Anyway, a year into that Jack had left the MRC Social Psychiatry Research Unit and I was asked to get involved with Michael Rutter and Philip Graham and Kingsley Whitmore

and Jack in the Isle of Wight survey.<sup>105,106</sup> That took the next nine years or so of my life. I learned a little about a lot of different conditions. The big thing that came out for me from the Isle of Wight surveys and the follow-up that we did, Mike Berger and I with Mike Rutter, later in London, was that it showed the enormous amount of morbidity within the general population and it was very clear, if it hadn't been before, that the way in which the child mental health services were delivered, that model was absolutely useless to reach the vast majority of people who needed help and other things needed to be done.

Just before I went to train at the Maudsley, Jack Rachman had come from South Africa where he'd worked as an assistant to Joseph Wolpe who, following his studies of neurotic sheep, introduced Psychotherapy by Reciprocal Inhibition. He had brought this to the job of working as a psychologist in the children's department, following in the footsteps of the founder of the clinical psychology course, Monte Shapiro. So that, in fact, the first three heads of the clinical psychology course, Monte, Jack and myself, all did our work for a time in the children's department.

It was very different, it was multi-disciplinary, as Mike has said, but looked at from our lowly status, in a way, the twice-weekly clinical presentations were really quite interesting. They were held in the waiting room so the poor patients waiting were kicked out somewhere and people trooped in. In those days the consultant psychiatrists trooped in, in pecking order down the front, and so after the case was presented then the front row went back up the pecking order to make their learned comments. Thank God that has gone. It died the death and we got on with actually doing much more interdisciplinary work in the way that Lionel and Mike said.

I worked with Lionel for 15-16 years, perhaps more, and for 13 of those the third member of our team who's sadly not here today. Judy Treseder, social worker and her guide dogs were very good diagnosticians, I assure you. We learned an awful lot by watching the dogs and not just listening to them

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105 Rutter, et al, *Education, Health and Behaviour* (1970).

106 Rutter M, Graham P & Yule W. *Neuropsychiatric Disorders of Childhood* (London, Heinemanns, 1970).

coughing. So we watched carefully - but that's another old story. Jack Rachman, having brought over the work from South Africa I've mentioned, published a seminal paper in the *JCPP* in 1962.<sup>107</sup> He reviewed what was known then about the application of learning theories to children's difficulties. That was the sort of thing we began doing but we weren't allowed to do it officially - psychologists were then not allowed to do any treatment. Aubrey Lewis may have been very broad minded in some areas, but the thought of psychologists doing treatment made him apoplectic. I once read the medical committee minutes when it was suggested that the psychologist do some treatment. The situation was that we were allowed to do "experimental investigation of individual cases" - and of course, basically that was trying to get symptoms under control, in other words, "treatment with feed-back and evidence". So a little while later that was acceptable and when I went back in 1969 there were two psychologists, Mike Berger and myself, working in the children's department responsible for the psychology for two wards and ten out-patient clinics. By that time there was an appetite building up for us to do some treatment, well, you couldn't - you know it was just impossible - the role of being the diagnostic tester was there and was still very important, but we couldn't do everything and so with the very great support and connivance of our medical colleagues we gave the administration an ultimatum that unless they increased the number of psychologists by doubling it, in three months time we would withdraw our services from certain units. And so three months came and nothing happened and we did and Mike Berger and I got the reputation of going on strike! However we got the extra posts and that took us on a long way.

Wilfred Warren, as you have heard, a man of few words but great wisdom, was on one occasion chairing an in-patient diagnostic in-take and the child was being discussed and he turned to Mike Berger and said "Ah, Mr Berger is this one for puppy-training then?" and that was the point behaviour therapy had arrived!

Dora mentioned being first in the field in post-traumatic stress work. As

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107 Rachman J. 'Learning theory and child psychology: therapeutic possibilities' *Journal of Child Psychology and Psychiatry* (1962) 3: 149-68.

some of you know, I did follow on after the work we did for the Herald of Free Enterprise and that brought me into contact with Bob Pynoos in the United States, and a great friend of Dora's as well. And the first or second time I met him he said "You don't recognise me do you?" I said "No." He said – Well, as a medical student he had come during a lecture to sit in one of Michael Rutter's clinics - and I was a psychologist on the team at the time and he could remember me and he said that his experiences then of seeing how teams worked and how scientific values were brought into clinical work, revolutionised the practice that he did. So our approach has been a major influence on the management of traumatic stress particularly in the States.

As I mentioned, Jack Rachman published a paper in 1962 in which he had looked at a number of ways in which learning theories could be applied to children with disorders. In 1991 I published a follow-up paper asking what differences there were between Jack's paper in '61 and now in the nineties, what had changed?<sup>108</sup> It was remarkable how much he had spotted. We were already doing a lot of work on enuresis, encopresis, and so on, and that continued. Indeed most of the papers in *JCPP* were concerned with that and not much else as far as behaviour therapy went. In, I think it was the mid-'60s, Jack Rachman was invited by the ACPP to give one of these talks you heard about at the Royal Society of Medicine. He went one stage further and got in a lot of television screens and for the first time they saw children being treated with behaviour therapy. It came to discussion time - it won't happen today I hope – but, and up jumped - we've heard a lot about him - Donald Winnicott. He was apoplectic. "You mustn't treat children like guinea pigs" he said, and so that sort of divide was there in the room. But the developments have gone on and many, many more applications were given to looking at fears; systematic de-sensitisation became the treatment of choice. There wasn't much about flooding as was being used in adult work because that was considered to be a bit too unpleasant to do to children, but if it's done properly it can work. It came into its own when we got going

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108 Yule W. 'The changing face of behavioural psychotherapy: children's problems' *Behavioural Psychotherapy* (1991) 19: 88-91.

with Post-Traumatic Stress Disorder in the '90s, but that's outside the time-limits for today.

I need one more minute to cover the work on chronic disorder and the family work that Gerald Patterson did in Oregon. Out of that came the parent training work in which Roger McAuley working in Belfast did some marvellous work. He and his wife wrote the book on parent training from the Falls Road Practice, never mentioning "The Troubles" - an amazing omission, in a way, and an amazing thing that they managed to do.<sup>109</sup> So a lot of my work from then on was giving away therapy. We knew that there were children and families out there who needed help, and we were doing things like training teachers, training parents, and most recently the work that we did training foster-carers. I did do an analysis a while ago and I'll give it to Philip later but the trouble is, a lot of these things we know about, we believe and then we go back and look at the data base - it's not there. There are very few empirical papers actually published and quite embarrassing when you see some of them, looking at it today. But then came the big move, towards the end of the epoch we're looking at towards cognitive therapy. It's still got a long way to go. It's happening, people do recognise, there's cognitions that children have, but then we did know that a while ago, but we just didn't call it cognitive therapy. And if you look at the final sentences of the chapter that perhaps I'm proudest of, written with Lionel Hersov and Judy Treseder, on our work with school refusers, what we made very clear there was that you don't get anywhere without listening carefully to the child and it's not going to be successful if it's not successful in the child's eyes.<sup>110</sup> Thank you, Philip.

**Philip Graham:**

Thank you very much, Bill. The reference to dogs may not have been obvious to everybody. Judy Treseder was severely visually impaired and it was her guide dog who was in the room when the assessments were being carried out. I think for the record we ought just to mention that. Lionel -

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109 McAuley R & McAuley P. *Child Behaviour Problems: An Empirical Approach* (London, Macmillans, 1977).

110 Yule W, Hersov L & Treseder J. 'Behavioural treatment in school refusal' in *Out of School*, Hersov L & Berg I (eds) (Chichester, Wiley, 1980).

**Lionel Hersov:**

The point is that she was called Goldie, a Labrador, and when we were presenting the case if she moaned I stopped the meeting and said “What do you think is really going on?” She really was a guide dog in that sense wasn’t she, Bill?

**Bill Yule:**

Yeh!

**Philip Graham:**

I think perhaps we should - as Bill is the only psychologist here - I think it would be appropriate to mention, just for the record again, the contribution of other psychologists, particularly academically. I’m thinking particularly of Mike Berger, whom you mentioned, and who might well have been here - he continues to be active but was very involved in the studies at the Institute of Psychiatry and the Maudsley. Trian Fundudis, who worked with Issie Kolvin in Newcastle, was a very important influence, and Richard Landsdown at Great Ormond Street, who played a very significant part and was Secretary General to IACAPAP [International Association of Child and Adolescent Psychiatry] at the meeting in Dublin in 1982, when Lionel was President of the International Association of Child and Adolescent Psychiatry and Psychology. Just a second. Yes, you can when the microphone arrives.

**Leeds Psychologist:**

Sorry, it’s just another psychologist in Leeds. Dorothy Fielding worked with me for very many years, was superb clinically, brought in a lot of students doing behavioural work and wrote a thesis on day wetting in children, practically the first of the studies on day wetting that were done.

**Philip Graham:**

Hugh, and then Mike, and then we’ll have to stop for the next presentation.

**Hugh Morton:**

I should also like to mention Rudolf Schaffer who had been a colleague of Fred Stone’s in the Glasgow Department of Child and Family Psychiatry

when it was housed in premises in University Avenue.

**Michael Rutter:**

Bill, do you want to say a word about the contrast and similarities between the developments in clinical psychology between UK and US? I'm very struck that there are big differences, almost all the people in the States who are renowned in clinical psychology did not work in medical schools, whereas in the UK that's not the case. The difficulties of psychology having its own position were certainly present in the beginning but psychologists gradually achieved considerable independence working within a multi-disciplinary setting.

**Bill Yule:**

There are a number of differences. The structural differences as you are pointing out - and among those there was this huge split between research and clinical work and that continued to go back and forth in the States in a way that we haven't had quite so much over here, although it has to be said that a survey done of the amount of research that clinical psychologists subsequently produced is disappointing and so there are shortcomings here too. There were so many more places over there that trained people, but there were also more schools, by which I mean sharp divisions in terms of what was studied. I remember in '73 going to Kansas where they were doing an enormous amount of fantastic work in training teachers to work with very severe delinquents in a residential setting. I was asked to make a presentation of one of our cases using systematic desensitisation. They'd never heard of it and I said "but it's been published umpteen times in the *Journal of Child Psychology and Psychiatry*." - "Journal of What?" - and there was one copy in a university library down the road but as it wasn't in a book that was published by one of their own faculty members, they didn't get it. Now I think that's changed a bit and one hopes that the access to the Internet will make a big difference, but I can't go much beyond that really. As far as the role of psychologist is concerned, I decided not to go too much into it because I think the role of the other disciplines is also very important. I certainly very much valued having a multi-disciplinary team to work with

and we each respected each other's views. I think the break-up of the professional organisations there were south of the border has been very detrimental. It's all very well having "a team" around an individual child but if it's a different team each time and they don't know each other, then you lose what you gain by working in a team.

**Philip Graham:**

Thank you very much, Bill. *[Applause]*

Now we move on to Sebastian Kraemer. While Sebastian's getting fitted up I just want to bridge this by referring to another difference between UK and US child and adolescent psychiatry over this period. We had a number of American child and adolescent psychiatrists and paediatricians come to our department over this period, people like Tony Earls, David Mrazek (who also went to the Maudsley), Barry Zuckerman, John Leventhal. They were astonished that at that time - of course things have changed since - that all the child and adolescent psychiatrists were not psycho-analytically trained. Now we've heard very little up to now about the importance of psycho-dynamic theory and practice, but that will now be corrected. Sebastian Kraemer, who is Consultant Child and Adolescent Psychiatrist at the Whittington, and I think at the Tavistock - Honorary at the Tavistock - is going to talk about developments in psycho-analysis as well attachment theory and paediatric liaison services. Sebastian -

**Sebastian Kraemer:**

Thank you, Philip. I'm taking a risk here, but I think I'm correct in saying that I'm not used to being the youngest person in any gathering - as a speaker! Sorry folks! So I'll rush through.

In 1965 I started as a medical student at Guy's Hospital and the first child psychiatrist I ever met was Gerry Vaughan.<sup>111</sup> He had been appointed a consultant there a few years earlier. He taught us that child psychiatry was something you could do with your curiosity; you could get family stories, children would play and draw. One student said (it sounded like we were at

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111 Sir Gerard Vaughan (1923-2003), child psychiatrist, also Conservative politician. Minister of Health (1979-1982) in Mrs. Thatcher's first government.

school) “Please sir, why do children who soil themselves draw brown pictures?” and Gerry Vaughan said, “Surprise, surprise!” For some reason he wasn’t popular with the paediatricians. I think that’s partly because he was a psychiatrist. I don’t know if it was to do with his personality, but he seemed to me to be a good teacher. I’ll come back to the tension between paediatricians and psychiatrists later.

With some fellow students I started a psychology society and we invited Donald Winnicott to give a lecture.<sup>112</sup> While waiting for the slide projector to be fixed, he asked me what I wanted to do and I said I wanted to be a child psychiatrist. He encouraged me to take up paediatrics first in order to make the connection between paediatrics and child psychiatry. That’s what he’d done. As a paediatric student, I was taken to a meeting in Windsor by my consultant, Ronnie MacKeith.<sup>113</sup> There I met three leading child psychiatrists from the Maudsley Hospital, Lionel Hersov, Chris Dare and Michael Rutter, which was a great privilege. I’d never heard of the Maudsley but I later went there to train in psychiatry. As advised by Winnicott, I started first in paediatrics. My first job in paediatrics was as a pre-registration surgical house officer in Oakbank Hospital, just up the road from here, a former fever hospital that was temporarily the Royal Hospital for Sick Children while the new one was being built. It was physically more like a prison than a hospital. I was taken to see Fred Stone who was interviewing a child.<sup>114</sup> He was a breath of fresh air. He was mischievous and had a wonderful way with children. He was the only child psychiatrist I met in the whole of my time in paediatrics - three years - an indication of the limited presence of mental health liaison in paediatrics in those days of the early ‘70s. So one of the themes of this short presentation is that during the three decades we’re talking about paediatric liaison came to life in many places, though there is still not enough of it.

I went on to the Maudsley Hospital and met Robin Skynner who introduced

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112 See footnote 31.

113 Dr Ronald C MacKeith (1908-1977), British paediatrician famous for integrating disciplines in child health, particularly around ‘developmental medicine and child neurology’, and founder of the journal of that name.

114 See footnote 10.

me to family therapy.<sup>115</sup> That was the beginning of seeing fathers as part of the picture in child mental health practice. I worked as a registrar for Lionel Hersov and with the blind psychiatric social worker Judy Treseder, her guide dog, and clinical psychologist Bill Yule, sat listening to the dog and the families of children who refused to go to school. I've learned to be deeply respectful both of Lionel's research and of the stubbornness of these children as they cling absolutely madly (and that's a carefully chosen word) to their mothers.<sup>116</sup> There's a triangle here: mother, father on either side at the top and the child at the bottom. What Lionel showed is that the child is preoccupied with his mother in such a way that he can't get away from her. The father doesn't have the power to help, so the family triangle is not working well. Not all his patients had this problem, but I became very interested in the particular quality of anxious attachment that some of them demonstrated. This was just after the second volume of John Bowlby's trilogy (I will come to Bowlby later).

Chris Dare was the first person to supervise my individual clinical work. On behalf of several generations of Maudsley trainees whom he supported and encouraged, I want to record our debt to him. He was responsible for sending me to the Tavistock Clinic where he himself had trained. I also met Michael Rutter at the Maudsley, although I didn't work with him. I will mention his work in a minute in relation to child psychiatry practice. I worked for Philip Connell in the adolescent inpatient unit at the Bethlem Royal Hospital. He smoked cigars in ward rounds! He once asked why I wasn't on the ward all the time. The answer was I was sometimes having analysis at the other end of London with Joe Redfearn, a Jungian analyst.<sup>117</sup> He helped me to listen to my own thoughts, a very useful thing. Those who have not had psychotherapy or analysis may think that what the analyst says is the most important input, but what one discovers in the meantime are surprising new thoughts of one's own, not always spoken. The capacity to attend to these is a vital professional skill, both in clinical work and in relationships with

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115 Robin Skynner (1922-2000), child psychiatrist, pioneer in family therapy.

116 Hersov, 'Persistent non-attendance at school' (1960).

117 Dr Joseph Redfearn, Maudsley trained psychiatrist, leading member of the Society of Analytical Psychology (the London group of Jungian analysts).

colleagues.

In 1976 I went to the Tavistock Clinic to train as a senior registrar in child psychiatry and was supervised by Ron Britton a child psychiatrist whose work in our profession has left little trace because he went on to become a distinguished psychoanalyst.<sup>118</sup> He demonstrated in seminars how anxieties in complex cases, such as child abuse, can infect the professional network so that all the people involved, social workers, psychologists, psychiatrists, start acting as if they were in a play run by the family. This led another of his trainees, a contemporary of mine, Peter Reder to explore with others the many cases where children had been murdered by their parents.<sup>119</sup> They showed how dissociation gets into the network, and blinds professionals from seeing what is going on. It is still happening today after two enquiries by Lord Laming into the deaths of children at the hands of their carers.<sup>120</sup>

At the Tavistock, John Byng-Hall created the family therapy training and introduced us to Salvador Minuchin, amongst many other innovators from overseas.<sup>121</sup> Minuchin was the most charismatic child psychiatrist I ever met. From him we learned how to deal with the triangle, to get these people, mother and father (or whichever adults - such as mother and grandmother - ran the household), to collaborate. This is structural family therapy. When they were able to do so, the child's anxieties would diminish because the boundary between generations is restored. This applies whatever the condition of the child, even when he has a physical illness. This was an eye-opening enlightenment for me. And Arnon Bentovim - at that time he was still doing psychoanalysis - taught us clearly and without mystification how to apply psychoanalysis in work with parents of children receiving individual therapy elsewhere in the department.

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118 Dr Ronald Britton, formerly an army child psychiatrist who became chair of the Department for Children and Parents at the Tavistock Clinic and later the president of the British Psychoanalytical Society.

119 Reder P, Duncan S & Gray M. *Beyond Blame, Child Abuse Tragedies Revisited* (London, Routledge, 1993).

120 Herbert Laming, social worker, Member of the House of Lords, and author of various reports on child protection.

121 Dr Salvador Minuchin, Argentine born psychiatrist, founder of structural family therapy. Dr Minuchin pioneered work with very poor families in Philadelphia and with psychosomatic and eating disorders. In 2007, a survey of 2,600 psychology practitioners named Minuchin as one of the ten most influential therapists of all time. [http://en.wikipedia.org/wiki/Salvador\\_Minuchin](http://en.wikipedia.org/wiki/Salvador_Minuchin) accessed June 2010.

The main thing I want to record about the Tavistock is John Bowlby's gigantic contribution.<sup>122</sup> The reading list included works of Aaron Beck, George Brown, and psychoanalytic texts. That was my first introduction to real open-minded reflection on fundamental issues of child development, although Bowlby himself was of course by then very confident about attachment theory. Someone took a photograph of the seminar and Bowlby gave me a copy. He had written on the back "a souvenir of a seminar I very much enjoyed. JB." His greatness was surprisingly unrecognised at that time in the Tavistock because he had by then retired and they had moved on to family therapy and psychoanalysis. Yet he was the leading force behind the setting up of child psychotherapy training in the Clinic. He also started family therapy which no one had done before.<sup>123</sup> He set up the Tavistock's Children's department after the war, renaming it the Department for Children and Parents in the 1950s, because it supported families, not just children. He was thus a major figure in multidisciplinary child mental health as well as in developmental psychology.

I must mention the remarkable adolescent psychiatrist, Peter Bruggen. He devised an inpatient treatment programme (at Hill End Hospital) based on the parents' inability to manage their adolescent child at home, rather than on a specific medical or psychiatric condition. This was both a controversial and a revolutionary project. Before admission the parents and psychiatrists had to agree on achievable conditions for discharge.<sup>124</sup> This was an early application of structural therapy, putting the triangle together again. Margaret Rustin was the first child psychotherapist I met.<sup>125</sup> I learned from her that child psychotherapy is a very sharp instrument because it is aimed directly at the child, unlike a lot of the work that we psychiatrists do. As Bill Yule says, you have to know what the child is thinking, you have to be in touch with the child's experience. Child psychotherapists have refined that

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122 Dr John Bowlby (1907-1990), psychoanalyst and child psychiatrist, originator of attachment theory. See Holmes J. *John Bowlby and Attachment Theory* (London, Routledge, 1993).

123 Bowlby J. 'The study and reduction of group tensions in the family' *Human Relations* (1949) 2: 123-8.

124 Bruggen P, Byng-Hall J & Pitt-Aitkens T. 'The reason for admission as a focus of work for an Adolescent Unit' *British Journal of Psychiatry* (1973) 122: 319-29.

125 Margaret Rustin, head of child psychotherapy at the Tavistock Clinic, and later chair of the Clinic's professional committee.

skill enormously, from which we can all learn.

I was appointed consultant at the Child Guidance Training Centre (CGTC) in 1980. This was a quite separate clinic on the first floor of the Tavistock Centre, just one floor below the Department for Children and Parents where I had been trained. I mention it because hardly anybody remembers this pioneering organisation any more - Lionel Hersov was a consultant there; Bowlby had been a trainee there in the 1930s when it was called the London Child Guidance Clinic, and both had gained crucial clinical experience that led to landmark research publications.<sup>126</sup> Michael Fordham, the leading British Jungian analyst of his generation, had also worked there before the Second World War. In 1985 CGTC was absorbed into the Tavistock Clinic to create the much larger Child and Family Department.

I was also appointed to liaison sessions at the Whittington Hospital paediatric department, taking over from the distinguished child psychiatrist Jack Kahn, who had been a locum there for a few years after his retirement. In the 1960s the paediatrician Sam Yudkin had given up three of his Whittington sessions for a child psychiatrist (Marjorie Collins) so that he could do private practice. Although he was a socialist he drove a Bentley. His elegant move created a space in the Whittington for developments in paediatrics and mental health that are still going. In 2010 I shall have been in that post for 30 years.

Finally, brief comments about paediatric liaison, training in child psychiatry and psychoanalysis. The names in paediatric liaison I want to mention are Lionel Hersov, Fred Stone, Mary Lindsay, Issy Kolvin, David C Taylor, Rob Wrate, Dora Black, Bryan Lask, Shirley Leslie, Philip Graham, Elena Garralda, Mary Eminson and Peter Loader (all people, except for Shirley Leslie, I have met and learned from). These are the colleagues by whom we've been inspired to work together with paediatricians in hospitals; and of course there are the imaginative paediatricians and nurses, teachers, psychologists, psychotherapists, social workers and others who have made

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<sup>126</sup> The East London Child Guidance Clinic (now the Emanuel Miller Clinic) was the first in Britain, set up in 1927 for Jewish families. The London Child Guidance Clinic opened in Canonbury in 1929, and was the first such clinic for all children.

these relationships possible. It's not a comfortable relationship, indeed if it is, you've gone native.<sup>127</sup> You have to feel that you're not quite part of the system, that you have a visitor's visa rather than a permanent passport.<sup>128</sup> Looking again at the triangle, there's the paediatrician at one point, here's the child psychiatrist at the second, and there's the patient and the patient's family at the bottom. The professionals are in a kind of marriage in relation to the child patient whom they have to share. We are not simply there for the patients, but also for the doctors and nurses.

For 16 years I was the director of child psychiatry training at the Tavistock Clinic. The greatest innovation in British child psychiatry training was CAPSAC (Child and Adolescent Psychiatry Specialist Advisory Committee).<sup>129</sup> Mike Rutter was one of the first members of it. This was a body which really created and maintained a broad church of child psychiatric training, covering everything from scholarship and research, to rolling up your sleeves and getting on with the job. These visits to training schemes were a form of peer review unrivalled in its effectiveness, and I'm very sorry to say it's not happening any more. They don't do visits; they just do paper assessments - a very risky practice. Child psychiatrists are the general practitioners of child mental health and it's very important to have a broad training. The basis of that is that the public health information which the monumental research of Rutter and others has provided us with, including knowledge of the normal children that we would otherwise rarely meet. Being on CAPSAC was one of the most inspiring experiences for me because you went to visit people who were training child psychiatrists and they came to visit you.

I think psychoanalysis is still at the foundation of much clinical work. It is no longer visible in child mental health (except of course in child psychotherapists) but, while Bill Yule may disagree with me, cognitive

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127 Kraemer S. "The menace of psychiatry": does it still ring a bell? *Archives of Disease in Childhood* (2009) 94: 570-2.

128 Anders T & Niehans M. 'Promoting the alliance between pediatrics and child psychiatry. Symposium on pediatric consultation-liaison' *Psychiatric Clinics of North America* (1982) 5: 241-58.

129 CAPSAC is a sub-committee of the Joint Committee on Higher Psychiatric Training (JCHPT). See below.

therapy and family therapy both have their roots in psychoanalysis, as we work in the here-and-now trying to understand what is happening in the room, and what in particular is happening to ourselves as clinicians. We all have to do this, more or less consciously, whatever our ideological view of the primary task. And child psychotherapists are still helping patients that no-one else can help (though it's true that one problem they probably can't help so much with is OCD, which may have given them a bad press).

I conclude with a reminder that the three decades that we're looking at are not only the decades of epidemiology. They are also the decades of Bowlby's trilogy - 1973, 1969, 1980 - the "decades of attachment theory". As John Bowlby's niece has said "attachment theory is the acceptable face of psychoanalysis."<sup>130</sup> Psychoanalysis survives in altered - you could say unrecognisable - forms but it is a science of observable relationships which is the basis of many of our interventions. Thank you. *[Applause]*

**Philip Graham:**

Well, just some quick thoughts arising from what you said. You mentioned David Taylor, who I think should be mentioned at this point. One of the people who saw himself as a neuro-psychiatrist very early on - the only one of us with a syndrome named after him, Taylor's cortical dysplasia - and Professor of Child Psychiatry in Manchester where he led a very active programme. For the record I also thought Mike Rutter was the first chairman of CAPSAC but on looking at the record it turns out that Tom Main actually did it for a few months beforehand. Mike looks puzzled and I can only refer him to the record if he disagrees with me. But certainly it was Michael who produced the original CAPSAC guidance. This was comprehensive and I think provided a model that the other specialist sub-sections, sub-specialities and general psychiatry followed. The parent committee was not too happy. Its records reveal that the joint committee on higher psychiatry training felt that child psychiatrists were demanding too much of their trainees.<sup>131</sup> It was felt that child psychiatrists must "temper idealism with reality" - but I think

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130 Juliet Hopkins, retired senior child psychotherapist, Tavistock Clinic.

131 The minutes of CAPSAC are not to be found in the archive of the Royal College of Psychiatrists, but those of the parent committee, JCHPT, are available there.

that the high standards that we set were actually very important at that time and the other specialities fell into line with us rather than the other way round.

Psychoanalysis has been significant in our specialty in different ways. Of course, attachment theory is one way - but it's not the only way in which it's been significant over this period of time in child and adolescent psychiatry. As it happens, 1960, the year that we begin, was also co-incidentally the year that Melanie Klein died but her influence continued and continues to some degree quite significantly, some would feel for good, some would feel for ill, but the fact is that interviewing techniques, listening, many people feel that they have learnt their capacity to listen to children from people with psychodynamic orientations and that has been the case right the way through. There are other ways of learning to listen to children but psychodynamic training has fostered skills that child psychiatrists have perhaps more than any other medical specialty.

I've talked too much and there are three people who want to contribute -  
Arnon Bentovim -

**Arnon Bentovim:**

Thank you. I just wanted to pick up on one of the points Sebastian has made. There are indeed enormous controversies in our field. Certainly when I was at the Tavistock, John Bowlby was really quite a peripheral figure, despite his having set up the Child Psycho-therapy Service, because the influence of the Kleinian group was so powerful it had a very displacing effect. But the issue to which this links was the way in which each of the disciplines within the team wanted to have independent consultants and independent capacity to practise. The role of the psychiatrist and the role of the child psychotherapist and psychologist as independent practitioners was very much an issue which came up at that particular time. It seems to me that we really ought to bring that issue to the fore because I think it had a major influence on psychiatrists' role as the "leader of the team", which was certainly the position when I was at the Child Guidance Training Centre briefly, before coming back to Great Ormond Street. That role was such a

key one, very comfortable for us, in a very well worked out process. The change which occurred - very much associated with development of family systemic views and the increasing authority of each of the disciplines characterised by the battle between the Kleinian group and John Bowlby at that time - links with the autonomy of professional groups which is so characteristic of the present situation.

**Philip Graham:**

Thank you. I think Ian Berg was next and then Bryan.

**Ian Berg:**

One concept which lingered in Leeds for a long time when I was there amongst paediatricians was the idea of “The Whole Child”. They regarded themselves as primary in looking after “The Whole Child”; anybody else was subsidiary and they would have a galaxy of occupational therapists and physiotherapists and speech therapists and almoners - and yeah, okay, child psychiatry occasionally could be included but never in the sort of way you’ve been talking about, which perhaps occurred in London. I don’t think it was just Leeds, it was in other places as well that child psychiatrists were not listened to because paediatrics came first.

**Sebastian Kraemer:**

The great paediatrician James Spence - and this is confirmed by his obituary written by Donald Court - was very much against the creation of child psychiatry as a profession because he believed, as you say, that paediatricians should be able to do everything themselves.<sup>132</sup>

**Bryan Lask, Emeritus Professor of Child and Adolescent Psychiatry at Great Ormond Street Hospital for Children and University of London:**

Thank you, just a couple of points for the record. In relation to paediatric liaison - Fred Stone wrote I think one of the very earliest and certainly one of the best books on liaison in child psychiatry and paediatrics, entitled *Child Psychiatry and the Paediatrician*, and I can remember reviewing that, however many years ago it was, and concluding my review with “I wish I’d

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132 Court D. ‘Sir James Spence’ *Archives of Disease in Childhood* (1975) 50: 85-9.

written this book.” It was so superb.<sup>133</sup> The other point I wanted to make was about a most wonderful paediatrician by the name of John Apley and he was famous not only because he was a brilliant paediatrician but for his aphorisms. Indeed, his brother, Graham, published a book entitled “John’s Aphorisms,” of which the one that I think is most memorable is “It’s high time that the paediatrician and the child psychiatrist got married, if only for the sake of the children.”

**Sebastian Kraemer:**

I’m very glad to say I quoted that in a forthcoming leader in the *Archives of Disease in Childhood*, and the only published reference to it is from Lionel’s recollection of it in *JCPP*.<sup>134</sup>

**Philip Graham:**

I think, Bob Jezzard to make the last comment before we ...

**Bob Jezzard:**

I was going to bring together Apley and MacKeith because a book that actually had quite a bit of impact on me was *The Child and His Symptoms*, and I remember as a medical student Ronnie MacKeith really introducing in his teaching the importance of the emotional world as far as treating children with physical health problems - so I think probably my child psychiatry interest actually developed more from Ronnie’s than Gerry Vaughan’s influence.<sup>135</sup>

**Sebastian Kraemer:**

Hear, hear! As this is for the record I should say that Ronnie MacKeith was married to my late mother’s sister (to Elizabeth MacKeith, now one hundred years old) so I knew him from childhood as “Uncle Ronald”, and seemed in student days to see more of him than my cousins did because he spent so much time in the hospital. While he wrote very thoughtfully about children’s emotional development and organised superb conferences with child

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133 Stone, *Psychiatry and the Paediatrician* (1976).

134 Hersov L. ‘Child psychiatry in Britain – the last 30 years’ *Journal of Child Psychology and Psychiatry* (1986) 27: 781-801.

135 Apley J & MacKeith R. *The Child and His Symptoms* (Oxford, Blackwell Scientific Publications, 1962).

psychiatrists, he did not work clinically with them.

**Philip Graham:**

Well, yes, perhaps I should conclude the session by saying my observation was that many of the paediatricians who were most positive and sensitive about children's emotional development found it hardest to work with child and adolescent psychiatrists who had a different perspective from them. Thus a rather ironic situation that arose; the most psychologically sensitive paediatricians found it hardest to work with child psychiatrists. Otto Wolff was an exception to that rule.

I think that we must stop for tea. Malcolm Nicolson has an announcement, I think.

**Malcolm Nicolson:**

Tea is in the room just opposite.

TEA BREAK

**Philip Graham:**

We did have a really long session before tea and fortunately there are fewer presentations in the next set. I think by the time my turn comes I will probably have said pretty well everything I was going to say so mine will probably be shorter than billed. In the meantime we are fortunate to have one of the pioneers of family therapy in the UK, Bryan Lask, who was Consultant Child and Adolescent Psychiatrist at Great Ormond Street then at St George's, and is now very active in Norway. He's now going to talk about the growth of family therapy. Bryan -

**Bryan Lask:**

Thank you, Philip. It's very hard to imagine this, but in 1972 I was a young trainee at the Maudsley, suffering all the ups and downs of being a trainee at the Maudsley, and then I had the delightful breath of fresh air going into the children's department which was right at the end of my three years, and there I met Mike Rutter's scientific rigour, Lionel Hersov's wonderfully inspiring clinical skills, his way of communicating with children and with their

distressed parents, his patience and humanity. And there I had my first exposure to family therapy which, as Sebastian mentioned, was with Chris Dare. Chris made it all seem so utterly logical and it was very exciting, exploring how families contribute to children's problems, how they can perpetuate the problems, and the fact that you could actually work on the issues in the room at that time.

There was an interesting debate at that time about how family therapy started and where it started. Traditionally it was felt that it started in the USA. Some Americans came over to the Tavi - I think it was, and I'm sure someone else will correct me later on - and they were debating, discussing what was happening, and the Americans saying "Oh, we see whole families," and the Tavi people said "Oh wow, that's interesting, we ought to do that." So they started seeing whole families and then about a year or two later the Americans came back and said "So what are you doing?" and the Tavi people said "Oh come and have a look," and there they were seeing whole families and the Americans were amazed because when they said they were seeing whole families what they actually meant was that they were psycho-analysing all the family members separately.

In the meantime in the UK there was already a lot of work going on with adults with schizophrenia at the Institute of Psychiatry, led by Julian Leff and colleagues. At that point, armed with enormous enthusiasm, I went off to Great Ormond Street and what a contrast that was. The registrars at the Maudsley would complain bitterly if they had to see more than two patients a day because it broke into their talking-with-each-other-time! At Great Ormond Street it was eight full days a week with interminable evenings with Arnon Bentovim's Family Therapy Seminars! And they went on - I think from seven until ten - and there was a discussion of systems and cybernetics and epistemology and other long words that I didn't understand and could see no relevance to.

But Arnon was very persuasive and captivating in his enthusiasm and kept us all on the move, as did Robin Skynner, who was the real pioneer of family therapy in the UK, and then, for better or worse, came the invasion of the

missionary colonialists from the USA.<sup>136</sup> They came in to spread the word, including the Ackerman Clinic gang who were wonderful. There was Karl Whittaker, who was an amazing man who could engage in the most amazing conversations with psychotic adults. And then of course there was the giant of them all, Salvador Minuchin, whom Sebastian mentioned.<sup>137</sup> He was a pragmatist, an inspiration and a great teacher, and I think Sebastian just captured what he did. But he didn't suffer fools gladly and I remember a series of supervision sessions we had with Sal in which we, each in turn, had to present a video tape of our work. It was the misfortune of Gill Gorell-Barnes, who was also one of the early leaders of family therapy in this country, to present one evening and she presented a truly appalling piece of work. It was really bad, even I could see it was bad and I was really cringing on her behalf. Sal, in his inimitable way, tore it apart completely and it was the most awful experience. So as I was on the next week I decided I wasn't going to show bad therapy, I was going to show good therapy, so I chose my very best tape, took it along. Predictably it got torn apart and it was awful because I thought it was the best piece of work I'd ever done. But I learned an enormous amount about how to do family therapy during that time.

All the enthusiasm going on in the UK and elsewhere led to the development of AFT (Association of Family Therapy), IFT (Institute of Family Therapy), JFT (Journal of Family Therapy), EFTA - which you may think stands for European Free Trade Association! - but is actually European Family Therapy Association, and IFTA, which is the International Family Therapy Association. And then there were more plane-loads of these flying gurus coming in with yet more epistemologies and more jargon; more fads and fashions, and most particularly factions as always happens in any profession, there are factions and debates and disagreements.

The most widely admired of these set of flying gurus were Milan Systemic Family Therapists, led by Palazzoli, et al.<sup>138</sup> They were the best thing since baked beans and probably much better than sex! They claimed that they had

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136 Skynner R. *One Flesh, Separate Persons* (London, Constable, 1976).

137 Minuchin S. *Families and Family Therapy* (London, Tavistock, 1974).

138 Palazzoli MS, Boscolo L, Cecchin G, & Prata G. 'The problem of the referring person' *Journal of Marital and Family Therapy* (1980) 6: 3-9.

all the answers and they behaved as if they knew they had all the answers. Meantime I was sitting there thinking “I think a little bit like the little boy watching the Emperor with the new clothes,” and I actually couldn’t see the new clothes, but I attributed that to my stupidity. But then there was the final straw for me when we were invited to present our work to these visitors. Just as with Sal Minuchin, I took along a particularly problematic case and the two members of that team - Boscolo and Cecchen - interviewed me, interviewed the family, and then sent all of us, the family and me, out of the room and discussed with the 200 delegates at this one-day conference what was going on; brought us back in - I felt quite humiliated by this experience because I thought I was consulting but I was actually being treated as a member of a pathological system. I was brought back in and told that it was all down to the network and the system and here were the issues that were going wrong with this system, including me, as one of the leaders of the system. I didn’t understand how this could be the case because this child had been ill long before she came to Great Ormond Street, but nonetheless, that was the way they saw it. And maybe two, three, four weeks, two, three, four months later the child divulged non-stop sexual abuse by her father which had been going on for many, many years. So I became very disillusioned with all this external and foreign consultation and also was aware, at that time, of the lack of any really good evaluative research of family therapy: family process, yes, but not the actual evaluation of the therapy itself. So I set up a little randomised control trial of family therapy for childhood asthma and in fact it was the first RCT of family therapy for a physical illness.<sup>139</sup> It was a model study and the results were relatively modestly in favour of family therapy, which was a good start - the numbers were terribly low.

At the same time, at Arnon Bentovim’s behest, I applied for a consultant job at Great Ormond Street, because after Philip I was the second most excited person that Philip got his Chair because it gave this vacancy at Great Ormond Street. So I applied for the job, not for a moment expecting to get it, and found myself exposed on the appointments panel to Philip Graham,

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139 Lask B & Matthew D. ‘Childhood asthma – a controlled trial of family psychotherapy’ *Archives of Diseases in Childhood* (1979) 54: 116-9.

Arnon Bentovim, Michael Rutter, Otto Wolff, the senior professor of paediatrics at Great Ormond Street and Lady Audrey Callaghan, who was the wife of the Prime Minister, and I most certainly didn't expect to get this job. In fact I was certain I wasn't going to get it, but nonetheless I did my best and it went okay until the last person started asking me questions, and that was Michael Rutter, and he asked me a very simple, very good question "Dr Lask, what do you think were the weaknesses in your research?" and I panicked and I froze like a rabbit in the headlights, I couldn't think of anything. Although I knew there were many flaws, I couldn't think of anything and I went out of the room quite certain I didn't get the job.

Time is short and I want to just try and pull it all together in terms of what's happened to family therapy in the UK since all of that. We're forty years on from when family therapy first started. Clinical practice is now very well established. CAMHS have family therapists, I think it's all thriving, it's full of narratives - I haven't quite worked out what a narrative is, but I'm sure we'll sort that one out in due course. *The Journal of Family Therapy*, which Chris Dare was the first editor of, and then I took over from him and that's also thrived, and has got a very reasonable impact factor, etc. Training in the UK is very well established, numerous courses from Foundation through to Advanced, accreditation with the UKCP, even training courses for supervisors of family therapy have been running for quite some time now.

As far as research is concerned there's much activity but it's still mostly process-oriented and as with other psycho-therapies, there is rather little in the way of treatment trials. There's an honourable exception in the UK and that's at the Institute of Psychiatry, where they're doing some excellent studies of family therapy for eating disorders. These are very problematic studies to construct and conduct but nonetheless one hundred percent to them for the efforts that are being made there.

So in conclusion I think the 1970s in the UK reflected for us the joy of having a new-born baby in the family, and the 1980s was the fun and enthusiasm and exploration associated with childhood. The 1990s - the delightful, but naïve "I-know-it-all" of adolescence - and now I think the reality of adult life with all its ups and downs, I think that's where family

therapy is, and if I may end with a comment to you, Mike, I can assure you that I could now bore you silly for five to ten hours with all the weaknesses of that study. *[Applause]*

**Philip Graham:**

But you didn't make it clear, Bryan, you did get the job!!

**Bryan Lask:**

Yeah, yeah! Right! Oh, I would love to know what went on on that appointment's panel! Maybe after a few drinks you'll finally tell me.

Can I just add something to that? Because in those days you - the decision was made on the day and all the candidates wait outside, and I think there were six of us, and you wait and you wait, because I was the youngest candidate - I actually poured the tea for everyone else and handed it round, and then eventually I was called in and Lady Audrey Callaghan said "Dr Lask, please come and sit down," and then she looked at me and she said "We've decided to give youth its chance." So I looked round to see who this youth was. *[Laughter]*.

**Philip Graham:**

Well done! Right who would like to open the discussion? Bill Yule -

**Bill Yule:**

Thanks. Now I can still vividly remember the weekly seminars in which the whole of the children's department were being asked to do sculpting and God knows what, and so on - excruciatingly embarrassing - but what I saw, slightly different, I think, that is that up until about then the social workers in the multi-disciplinary team did what they called "case-work" and the profession would not allow them to call themselves "therapists". When family therapy came along en masse they became "therapists" and I think that was a good thing. I would also like to see some more evidence, but that's another matter.

**Bryan Lask:**

That's interesting, because I think the majority of family therapists, rather

than the majority profession within family therapy, comes from social work and I think that co-incident with the onset of family therapy as a profession was the change in the nature of social work.

**Philip Graham:**

You mentioned about the amount of work at Great Ormond Street and the contrast with the Maudsley. Though, of course, Mike Rutter at the Maudsley worked and still works all the hours that God gave. I just want to say though that my own personal experience is by no means remarkable and I think this was true of pretty well all my colleagues, senior colleagues at Great Ormond Street, we were definitely workaholic. From 1964 to 1994 I worked 80 hours a week the whole time, except when on holiday.

**Bryan Lask:**

Is that all!?

**Philip Graham:**

Enough of that, Bryan! *[Laughter]* You got the job; now watch it! It was indeed a very demanding experience. I used to say, I still say, that I worked a third of my time in research, a third in clinical work, a third in teaching and a third in administration - and people said "But that doesn't add up," and it was right, it didn't add up. I'm really rather pleased that among younger people there isn't that ridiculous commitment to work all those hours because it isn't necessary, and what Dora said about the need for - it isn't just married women who need to commit themselves to their families, it's men as well, and I'm not proud of having put in all those hours. Other comments? Yes - two more comments, one there and then Bob Jezzard.

**Graham Bryce:**

Child psychiatrist here and sometime family therapy trainer in Scotland. You mention flying gurus and their recursive visits to London; we were generally spared from much guru visitation; aside from two that I can recall. One is that Minuchin came here in May 1982 and did a seminar - just down the hill in one of the university buildings - to a large audience and it turned my head, I have to say, it influenced me very substantially, and I then decided I

wanted to go to child psychiatry, which was the only place in the NHS that I had any chance of getting trained in this - what was, apparently - a mystical art. And the other was that I met Maria Selvini Palazzoli's son in a bed and breakfast on the Isle of Skye in about 1985 and that was the closest I ever came to Milan. So I suppose the point I really want to make is that I think there's a whole generation of people in Scotland whose exposure to family therapy was to the altogether more pragmatic version that Rob Wrate and David Will elaborated in the Tavistock publications published as integrated family therapy.<sup>140</sup> I don't think anyone would detract from your criticisms about the lack of outcome research but I think there's a whole generation of people who actually have honed their capacity to work with children, young people and families from that kind of training experience.

**Philip Graham:**

Bob Jezzard, last. I know there are other people who want come in -

**Bob Jezzard:**

I just wanted to comment because I think it was a very exciting time in the mid-70s when a lot of work was going on with development of family therapy but it was more than teaching people family therapy, per se, it was actually helping people to learn how to work with families, and that became particularly important in my experience in terms of working with young people in in-patient care to be able to work with whole families. So you were learning approaches and strategies of working with families, interviewing families, and it was more than family therapy, per se, that offered a value to the profession.

**Philip Graham:**

Thank you very much, Bryan. *[Applause]*

Now we have Michael Rutter to talk about the second part of our period, from the 1980s, and he's particularly going to be talking about the further scientific advances and changes in direction that occurred at that time.  
Michael Rutter -

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140 Will, et al, *Integrated Family Therapy* (1985).

## **Michael Rutter:**

The 1980s proved to be as exciting and important as the 1960s and 70s. For me, a key event was the setting up of the MRC Child Psychiatry Unit in 1984.<sup>141</sup> It built on all that I had learned during the previous two decades, and it was especially influenced by the model of the social psychiatry unit in being highly inter-disciplinary and in seeking to integrate genetic, social and developmental concepts and research strategies. Later, the same conceptualisation led to the establishment of the Social, Genetic and Developmental Psychiatry Research Centre in the early 1990s.<sup>142</sup> There were separate sections in the Child Psychiatry Unit dealing with genetics and with environmental risk factors being studied primarily through epidemiological/-longitudinal methods. Whilst at the Social Psychiatry Unit, I had received some training in statistics at the London School of Hygiene and Tropical Medicine and it was clear to me that modern research required creative and skilled statistical methods, and another section, led by Pickles, was set up for this purpose. As far as disorders were concerned, the main focus was on autism, ADHD, conduct disorders and depression. But the guiding principle was not diagnostic classification but rather views on the patterns of psychopathology that would profit from the bringing together of genetic and environmental strategies, as applied to normal and abnormal development.

During the 1970s and 1980s, much work was undertaken in psychiatric and behavioural genetics. Although initially resisted by many people in developmental psychology and child psychiatry, it was increasingly apparent that genetic influences were very important in relation to mental disorders in childhood and adolescence.

Members of my MRC Unit pulled together findings to produce an overview of what could be done through twin, adoptee and family studies - concluding that the findings seemed reasonably robust.<sup>143,144</sup> Molecular genetics had

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141 Rutter M. 'Child psychiatry: the interface between clinical and developmental research' *Psychological Medicine* (1986) 16: 151-69.

142 Rutter M & McGuffin P. 'The social, genetic and developmental psychiatry centre: its origins, conception and initial accomplishments' *Psychological Medicine* (2004) 34: 933-47.

143 Rutter M, Bolton P, Harrington R, LeCouteur A, Macdonald H & Simonoff A. 'Genetic factors in child psychiatric disorders – I. A review of research strategies' *Journal of Child Psychology and Psychiatry* (1990) 31: 3-37.

now become possible as a result of technological advances but it was still in its infancy in the 1980s and it was proving difficult to replicate initial claims. Nevertheless, by the end of the 1980s, it was obvious that molecular genetics was going to be hugely important in understanding genetic risk and protective mechanisms, and so it proved to be. It was also obvious that collaboration across research groups was going to be essential in order to have samples of sufficient size to undertake the necessary analyses. First, many research groups were stubbornly insisting on going it alone on the quite mistaken view that it would be relatively straightforward to identify the genes for autism (or other disorders). It was not really until the early 1990s that good sense prevailed and now collaborative studies are very much the name of the game. The potential importance of gene/environment interplay, in the form of gene/environment correlations and interactions, had been noted in the 1970s, and taken further in the 1980s. During the 1980s, attention was focused on major individual variations in response to environmental stress and adversity.<sup>145</sup> It is really only much more recently (in the last decade) that the availability of molecular genetic methods has made it possible to examine the interactions between identified susceptibility genes and identified and measured environmentally mediated risks.<sup>146,147</sup> By the 1980s, there were several dedicated research units as well as the MRC Child Psychiatry Unit. Thus, in the UK there was the developmental psychology unit, led by O'Connor, and the Department of Health Thomas Coram Research Unit, led by Tizard (both of whom had been in the Social Psychiatry Unit). In the US, there were several divisions or sections of the National Institute's intramural programmes (i.e. the US equivalent of the MRC Unit) concerned with child development or child psychiatry. For example, there was the section on child psychiatry, led by Rapoport, and the laboratory on Developmental Psychology, led by Radke-Yarrow. One of the

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144 Rutter M, Macdonald H, LeCouteur A, Harrington R, Bolton P & Bailey A. 'Genetic factors in child psychiatric disorders – II. Empirical findings' *Journal of Child Psychology and Psychiatry* (1990) 31: 39-83.

145 Rutter M. 'Resilience in the face of adversity: protective factors and resistance to psychiatric disorder' *British Journal of Psychiatry* (1985) 147: 598-611.

146 Rutter M. *Genes and Behaviour: Nature-Nurture Interplay Explained* (Oxford, Blackwell Scientific, 2006).

147 Rutter M (ed.) *Genetic Effects on Environmental Vulnerability to Disease* (London, Novartis Foundation, Wiley, 2008).

very important advantages of these units both sides of the Atlantic was that it made it possible for there to be strategic developments that were not dependent on a specific research question and it also enabled the development of research strategies, methods and measures, as well as the use of longitudinal research strategies.<sup>148</sup> For example, Rapoport made the important discovery that stimulant medication did not produce a paradoxical effect in children with ADHD.<sup>149</sup> Rather, the effects were similar in normal children, although the benefits were less because there was less inattention that needed modification. She also highlighted the likelihood of age-related differences in the response to drugs – both therapeutic and illicit.

The 1980s was the time when the concept of developmental psychopathology came to the fore and indeed moved from being a rather peripheral interest to an approach that became mainstream in the whole of psychiatry. Psychologists such as Garmazy, Sroufe and Cicchetti were pioneers in this connection, but some of the most important discoveries came from adult psychiatrists examining the childhood origins of psychoses in adult life.<sup>150,151,152,153</sup> The complex mix of continuities and discontinuities across the age span and also across the span from normality to disorder became clear. These discoveries had major implications for the approach to clinical services.

During the 1970s, pioneers such as Garmazy had emphasized huge

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148 Rapoport JL. 'Personal reflections on observational and experimental research approaches to childhood psychopathology' *Journal of Child Psychology and Psychiatry* (2009) 50: 36-43.

149 Rapoport JL, Buchsbaum MS, Zahn TP, Weingartner H, Ludlow C & Mikkelsen EJ. 'Dextroamphetamine: cognitive and behavioural effects in normal prepubertal boys' *Science* (1978) 199: 560-3; Rapoport JL, Buchsbaum MS & Weingartner H. 'Dextroamphetamine: cognitive and behavioural effects in normal and hyperactive boys and normal adult males' *Psychopharmacology Bulletin* (1980) 16: 21-3.

150 Garmazy N. 'The study of competence in children at risk for severe psychopathology' in *The Child in His Family: Children at Psychiatric Risk*. International yearbook, vol.3, Anthony EJ & Koupernik C. (eds) (New York, Wiley, 1974): 77-97; Rutter, M & Garmazy, N. 'Developmental psychopathology' in *Socialization, Personality, and Social Development*, Vol.4, Mussen's handbook of child psychology (4th edn) Hetherington, EM. (ed.) (New York, Wiley, 1983): 775-911.

151 Sroufe LA & Rutter M. 'The domain of developmental psychopathology' *Child Development* (1984) 55: 17-29.

152 Cicchetti D. 'The emergence of developmental psychopathology' *Child Development* (1984) 55: 1-7; Cicchetti D. 'A historical perspective on the discipline of developmental psychopathology' in *Risk and Protective Factors in the Development of Psychopathology*, Rolf J, Masten AS, Cicchetti D, Nuechterlein KH & Weintraub S. (eds) (Cambridge, Cambridge University Press) 1990:1-28.

153 Rutter M. 'Developing concepts in developmental psychopathology' in *Genetic and Environmental Influences on Developmental Psychopathology: Why the Wild Things Are*, Hudziak JJ. (ed.) (Washington DC, American Psychiatric Publishing, 2008).

individual differences in children's response to stress and adversity and identified the important phenomenon of resilience. During the 1980s, further work was done identifying protective factors and also taking forward the concepts and the implications for policy and practice.<sup>154</sup> The topic has now become one of wide interest but it is clear that further rigorous research is going to be needed in order to identify the multiple mediating processes and, hence, situations that offer opportunities for making use of the concept in prevention and intervention.

In the mid-80s there was a major step forward brought about through a study by Frith and Baron-Cohen showing that a deficit in so-called "theory of mind" might underlie the social deficits that are characteristic of autism.<sup>155</sup> The research was largely undertaken by psychologists, rather than psychiatrists, but the implications for the understanding of psychiatric disorders were profound. There was initial excitement over "theory of mind" but, since then, studies of social cognition have included a lack of central coherence and also impairments in executive planning.<sup>156</sup> One of the very important aspects of all of this research was the substantiation of the claim first made by Hermelin and O'Connor that the study of normal individuals could throw light on the development of abnormality and, conversely, that the study of patients could shed light on processes that were characteristic of normal development.<sup>157</sup> At first that was controversial, but it is no longer so.

The brain imaging techniques available during the 1980s were rather limited in their application to child and adolescent psychiatry but it was already apparent that these were going to be able to cast light on associations between structural brain features and psychopathology.<sup>158</sup> The later

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154 Rutter M. 'Implications of resilience concepts for scientific understanding' in *Annals of the New York Academy of Sciences, Volume 1094, Resilience in Children*, Lester BM, Masten A & McEwen B. (eds) (New York, The Rockefeller University, 2006): 1-12.

155 Baron-Cohen S, Leslie AM & Frith U. 'Does the autistic child have a "theory of mind"?' *Cognition* (1985) 21: 37-46.

156 Frith U. *Autism: Explaining the Enigma* (Oxford, Blackwell, 1989); Happé, FGE. *Autism: An Introduction to Psychological Theory* (London, University College London Press, 1994).

157 Hermelin, et al, *Psychological Experiments with Autistic Children* (1970).

158. Rutter M (ed.) *Developmental Neuropsychiatry* (New York, Guilford Press, 1983); Rutter M. 'An overview of developmental neuropsychiatry' in *The Brain and Behaviour: Organic Influences on the Behaviour of Children. A Special Supplement to Educational and Child Psychology*, Besag F & Williams R. (eds) (1993) 10: 4-11; Herold S, Frackowiak RSJ, LeCouteur A, Rutter M & Howlin P. 'Cerebral blood flow and metabolism of oxygen and glucose in young autistic adults'

development of functional brain imaging, of course, hugely transformed the ability to examine in detail the interconnections between the workings of the brain and the workings of the mind.<sup>159</sup>

It is sometimes thought that the identification of new psychiatric syndromes is a matter of the past only, but it is clear from research from 1960 to 1990 that that is not the case. Thus, Rett's discovery of the syndrome now named after him, which was put on the map by the systematic study by Hagberg et al. in 1983, is an obvious example.<sup>160</sup> However, the same time period also saw the identification of the fetal alcohol syndrome, bulimia nervosa, and disinhibited attachment disorder.<sup>161,162,163</sup>

Finally, attention must be drawn to look at Campbell's very important work on the use of natural experiments to test causal inferences from observational studies.<sup>164</sup> The focus at that time was not particularly on child psychiatric disorders (that came quite a bit later) - see Rutter (2007)<sup>165</sup> - but what it did do was introduce child psychiatrists, as well as others, both to the need to test the causal inference and to the range of techniques available for doing so.

The huge advances in technologies of molecular genetics, and brain imaging, have revolutionized what is possible in the scientific study of child psychiatric disorders, just as they have across the whole field of medicine. However, although the technologies have taken us far beyond the point that was reached by 1990, the roots are evident in some of the pioneering earlier work during the three decades covered by this seminar.

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*Psychological Medicine* (1988) 18: 823-31.

159 Frith C & Frith U. 'What can we learn from structural and functional brain imaging?' in *Rutter's Child and Adolescent Psychiatry* (5th edn.), Rutter M, Bishop D, Pine D, Scott S, Stevenson J, Taylor E & Thapar A (eds) (Oxford, Blackwell, 2008): 134-44.

160 Hagberg B, Aicardi J, Dias K & Ramos O. 'A progressive syndrome of autism, dementia, ataxia and loss of purposeful hand use in girls: Rett's syndrome: report of 35 cases' *Annals of Neurology* (1983) 14: 471-9.

161 Jones KL & Smith DW. 'Recognition of the fetal alcohol syndrome in early infancy' *Lancet* (1973) 2: 999-1000.

162 Russell, GFM. 'Bulimia nervosa: an ominous variant of anorexia nervosa' *Psychological Medicine* (1979) 9: 429-48.

163 American Psychiatric Association *Diagnostic and Statistical Manual of Mental Disorders* (3rd edn) (Washington DC, American Psychiatric Association, 1980).

164 Cook, TD & Campbell DT. *Quasi-Experimentation: Design and Analysis Issues for Field Settings* (Chicago, Rand-McNally, 1979).

165 Rutter M. 'Proceeding from observed correlation to causal inference: the use of natural experiments' *Perspectives in Psychological Science* (2007) 2: 377-95.

Lastly, a word about psychoanalysis - not because it was a science, but rather because it claimed to be one whilst actually being an ideology outside of science. The problem was not that the theory was wrong - although as a theory of child development it certainly was disastrously wrong.<sup>166</sup> Rather, the damage to child psychiatry stemmed from four other features.

First, it acted like a religion in which views had to accord with the religious tenets. In a very real sense, psychoanalysis was to psychiatry what creationism is to biology. Second, Winnicott's assertion, backed by the two paediatric bulldogs, Tizard and Davis, that clinical training was irrelevant and research harmful was very damaging.<sup>167,168,169</sup> The idea that the only requirement was paediatrics plus suitable indoctrination through personal therapy was always absurd. Third, the "blame the parents" movement led in child psychiatry by the abusive and dishonest Bettelheim caused not only family distress but damaging removal of children from parental care.<sup>170</sup> Fourth, there was an ethos of lack of concern for confidential handling of consultations and a disregard of ethical behaviour.<sup>171</sup>

It is good that things have moved on. Nevertheless, I agree with Eisenberg that we must not forget the good that also came with psychoanalysis.<sup>172</sup> Trainees were taught to listen to patients and understand their distress. Attention was paid to mental mechanisms, to the impact of memory and its vulnerability to distortions, as well as its centrality in each person's life narrative. In our well based excitement over the enormous advances in genomics and neuroscience, we lose that at our peril. As Eisenberg put it, we

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166 Bowlby J. *A Secure Base: Clinical Implications of Attachment Theory* (London, Routledge, 1988); Rutter M. 'Normal psychosexual development' *Journal of Child Psychology and Psychiatry* (1971) 11: 259-83.

167 Winnicott DW. 'Symposium: training for child psychiatry' *Journal of Child Psychology and Psychiatry* (1963) 4: 85-91.

168 Tizard JPM, Stapleton T, Cox PJN & Davis JA. 'The role of the paediatrician in mental illness' *Lancet* (1959) 2: 193-5.

169 Lewis, 'Symposium' (1963).

170 Pollak P. *The Creation of Dr. B: A Biography of Bruno Bettelheim* (New York, Simon and Schuster, 1997).

171 Maddox B. *Freud's Wizard: The Enigma of Ernest Jones* (London, John Murray, 2006); Callil C. *Bad Faith: A Story of Family and Fatherland* (London, Vintage, 2007). See also Graham P. *Susan Isaacs: A Life Freeing the Minds of Children* (London, Karnac, 2009).

172 Eisenberg L. 'Postscript: looking back, dreaming forward: reflection on the history of child psychiatry' in *Lewis's Child and Adolescent Psychiatry*, Martin A & Volkman F. (eds) (Philadelphia, Wolters Kluwer, Lippincott Williams and Wilkins, 2007): 1032-8.

must avoid the danger of replacing a brainless psychiatry with a mindless psychiatry.<sup>173</sup> [Applause]

**Philip Graham:**

Well, thank you very much, Mike, and you finished well within your time! Right, who would like - I've got one or two points I'd like to make, but who would like - Harry Zeitlin -

**Harry Zeitlin:**

Bryan had before talked about The Emperor's New Clothes and at the end you talked about some of the things that you thought were false trails, I wonder - this is the historical perspective - whether there are, during this period, any trends which have continued which you would see being retrogressive rather than progressive. We're talking about some of the wonderful developments but I wonder if there were any which you would express concern about during that time?

**Michael Rutter:**

During the '80s?

**Harry Zeitlin:**

Well, the period that we're talking about.

**Michael Rutter:**

Well, I think in almost all the fields there have been false claims, false trails as well as real advances, and the problem with all of these is to avoid throwing out the baby with the bathwater - that really is a problem. So that in being critical as I have been of some of the bad things that came with psycho-analysis I ended by pointing out the strengths that came too. But I would say exactly the same in relation to genomics and brain-imaging. Wonderful technologies, hugely advantageous in research but carrying with it the danger of, as it were, a reductionism of an unhelpful kind, so we need to keep a questioning approach to all of these things presented wherever they come from - but a questioning approach, not a dismissive approach, and that

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173 Eisenberg L. 'Mindlessness and brainlessness in psychiatry' *British Journal of Psychiatry* (1986) 148: 497-508.

is a real dilemma. How do we sort out t'other from which?

**Philip Graham:**

I'd like to raise the issue of genetics and whether this has been oversold. I think I'm quoting Jack Tizard correctly when I say he wrote that it was important to remember that genetic influences were likely to be important in explaining differences in, for example, height, anxiety, depression, intelligence between individuals within populations, but when you looked at differences between populations, like why was there so much more violence in the US than there is in Europe, it was not sensible to look at genetic influences, and I think that there is a difference between looking at within-population-differences and between-population-differences, that, he pointed out, is something that people sometimes don't bear in mind.<sup>174</sup>

**Michael Rutter:**

I don't agree that genetics has been oversold. Indeed, its crucial role in environmental susceptibility underlines its importance.<sup>175</sup> However, the point that you make about unjustified extrapolations from within-population variance to between-population variance is certainly valid and important. Arthur Jensen has been very resistant in public to accepting that he got it wrong in his 1969 paper, although in private he has agreed.<sup>176</sup> I rather doubt that Jack Tizard claimed that between-population variations could not be genetic and, if he did, he was wrong. There are plenty of well-documented differences known to be genetic. That applies, for example, to ethnic differences in the frequency of  $\beta$ -thalassemia mutations, the high rate in Ashkenazi Jews of particular mutations in the chromosome 11 gene giving rise to Tay-Sachs disease, and the ALDH2(2) mutant allele found in Asiatic groups that is responsible for an unpleasant flushing response to alcohol.<sup>177</sup>

There is one other thing that we must bear in mind about genetics. There is an unfortunate tendency to move from well-replicated findings on the

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174 Tizard J. 'Race and IQ: the limits of probability' *New Behaviour* (1975) 1: 6-9.

175 Rutter, *Genetic Effects on Environmental Vulnerability* (2008).

176 Jensen AR. 'How much can we boost IQ and scholastic achievement' *Harvard Education Review* (1969) 39: 1-123.

177 Rimoin DL, Connor JM, Pyeritz RE & Korf BR. (eds) *Emery and Rimoin's Principles and Practice of Medical Genetics* (London, Churchill Livingstone, 2002).

importance of genetic influences to an assumption that there is a gene “for” antisocial behaviour, depression or autism. Ken Kendler noted that the average odds ratio for replicated susceptibility genes is only about 1:3.<sup>178</sup> Genes do not code for psychiatric diagnoses; rather they have effects on protein products, which by long indirect paths (mostly unknown at the moment) lead on to mental disorder. Moreover, as well shown by the experimental use of brain imaging to study gene-environment interactions in individuals without psychopathology, the biological pathways may involve mechanisms observable in all of us.<sup>179</sup> As Philip rightly noted, research, as well as the media, have sometimes given a misleadingly deterministic picture of genetics.

**Philip Graham:**

Arnon Bentovim -

**Arnon Bentovim:**

Can I just come back a bit on the distinction you raise between psychoanalytic theory and practice because I think there’s a false dichotomy here? I take your point absolutely on some of the very early theories regarding the notion of structures of mind which are just impossible but which were reified and seen as being very key. But now there is more emphasis on psychoanalysis as a psychology describing relationships. My own psychoanalytic training was very much middle group - Winnicott and relationship-bound, interactional, rather than inner-world focussed. Remember that Bowlby’s basic argument with the Kleinian group was that he said “If children are frightened they usually have something to be frightened of,” which was one of his tenets, versus the notion that people are frightened of issues in their inner world which are not linked with their outer world. So that I think that the psychoanalytic language of relationships, issues such as transference, counter-transference - which has come into all the therapies though they use different languages - is perhaps what’s important. I agree with your focus on what’s important, but it’s inherent in

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178 Kendler KS. ‘A gene for... the nature of gene action in psychiatric disorders’ *American Journal of Psychiatry* (2005) 164: 1243-52.

179 Meyer-Lindenberg A & Weinberger DR. ‘Intermediate phenotypes and genetic mechanisms of psychiatric disorders’ *Nature Review of Neuroscience* (2006) 7: 818-27.

the theory to some extent.

**Michael Rutter:**

To some extent. I mean I absolutely agree with you, humans are social animals and relationships have to be key in this, and there's no doubt that psycho-analysis brought with it a focus on this. But I well remember the Freud Memorial Lecture that Dan Stern gave when he was torn apart for daring to suggest that actual events, actual experiences, influence children's pathology. Similarly Bob Wallerstein in presenting the Menninger Clinic Study also at a Freud Memorial Lecture got torn limb from limb at a time when he was President of the International Psychoanalytic Association because he'd dared to compare what was called supportive psychotherapy and psychoanalysis. I should say for those who don't know the study, supportive psychotherapy was actually quite intensive but it wasn't psychoanalytic in that sense. It was dismissed outright as being outrageous to even look at it, but I tried to make it clear I was talking about the history, I'm not talking about present-day practice which is, I think, very different.

**Philip Graham:**

And we are talking about history so it's quite appropriate to do that. We've got another moment and there's a whole area of research and practice that has become very important in the last twenty years but was growing in importance before that over our period, and that is medication. Eric Taylor - who's otherwise occupied - if he were here we would be talking about this. Now in a paper I wrote in 1976, I pointed to an increase in the use of medication in child psychiatry at that time and I think we'd all agree there's been a very significant increase since then.<sup>180</sup> Now although Eric Taylor's work has been very important and significant, I think one has to say this increase is much more marked in the United States - largely because of the vast sums of money poured in by pharmaceutical companies that have been leading the way. Nevertheless, in terms of practice it has been a very important development over here, not during the 1960s, but particularly during the 1970s and 1980s and, more especially, after that.

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180 Graham P. 'Management in child psychiatry: recent trends' *British Journal of Psychiatry* (1976) 129: 97-108.

**Michael Rutter:**

I'd agree with that, but I think there is also a UK-US difference in the sense that on the whole the therapists here - I mean Eric Taylor's a prime example - have a very balanced view on this. They are users of medication but they're not gullible in applying it to everything without thought, and the situation in the US particularly with pre-school children has been worrying in just treating this as "Okay, here's your prescription, off you go."

**Philip Graham:**

Last brief comment from Ian Berg -

**Ian Berg:**

The definition of "autism" - I get the feeling that it was easy 20-30 years ago because you'd read Kanner - in fact I'd heard Kanner lecture, I'd worked with somebody who'd worked with Kanner in Baltimore, and one knew what autistic children were like then and that's not the feeling now.

**Philip Graham:**

We're talking about 1960 to 1990 and please be brief, Mike, because you could talk for hours on this!

**Michael Rutter:**

No, I can be very brief! Yes it was easier, but the change has come about through good evidence as well as fads, that's to say the genetic evidence and the epidemiological evidence are clear-cut in requiring a broadening of the concept. The problem is there wherever the boundaries are drawn and that has led to an extensive use of this diagnosis. Much of that is I'm sure valid but some of it probably is not, and this comes back to major issues we haven't really talked about which is the problems of measurement in the field of social relationships. Not all social problems are due to autism.

**Philip Graham:**

Thank you very much, Mike. *[Applause]*

Now we move on to the third, or even perhaps the half of childhood and adolescence that we haven't touched on so far. Bob Jezzard was Consultant

Psychiatrist at Guy's Hospital and also played a very important function more recently as "Dr Child Psychiatry" in the Department of Health but his special interest and expertise is in adolescent psychiatry. It is that that he's about to talk about now.

**Bob Jezzard:**

Sebastian - and I have checked - I am younger by four years, so I am the baby of the presenters and so, because I trained in the mid-'70s, or started my training in child psychiatry in the mid-'70s, which is half way through these three decades, I've had to look back a bit and so am indebted to people's historical accounts, particularly William Parry Jones, who wrote a separate paper on the history of adolescent psychiatry, but also colleagues such as Lionel Hersov and Richard Williams.<sup>181,182,183</sup> The development of adolescent psychiatry as a specialty or sub-specialty is largely the story about in-patient care, but not exclusively about in-patient care. There are some other themes which I won't have time to cover properly in ten minutes, but I thought I'd just mention them so we don't lose them forever.

One is the interest in delinquency and forensic psychiatry, which was very, very important to a lot of psychiatrists working with young people in the early days. Another is the role of consultation with other agencies looking after young people, as a way of helping services improve, and of helping others work with young people. Then there is the study of adolescent development and the gradual move from purely psychoanalytic understanding to a rather more empirical approach. For me, the seminal paper was the 1976 one from Michael Rutter 'Adolescent turmoil: fact or fiction' - a very important study.<sup>184</sup> There are also the varying approaches to treatment, which were often quite polarised and different within the in-patient settings of the '60s and '70s, and then finally the debate in the latter

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181 Parry-Jones W. 'Adolescent psychiatry in Britain: a personal view of its development and present position' *Psychiatric Bulletin* (1984) 8: 230-3.

182 Hersov 'Child psychiatry in Britain' (1986).

183 Williams R & Kerfoot M. 'Setting the scene: perspectives on the history of and policy for child and adolescent mental health services in the UK' in *Child and Adolescent Mental Health Services: Strategy, Planning, Delivery and Evaluation*, Williams R & Kerfoot M. (eds) (Oxford, Oxford University Press. 2005).

184 Rutter M, Graham P, Chadwick O & Yule W. 'Adolescent turmoil: fact or fiction?' *Journal of Child Psychology and Psychiatry* (1976) 17: 35-56.

part of this period, which took place amongst psychiatrists, about the role of the psychiatrist. There was quite a lot of conflict at times about what psychiatrists should be doing, their roles within the issues around training, care, control, etc.

Those are themes that I probably won't get to, so let's start with in-patient care. The first two adolescent in-patient units were established in 1948-49, one at St Ebbas at Epsom, and one at the Bethlem. At the Bethlem, the two consultants there who led that unit were Wilfred Warren (who's been mentioned) and also Kenneth Cameron. Wilfred I did meet, but not Kenneth Cameron. There were just a few units, about seven units around the country up until the early '60s. It is interesting to note - perhaps because I used to work at the Department of Health I immediately started looking at *Hansard* when preparing this talk, an unusual sort of activity for a child psychiatrist you might think! - but there was a very lively debate in 1965 about mental health care where the issue about young people in adult wards was central to people's concerns - *plus ça change* you might say. Such was the concern about young people being looked after on adult wards that in 1964 there was a memorandum from the Ministry of Health which was promoting the idea that there should be regional adolescent in-patient units with beds about 20 to 25 per million.

What was astonishing was what happened following that memorandum. In 1964 there were seven units, while in 1981 there were 61 units, so it had an astonishing impact. But, as Arnon Bentovim and Lionel Hersov mentioned in a book chapter, this was largely driven by people with idiosyncratic approaches and very personal and strongly held views about the style and approach to in-patient care.<sup>185</sup> The units were not set up in a planned, systematic and coherent fashion such that they could produce a sustainable service for young people around the country. Although a large number of units did develop, they were vulnerable as a result of the lack of formal planning, the bad financial times that hit the country at the time, and the impact of market forces. As a result, the adolescent beds dropped by 45 to 50

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185 Hersov L & Bentovim A. 'In-patient and day patient units' in *Child and Adolescent Psychiatry: Modern Approaches*, Rutter M & Hersov L. (eds) (Oxford, Blackwell Scientific Publications, 1985).

percent in the period between 1985 and 1990. So this astonishing increase in adolescent in-patient care wasn't established in a way that was sustainable and suddenly it dropped off. And it's perhaps now, only now, that there is a slightly more careful and thoughtful approach to the role of in-patient care and of course, to the alternatives of in-patient care that have developed since those times.

Now I think I should also mention APSA - the Association for the Psychiatric Study of Adolescence - as it was then. It is now called The Association for Professionals in Services for Adolescents; this organisation was essential to the development of adolescent psychiatry, I think, in terms of bringing together all those working within the field of young people's mental health. It was a multi-disciplinary organisation, and a multi-agency organisation to a lesser extent. In 1966 there was the first UK conference that was focused on adolescent in-patient care. This was set up by William Allchin, who was the adolescent psychiatrist at the Leigh House Adolescent Unit in Southampton, and he, with John Evans, who was mentioned earlier on this afternoon, and David Duff, who, I think, was a hospital administrator by background, used the interest in adolescent psychiatry to set up APSA as an organisation in 1969.

Conferences were held annually and I remember, when I started going to these conferences in the mid-'70s, that they were more than just conferences about adolescent psychiatry. They were also conferences that were great fun, characterised by a certain amount of adolescent behaviour, but I did learn things as well! And then eventually the *Journal of Adolescence* was launched. I have here Volume I, Issue I, 1978, and it's a publication that I think has developed and improved its credibility over the years. But these were very important early days because they brought together people to discuss and think about adolescent development and adolescent services, and it has now broadened to address not just adolescent psychiatry or adolescent in-patient care, but a wide range of adolescent issues.

I want to reflect for a moment about the young people who were admitted into the adolescent unit at the Bethlem when I was a trainee. In retrospect it seems quite astonishing how many young people seemed to remain in the in-

patient unit for long periods of time in those days. School-refusers admitted for a year or two in an in-patient unit! Can you imagine that happening now? Or young people with anorexia nervosa occasionally remaining in hospital for two or three years? I think things have changed for the better in many ways since then. On the other hand, I did learn a huge amount about working with young people of that age group as a result of getting to know them during these quite lengthy admissions.

Derek Steinberg was the lead consultant and Philip Connell, a key consultant working particularly in the field of adolescent substance misuse, was another. Michael Rutter occasionally also had responsibility for young people in the unit. I have powerful memories of the small group work that was undertaken in the unit, and of the humiliation I experienced in the groups when, as a naive trainee, I was attempting to interpret the young people's difficult behaviour; indeed, I almost gave up the whole specialty on the basis of one event with one group after being set-upon by four unruly young people. I survived and took some comfort from Winnicott's notion that it was the job of the adult to survive the murderous impulses of teenagers. So the pattern of care, I think, has changed very considerably since those days. I have to say Derek Steinberg had a huge influence on me, as did his book *The Clinical Psychiatry of Adolescence* - clinical work described from a social and developmental perspective.<sup>186</sup> He influenced people in a variety of different ways but one of the things that he was very, very good at was making it very clear that he valued the input from everyone on the team, all the professionals, from the psychologist to the teachers, to the occupational therapists, and to the social workers from whom I learnt a huge amount when I was based at the adolescent unit.

Another event during the mid-'80s that was important but appeared to have no impact whatsoever was the publication of *Bridges Over Troubled Waters* - the Health Advisory Service's attempt to demonstrate the importance of adolescent in-patient care and adolescent services in general, and the need

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186 Steinberg D. *The Clinical Psychiatry of Adolescence: Clinical Work from a Social and Developmental Perspective* (New York, Wiley, 1983).

for a more rational approach to planning and developing integrated care.<sup>187</sup> It was a very valuable document, but it was not greeted by everybody in the same way and was shelved. It had no impact at government level and I think that was part of the reason why the beds suddenly disappeared from sight.

Now I want to mention just a few other names of those people working with young people involved in youth crime. I referred earlier to the topic of delinquency, the term we used at the time. I think it is important to describe the strand of forensic work that went through adolescent psychiatry at the time. Two people: firstly, Trevor Gibbens, who published a psychiatric study in 1963 of Borstal lads illustrating the interest in the field of attempting to understand delinquent behaviour.<sup>188</sup> Secondly, Kenneth Cameron, who was one of the original consultants at the Bethlem in the late-'50s, who wrote about work within an Approved School, and about the consultative work that went on within other types of therapeutic environments and other residential settings for young people.<sup>189</sup> Residential treatment settings were in extensive use and the role that mental health professionals - particularly psychiatrists - had in those days in supporting the work of others was very, very important.

The polarised positions that I also referred to in my opening comments were largely due to, what I tended to see at the time, as a north/south of the river divide; in the north, psycho-dynamic and psychoanalytic perspectives dominated the thinking; and in the south, a more empirical perspective, especially emanating from the Maudsley. This meant that the units that were established were very variable - so much so that in some, it was not easy to admit or treat a young person with a psychotic illness.

Okay, I think I've pretty well come to an end, except to mention the issue of the role of the psychiatrist. This continuing debate emerged during this period and focused on whether psychiatrists should be involved in the broad range of work with young people with a wide range of disorders or whether they should be limited to a more obviously medical approach addressing the

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187 *Bridges Over Troubled Waters. A Report from The NHS Health Advisory Service on Services for Disturbed Adolescents* (London, NHS Health Advisory Service, 1986).

188 Gibbens T. *Psychiatric Studies of Borstal Lads* (London, Oxford University Press, 1963).

189 Cameron K. 'The role of the psychiatrist in an approved school' *Journal of Child Psychology and Psychiatry* (1960) 1: 306-12.

treatment of mental illness, particularly with the use of medication. That debate goes on, though hopefully there's now a rather broader perspective about the role of psychiatry. Thank you very much. *[Applause]*

**Philip Graham:**

Right, a number of people - somebody who hasn't spoken, at the back, yes?

**Michael Morton, consultant child and adolescent psychiatrist, Yorkhill, Glasgow:**

I'm consultant in the children's hospital here in Glasgow. I'm very grateful to you, Bob, for your account of the divisions that existed which I think have been threading through the discussion of the development of the specialty. As a trainee in the late-'70s or early '80s in Edinburgh and then moving South, I suppose I had a choice as to where I went for my higher training and David Taylor was talking about doctors in child psychiatry in Manchester. He pulled together a group of trainees from across the UK who were really interested in something that hasn't been talked about so far very much here, which is the practical getting-on-with-the-job-in-the-district kind of child psychiatry in places like the North-West of England, which was full of opportunities: i.e., seriously under-resourced, very deprived urban areas with nothing that approached a clinic in it! And Pat Ainsworth, who ran the adolescent unit in Prestwich at that stage, quietly presided over a unit which really did everything. I remember my first APSA meeting, which I went to with Pat, and the sense that in APSA there were all these divisions but within the Prestwich unit - we were the regional unit - we just got on with it. And I think in a sense, and I suppose it is a criticism of this seminar, that not enough space has been given to the people who just quietly got on with it in the late-'80s trying to resolve these conflicts and run clinics in very difficult circumstances.

**Philip Graham:**

Yes, I accept that criticism. I would indeed just make the more general point that clearly if someone else had been organising this seminar they would have come up with a different group of people. Inevitably one has to be selective and the person responsible for choosing inevitably has his or her

own biases and prejudices and so on. But I think you're absolutely right. I suspect that the London Borough of Camden, population of 100,000, has over our period - and indeed still has - more mental health professionals in it than the counties of Lancashire and Yorkshire together. The inequity in resource distribution was appalling and remains so to a very considerable degree, so let me acknowledge the significance and validity of the point that you've made.

Let me add that I do realise there are some important omissions. For example, we've not made space for any description of child psychiatry services in Wales where, towards the end of our period, Michael Shooter (more recently President of the Royal College of Psychiatrists) made a most significant contribution to our specialty.

Two more - three more - we can take these three, but that's it. Hugh -

**Hugh Morton:**

First, a minor point - John Evans also wrote about the role of the psychiatrist in the Approved School, I think, after Cameron, but I can't be certain about that. You mentioned the shelving of *Bridges Over Troubled Water* - I'd just like to make the point that throughout the three decades we're talking about, there's been a kind of basso ostinato, if I can put it that way, of child psychiatrists trying to plan for service development and having to sit on working parties and quite often finding hours, weeks, months, years of work shelved, for one reason or another. Somebody sometime should actually try and quantify the amount of time which professionally we have wasted on this kind of thing. I think Graham Bryce in Glasgow will correct me on this if I'm wrong because he's been doing some of this more recently. I think people are actually much better at this now than we were. Certainly in Scotland I spent many, many hours on a working party on the Future Shape of Services.

**Philip Graham:**

I never think such time is completely wasted because you never know when it's going to have its impact. That's been my thought over the years. I agree that you can waste a huge amount of time but actually there have been

moments where suddenly the time is ripe and you have a plan or a set of ideas ready and you do have an impact. I've failed to mention a name that I think is very important, John Coleman - clinical psychologist - very much involved with adolescents, who was editor of the *Journal of Adolescence* for quite a long period of time after John Evans, and set up the Trust for the Study of Adolescence which had quite an impact on me personally in terms of the amount I learned from its publications and from John Coleman himself.

**Sebastian Kraemer:**

Arnon Bentovim picked up a point earlier about leadership of child psychiatrists and the role of psychiatrists generally. Until then that remark the word "leadership" has not been mentioned today. Even the word "doctor" has hardly been heard. If you're in serious clinical difficulty in multi-disciplinary teams you do want to call "the doctor" for help, and in child mental health practice that is the psychiatrist. Our leadership as a discipline was greatly developed during the three decades in question in spite of the fact that at the same a more democratic structure in teams was evolving. Because we are the only members of the multidisciplinary team to have encountered - as a matter of routine - birth, death and madness in our training, we retain a capacity to manage extreme anxieties. Consultation to other disciplines is the application of this authority. This is a far cry from the diagnostic and prescribing privileges of doctors which are often assumed to be our primary skills.<sup>190</sup> We do have to think, as a postscript, what is left for child and adolescent psychiatrists to do in modern CAMHS clinics, but that's for another conference.

**Dora Black:**

I just thought we ought to mark the rise in expert witness work - working in the legal system. This really took a fillip as far as child psychiatry was concerned with the Children and Young Persons Act 1969, and the Children Act 1989, which introduced the concept of "significant harm". We then got brought in to try to help the courts with where significant harm was likely to

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190 Kraemer S. 'Who needs child and adolescent psychiatrists?' *Clinical Child Psychology and Psychiatry* (1999) 4: 121-7.

have happened to the child or might happen if the child wasn't taken into care. That really was the sort of beginning of our involvement which is now very great with civil forensic work, as opposed to criminal forensic work.

**Philip Graham:**

Thank you, Dora, and thank you, Bob.[*Applause*]

There may be some people who wish to move off a little early and I'd just like to reassure people that I've been cunningly inserting most of my talk into my comments so that I think five minutes will be enough for my own presentation and that could be followed by five minutes for discussion and wind up. In the meantime, it's a pleasure to introduce my long-time colleague, Arnon Bentovim, who worked in the next room to me at Great Ormond Street for 20 to 25 years. He worked to such effect in abuse services at Great Ormond Street I sometimes wondered if we were doing anything else. But he worked very effectively and imaginatively. It's a pleasure for me to introduce him. Arnon -

**Arnon Bentovim:**

Thank you, Philip. The first chapter I wrote about caring for abused children was in 1974. This book, edited by Jan Carter, called *The Maltreated Child* sold for £2.95 at the time! A book launched this week *Safeguarding Children Living with Trauma and Family Violence. 2009*, written with Professor Tony Cox, Liza Bingley Miller and Stephen Pizzey, was rather more expensive. There is a continuing process of re-discovery of ways of working which are already well established - e.g., in *The Times* last week, it was stated that paediatricians are being advised that children who are abused ought to stay in hospital, an approach seen as essential many years ago.

After I trained at the Maudsley Hospital I went to Great Ormond Street in 1966, as a senior registrar working with Lionel Hersov and Guy Michell. Guy was a paediatrician who followed Donald Winnicott's lead, being trained as a psycho-analyst and then moving into child psychiatry. He had significant difficulty meeting expectations at Great Ormond Street where he had been a paediatric registrar. This may have been due to the lack of basic training and experience which came from a training such as we had at the

Maudsley, despite his significant clinical skills. This made it very difficult for him, and he resigned in 1968. Lionel Hersov had already left to go to the Maudsley, and Guy went into private practice. Myself and a group of colleagues found ourselves running the department, which was quite a challenge. 1968 was a time when early Family Systems thinking was very much a focus of clinical excitement. We had links with Nate Epstein's group in Canada looking at early models of family therapy; group ideas from Robin Skynner; and ideas from the Ackerman clinic in New York.

The role of Otto Wolff, the Professor of Child Health at Great Ormond Street, was key to encouraging psychological thinking at GOS. His brother was Heinz Wolff, an inspirational psychotherapist at the Maudsley for all of us who were aspiring to work psycho-dynamically. Otto was one of the group of paediatricians who worked with Anna Freud looking at the psychological aspects of paediatrics, and he was very positive in fostering relationships between psychiatry and paediatrics. He would surround himself in his ward rounds with biochemists, and pathologists, as well as the ward psychiatrist, and would orchestrate this extraordinary group of professionals. For me, the model was important when it came to thinking about how to manage child abuse. The paper which had a seminal effect was Henry Kempe's (1962) *The Battered Child Syndrome* and the text *Helping the Battered Child and his Family*, which was published in 1972.<sup>191,192</sup> I remember buying the purple book with the rag doll on the front in its first edition. There I found a world that I knew nothing of from my paediatric and child psychiatric training. I was not prepared for this shocking exposé of parental harm to children. A committee was set up at GOS, soon after I was appointed in 1968, to consider how to manage this "newly recognised" problem. I'd like to read you a section that I wrote in 1974:

“A special interest group of senior and junior paediatricians, neurosurgeons, psychiatrists, medical social workers, nursing sisters, was alerted when there was a concern about a child

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191 Kempe CH, Silverman FN, Steele BF, Droegemueller W & Silver HK. 'The battered-child syndrome' *Journal of the American Medical Association* (1962) 181: 17-24.

192 Steele B. 'Psychodynamic factors' in *The Battered Child*, Helfer R & Kempe CH. (eds) (Chicago, University of Chicago Press, 1968).

admitted to hospital. Through regular meetings, policy decisions would be made, watch would be set of parents, we should talk to parents when suspicions were confirmed. The role of the informal conference was to establish the need for monitoring. District medical team could be invited, liaison could be made with health visiting, welfare clinics, GP, social services, police officers from the juvenile police bureau. The primary task of the conference was to make decisions about the treatment of cases.”

“Treatment” was very much a basic element that we brought into our first multi-disciplinary approach to child abuse. One of the key authors of *The Battered Child* was Brandt Steele, psychiatrist in Denver. His descriptions of ways of working therapeutically by targeting inter-generational abusive patterns through the re-parenting of mothers was influential.

There are three phases to which I want to refer: One, the 1970s was focused on the way in which we managed basic child abuse, physical abuse and neglect. There were various teams: Kit Ounsted and the group in Oxford played an important role in admitting families to the Park Hospital, and David Jones subsequently found great value in that approach. Then there was the work in Newcastle with Tina Cooper who influenced many paediatricians including Margaret Lynch, who trained with her; she subsequently worked in Oxford. At GOS we used our day centre as a way to work with abusive families. There was a general development, in the country, of multi-disciplinary ways of managing child maltreatment. Child protection conferences brought together professionals and the whole process, area review conferences, child protection conferences, safeguarding boards, structured the whole process of attempting to work in a multi-disciplinary fashion. But we still have tragedies and there are still many issues to understand in terms of development.

Two, the ‘80s marked the awareness of the reality of sexual abuse, rejecting Freud’s notion of children’s statements about abuse with parental figures being based on wishes and fantasies. Feminist thinking brought this issue to the fore. Henry Kempe, in 1976, lectured at the London International Conference of Child Abuse and Neglect and told us that we would be seeing

children who were sexually abused. Pat Beasley Mrazek, who had worked in Denver with Henry Kempe and was on a sabbatical in London, asked whether we would collaborate and use GOS to send out some forms to practitioners to see how many children were being seen who had been sexually abused. The responses demonstrated that sexual activities with children were perceived as a criminal act against a child and the criminal response was the model of approach, rather than this being seen as a failure of child protection.<sup>193</sup> Because we were perceived as being interested in the topic, we were asked to assess and treat children who had been sexually abused and their families. A number of colleagues agreed to work with us including Tilman Furness, Eileen Vizard, Danya Glaser, Anne Elton, Marianne Bentovim and Liza Bingley Miller. We eventually developed the first sexual abuse assessment and treatment programme in Europe using individual, group and family approaches with victims, protective family members, and abusing parents and young people. This enabled us to gather systematic information about the nature of sexual abuse and its management.

Three, we were also involved with parents who create illness states in their children so that they can be the parents of a sick child. We described non-accidental poisoning, in 1976, and illness induction states later.<sup>194</sup> Subsequently, Roy Meadow labelled this phenomenon “Munchausen Syndrome by Proxy”, built on the notion that the parent perceives or induces the illness states, convinces the paediatrician to carry out the investigations to confirm the belief, and then moves on to another symptom if results are normal.<sup>195</sup> Emotional abuse, especially its definition, became a major concern in the ‘80s.

The recognition of the different ways in which children’s health and well being can be affected by harmful parenting touches on the work of many different professionals working with children. “Working Together” became the way forward, although it was decided early on that social workers need

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193 Bentovim A, Elton A, Hildebrand J, Tranter M & Vizard E. *Child Sexual Abuse Within the Family* (Bristol, John Wright, 1988).

194 Rogers D, Tripp J, Bentovim A, Robinson A, Berry D & Goulding R. ‘Non-accidental poisoning; an extended syndrome of child abuse’ *British Medical Journal* (1976) 1: 794-6.

195 Meadow R. ‘Munchausen's Syndrome by proxy; the hinterland of child abuse’ *Lancet* (1977) 2: 343-5.

to be the key professionals to manage the welfare issues. Of course, child abuse has always been an enormously controversial field; there have been many major public enquiries, following tragedies from Jasmine Beckford to Baby Peter. These have resulted in major changes of policy. The introduction of The Children Act in 1989 was directly influenced by the Cleveland enquiry to ensure that there was a balance between professional and parent.<sup>196</sup> “Harm” had to be significant before a child could be removed from a parent, rather than because of suspicions over, for example, “reflex anal dilatation”. The Climbié case resulted in changes to bring children’s health, social services and education into a closer organisational alliance, so that children could be provided with a more integrated approach to recognise harm. There have been many swings of the pendulum with the voice of the child sometimes lost in professional and parental argument, but needing to be heard afresh in every generation. *[Applause]*

**Philip Graham:**

Arnon, it’s a concern to a lot of us that this concentration on abuse has led to undue concern about any sort of physical contact between parents and their children and certainly between teachers and children. I once co-authored a book on childhood depression for parents and teachers and in the first draft suggested that a teacher might put an arm - a reassuring arm - around the shoulder of a child in distress; a senior teacher told me “You can’t put that, we’d be had up if we did that sort of thing!” And it just seemed very sad to me that that was the case and I think this had already happened by the time we are talking about in the 1980s.

**Arnon Bentovim:**

One of the problems in the development of this field has been the role of the public media. At one point we saw talking to the press, discussing the theme, raised consciousness, and early television programmes about sexual abuse had people phoning through and saying that they’d kept this a secret for the whole of their lives so that awareness of this was valuable. Our work has probably played a part in the inappropriate degree of protection of children.

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<sup>196</sup> Butler-Sloss E. *Report of the inquiry into Child Abuse in Cleveland in 1987* (London, HMSO, 1988).

The concept of “stranger danger” has grown despite experts’ pointing out that most abuse is not perpetrated by strangers, but in the family; however, the belief persists. Smaller families, the preciousness of children, fears for their safety, have all led to more protection - avoid contact, don’t be seen as the “stranger”. I notice that currently there are programmes which are saying “We need to institute ways of working where contact is actually perceived as valuable.” It’s almost having to be brought back as an appropriate approach in working with children who are disadvantaged. I agree it’s had complex effects.

**Philip Graham:**

A last comment from the back, please -

**John Stewart, Director of the Centre for the Social History of Health and Healthcare, Glasgow Caledonian University:**

My name’s John Stewart and I wanted to ask you about your final remark which, in a sense, has run throughout several of the contributions and that’s to do with the role of the social worker. Could you expand a bit more on that, not least in the context of some of the changes that have taken place in social work training over the past 30 or 40 years, including the demise of psychiatric social workers as a distinct profession. So could you just expand a bit on what you’ve said about social workers?

**Arnon Bentovim:**

At the time when people began to be concerned about child protection a move was taking place from social work organised separately in children’s departments, adult departments, hospitals, clinics, to being seen as a unitary professional group, serving the community in various settings, rather than being employed in different settings.<sup>197</sup> Social work became generic, so the specialist training such as that of the psychiatric social worker became subsumed into the generic field. The priorities were set by the community concerns. Because they’ve always had a welfare responsibility, social

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<sup>197</sup> *Report of the Committee on Local Authority and Allied Personal Social Services: the Seebohm Report* (London, HMSO, 1968): this created a profession of generic social work in place of the previous specialized work force.

workers have been deputed to take the leading role in child protection, but the placement and other skills in that field can easily be lost. Having to take a key role in child protection makes them very vulnerable, because they may not have the knowledge or skills to deal with those tasks which are the preserve of other professionals - health, police or education. In some countries there is a specific multi-disciplinary child protection team that's not perceived as part of welfare and has its own specialised role - as we've chosen to go down this route social workers have been put into a no-win situation, damned by the media and politicians if they get it wrong, and damned by parents if they get it right, because taking responsibility for abuse invites condemnation. We medical practitioners are relatively better protected but we can also be vulnerable, as the example of Roy Meadow showed.

**Philip Graham:**

Thank you very much. I should now like to fill a few gaps. The increasingly scientific approach in child and adolescent psychiatry meant the subject began to be taken a great deal more seriously, both nationally and internationally. Hugh Morton mentioned the contribution that Fred Stone made, to the Houghton Committee on adoption and the Kilbrandon Committee on juvenile justice, both very important contributions. In 1976, the Court Committee on which Michael Rutter served produced its report on child health services with many excellent recommendations, some alas not implemented.<sup>198</sup> In 1978, the Warnock Committee on Children with Special Educational Needs reported and its recommendations were implemented within a few months, some of them perhaps not all that wisely, but nevertheless it was very rapidly implemented.<sup>199</sup> Indeed, virtually every official government report into the health and welfare of children since 1970 has referred to epidemiological research carried out by child and adolescent psychiatrists.

With this increasing respect for the subject and an acceptance of its scientific

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198 *Report of the Committee on Child Health Services* (1976).

199 *Report of the Committee of Enquiry into the Education of Handicapped Children and Young People: the Warnock Report* (London, HMSO, 1968).

standing came an increase in the number of chairs created in postgraduate and undergraduate medical schools. At the beginning of our period, in 1970, there were no such chairs. By 1990, not only were there the Chairs we've already mentioned, at the Institute of Psychiatry and Child Health, but also Chairs in Manchester (David Taylor), Newcastle (Issy Kolvin), Nottingham (John Pearce), Leicester (Rory Nicol), Liverpool (Antony Cox) and Glasgow (Fred Stone and then William Parry-Jones). Others followed shortly after 1990: even Oxford and Cambridge did not follow far behind. Further during the 1980s, a number of now eminent academic child psychiatrists carried out important research. I'm thinking particularly of Ian Goodyer and David Skuse, but also of Richard Harrington, who sadly died very prematurely in 2004.

The Child and Adolescent Psychiatry Specialist Section (now Faculty) was founded in 1942 as a sub-group of the Research and Clinical Section of the RMPA. In 1958 it began to hold residential meetings, but it was not until 1965 that the meetings developed a recognisable research component. At that meeting, as well as Naomi Richman, of whom we heard earlier, one of the other speakers was Desmond Pond, who, as we also heard earlier, was both a child and adult psychiatrist with an interest in epilepsy. His Goulstonian Lectures, published in the *British Medical Journal* in 1959, were on childhood epilepsy.<sup>200</sup> After leaving the Maudsley and UCH in 1958, he was appointed Professor at the London Hospital, and appointed Stephen Wolkind to a Senior Lectureship in Psychiatry - though Harry Zeitlin tells me his was the first Senior Lectureship specifically in child psychiatry at an undergraduate teaching hospital, the Westminster, in 1983. Desmond Pond was later elected, in 1978, to be the third President of the Royal College of Psychiatrists.

The programmes of the residential and one-day meetings of the section, held by the College, provide a record of scientific progress in our field. I shall be highly selective in my description of these meetings and only go up to 1977. In 1967, Dorothy Heard spoke on attachment. In 1968, Ate Hermelin spoke in a symposium on the autistic child. This was the first occasion an

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200 See footnote 83.

experimental study was presented. In 1969, Michael Rutter, Sula Wolff, Issy Kolvin and Albert Kushlick presented in a symposium on epidemiology. In 1970, Michael Rutter chaired a symposium on treatment at which Bill Yule and Mike Berger spoke on operant principles in speech training. 1971 was the first occasion in which there was a discussion of the place of child psychiatry in the undergraduate curriculum (Issy Kolvin and Sula Wolff).

That year (1971) was the first time that space was given for presentations by young researchers (Rory Nicol, Claire Sturge and Ann Gath). There was also the first discussion of classification. David Shaffer, then at the Institute of Psychiatry, presented. David left for the USA in 1977, for a glittering career in American child psychiatry at Columbia University in New York. In 1973, Arnon Bentovim led a discussion of communication between child psychiatry and paediatrics. In 1975, Bryan Lask presented the first controlled trial of family therapy in children with asthma that he mentioned earlier. In 1976, William Parry-Jones spoke on adolescent in-patient units, and that year Michael Rutter reported for the first time on his ground-breaking studies into school effects on behaviour and attainment. By 1977 the meetings were of very high scientific quality. At the one-day meeting that year the speakers included Alan Clark, Stephen Wolkind, Judy Dunn, Lex Kalverboer, John Newsom and Arnon Bentovim.

The views of British child and adolescent psychiatrists were taken with increasing seriousness over this period, not just nationally, but internationally as well. Michael Rutter and I served as WHO consultants in 1976 to a committee that produced a technical report on Child Mental Health and Psychosocial Development that was widely used for many years.<sup>201</sup> About that time I organised a symposium for European Child Psychiatrists, which was the first of a number of European symposia in child psychiatric research that have continued until very recently.<sup>202</sup>

In 1978 I was appointed co-ordinating consultant to the Child Mental Health Programme, and this wasn't because of any particular brilliance or virtue on

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201 *Child Mental Health and Psychosocial Development*, Technical Report 613 (Geneva, World Health Organisation, 1977). [http://whqlibdoc.who.int/trs/WHO\\_TRS\\_613.pdf](http://whqlibdoc.who.int/trs/WHO_TRS_613.pdf) accessed June 2010.

202 Graham P (ed.) *Epidemiological Approaches in Child Psychiatry* (London, Academic Press, 1977).

my part. It was because I had access to epidemiological studies, and to some degree training, that was found valuable at an international level. Indeed, I found myself assisting in the formulation of national plans for child mental health in around 20 countries.<sup>203</sup> Now I won't say these national plans for child mental health had any effect in more than a small minority of those, perhaps half a dozen, but nevertheless, that was an extraordinarily important international input of child psychiatric knowledge, particularly epidemiological but also service expertise, over that period of time. Around 1981, the British Council approached Naomi Richman and myself to run international workshops in child mental health and psychosocial development, and we ran two such workshops for overseas people in 1982 and 1984, very similar to those that were mentioned last year by Professor Tom Arie at the Witness Seminar held last year on psycho-geriatrics here. From the early 1970s, Michael Rutter gave countless keynote addresses abroad, to psychiatric groups, to groups of developmentalists, to groups of paediatricians, to groups of general psychiatrists, and so on, raising the profile of child mental health. That's the up-side.

But I should like to conclude, before I open to general discussion, with a serious down-side. Throughout the time all this truly impressive scientific activity and service development took place, the rate of child psychiatric disorders went up inexorably.<sup>204</sup> Such evidence as we have on the rates of emotional and behaviour disorder suggest that our contribution could not have been having an influence on prevalence. I suppose one could say "Well the rates might have gone up even higher", and maybe they would, but the fact is there is a serious question to be asked about preventive approaches to child and adolescent mental health problems. In this disparity between the increase in our activity, the scientific activity, and the prevalence of these disorders there is a dilemma, a problem that that raises important questions. I think therefore that quite appropriately we finish our witness seminar with a question rather than with an answer. Open to discussion! *[Applause]*

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203 Sartorius N & Graham P. 'Child mental health experiences in eight countries' *WHO Chronicle* (1984) 38: 208-11.

204 Collishaw S. 'Time trends in child and adolescent mental health' *Journal of Child Psychology and Psychiatry* (2005) 45: 1350-62.

**Sebastian Kraemer:**

I have to answer that question otherwise it will get lost in other reflections. It's been a very, very good day, thank you, Philip. I just wanted to say that there are some quite good data now coming out from Richard Wilkinson, who has been working for many years examining the links between social inequality and both physical and mental health.<sup>205</sup> Social inequality has been rising fairly consistently since the 1970s and that seems to account for many disorders. He hasn't looked at child mental health exclusively, but many social and medical indices - teenage pregnancy, mental illness, drug abuse, homicide, for example - are associated with lower levels of social cohesion and equality. The only condition which seems not to rise with increasing inequality is suicide. Thank you.

**Philip Graham:**

Ken please? Briefly everybody, please because we're coming to the end.

**Ken Fraser:**

Thank you for this seminar, I think it's been fascinating to everybody to hear the variety and quality of research that's been produced. I think as this is a historical seminar that we should emphasise that this is a young specialty - it only started, really, in the 1930s. By the 1940s, the few who originally started it, when you asked them what they did, they said "Well we just made it up at the time." Then came the group that we mentioned - Mildred Creak, Portia Holman, Anna Freud, Margaret Methven, and then after them came the middle group, with say Lionel Hersov at the Maudsley, Robin Skynner who was my senior registrar when I was training at Brixton and then the other group of us who went out into the periphery, as Senior Registrars - to spread the word.

**Philip Graham:**

Ken, I think we need to stop fairly shortly.

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205 Wilkinson R & Pickett K. *The Spirit Level: Why More Equal Societies Almost Always Do Better* (London, Penguin, 2009). <http://www.equalitytrust.org.uk/> accessed June 2010.

**Ken Fraser:**

Right. I just wanted to emphasise that child psychiatry outside the research field did grow, and I mean the number of child psychiatrists now is much greater than it was at the beginning of the period in question.

**Philip Graham:**

Thank you, Ken. Behind you – briefly, Harry -

**Harry Zeitlin:**

Should there be some mention during these three decades of the dreadful impact of media violence and of the huge rise in the aggressive sale of drugs and substances, because if you're talking about the rise of psychopathology they did have an impact? But we haven't had anything on those and they were dreadful.

**Philip Graham:**

Well, thank you very much for raising those issues. I think there was an exponential increase in the relevance in those influences but maybe just after the period we're talking about. Any other points?

In that case it is only left for me to say thank you so much to all of you in the audience for coming to this seminar, and for attending so carefully to what those of us who have been looking back have said. It's unusual for people of our generation to have the luxury of being able to share ideas in this sort of way. You've been very indulgent towards us; we're very grateful and we hope you've had as interesting afternoon as we have. Thank you very much, indeed.

## Reflections

### Helen Minnis

I was asked by Philip Graham to take notes on the Witness Seminar and comment on behalf of the generation of child and adolescent psychiatrists who trained after 1990. This was a pleasure.

I myself chose child and adolescent psychiatry because it was a young specialty and I was excited by the expectation that it would change rapidly during my working lifetime. At the Witness Seminar, I had the opportunity to hear from the men and women who have driven that change. It was a privilege to hear from some of the giants of British child and adolescent psychiatry on whose shoulders my generation now stand.

It was striking that all but one of the speakers were white men, mainly from a rather particular social background. The one woman, Dora Black, was invited to speak about issues mainly pertinent to women. On the other hand, it is these men who have embraced innovation such that even the demographics of professional leadership in child and adolescent psychiatry have begun to change. For example, there was much discussion throughout the day about the Child Psychiatry Research Society (CPRS), a “research club” that continues to have an important place in the development of the specialty. One clear piece of evidence of change in demographics is that CPRS has been recently chaired by Professor Anita Thapar, an Asian woman, who is regarded as one of the leaders in our field. It will be interesting to see how those changing demographics - which include myself - might impact on the topics we research and the ways in which we innovate over the next few years.

Although the seminar was held in Glasgow, the great majority of the speakers were from London, and I think this reflects the fact that child psychiatric leadership has been heavily dominated by London since the 1960s. This continues to be the case, particularly in the academic sphere, and is of concern from the standpoint that valid research questions arising in other parts of the UK may not have the opportunity to be addressed. My own impression is that, outside London, research training for child and adolescent psychiatry trainees tends to be somewhat undervalued and this is

something I think we need to consider as our specialty moves forward.

But the main focus of the afternoon was to hear how child and adolescent psychiatry developed between 1960 and 1990. This was a crucial period for a young field. I was amazed to hear that Michael Rutter had taken Aubrey Lewis's advice and had not actually trained in child and adolescent psychiatry because "the training at that time was not very good and, particularly, that it was of a kind that was likely to inhibit creative thinking and research innovation" (page 23). Instead he focussed on child psychiatry, neuropsychiatry and epidemiology. No-one would, I think, now suggest that a child and adolescent psychiatry training would inhibit creative thinking because, on the contrary, current trainees are expected to have a good understanding of the complex ways in which genetics and environment interact to produce strengths and difficulties in children and their families. Rather than being considered a bit of a poor sister to other medical specialties (which was the case when I began training in the early 1990s), it seems that medicine and society at large have begun to realise the fundamental importance of the early weeks and months of life for the development of mental and physical health across the lifespan. Bizarrely, this understanding does not yet seem to have had a major impact on the way we practice child and adolescent psychiatry in the UK, but I would predict that a greater focus on infant mental health might be the major change in direction of our specialty over the next few years.

Many considered that British and, to a certain extent, world child and adolescent psychiatry was invented by Michael Rutter, and his overview of his contribution had such breadth and depth that this impression was confirmed. However, he was the leader of a group of innovative thinkers, all of whom took a share in driving thinking about the mental development of children forwards, and many of them presented at the seminar.

It was inspiring to be reminded of the female pioneers of our profession. Sula Wolff, who has sadly died since the seminar, was in the audience, and Naomi Richman had to give apologies at the last minute because of illness. The extent of achievement of these extraordinary women was underscored by Dora Black, who described actually having to VOLUNTEER in order to get her training (page 41), and by Sula, who commented that when she got into medicine, King's only took seven women a year (page 46). Thank goodness both the men and women driving our profession from

the '60s to the '90s realised that things had to change. Phillip Graham (page 73) made an accurate observation that nowadays both men and women in child and adolescent psychiatry are more willing to embrace family life as well as work.

Bill Yule made interesting observations on how non-psychiatric specialties became integrated into child mental health and helped develop practice from the 1960s to '90s. For example, he commented that social workers trained "en masse" to become family therapists in a way that made an important contribution (page 72). Sadly, this trend has since reversed and most of my social work colleagues are now too busy writing child protection reports to have any therapeutic role. Those who are trying to get more involved in close working with CAMHS seem to have lost a lot of confidence in their ability to do clinical work. As child psychiatrists, we may have limited influence on this unfortunate trend, but at least we can lament it in the hope that our colleagues' managers will see that change could benefit all of us.

I thought Michael Rutter's comments on psychoanalysis being "an ideology outside of science" (page 79) were very important. I suspect that many of us (particularly in academia) feel strongly about this but have been unable to say it. It is so important, particularly in a young field like CAMHS, that we resist ideologies that are driven by prominent individuals, as these can be an enormous barrier to change. A modern example is the battle between members of the attachment field - researchers versus clinicians. Rather than useful open debate, this has become a war in which each side refuses to listen to (or more to the point publish) the views of the other. As Michael said, there is always a danger of "throwing the baby out with the bathwater" (page 80) in any ideological debate, as both sides are probably partially right.

And what of the future? I was struck by Michael Rutter's comment that he came to the Maudsley with no intention of becoming a researcher - true of many of us working now in academic child and adolescent psychiatry. It appears that, with the new training pathways, it is going to be very difficult to enter academic medicine unless one decides to do so at medical school, and I am concerned that the academic underpinnings of our profession are now under threat. On the positive side, I feel a great debt to the men and women who presented the Seminar as they have helped to turn a sleepy, ideology-driven specialty into a field that is full of scientific energy and clinical innovation. There were useful pointers for the future from the Seminar: Phillip Graham cautioned us to grapple with preventive child psychiatry (page 103);

Michael Rutter reminded us that we must combine scientific understanding of genetics and environment with listening to the patient (pages 78-80). However we achieve it, my generation has a responsibility to try and ensure that in the next 30 years we help effect a similar degree of rapid and positive change as did our colleagues between 1960 and 1990.

## Participants

### *Main Participants:*

Malcolm Nicolson

Philip Graham

Hugh Morton

Lionel Hersov

Michael Rutter

Ian Berg

Dora Black

Arnon Bentovim

Bill Yule

Sebastian Kraemer

Bryan Lask

Bob Jezzard

### *Audience Participation from:*

Sula Wolff

Ken Fraser

Harry Zeitlin

Graham Bryce

Helen Minnis

David James

David Stone

Forrester Cockburn

Elaine Lockhart

Michael Morton

John Stewart

## **Appendix**

### **Biographical Information**

#### **Hugh Morton**

A native-born Scot, I am a graduate of St Andrews University. I was attracted to psychiatry by the fine undergraduate course led by Professor Ivor Batchelor, and during postgraduate training was particularly drawn to child and adolescent psychiatry. There followed an extended attachment to the Dundee child and adolescent psychiatry service before I became a senior registrar on the training scheme based on St Georges, London. Thereafter I returned north to a consultant post in Dundee, with a particular remit to develop a service to four local Approved Schools. I served on the working group of the Scottish Health Service Planning Council on the future shape of child and adolescent mental health services in Scotland, between 1978 and 1982; and later on a Scottish Office Working Party on Secure Units. I have been a clinical tutor, and was chairman of the Child and Adolescent Psychiatry Section of the Scottish Division of the College. Outwith child psychiatry, I chaired my local Committee for Hospital Medical Services, and served on the parent Scottish Committee. In 1991, I was appointed as an assessor to the Scottish High Court judge, Lord Clyde, who had been requested by the Secretary of State for Scotland, to hold a Public Enquiry, in Orkney, into the actions of agencies involved in the removal of a number of children from their homes, following allegations of sexual abuse. I retired in 1997.

#### **Lionel Hersov**

I was born on 19 November, 1922, in South Africa. I grew up in the countryside until I was old enough to go to school. After matriculating in 1939 I began training at the University of Witwatersrand Medical School. I turned twenty-one in 1943 and in my fourth year volunteered for full-time service in the 6th South African Armoured Division in Italy. After a period of training, I was posted as a combat medical technician to the Royal Durban Light Infantry. I saw action in the breakthrough of the Gothic Line and the crossing of the Po river until peace was declared. My experiences in the Army had some influence on my later decision to become a psychiatrist.

On return home I continued my medical training, graduating MB,BCh, in 1948. After two years experience as a house officer, I chose to train in psychiatry. After fifteen months unsatisfactory work experience I travelled to London and applied for a training post at the Bethlem Royal and Maudsley Hospitals. I completed training in general psychiatry, gaining the Academic Diploma in Psychological Medicine, followed by training in Child and Adolescent Psychiatry while completing an MD Thesis.

My consultant appointments were at the Child Guidance Training Centre, the Hospital for Sick Children, Great Ormond Street, Hammersmith Hospital and the Royal Postgraduate Medical School, and the Bethlem Royal and Maudsley Hospitals. While I was at the Maudsley I was appointed Civilian Consultant in Child and Adolescent Psychiatry to the British Army (Ministry of Defence).

As President of the International Association of Child and Adolescent Psychiatry and Allied Professions, I presided over the Tenth International Congress in Dublin. In 1963, I became editor of the *Journal of Child Psychology and Psychiatry* and a committee member of the Association of Child Psychology and Psychiatry until 1984. In 1984, I became Professor of Psychiatry and Pediatrics at the University of Massachusetts Medical School and Medical Center in Worcester, Massachusetts. I remained in Worcester until 1990, when we returned to London. I am now an Honorary Distinguished Visiting Scientist at the Tavistock Clinic and the Tavistock and Portman NHS Foundation Trust.

I married Zoe in 1952 and we have four children. My wife is a historian and theologian.

### **Michael Rutter**

I trained in medicine at the University of Birmingham, England, with postgraduate training in neurology, pediatrics and psychiatry in the UK, and then training in child development at Albert Einstein College of Medicine, New York. Until 1998 I was Professor of Child Psychiatry at the Institute of Psychiatry, Kings College, London; Director of the Medical Research Council Child Psychiatry Research Unit, and the Social, Genetic and Developmental Psychiatry Research Centre in London. My research interests span a wide field, but with a particular focus on the developmental interplay between nature and nurture and on the use of natural experiments to test

causal hypotheses about genetic and environmental mediation of risk in relation to normal and abnormal psychological development. I am the recipient of numerous international awards and honours and was elected a Fellow of the Royal Society in 1987. I was President of the Society for Research in Child Development from 1999 to 2001, and the International Society for Research into Child and Adolescent Psychopathology from 1997 to 1999. My books include *Maternal Deprivation Reassessed*; *Antisocial Behaviour by Young People* (jointly); *Sex Differences in Antisocial Behavior*; *Conduct Disorder, Delinquency and Violence in the Dunedin Longitudinal Study* (jointly); and, with my wife Marjorie, *Developing Minds: Challenges and Continuity Across the Lifespan*.

### **Ian Berg**

I qualified in medicine at the University of Leeds Medical School in 1956 and after “house jobs” at Leeds General Infirmary and St James’s University Hospital, respectively, I joined the McGill University Psychiatry Training Scheme in Montreal, Canada, and worked at the Royal Victoria Hospital and the Children’s Hospital there. Having returned to the UK, I became Registrar in child psychiatry at the Great Ormond Street Hospital, London, and then Senior Registrar at the Royal Hospital for Sick Children, Edinburgh. From 1965, I was Consultant Child and Adolescent Psychiatrist at Leeds General Infirmary and the western part of Yorkshire, as well as Senior Clinical Lecturer at the University of Leeds for about thirty years. Subsequently, I continued to work as a Consultant Child and Adolescent Psychiatrist in the NHS in various parts of the United Kingdom, including Dumfries, West Lothian, Aberdeen and the West Country, as well as London: St Mary’s Paddington and Great Ormond Street Hospital. I published over 80 papers in peer-reviewed journals and chapters in books, on psychiatric conditions affecting children and adolescents, mostly on my own research projects carried out with colleagues. Subjects included school attendance problems, elimination disorders, and assessment. I have often been asked to act as an expert witness in medico-legal cases. I was involved in various societies and committees concerned with child psychiatry, including those at the Royal College of Psychiatrists, European societies for child psychiatry and for psychology and law, ISRCAP, and the Mental Health Foundation Research Committee. I was a founder member of the Child Psychiatry Research Society and the former Society for the Psychiatric Study

of Adolescents. I was Secretary and then Academic Secretary of the Child Psychiatry Section at the Royal College of Psychiatrists, and Academic Secretary for the 1991 London Conference of the European Society of Child and Adolescent Psychiatry. I am married with three children and now live in Edinburgh.

### **Dora Black**

I was born in 1932, and, having been evacuated (with mother and younger sister) to USA during World War Two, attended sixteen schools in all. I graduated in medicine at University of Birmingham in 1955, and after pre-registration house posts and marriage to Jack, a solicitor (we celebrated our Golden Wedding in 2005), I started my psychiatric career at a large mental hospital, Napsbury, in outer London, moving to the Maudsley Hospital and Bethlem Royal to gain a proper training. My first child was born in 1960, and two others followed in 1961 and 1963. Part-time SHMO posts followed in child guidance clinics, while rearing the children. In 1966, I was appointed to my first consultant post, part-time, at child and family psychiatric clinics in Hertfordshire, moving, in 1968, to a newly established child guidance clinic in Finchley with sessions at Edgware General Hospital; the first time they had had a child psychiatrist on the staff. There I developed a liaison service to the paediatricians, and I developed this further in my first full-time post, in 1984, at the Royal Free Hospital. I was a founder member of the Royal College of Psychiatrists in 1972, being elevated to Fellow in 1979, and was honoured with Fellowship of the Royal College of Paediatrics and Child Health in 1990.

I was much influenced in my clinical work by Bowlby's work on attachment, Winnicott's ideas about "good-enough" parenting, and George Brown's, Gerald Caplan's and Colin Parkes' research on bereavement. In 1993, driven by my experience with traumatically bereaved children (especially those bereaved by one parent killing the other) and my modest research on ways of helping them, I founded a Children's Trauma Clinic, initially at the Royal Free Hospital, and subsequently, linking with an adult traumatic stress service, at the Traumatic Stress Clinic, London. I retired from the NHS in 1997 but continue to do expert witness work for the courts.

What am I most pleased about looking back over my career? Firstly, having found a satisfying career in medicine whilst enjoying a normal family life; secondly, the

satisfaction of clinical work in an autonomous setting; thirdly, taking part in the pioneering of paediatric liaison and of the recognition of and treatment of traumatic stress in children and adolescents.

### **William Yule**

I graduated in psychology from Aberdeen and then trained in clinical psychology at the Maudsley. My first post was as research officer in the Social Psychiatry Research Unit investigating the reasons for lack of change in care in institutions. My mentor was Jack Tizard, who had a great impact on my thinking. When Jack was appointed to the first Chair in Child Development at the Institute of Education, I was recruited to supervise the psychological aspects of the Isle of Wight epidemiological studies, where I worked with Mike Rutter and Philip Graham.

I returned to the staff at the Institute of Psychiatry, became head of the clinical course and director of clinical psychology services, and worked clinically with Lionel Hersov and Judy Treseder. I published widely in child behaviour therapy, parent and teacher training, dyslexia and later developed a new field of work in child post traumatic stress disorder.

I was made an Honorary Fellow of the British Psychological Society and received a lifetime achievement award from the International Society for Traumatic Stress Studies. I have been civilian advisor in clinical psychology to the British Army and am currently Chair of the Children and War foundation ([www.childrenandwar.org](http://www.childrenandwar.org)).

### **Sebastian Kraemer**

I was born in 1942, and educated in Edinburgh and Sussex. After a philosophy degree at University College London, in 1964, I worked as a teacher in an east London secondary school for six months, then spent the rest of the decade in Guy's Hospital Medical School, where I was a student of Ronald MacKeith. I worked as a junior paediatrician in Glasgow, Manchester and the original (now demolished) Evelina Hospital of Guy's, then trained in psychiatry at the Maudsley Hospital, moving, in 1976, to the Tavistock Clinic to complete child and adolescent psychiatry training.

In 1980 I was appointed consultant at the Child Guidance Training Centre (which was taken over by the Tavistock Clinic a few years later) and at the Whittington Hospital, where I have remained for almost 30 years. I began in the paediatric

department as a lone professional and developed a small multidisciplinary team of part timers to provide a highly regarded service, on which the mental health section of the 2003 National Service Framework for children's hospital services was based.

At the Tavistock I was programme director of the child and adolescent psychiatry training from 1986 to 2001, a large and successful scheme incorporating many placements in north London and Hertfordshire. For five years I was a member of the RCPsych special advisory committee on child and adolescent psychiatry (CAPSAC), visiting and inspecting schemes all over Britain. I retired from the Tavistock Clinic in 2003.

I have written - and peer reviewed - many papers and chapters, on family therapy and its relationship with psychoanalysis, the role of fathers from anthropological and current social perspectives, the fragility of the developing male, child protection, paediatric liaison, work discussion, group relations and professional development, attachment and social inequality in social policy, and given frequent conference presentations - mostly in UK and Ireland - on these themes over the past twenty years. I am a trustee of the Association for Infant Mental Health, the Association for Child and Adolescent Mental Health, the Tavistock Clinic Foundation and ParentingUK. I was appointed honorary senior lecturer at UCL in 1981, and awarded an honorary Doctorate of Education by the Tavistock Clinic and the University of East London in 2007.

### **Bryan Lask**

I am Emeritus Professor of Child and Adolescent Psychiatry at Great Ormond Street Hospital for Children and the University of London; Academic and Research Director, Ellern Mede Centre, London; and Visiting Professor and Research Director at Ulleval University Hospital, Oslo. I am also President-Elect of the Eating Disorders Research Society. My clinical and research interests have included many aspects of child psychiatry and particularly the psychological aspects of childhood illness. More recently my interests have focussed on early onset eating disorders. I have published over 180 papers as well as numerous chapters edited by others, and have written nine books. I have also been the Editor of the *Journal of Family Therapy* and of *Clinical Child Psychology and Psychiatry*.

### **Bob Jezzard**

I studied natural sciences and medicine at Gonville and Caius College, Cambridge and then at Guy's Hospital, London, and qualified as a doctor in 1971. After undertaking a number of medical posts I obtained membership of the Royal College of Physicians in 1974, and then joined the psychiatry training scheme at the Maudsley and Royal Bethlem Hospitals. My higher training, at the same hospitals, was in child psychiatry, and in 1980 I was appointed as consultant child psychiatrist at the Bloomfield Clinic, Guy's Hospital. My responsibilities included the in-patient care of adolescents and the provision of psychiatric services to Southwark Social Services, and a special school for children with emotional and behavioural difficulties. Following a period as Clinical Director, I was seconded part-time to the Department of Health as a Senior Medical Officer in 1994. I was made a Fellow of the Royal College of Psychiatrists in 1993, and a Fellow of the Royal College of Physicians in 1995. In 2000 I was appointed as Senior Policy Adviser in child and adolescent mental health at the Department of Health but continued with some clinical work, with a specialist mental health team for looking after children in Southwark. In 2006 I was awarded an OBE for my contribution to national policy for the mental health of children and young people, while at the Department of Health. I retired in 2006, but was invited to be Vice Chair of a national review of CAMHS in England, in 2008.

### **Arnon Bentovim**

I grew up in a medical household; my father was a general practitioner who had aspirations to be a psychiatrist. Because of the era he grew up in he became a general practitioner, attended Balint Groups, learnt acupuncture and medical hypnosis, and was generally interested in psychological approaches.

I went to St Thomas's Hospital, a conservative "Doctor in the House" institution, with excellent scientific medicine through Professor Sharpey-Shaeffer, Hugh de Wardener who pioneered renal medicine, and Ivor Mills, endocrinological medicine. William Sargant was the charismatic psychiatrist and a good model for those of us interested in mental health. I qualified in 1959, went to the Maudsley 1962 to 1966, where I became interested in psychotherapeutic approaches, and through interest in paediatrics, the child psychiatry rotations. I began to think about Family Systemic

Approaches having been assigned systems papers by Aubrey Lewis, and the subversive anti-psychiatry role of Ronnie Laing in my period at the Maudsley, 1962 to 1966.

I went as a Senior Registrar in 1966 to Great Ormond Street Children's Hospital. Through excellent supervision from John Bremner, a pioneer Kleinian Child Psychotherapist, I began to understand how the processes in adult psychotherapy could be applied to childhood. I underwent the psychoanalytic training but was also very much influenced by the growing interest in family systemic thinking in the late '60s, and was involved with the formation of the Association and Institute of Family Therapy.

I was appointed at Great Ormond Street in 1968, and in 1975, I took some sessions at the Tavistock Clinic, hoping that I could find a way of marrying my psychoanalytic and family systemic interests. The development of work in the child abuse field became an increasing part of my work with the establishment of the Sexual Abuse Assessment and Treatment Service and the Child Care Consultation Service. Our attempt to work with families responsible for sexually abusive action was as controversial with feminist groups, who disbelieved there was potential for families to be reunited, as from those who disbelieved children's account of abusive experiences.

After I retired from the hospital in 1994, I established an independent, multi-disciplinary child and family practice to provide a multi-disciplinary team approach available in the independent sector, and established a training organisation - Child and Family Training - to train workers in evidence based approaches to assessment in the welfare field.

### **Philip Graham**

I was born in 1932 and brought up in Luton, Bedfordshire, where my father was a dentist and my mother a socialist. At ten years of age I was sent to a Jewish boarding house at the Perse School, Cambridge. After Higher Certificate in 1949, I was given a place to read law at Cambridge and then, for a gap year, went to the Sorbonne, Paris. There I changed my mind and decided I wanted to be a psychiatrist. I took a first MB at Luton Technical College, in 1951, and then did two years National Service in the RAF, as a fighter controller.

I read Natural Sciences with a Part 2 Psychology at Cambridge, and then clinical medicine at UCH, London, qualifying in 1959. After a couple of years of house jobs, having by some miracle obtained the MRCP (London), I went to the Maudsley in 1961. After taking my DPM, in 1964, I began to work with Michael Rutter on various epidemiological studies. It was a sharp learning curve. I worked mainly on the Isle of Wight and Family Illness studies.

In 1966 I was appointed to a consultant child psychiatry post at the Maudsley and Brixton Child Guidance Clinic, and to a senior lecturer post at the Institute of Psychiatry. I left in 1968, on appointment to be Head of the Department of Psychological Medicine at Great Ormond Street Children's Hospital. There I was involved in building up the department in collaboration with a number of wonderful colleagues, especially Arnon Bentovim, Richard Lansdown, Naomi Richman, Bryan Lask, Ann Elton and Roy Howarth.

In 1974, I was appointed to the new Chair of Child Psychiatry at the Institute of Child Health, London. At various times I've been elected to be Chair of the Child Psychiatry Section of the RCPsych (1974 to 1977) and President of the European Society for Child and Adolescent Psychiatry (1987 to 1991). From 1985 to 1990 I was Dean of the Institute of Child Health.

In 1994 I retired from my University position. Since then I've held a variety of mainly honorary positions. I was part-time Professor of Child Psychiatry in the University of Oslo, Norway (1994 to 2000), Chair of the National Children's Bureau, from 1994 to 2000, and Chair of the Association of Child Psychology and Psychiatry, from 2001 to 2003.

Over the years I've written a number of articles and books, including *Child Psychiatry: A Developmental Approach* (now jointly authored, 4th edn. 2007), *The End of Adolescence* (2004) and, most recently, a biography of Susan Isaacs (2009). I've edited *Cognitive Behaviour Therapy for Children and Families* (2nd edn. 2005).

I think I've been incredibly lucky to spend my working life in a fascinating, expanding field in which I've had the opportunity to work with friendly, stimulating colleagues, to continue to learn, to develop my personality, and to travel widely. My only serious regret is that my workaholic habits meant I spent less time with my

family than I now wish I had.

**Helen Minnis**

Helen is Senior Lecturer in Child and Adolescent Psychiatry in the University of Glasgow.