

HISTORY OF CHILD PSYCHIATRY

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“How soon can a child go mad?” asked Henry Maudsley in his 1895 textbook *The Pathology of Mind*, “Obviously not before it has got some mind to go wrong, and then only in proportion to the quantity and quality of mind which it has”, alluding to the widespread belief, even at the end of the 19th century, that children’s minds were not developed and stable enough to be able to show much psychopathology.

The history of child psychiatry—a term that can mean a collection of services, a body of knowledge, and a profession—is inextricably linked to the history of childhood; recognising childhood as a distinct period of development is a prerequisite to acknowledging child psychiatry as a discipline (a full chapter, J.9, is dedicated to the history of childhood in this book). Thus, the history of child psychiatry is interlocked with our understanding of development, child-rearing practices, the place of children in society, and with non-medical fields such as juvenile justice and education. For example, some historians date the beginnings of child psychiatry in the US to 1899 when the state of Illinois established the nation’s first juvenile court in Chicago (Schowalter, 2003).

Few references can be found about childhood psychopathology prior to the 19th century. This is not restricted to children’s mental disorders; paediatrics began to emerge as a medical specialty only by the end of the 18th century. *L’Hôpital des Enfants-Malades* founded in 1802 in Paris was the first hospital especially established for the treatment of sick children (TEC, 1981). Great Ormond Street opened in London 50 years later. However, hospitals in the UK and elsewhere had been providing inpatient care for substantial numbers of children long before then (Williams & Sharma, 2014).

The first child psychiatry shoots did not appear in the clinical tree until as recently as the 1920s with the child guidance movement. For example, what we now call the International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) started in 1937, the American Academy of Child & Adolescent Psychiatry (AACAP) was founded in 1953. The Union of European Paedopsychiatrists, which later became the European Society for Child and Adolescent Psychiatry (ESCAP), had its first meeting in October 1954. In many countries child psychiatry is not yet formally recognised as a subspecialty, not taught in medical schools, and no formal training is available.

Given its short lifespan, is a *history* of child psychiatry justified? While child psychiatry as a subspecialty is in its early days, it is important to chart its development, particularly now when many of its pioneers are still alive or can be remembered by people who learned first-hand from them. Not recording past trends and some of the key events would be negligent since much of that history may be forgotten and an opportunity to learn from past mistakes and successes missed. It will also allow placing the current issues in a historical context. Nevertheless, trying to summarise the history of child and adolescent psychiatry globally—the specialty has evolved differently in different countries, e.g., Argentina, France, Soviet Union, UK—is a large undertaking and cannot be accomplished with the detail it deserves in the setting of this chapter. To this end and to give an indication of the variety of practices and traditions, a large fresco is painted. Against this background, brief summaries of the history in a few specific countries or geographical regions are presented to highlight similarities and differences, to

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show that political, economic, social and cultural factors had an impact on its development, and that people from many countries made great contributions to the discipline, often not recognised enough in the dominant narrative, written in English. In this chapter the term “child psychiatry” is used to mean infant, child and adolescent psychiatry, as appropriate.

CHILD PSYCHIATRY PRIOR TO THE 20TH CENTURY

Before the 1900s little interest in child psychiatric disorders can be found. Not a single article that made reference to children was published in the first 45 years of the *American Journal of Insanity* (1844–1889), the forerunner of the *American Journal of Psychiatry* (Levy, 1968a). Benjamin Rush (1812)—probably the first American psychiatrist—made no mention of children in his influential textbook *Medical Inquiries and Observations upon the Diseases of the Mind*.

Although some children in every era have shown emotional and behavioural problems, these were not seen as medical concerns and were dealt with in different ways through the centuries. Behavioural disorders were largely considered moral problems, thus deserving punishment (the result of *badness* rather than *madness*). Failure to learn usually led to a marginalised existence, for example as a village idiot. The scarce 18th century medical writings focused mainly on issues such as seizures, fear in dreams, sleep disturbances, stuttering, sibling rivalry, and epilepsy. The prevailing view being that “insanity did not occur before puberty, and it was often observed that children were not seen in public asylums or private madhouses” (Parry-Jones, 1989). The situation changed in the 19th century when general psychiatry textbooks began mentioning madness in children. For example, Maudsley’s 1895 book dedicated a chapter to “the insanity of early life”, while Griesinger (1867) noted that mania and melancholia did occur in children. “A study of over 300 juveniles, aged up to 19 years, admitted to Oxfordshire asylums in the 19th century reveals a wide range of clinical presentations including a substantial number of mentally defective children [...] The supposed causes of insanity fell into two broad categories. Firstly, there were psychological causes such as fright and grief and, secondly, physical causes, including epilepsy and infectious fevers, like typhoid and measles” (Parry-Jones, 1989). Lunatic asylums were the forerunners of psychiatric hospitals.

Towards the end of the 19th century, there was a growing understanding of the multiple factors involved in the development of childhood psychiatric disorders, although the emphasis was on heredity: “The course of the growth and development of the brain is marked by many dangers — and no wonder—for it is the process of bringing to perfection of by far the highest evolution in Nature, this process being constantly impeded and endangered by diseases peculiar to the period, by parental ignorance of what the brain needs, and by unhygienic conditions of all kinds. Above all, the process cannot be completed properly in very many cases because there is an adverse heredity—a true fate against which knowledge, affection and will and the command of every favourable condition are often powerless to contend [...] Hereditary tendency towards insanity, however strong, seldom develops into a mental disease till after the period of adolescence is well on” (Tuke, 1892, p357).

It was widely believed that full human development was not achieved until around the age of 25 (confirmed recently by brain imaging techniques), and that insanity was rare in adolescents, becoming more common in young adults: “There is no period of life when uncomplicated insanity occurs more frequently than during the completion of the physiological era of adolescence, from twenty-one to twenty-five. As regards the two sexes our statistics seem to show that adolescence does not appear to be so powerful an upsetter of mental equilibrium in women as in men.” (Tuke, 1892, p262). Puberty was recognised as a significant cause in insanity and Durand-Fardel (1889) highlighted the existence of suicide in children.

Although juvenile insanity was thought to be rare, its existence became widely accepted—by the end of the 19th century most textbooks included sections on children—and juvenile insanity was differentiated from mental retardation and epilepsy (Parry-Jones, 1989). In 1887 the German psychiatrist Hermann Emminghaus (1887) published one of the first treatises in child psychiatry (*Psychic Disturbances in Childhood*). By contrast, Kraepelin’s ground-breaking psychiatric taxonomy published in 1883 ignored children’s disorders.



Henry Maudsley (1835-1918), a British psychiatrist, was one of the first to describe insanity in children in his 1895 textbook.

20TH CENTURY

THE CENTURY OF THE CHILD

Ellen Key, a Swedish writer and suffragist best known for her 1900 book *The Century of the Child* (*Barnets Århundrade*) proposed that the world’s children should be the central concern of society during the 20th century, which she named “the century of the child”. Her book became very influential as far as the understanding of children in society (see Chapter J.9) and child psychiatry are concerned. Many significant advances occurred in the early 1900s that set the scene for child psychiatry to become the fully-fledged medical discipline that it is today. These include improvements on measurement, advances on developmental psychology, the advent of psychoanalysis, and the mental hygiene and child guidance movements.

The second half of the century, after World War II, witnessed an explosion in research with big advances in the understanding of the nature of childhood mental disorders, their diagnosis and classification, and in treatment—led by cognitive and behavioural approaches and psychopharmacology. It also witnessed the definite establishment of the discipline as a medical specialty.

MEASUREMENT

The ability to reliably quantify phenomena is at the very core of scientific progress; that is the case also in mental ill health. The development of measuring instruments has allowed the scientific progress of the discipline and child psychiatry to become a respected part of medicine. Further, the last century has seen a shift from concerns about just survival to a conceptualization of health as an absence of disease, as individuals’ ability to perform their daily activities, and in terms of quality of life, increasingly acknowledged to be greatly influenced by a person’s mental health, resilience, and ability, factors that needed to be measured reliably.



[Click on the picture to watch a web-documentary about Alfred Binet \(in French\)](#)

Intelligence

Alfred Binet (1857-1911), one of the most influential French psychologists and scientists, transformed the measurement of intelligence, setting the foundation for quantitative psychology and psychiatry. In 1905, Binet together with Théodore Simon published the first standardized scale of intelligence, the *Binet-Simon Test*. The score on the scale would reveal a child's *mental age* and would allow to establish its concordance or otherwise with physical age. The test consisted of thirty tasks of increasing difficulty, the product of more than 15 years of work and experimental research with children. Binet and Simon's test was standardized in the US shortly after by Lewis Terman, a Stanford University psychologist. First published in the US in 1916, it was called the *Stanford-Binet Intelligence Scale* and soon became the customary intelligence test used in the US. An updated version is still in use.

Binet did not think that his test measured an inborn, crystallised cleverness; on the contrary, he believed that intelligence scores could differ with a variety of factors such as temperament and motivation. He hypothesized that intelligence was the sum of a variety of skills and that a reliable estimate could be obtained by sampling these skills and adding the results. The figure thus obtained is more reliable than teachers' and parents' estimates. Debate about what intelligence *is* has raged ever since and is still far from settled. Nevertheless, the introduction of intelligence testing revolutionised clinical practice and research by allowing interventions to be tailored to the needs and capacity of individual children.

The creation of a new instrument, which addressed some of the limitations of the *Stanford-Binet Test* by David Wechsler (1896-1981), an American psychologist, represented the next step forward in intelligence testing. In 1939 he compiled a

battery of tests for adults known as the *Wechsler-Bellevue Intelligence Scale*. Wechsler believed—like Binet—that intelligence involved a variety of mental abilities and stressed that factors such as personality contribute to intelligence. He rejected the concept of an *ideal* mental age against which individual performance can be measured and defined *normal intelligence* as the mean test score for all the members of an age group; the mean could then be represented by 100 on a standard scale.

The *Wechsler Intelligence Scale for Children* (WISC) was published in 1949. The WISC was an adaptation to children of several of the subtests which made up the *Wechsler-Bellevue Intelligence Scale* with other subtests specifically designed for the WISC. The subtests were organized into *verbal* and *performance* scales, and provided scores for a *Verbal IQ* (VIQ), a *Performance IQ* (PIQ), and a *Full Scale IQ* (FSIQ), highlighting that abilities are not necessarily homogeneous. That is, some children may have high verbal ability but low performance skills such as in visuospatial tasks. The WISC, which has been updated regularly since then and normed in different countries and cultures, has become the most widely used intelligence test in children.

Although measuring school achievement had taken place previously, publication of the *Stanford Achievement Test* by Terman and colleagues in 1923, made large scale school testing possible. Achievement tests are now widely used in clinic settings, to detect areas of educational need, and for school funding.

Questionnaires

G Stanley Hall (see below) was the major force behind questionnaire development. His questionnaires covered topics as diverse as fears and dreams. Not long after, William Healy (one of the initiators of the child guidance movement) and Grace Fernand published in 1911 a series of tests to evaluate delinquent children. Many other questionnaires were subsequently developed to measure specific symptoms (e.g., depression, hyperactivity) or, from the 1960s, a wide range of problem behaviours. The last type, pioneered by Achenbach, has evolved into an empirical system of clinical diagnosis: *ASEBA* (Achenbach, 2009; see also Chapter A.3). More recently there has been growing interest in brief questionnaires that can be used for screening purposes, for example Goodman's (1997) *Strengths and Difficulties Questionnaire* (SDQ). Achenbach (1987) also highlighted that to achieve a more valid picture in child psychiatry, information needs to be obtained from a variety of sources—parent, child, teacher—that often disagree. The need for this is widely acknowledged although there is argument about how such information should be integrated. Questionnaires have become an integral part of good everyday clinical practice mostly to measure severity of symptoms and track response to treatment.

Diagnostic interviews

The need to improve the reliability of psychiatric diagnosis, which became evident in the 1960s and 1970s, not only spurred the creation of better taxonomies but also the development of structured and semi-structured diagnostic interviews, themselves facilitated by the availability of operationalised diagnostic criteria (e.g., in DSM-III). One example of structured interview is the one designed by David

Shaffer and his colleagues (1996) following a model used for adults. Structured interviews use a set of questions that tap specific symptoms required to make a diagnosis with “yes” or “no” answers, therefore capable of being administered by lay people. These interviews have been used mainly in epidemiological studies and their administration has been simplified greatly by the introduction of mobile computing.

Semi-structured interviews consist of a variety of specified symptoms (matching the diagnostic criteria for a particular disorder) that need to be rated and have tight rules for scoring but the interviewer has freedom to ask questions and clarification. Initially these were administered by clinicians, which was prohibitively expensive. An example of a semi-structured interview is the *Kiddie-SADS* developed by Joaquim Puig-Antich and his colleagues.

DEVELOPMENTAL PSYCHOLOGY

Developmental psychology seeks to explain how children change over time. Understanding development is important for the study of psychopathology. Interest in this field grew with the acknowledgement of childhood as an important area of study in the 19th century (see Chapter J.9). The ongoing theme has been the tension between proponents of the roles of nature *vs* nurture and their interplay in development.

The emergence of developmental psychology as a discipline is imprecise but can be traced back to 1882 when Wilhelm Preyer, a German physiologist, published *The Mind of the Child*. In this book Preyer presented his observations on the development of his own son from birth to the age of three; work admired more



Front row, from left: Sigmund Freud, G Stanley Hall, CG Jung; back row: Abraham A Brill, Ernest Jones, Sándor Ferenczi. Clark University, 1909.

for its methodology than for the originality of its thinking. The discipline became further established following the work of Alfred Binet on intelligence measurement and of James Mark Baldwin (1861-1934), a US psychologist best known for the “Baldwin effect”—that epigenetic factors shape congenital endowment as much as, or more than, natural selection.

G Stanley Hall

G Stanley Hall (1844-1924) is considered the founder of organised psychology in the US. He started the first American journal of child psychology in 1891 (*Pedagogical Seminary*) and the first society of child study in 1894. He was strongly influenced by scientists in Germany, where he spent his early professional years. His invitation to Sigmund Freud to speak at Clark University in 1909 brought psychoanalysis to America. He also succeeded in securing the recognition of psychology as a profession. One of Hall’s most important publications was his two volumes dedicated to adolescence, which he conceptualised as the developmental stage between 14 and 24 years of age (Hall, 1904). Apart from describing adolescence as a time of “storm and stress”—a concept much maligned in subsequent years—he already noted that adolescence was characterised by an increase in the prevalence of depressed mood, crime rates, sensation seeking, and susceptibility to media influences. He also highlighted the importance of peer relationships. Likewise, Hall defined what today is often labeled as “relational aggression”—so common in this social media age, particularly among girls. That is, aggression expressed through gossip, rumour, and ostracism. He supported an evolutionary view of development, which among other consequences led him to believe that children should not be taught to read until the age of eight years because literacy had happened very late in human evolutionary history (Arnett, 2006).

Psychoanalysis

One of the figures who dominated psychiatric thinking during most of the 20th century was the Austrian neurologist and psychiatrist Sigmund Freud (1856-1939). Freud’s understanding of development grew out of his approach to human personality and psychopathology based on his and his patients’ recollections. Freud developed a model in which the *libido* (sexual drive) of the child focuses on different parts of the body as the child grows up (oral, anal, phallic, latency, and genital stages). His model is an interactive one; he believed that although the sequence and timing of these stages is biologically determined, successful personality development depends on the experiences children have during each stage. Freud argued that neurosis could be explained in terms of a fixation in or regression to these phases due to trauma or other experiences and could be reversed using psychoanalytic techniques. Although many details of Freud’s theory of development have been widely discredited, his emphasis on the importance of early childhood experiences has had a lasting impact.

Anna Freud (1895-1982), Sigmund’s youngest daughter, and Melanie Klein (1882-1960) have been two of the most influential figures in child psychoanalysis (Anthony, 1986). Both were born in Austria and practised in England where they



[Click on the image to view a short biography of James Mark Baldwin \(1861-1934\), a US psychologist who made important contributions to developmental psychology \(in Spanish; 7:31\)](#)



Jean Piaget (1896-1980) with **Bärbel Inhelder**, his best known collaborator.

[Click on the image to view "Piaget on Piaget", a documentary about Jean Piaget's genetic epistemology. It shows some of the classic experiments about seriation, conservation of volume and drawings. Filmed in Switzerland in 1977 \(in French with English subtitles; 41:34\)](#)

developed their own, quite different, approach to child analysis. Their influence on child psychiatry, particularly through the child guidance movement, has been vast. It is of note that the journal *The Psychoanalytic Study of the Child*, a joint Anglo-American venture, has been in continuous publication since 1945.

Piaget, Vygotsky and Bowlby

The blooming of developmental psychology occurred after World War I with Jean Piaget (Switzerland), Lev Vygotsky (Russia), and John Bowlby (UK). *Piaget* (1896-1980) postulated that children think differently than adults, going through four stages of cognitive development (sensorimotor, preoperational, concrete operational, and formal operational). For Piaget development is biologically driven and changes as the child matures. Piaget's ideas and methodology revolutionised developmental psychology and had an enormous influence on education and in future researchers. This does not mean that there were no criticisms of his theories. For example, not everyone accepted that development occurs in stages preferring to see it as continuous. Also, Piaget's method was quite subjective, involved a small group of children and thus was subject to bias, and underestimated the importance of social and cultural influences.

Vygotsky (who died of tuberculosis in 1934 at the age of 37) believed in the fundamental role of social interaction in cognitive development. Unlike Piaget's notion that children's development must precede learning, Vygotsky argued that social learning comes *before* development. He suggested that learning occurs through the interactions children have with their peers, teachers, and others and that language plays a key role in this process. His theories had a great influence in the Soviet Union but were not noticed in western countries until the 1960s; they gave impetus to considerable research on the importance of social interactions in learning.

John Bowlby (1907-1990) was a psychiatrist trained in psychoanalysis who became the director of the influential Tavistock Clinic in London. Bowlby was born to an upper-middle class family who believed that too much parental affection would spoil a child and as a result he was sent to boarding school at the age of seven, which he later described as traumatic. He was influenced by



John Bowlby

[Click on the image to view a critical summary of the theories on maternal deprivation \(The work of René Spitz, John Bowlby and Michael Rutter\) \(6:51\).](#)

ethological theories popular at the time, particularly Lorenz's (1935) study of imprinting. Lorenz showed that attachment in ducklings is innate and therefore has a survival value. The thinking of psychoanalysts such as Melanie Klein also influenced him. However, he disagreed with the psychoanalytical belief that infants' responses related to their internal fantasy life rather than real-life events. His 1951 monograph on maternal deprivation, *Maternal Care and Mental Health*, was extremely influential, particularly his arguments about the importance of early attachment relationships and the damage inflicted when the parent-child relationship is thwarted such as in institutional care or through separation. Some of these issues had already been highlighted by René Spitz through what he called "anaclitic depression" referring to partial emotional deprivation, and "hospitalism" (total deprivation). Bowlby believed that attachment behaviour is instinctive and is activated when the child separates from the mother, feels insecure, or fearful. He suggested that a child would initially form only *one* attachment relationship and that this attachment figure acts as a secure base for exploring the world, becoming a prototype for all future relationships, so that disrupting this bond can have severe long term consequences. Later research showed that Bowlby's belief of a sensitive period—between six months and three years—during which attachments can form is too narrow. It is now widely accepted that while there is a sensitive period during which attachments will form if possible, the time frame appears to be broader and the consequences less fixed and irreversible. Attachment theory became an important model for psychotherapy and, to a large extent, is the acceptable face of today's psychoanalysis. It influenced child care policy worldwide.

Nature vs nurture

The dictum "give me a child until he is seven and I will give you the man" summarizes the position of those who have believed in the pre-eminence of the environment. This view was embraced in the second half of the 20th century by behaviourists such as the American psychologist BF Skinner who thought that human behaviour was learned, e.g., the result of rewards—what he called "operant conditioning." However, the nature/nurture debate goes back to antiquity. For

example Aristotle thought that the mind was a blank slate (*tabula rasa*), making education and environment the key factors in development, while Plato believed in an innate knowledge, which is awakened by learning and experience. Aristoteles' ideas were elaborated further by Avicenna and, more recently, by thinkers such as John Locke and Jean Jacques Rousseau.

The view that behaviour is predominantly the result of genetic endowment (*breeding*) was the most widely accepted belief in medical circles in the 19th and first half of the 20th century—epitomised by the popularity of the eugenics movement. It is widely accepted now that the dichotomy between nature and nurture, genetics and environment, is simplistic, inaccurate or even misleading and that it should be abandoned.

During the last four decades there has been a remarkable increase in the understanding of nature (genetics), nurture (environment), developmental processes, and their interaction, which highlights that all of them are important, influence each other, and all contribute to development. For example, it is known that a large proliferation of neurons and synapses takes place during the early stages of development. This is followed by a selective pruning—that continues until the mid-twenties—shaped by environmental contingencies that fine-tune each individual's brain to make the best of the environment in which persons find themselves. Some—probably many—aspects of brain development depend on children being exposed to particular experiences at particular times (e.g., the visual cortex does not develop in individuals who are blind or reared in the dark during a sensitive period). That is, genetics shape the behaviour of children by making them seek specific experiences but these experiences actually modify brain structure and function and influence later behaviour. These issues are well summarised by [Rutter \(2002\)](#), one of the scholars in this field.

Developmental psychopathology

Developmental psychopathology is the integrative study of the development of psychiatric disorders, such as schizophrenia, depression, and conduct disorder. That is, it seeks to expose the interactions between biological, psychological and social aspects of normal and abnormal development across the lifespan. The early studies go back to the 1970s as result of prospective longitudinal studies of children at risk for schizophrenia. Dante Cicchetti, an American psychologist, played a major role in defining and shaping this growing field ([Toth & Cicchetti, 2010](#)).

INTELLECTUAL DISABILITY

Throughout human history societies have not been kind towards people with disabilities, so much so that some ancient civilisations such as Rome and Sparta practised infanticide of those considered to be disabled or less fit. They had few or no rights (for example, in 13th century England guardianships were created to take over the financial affairs of people with intellectual disabilities, considered incapable of making decisions). Thomas Willis (1621-1675), a UK physician, was the first to describe intellectual disabilities as diseases of the brain. In the 18th and 19th centuries, driven by the social changes ushered in by the industrial revolution, housing and care of these individuals moved away from families and towards



[Click on the image to view an interview with Michael Rutter discussing maternal deprivation and gene-environment interactions \(8:21\)](#)



L'Enfant Sauvage (The Wild Child) a 1970 French film directed by François Truffaut presents a cinematic version of Itard's re-education work with Victor, the feral child of Aveyron.

From the army of 300,000 feeble-minded persons in the United States come the recruits that swell the ranks of the drunkards, criminals, paupers, and other social outcasts. 25% of the girls and boys in our reformatories are lacking in mental fibre and are unable to discern the difference between right and wrong or are too weak in character to do right whenever there is an inducement to do wrong. 65% of the children have a mother or a father, or both, who are feeble-minded. This country has so far taken no steps to segregate these irresponsible persons, so the number of them is constantly increasing [...]

This army furnishes the ranks of the criminals, paupers, drunkards, the ne'er do wells, and orders who are socially misfits. Their incapacity would be a priori cause of believing that they eventually would become public charges in one form or another, and investigation, in fact, proves that the groups of criminals, paupers, etc., actually do contain large percentages of people mentally irresponsible.

The New York Times, March 10, 1912

largely self-sufficient asylums, institutions that at best provided for the basic needs—food, clothing, and shelter—of inmates.

Implementation of universal compulsory education, introduced in Prussia in 1763 and gradually imitated by other countries, revealed a large number of children who were unable to cope with schooling. Systems were progressively developed to deal with this problem, mostly through institutional care and training. The first documented program of intervention for the intellectually disabled was developed in France in 1799. Jean-Marc Itard (1775-1838) established a skills-based program for a “feral child” discovered in the woods near Paris, whom he named Victor. This was important because for the first time a child with severe developmental delay was treated rather than sent to an asylum (see also the Albanian orphans’ box in page 14). Eduoard Seguin took Itard’s methods further and created a program to educate the “feeble-minded” at *La Salpêtrière* in Paris. Thus, French alienists (psychiatrists) such as Edward Seguin and Félix Voisin set the foundations for the education of intellectually disabled people. Seguin subsequently migrated to the US where he published an influential book on the topic in 1866 (Harbour & Maulik, 2010). It is of note that in France the term “idiocy” was synonymous at that time with mental illness and not just with developmental disability.

The Albanian orphans

A situation with consequences not dissimilar to those found in the feral child of Aveyron emerged in Albania in the early 1990s following the collapse of the Soviet Union. Thousands of children suffering from extreme emotional deprivation were found in very poorly run orphanages. Many were not orphans; they had been placed there by parents unable to provide for them because of poverty. Parents were powerless to control the size of their families because of a ban on contraception and abortion by the communist state, legally forcing women under 45 to have at least five children.

Children found in these orphanages showed a variety of disturbed behaviours such as limited capacity to speak and move, rocking, difficulty giving and receiving affection, autistic-like behaviours, and indiscriminate approach to strangers. “The children had been washed in the orphanage by being forcibly placed under a cold tap, so they had developed a terror of water. Their skin was grey when they arrived but there was no question of just popping them in the bath. We had to start by just washing the bits that showed with a face cloth. With the youngest one, I brought her upstairs to the bathroom when I was having a bath, and when I saw that she was no longer petrified, asked her if she wanted to come in, too” (Taylor, 2002).

A number of these orphans were adopted by UK and US families and some of them were followed up through the English and Romanian Adoptee Project. The study has shown that children who experience extreme institutional deprivation usually show a huge improvement in psychological functioning following successful adoption. However, a substantial minority of those adopted after the age of six months continue to experience significant problems.

Growing urbanization and the industrial revolution highlighted the importance of intellectual ability to survive in that rapidly changing world. The “feeble-minded” were often blamed for the poverty, illness, and crime that accompanied urbanization and the ghettos of disadvantage that ensued, leading to the development of a fearful, alarmist attitude in the media toward people with intellectual disability (see box in page 13). Criminal behaviour and intellectual disability were thought to be heritable.

Francis Galton (1822-1911) established in the UK a theoretical basis for the heritability of intellectual disability and provided a foundation for the eugenics movement—breeding must be managed to prevent the degeneration of the human species. A drive ensued to segregate developmentally disabled people to protect society and, even more importantly, to control their reproduction. Subsequently, several US states enacted sterilization laws (30 states had these laws by 1944). Between 1907 and 1944, more than 42,000 disabled people were sterilized in the US. In Britain, the Mental Deficiency Act of 1913 emphasized segregation of males and females over sterilization. In Germany, the Nazi government’s adoption of eugenics led to the 1933 compulsory sterilization law under which people with “congenital feeble-mindedness” could be forcibly sterilized—and thousands were subsequently exterminated (Harbour & Maulik, 2010). Regrettably, some psychiatrists and child psychiatrists were active participants in eugenic programs in Nazi Germany and elsewhere.

Some child psychiatrists were active participants in eugenic programs in Nazi Germany and elsewhere.

Attitudes began to change by the end of World War I and change gained momentum after World War II. Several factors contributed to this:

- Research advances began to show that intellectual disability was not necessarily inherited; metabolic disturbances (e.g., phenylketonuria)

and environmental factors, such as infections and iodine deficiency were common, preventable or treatable causes

- The Holocaust helped to discredit eugenic practices
- Families of children with intellectual disability began to advocate for their rights and demanded better education and rehabilitation services.

This attitudinal change gradually resulted in more enlightened policies—for example, President Kennedy established the President’s Panel on Mental Retardation, setting an agenda in the US for policy, research, prevention, education, and services (Harbour & Maulik, 2010)—and a growing emphasis on de-institutionalisation all over the world, with the exception of Soviet countries where institutional care of childhood mental disorders was the mainstay. This seismic change crystallised in the *Convention on the Rights of Persons with Disabilities*, a United Nations treaty that seeks to protect the rights and dignity of persons with disabilities. The text was adopted by the United Nations General Assembly on 13 December 2006. By September 2014, there were 159 signatories, including the European Union. The US is not yet a signatory.

THE CHILD GUIDANCE MOVEMENT

Although not formally established until the 1920s, the child guidance movement started in Chicago in 1906, led by the neurologist William Healy, in the context of the international mental hygiene movement and as a result of a group of lawyers, physicians, social workers, and philanthropists’ concern about treating and preventing juvenile delinquency (Levy, 1968b). The child guidance movement sought to move the focus from the juvenile justice system to the family, school and neighbourhood. “One of its basic ideas was that even the most apparently ‘normal’ child might, in the course of his or her emotional and psychological development, experience ‘maladjustment’. This meant that child guidance was, essentially, concerned with the whole child population, or at least that part of the

William Healy (1869-1963) sitting, 3rd from the left, together with colleagues and supporters at the 25th anniversary of the Institute for Juvenile Research. Next to him (2nd from left) sits Augusta Fox Bronner, one of his close collaborators. She was co-director of the Judge Baker Foundation, Boston, from 1930 to 1946.



child population which was not severely delinquent or, in the language of the time, ‘mentally defective’—in other words, the overwhelming majority of children” (Stewart, 2012). Child guidance clinics had a strong multidisciplinary and psychoanalytic ethos. Its approach represented a change from previous treatment models, which were largely individual, toward more innovative interventions. For the first time the mental health of children was considered an important focus for treatment by itself. Also “child guidance sought to be a form of preventive medicine promoting children’s mental well-being” (Stewart, 2012). In this the movement was well ahead of its time.

The child guidance model was soon adopted in other countries (the East London Child Guidance Clinic established in 1927 was the first in Britain) with local adaptations (i.e., in Scotland and Australia it had an educational bias). Scandinavian countries also began to set up services following the child guidance model. In India, the first child guidance clinic was set up 1937. In 2003, there were 164 child guidance clinics in India—a tiny number given the size and needs of a population of more than 400 million people under the age of 18. In Ireland, state-funded child guidance clinics were established quite late, in the mid-1950s.

In the UK, the child guidance movement received considerable impetus in the 1950s because of concern for children separated from their parents as a result of the evacuations that took place during World War II—it is of note that very little long term research is available on this area to guide policy; according to one of the few long-term studies, Finnish children evacuated to Sweden during World War II did not fare worse as adults than those who remained in Finland (Santavirta et al, 2015). The UK Education Act of 1944 placed for the first time “maladjusted” children in the same category as children with physical disabilities, thus becoming part of the school medical service. Local education authorities could set up child guidance clinics and for the most part it was these bodies which became the providers. In the late 1920s there were two child guidance clinics in England and Wales, by 1955 there were some 300 (Stewart, 2012).

Initially child guidance clinics represented a significant advance in service delivery—a move from institutional to multidisciplinary community care and to prevention—however their promise faltered:

- Child guidance clinics were often funded by non-medical organizations, such as charities or local councils, hence they often became isolated from mainstream medical, academic and research institutions
- Treatment—mainly psychoanalytic in orientation—was often open-ended and lengthy
- Rather than cooperation between psychiatrists, psychologists and social workers there was often tension
- There was no interest in specific diagnosis or treatment—children with a variety of problems were lumped together as “maladjusted” and offered non-specific treatment; and
- There was an inclination to blame parents, which caused considerable distress and alienated consumers. Particularly in the 1950s, the terms “schizophrenogenic mother” and “refrigerator mother” were widely used to describe the hypothesized role of mothers in the aetiology of schizophrenia and autism respectively.



Christchurch Health and Development Study staff in 2014. From left, front row: Geri McLeod, Morwenna Malcolm. Back row: Joseph Boden, David Fergusson, John Horwood.

The Los Angeles Child Guidance Clinic celebrated 100 years of continuous operation in 2014. In recent years the child guidance model has evolved and been updated by increasingly implementing evidence-based interventions and focussing on prevention (e.g., parent training) and early intervention, often as an important component of “community health centres”.

EPIDEMIOLOGY

Child psychiatric epidemiological research is a very recent endeavour. Lapouse and Monk (1958) are credited with having conducted the first epidemiological study in child psychiatry: the prevalence of parent-reported problems in a representative sample of 482 children aged 6-12. Epidemiological research became more sophisticated with the Isle of Wight studies in which not only parents but children themselves were interviewed (Rutter et al, 1970). To a large extent, these studies marked the beginning of a truly scientific child psychiatry. The introduction of new classification systems (e.g., DSM-III), which operationalised diagnostic criteria, further facilitated and encouraged epidemiological research. By the end of the 20th century epidemiological research had been conducted in many countries with broadly consistent findings. These studies have uncovered a large pool of unmet need: a considerable number of children and adolescents who suffer from psychiatric conditions, who are significantly impaired by them, but who do not receive treatment.

Prospective studies

A pioneer was the American sociologist Lee Robins (1922-2009) with her work on the adult outcomes of delinquent (conduct disordered) adolescents (Robins, 1966). Long-term, longitudinal studies of general population cohorts or selected clinical samples allow hypothesis testing and have offered many insights into clinical problems—for example showing that most psychiatric disorders have their onset during childhood or adolescence—and have underscored the potential this offers for prevention. A significant methodological obstacle in the measurement of psychological problems is recall bias, which is reduced in prospective studies.

An example of this type of research is the Christchurch Health and Development Study, which has followed the health, education and life progress through infancy, childhood, adolescence and adulthood of a group of 1,265 children born in Christchurch (New Zealand) in 1977 (Fergusson & Horwood, 2001). Prospective studies typically collect information from multiple sources

at regular intervals (e.g., every two years). Thanks to this type of research there is a much better understanding of the continuities and discontinuities between conditions in children and adults as well as factors that increase or decrease the risk, thus informing preventive interventions. Findings of prospective research have had a powerful influence in changing public policy and funding of services for children all over the world.

TAXONOMY

Taxonomy is essential for scientific progress. In psychiatry, the taxonomic tasks are made more difficult because taxonomy varies with the purpose and context in which classification is to be used (e.g., clinical-therapeutic, forensic, research, statistical). The early taxonomies—e.g., those of Philippe Pinel (1745-1826)—had a clinical focus, referred only to adults, and generally classified mental illness into *insanity* (including melancholia and mania), *dementia* and *idiocy* (*idiotisme*). Esquirol (1772-1840) added *monomania* to these. The concept of *moral insanity*, coined by James Prichard in 1835 to describe abnormal emotions and behaviours in individuals without intellectual impairment, delusions or hallucinations, also became popular in the second half of the 19th century. Emil Kraepelin's taxonomy, which he published at the end of the 19th century, moved from focusing on symptoms to syndromes but ignored childhood disorders altogether. However, his categorical approach is still used today in the main classification systems. Early diagnostic groups were based on pattern recognition, on how much an individual patient was similar to the clinical description of a case presented by an expert or authority.

The first modern taxonomy of childhood mental disorders was probably the one described by Maudsley (1895) in the chapter about *Insanity of Early Life* (pp259-293). He described seven different conditions:

- Monomania or partial ideational insanity (children possessed by uncontrollable impulses, for example to harm themselves, others, or steal)
- Choreic delirium or choreic ideational insanity (characterised by convulsive violence and incoherence)
- Cataleptoid insanity (e.g., lying for hours or days in a sort of mystical contemplation, with limbs more or less rigid or fixed in strange postures)
- Epileptic insanity (insanity that occurs in connexion with epilepsy)
- Mania (insanity)
- Melancholia (which could lead to suicide)
- Affective insanity or moral insanity (a strange perversion of some fundamental instinct or moral perversion that seems to be wilful wickedness).

In the first half of the 20th century, before the publication of DSM-III, the main classifications used were *ideographic* (Werry, 1985). That is, taxonomies were anchored in a particular theory (e.g., psychoanalysis) that sought to emphasize the total context of the individual person and not just the symptoms. For example, the child guidance movement largely conceptualised child psychopathology in terms of *maladjustment*—symptoms and behaviours were seen as the manifestation of deeply-rooted problems, largely within the milieu of family relationships, rather than representing different disease entities. Ideographic approaches are still widely used in clinical practice, for example in family therapy.

The international Classification of Diseases (ICD)

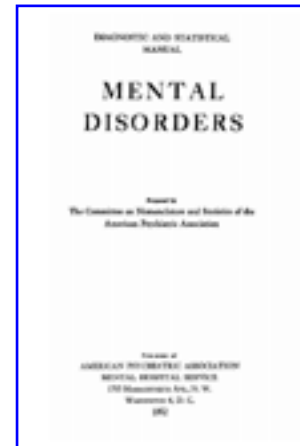
During the 19th century the need to have a classification of diseases that provided information about causes of death became increasingly clear. In 1853 a uniform classification of causes of death that could be used internationally was commissioned and adopted by several countries. Subsequently this classification was reviewed regularly and updated. The need for a morbidity classification was also recognised soon after; a list of diseases to meet the requirements of a variety of organizations, such as health insurers, administrators and clinicians. In the words of William Farr (1807-1883), the first medical statistician of England and Wales, a “system of nomenclature to diseases which, though not fatal, cause disability in the population” (Registrar General of England and Wales, 1856). In 1910, the *International Classification of Causes of Sickness and Death* was published in the US. However, there was no international uniformity; different countries often used their own classification. The Sixth Revision of the now called *International Classification of Diseases, Injuries, and Causes of Death* (ICD-6) was published in 1949; it included for the first time a section on mental disorders. ICD-7 and ICD-8 listed some childhood psychiatric disorders (e.g., mental deficiency). ICD-9, published in 1977, added “behaviour disorders of childhood”. Nevertheless, the classification of childhood disorders in ICD-9 was clearly inadequate. A significant improvement occurred with the publication of ICD-10 (endorsed in May 1990) where a multi-axial approach was introduced, similar but not identical to that in DSM-III. ICD-10 also included a description of the main categories and diagnostic criteria for research. ICD-10 is currently being revised.

According to Rutter (2011) multi-axial systems of classification have many advantages in child psychiatry because they:

- Avoid false dichotomies resulting from having to choose between two diagnoses that do not constitute alternatives in a meaningful sense
- Require a coding on each and every axis
- Avoid the unreliability resulting from different theoretical assumptions
- Provide a means not only to record the main clinical picture, but also makes it possible to include dimensional features (e.g., intellectual level and degree of functional impairment).
- Represent a style of thinking closer to most clinicians’ preferred style of working than a traditional categorical system.

The Diagnostic and Statistical Manual of Mental Disorders (DSM)

“The American Psychiatric Association Committee on Nomenclature and Statistics developed a variant of the ICD-6 that was published in 1952 as the first edition of Diagnostic and Statistical Manual: Mental Disorders (DSM-I). DSM-I contained a glossary of descriptions of the diagnostic categories and was the first official manual of mental disorders to focus on clinical utility. The use of the term ‘reaction’ throughout DSM-I reflected the influence of Adolf Meyer’s psychobiological view that mental disorders represented reactions of the personality to psychological, social, and biological factors” (APA). However, DSM-I did not specifically mention childhood disorders apart from “mental deficiency”. DSM-II



[Click on the image to access the DSM-I](#)

(published in 1968) included a section on the behavioural disorders of childhood and adolescence listing a variety of “reactions” such as withdrawing, overanxious, runaway, unsocialised aggressive, group delinquent, and hyperkinetic.

DSM-III (published in 1980) revolutionised the approach to the diagnosis of childhood (and adult) disorders because (Rutter & Shaffer, 1980):

- It used a phenomenological approach
- Recognized that disorders rather than individuals should be classified
- Introduced a multiaxial framework
- Provided a more comprehensive listing of child psychiatric disorders
- Improved diagnostic criteria
- Added codings for psychosocial stressors, and
- Recognised that disorders may persist into adult life.

DSM-IV, an updated version of DSM-III, was published in 1994 and DSM-5 in 2013. DSM-5 has abandoned the multiaxial model (for more details about changes in DSM-5, please go to Chapter A.9).

Other classifications

Not all countries use ICD-10 or DSM-5; the latter has been the classification more often used in research studies. A few use their own classification or modified versions. For example, because of perceptions that the main classifications did not take into account individual differences enough, were reductionist, and overly focused on operationalised diagnostic criteria, French child psychiatrists chose to develop their own classification, the *French Classification for Child and Adolescent Mental Disorders* (CFTMEA), initially published in 1983. CFTMEA is bi-axial: one axis lists the basic clinical categories while the other includes associated and possibly etiological factors (Mises et al, 2002).

Dimensional approaches

Dimensional classifications assume that psychiatric symptoms and illnesses cannot be simply defined by a “present/absent” dichotomy since they vary in severity, like blood pressure. Thus, depression can be severe, moderate, mild, subclinical etc. representing different degrees in a depression dimension and this variation has implications for treatment and outcome. There has been much argument over the last 50 years about the merits of categorical *vs* dimensional approaches, with the dimensional view being often preferred by psychologists and researchers due to its higher statistical power, while categories are favoured by health insurance companies and clinicians because they set thresholds for treatment more clearly. In practice both categorical and dimensional approaches have advantages and disadvantages and there have been moves to incorporate dimensional features into the categorical classifications (e.g., in DSM-5) and vice versa. The empirical [ASEBA](#) system of diagnosis is one example (Achenbach, 2009); it has the advantage that it incorporates ratings from multiple informants, takes into account cultural aspects, and can generate diagnoses consistent with DSM-5 (see Chapter A.3). Dimensional classifications are more problematic when dealing with uncommon conditions.



Aaron Beck (left) and Albert Ellis at the American Psychological Association Convention in Washington DC in 2000
(Photo: Fenichel)

COGNITIVE-BEHAVIOUR THERAPY (CBT)

The origin of CBT goes back to the Russian physiologist Ivan Pavlov's (1849-1936) famous experiments in *classical conditioning* (conditioned reflexes). One example of the therapeutic usefulness of Pavlov's findings is the enuresis alarm (bell and pad), although it appears that its discovery by the German paediatrician von Pfaundler in 1904 was accidental and not the result of his application of Pavlov's theories. The bell and pad alarm is still the most effective treatment for nocturnal enuresis.

A variety of therapeutic approaches based on behavioural principles (not only classical conditioning but also operant conditioning) became increasingly popular particularly in the US, delivered mainly by psychologists. Operant conditioning was popularised by the US psychologist BF Skinner (1904-1990) who showed that behaviour can be modified by its antecedents and consequences, called reinforcers.

The next important discovery occurred in the 1960s, the so-called *second wave* of CBT; the finding that thoughts (cognitions) can influence behaviour and feelings and vice versa. For example, Aaron Beck, a US psychiatrist, showed that depressed patients experienced negative thoughts about themselves, the world or the future that seemed to arise spontaneously (automatic thoughts). When these negative thoughts were recognised and challenged rationally, patients' thinking became more realistic and they felt better. This was called *cognitive therapy*.

Nowadays what is called CBT consists of a heterogeneous array of techniques both behavioural and cognitive that are structured, short-term, and present-oriented, loosely based on the above theories. CBT techniques are used

in the treatment and prevention of most mental disorder in youth and their effectiveness is supported by a rapidly growing body of research. CBT practitioners have emphasized all along the importance of measurement and of empirical testing of its effectiveness.

Currently there is a trend to focus not only on *what* people think but on *how* they think (*third wave*). These new approaches include Marsha Linehan's dialectical behaviour therapy, mindfulness-based cognitive therapies, and schema therapy, among others (Kahl et al, 2012).

FAMILY THERAPY

Family therapy is an umbrella term that covers a variety of clinical approaches that seek to treat child psychiatric disorders within the family system rather than focusing on the individual patient. They assume that family interactions play a key role in the causation and maintenance of children's maladjustment, thus interventions are designed to effect change in family relationships with the expectation this would lessen symptoms in the identified child.

The roots of family therapy can be found in the late 19th century: the industrial revolution, the rapid migration of peasants from the countryside to the cities, and the stress these changes caused in families and communities. The *modernist's* and the so-called *progressives'* view of society in the US was that, as a result of these vicissitudes, many families became victims of the quick social change and were in need of sustained help. Professional social work emerged in this context, mostly in the UK and in the US, largely to deal with the resulting poverty and homelessness. Another precursor of family therapy was the marriage counselling movement in the 1920s, which sought to provide troubled couples with information, support, counselling, and guidance by an assortment of *marriage counsellors*—clergy, lawyers, gynaecologists, social workers—not specially trained as such.

The formal development of family therapy, which did not take place until the late 1940s, was facilitated by the emergence of systems theory and social psychiatry. The former shifts the focus from the individual to the system (the family) while the latter emphasizes the importance of cultural differences and social settings in the causation of psychiatric disorder. Family therapy was promoted also by dissatisfaction with the traditional practice of individual child psychotherapy.

By the mid-1960s, several schools of family therapy had emerged such as Salvador Minuchin's structural family therapy, the Milan systems model, the experiential approaches of Virginia Satir, and intergenerational therapies, to name just a few. *Structural family therapy* was initially developed to work with children who showed significant behaviour problems or eating disorders. Its key concept is that of *boundary*: "functional" families are characterised by clear and flexible boundaries, "enmeshed" families are those whose members are excessively intrusive, "disengaged" families are those whose members are not available to one another. Structural family interventions seek, among other goals, to re-establish boundaries that are clear and flexible.

Systemic therapies, of which many variations exist, have their origin in the Milan School of Mara Selvini Palazzoli, an Italian psychiatrist, but also derive



Jane Addams (1860–1935) was a founder of the US Settlement House movement and is considered one of the early influences on professional social work. The settlement movement focused on the causes of poverty through the "three Rs" (Research, Reform, and Residence). They provided a variety of services including educational, legal, and health to needy families. These programs also advocated for changes in social policy. Workers in the settlement movement immersed themselves in the culture of those they were helping.

from the work of Minuchin. “Systemic therapy neither attempts a ‘treatment of causes’ nor of symptoms, rather it gives living systems nudges that help them to develop new patterns together, taking on a new organizational structure that allows growth” (von Schlippe & Schweitzer, 1998).

Parent management training

Arguably the most significant therapeutic advance in this domain has been the development of CBT-based family interventions, collectively known as “parent management training” or “parent effectiveness training”, grounded on social learning theory and stemming largely from the work in the 1950s and 1960s of Gerald Patterson, a US psychologist. Patterson (1982) proposed a model of how parental conduct may exacerbate children’s negative behaviour and result in what he designated as “coercive family processes”. His work showed that parents of disruptive children are more likely to be inconsistent in how they apply rules, and give commands that are either unclear or the result of their own current emotional state rather than contingent upon the child’s behaviour (Quy & Stringaris, 2012).

Parent management training focuses on parents as principal agents of change because they are their children’s best teachers, their advocates, and are responsible for managing many social environments. The goal of parent management training is to teach positive parenting skills and discourage coercive tactics. Parent management training programs—there are many available—have been shown to be effective in reducing troublesome child behaviour and to prevent the development of, or lessen a variety of disruptive and emotional disorders in children (Sanders et al, 2014).

PHARMACOTHERAPY AND SOMATIC TREATMENTS

No advance has revolutionised clinical child psychiatric practice as much as the introduction of psychotropic drugs. Opiates, bromides and chloral hydrate

Rivendell Paediatric Psychopharmacology Conference 1999, Sydney, Australia. From left, back row: Robert Redwin, Stanley Rapoport, John Werry, Susan MK Tan. Front row: Garry Walter, Felicity Waters, Jean Starling, Judith Rapoport, Joseph M Rey.



were widely used in the 19th century to treat agitation and epilepsy. Barbitol, also known as barbitone, was the first commercially available barbiturate. It was used as a hypnotic from 1903 to the mid-1950s, becoming popular in psychiatry for the treatment of schizophrenia through “prolonged sleep therapy” in the 1920s—this treatment was subsequently abandoned because it was ineffective and dangerous to patients. There were few reports of the use of these treatments in children except for barbiturates in epilepsy.

Georges Heuyer was the first to use electroconvulsive therapy (ECT)—a somatic treatment—in young people in the early 1940s. He achieved a dramatic improvement in some cases at a time when effective treatments were practically non-existent. Loretta Bender became a strong advocate of ECT in the US. Subsequently, in spite of its effectiveness and safety in mood disorders, ECT has become a controversial treatment—of last resort in the young—and its use in youth banned in some countries (Rey & Walter, 1997).

Charles Bradley reported in 1937 that a group of children with behavioural problems improved when treated with benzedrine (dl-amphetamine), a psychostimulant drug. However, this finding went unnoticed. The approval of methylphenidate (Ritalin[®]) by the FDA in 1955 and the growing awareness of children suffering from hyperkinetic disorder—diagnosis introduced in DSM-II in 1968 as “hyperkinetic impulse disorder”—were catalysts in the increasing use of stimulants for ADHD, which peaked at the end of the 20th century (see box in page 25). Stimulant drugs are the best studied in child psychiatry.

The pharmacological revolution of the 1950s

The Australian psychiatrist John Cade discovered in 1949 the effectiveness of lithium salts in treating mania. However, the psychiatric world was slow to adopt this treatment largely because of deaths resulting from relatively minor overdosing. Subsequent research by Mogens Schou and Paul Baastrup in Denmark and of Samuel Gershon and Baron Shopsin in the US helped to overcome resistance to the use of lithium and its prescription was approved by the FDA in 1970.

The potential role of chlorpromazine in psychiatry was first recognized by Henri Laborit, a surgeon and physiologist in the French army. Pierre Deniker and Jean Delay conducted in 1952 the first systematic studies of this drug showing its effectiveness in psychotic patients. The discovery of chlorpromazine ushered in real advances in the treatment of schizophrenia and the synthesis later on of several other dopamine antagonists. A new generation of antipsychotics (*second generation*) emerged in the 1980s. The second generation antipsychotics showed similar effectiveness but fewer extrapyramidal effects, although they have significant unwanted metabolic effects causing weight gain and diabetes. The first second generation antipsychotic, clozapine, was introduced in Europe in 1971. It was withdrawn by the manufacturer in 1975 because it could cause agranulocytosis. Its use, with the appropriate monitoring, was approved again in 1989 after having been shown to be effective in treatment-resistant schizophrenia.

Evidence of the antidepressant activity of iproniazid, a monoamine oxidase inhibitor and a well-known treatment for tuberculosis, was presented in 1957 by two US psychiatrists, George Crane and Frank Ayd. The initial report of the

effectiveness of imipramine (Tofranil®) for depression also occurred in 1957. This was the first of the tricyclic antidepressants. A new class of antidepressants, selective serotonin reuptake inhibitors (SSRIs), led by fluoxetine (Prozac®), became available in 1987. The SSRIs were subsequently found to be effective in the young not only for depression but also for anxiety disorders and had fewer side effects than the tricyclics.

Chlordiazepoxide (Librium®) was the first of another new class of drugs, the benzodiazepines, introduced in clinical care in 1960. Many others followed and their prescription for a variety of conditions boomed, so much so that by mid-to-late 1970s, benzodiazepines topped the “most frequently prescribed” lists. By the 1980s a more sober realization of their effectiveness began to dawn, together with growing concern about the risk of abuse and dependence. Thankfully, prescription of benzodiazepines for children has been much more restrained than for adults largely due to the lack of evidence of effectiveness in childhood mental disorders.

All these new classes of drugs, although tested in adults, were used widely in children without their safety and effectiveness having been examined fully in this age group, an ongoing problem that has plagued paediatric psychopharmacology. For example, it was found that tricyclic antidepressants are not, or are only marginally more effective than placebo in the young while they have serious side effects, particularly on overdose.

The data from the National Centre for Health Statistics reported in the side box highlight the impact of medication in clinical practice, which has been immense. Medication prescribing has become the largest component of the work of many child psychiatrists. The availability of psychotropic medications has facilitated the establishment of behavioural paediatricians as a subspecialty (see below), resulted in a decline in the use of talking therapies—increasingly provided by non-medical professionals—and, according to some, a de-skilling of the profession.

The growth in medication prescribing—often without an appropriate evaluation of the patient by professionals trained in child psychiatry—and polypharmacy, even in pre-school children, has raised concerns in the larger community about unnecessary prescribing and about an over-reliance on medication to the detriment of other therapy forms. Critics also worry about the long-term effects of psychotropic drugs on the developing brain, although no reliable data are available suggesting this might be a problem.

CHILD PSYCHIATRY AS A BRANCH OF MEDICINE

The term “child psychiatry” was coined only recently, in the later part of the 19th century. Hermann Emminghaus pioneered child and adolescent psychiatry with the publication in 1887 of his book *Die Psychischen Störungen des Kindesalters (Mental Disorders of Childhood)*, the first textbook in German dealing with emotional problems in children and considered by some as the dawn of child psychiatry. The Swiss psychiatrist Moritz Tramer (1882–1963) was probably the first to define the parameters of the discipline in terms of diagnosis, treatment, and prognosis; he also described the syndrome of elective mutism. In 1934, Tramer founded the *Journal of Child Psychiatry (Zeitschrift für Kinderpsychiatrie)*, which later became *Acta Paedopsychiatrica*, IACAPAP’s official journal from the 1960s to

“The latest estimate from the National Centre for Health Statistics reports that 7.5% of US children between ages 6 and 17 were taking medication for ‘emotional or behavioural difficulties’ in 2011-2012. The CDC [Centres for Disease Control and Prevention] reports a five-fold increase in the number of children under 18 on psychostimulants from 1988-1994 to 2007–2010, with the most recent rate of 4.2%. The same report estimates that 1.3% of children are on antidepressants. The rate of antipsychotic prescriptions for children has increased six-fold over this same period, according to a study of office visits within the National Ambulatory Medical Care Survey. In children under age 5, psychotropic prescription rates peaked at 1.45% in 2002-2005 and declined to 1.00% from 2006-2009.” (NIMH)

the 1990s, when it ceased publication because of financial problems (Schleimer, 2012).

The epidemic of *encephalitis lethargica* that spread around the globe after World War I—the precise cause of this illness is still unknown—resulted in many children subsequently developing behavioural problems and increased the need for services for them. As a result, some specialist units were created such as the children’s unit at Bellevue Hospital in New York City in 1920 (Chess & Hassibi, 1978).

The first chair of child psychiatry was created in 1923 in Rosario, Argentina, held by an Italian neuropsychiatrist and psychoanalyst, Lanfranco Ciampi. This was well before the first academic child psychiatry department in the US, set up by Leo Kanner in 1930 at Baltimore’s Johns Hopkins Hospital. Kanner is considered the first physician to be identified as a child psychiatrist in the US; his textbook, *Child Psychiatry* (1935), is credited with introducing both the specialty and the term to the English speaking world. Lauretta Bender (1897-1987) was also an influential figure not only for her work in language disorders, childhood schizophrenia, and for developing the *Bender Visual-Motor Gestalt Test* but particularly because she was the director of the children’s unit at Bellevue Hospital in New York City where she began training child psychiatrists in 1934, Stella Chess among them.

In a few countries (e.g., Germany, US) child psychiatry has evolved as an independent discipline, in others as a sub-specialty within psychiatry (e.g., Australia, New Zealand, UK), yet in others, particularly low and middle income countries, it is not yet recognised as a separate specialty from psychiatry or paediatrics.

Child psychiatry and paediatrics

The relationship between paediatrics and child psychiatry has been an uneasy one and has varied considerably according to institution, country and time. In the UK, for example, Aubrey Lewis (1900-1975) believed that “child psychiatry has the same relation to psychiatry as paediatrics does to medicine” (Graham et al 1999, p19). Aubrey Lewis was the first chair of psychiatry at the newly created London’s Institute of Psychiatry; he became a catalyst for the flourishing of psychiatry in

Encephalitis lethargica

Half a million to a million people were affected between 1916 and 1927, one-third of whom died. Only sporadic cases have been described since then. Patients who survived encephalitis lethargica often developed incapacitating neuropsychiatric sequelae (e.g., post-encephalitic Parkinson’s disease, catatonia, obsessive compulsive disorder, mutism, and severe conduct problems in children). “Younger children, between 5 and 10 years old, might merely irritate with their clinginess; their impaired concentration; their incessant restlessness and need for noise; and their lack of consideration for others—not unlike current attention deficit disorders. But as they grew in strength, their incorrigible impulsiveness escalated in violence and they posed a danger to themselves and others. Errant behaviours included cruelty to anyone who crossed them; destructiveness; lying; and self-mutilation including, in one example, removal of eyes. When they reached adolescence, these patients manifested inappropriate and excessive sexuality, including sexual assault without regard for age or gender. Bizarrely, these children were driven by impulsiveness, not self-interest. Thefts, for example, were not undertaken for personal benefit and stolen goods were often immediately forgotten, or given away” (Foley, 2011).

The cause has not been established. Some speculate that it might have been a post viral syndrome related to the 1918 influenza pandemic, although this seems unlikely. More recent work suggests it is an immunological disorder triggered by a streptococcal infection. What in recent years has been termed PANDAS (paediatric autoimmune neuropsychiatric disorders associated with streptococcal infections) may be a manifestation of the same disease.

the UK after World War II and was instrumental in Michael Rutter's decision to become a child psychiatrist. Lewis was a supporter of the independence of child psychiatry and the need for specialist training. Winnicott, on the contrary, believed that paediatricians should be trained as child psychiatrists mainly by doing child psychoanalysis (Graham et al 1999, p20). Donald Winnicott (1896-1971) was a British paediatrician who trained in psychoanalysis and became a very influential figure in the British Psychoanalytical Society and in child psychiatry in the 1950s and 1960s with his concepts of holding, the good enough mother, transitional objects, and the true and false self.

The uneasiness of this relationship is exemplified by the experience in the US—which has parallels in other countries—where the bulk of child psychiatry in the 1920s and 1930s was practised in the community-based child guidance and juvenile justice systems, far from mainstream medical centres. Paediatricians rarely worked in child guidance clinics, did not speak the same (psychoanalytic) language and had different priorities than psychiatrists. Paediatricians were more concerned with acute, short term care while child psychiatrists and psychologists focused mostly on long term therapy and chronic problems. That is, child psychiatric care was seen as irrelevant to the needs of the children looked after by paediatricians. Some influential paediatricians argued that they should be in control of the treatment, with the assistance of psychiatrists, social workers and psychologists when dealing with chronic, complex problems. As a result, for example, no child psychiatrist was appointed to the Boston Children's Hospital until after World War II. From the 1960s onwards, consultation-liaison services began to be set up with mixed success. Yet, the model of paediatricians being trained by child psychiatrists continued to be not acceptable to many paediatricians who preferred to be taught by their own colleagues (Haggerty & Friedman, 2003).

In 1984, several US institutions sought to integrate psychiatry and paediatrics by setting up a 5-year training program in paediatrics, general psychiatry and child and adolescent psychiatry ("triple board certification"), which continues today and has been modestly successful, although the number of people completing training has been relatively small. Physicians completing the triple board program are able to practice any of the three specialties alone or in combination. Australia has a similar program with comparable outcomes.

Behavioural paediatrics

Developmental-behavioural paediatricians seek to evaluate, treat and manage infants, children, and adolescents with a wide range of developmental and behavioural conditions and physical complaints ([The Society for Developmental and Behavioral Pediatrics](#)). Behavioural paediatrics as a paediatric subspecialty began to develop in the US in the 1970s in the context of a variety of circumstances, some of them already alluded to, namely the scarcity and limited availability of child psychiatrists; the introduction of psychotropic drugs, which made the time-consuming talking therapies less relevant for some disorders; the perceived increase of behavioural and psychosocial problems in children and adolescents coupled with a decrease in the incidence of traditional medical illnesses; and parents' and schools' increased expectations of treatment. It was also alleged that paediatricians, who had ongoing contact with children from infancy to adulthood, were in the

best position to prevent, detect and treat many of these problems (Haggerty & Friedman, 2003). The Society for Developmental and Behavioral Pediatrics (initially called the Society for Behavioral Pediatrics) was formed in 1982. Stanford B Friedman and Robert J Heggarty played a key role in its development. The Society began sponsoring the *Journal of Developmental and Behavioral Pediatrics* in 1985.

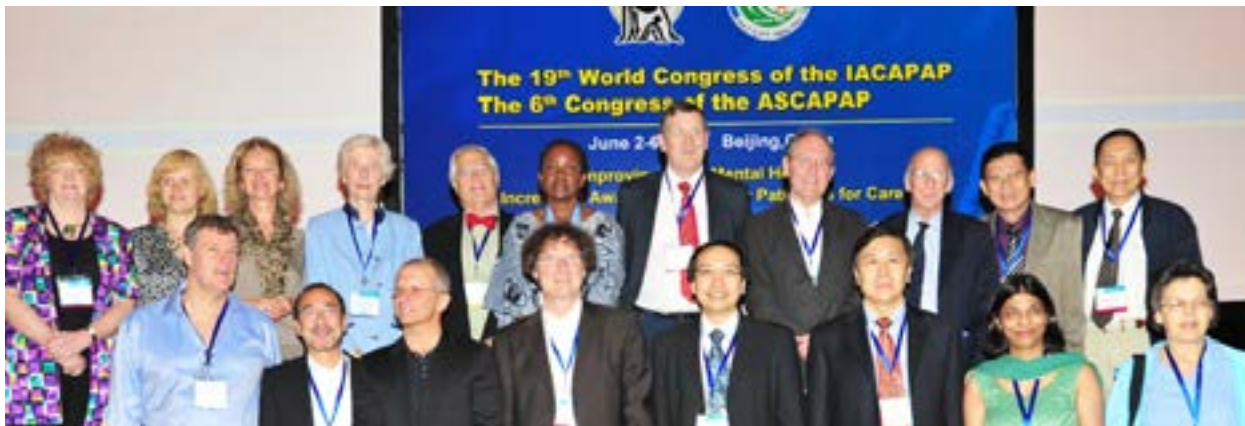
THE HISTORY OF IACAPAP

The history of child and adolescent psychiatry is best understood in terms of the development and progress of the international organizations that work for the establishment and expansion of child mental health activities all over the world, in developed as well as in less developed countries. The International Association for Child and Adolescent Psychiatry and Allied Professions (IACAPAP) is the professional umbrella organization for child and adolescent mental health associations and their individual members. IACAPAP advocates for the needs of troubled children and their families at a national and international level through its member associations and via links with the World Health Organization (WHO) and World Psychiatric Association (WPA), among others.

In 1935 a group of European psychiatrists started work to establish and expand contacts between psychiatrists working in the new field of child psychiatry. These pioneers were Georges Heuyer (France), Moritz Tramer (Switzerland), Paul Schröder (Germany), Carlos de Sanctis (Italy), Nic Waal (Norway), and Emanuel Miller (UK). What we call IACAPAP today started in 1937 as The International Committee for Child Psychiatry. This committee aimed at organizing a scientific congress and at promoting and supporting a scientific approach to the mentally ill child. Georges Heuyer, head of the *Clinique Annexe de Neuropsychiatrie Infantile* in Paris, was to be the organiser and chairman of the first congress in Paris in 1937—officially called The First International Conference on Child Psychiatry. Moritz Tramer was also involved in the organization of this congress, where delegates from 26, mostly European, countries participated.

Because of World War II, the second international congress was postponed until 1948 and took place in London. During this meeting The International Committee was renamed The International Association for Child Psychiatry (IACP). About 30 national societies were members at that time. All countries were

IACAPAP Executive
Committee, Beijing, 2010



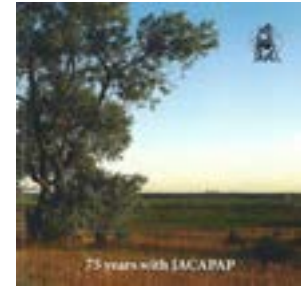
to have access to IACP, however a credentials committee was set up to verify the qualifications of each applicant. The name of the association was changed once more in 1958 to The International Association for Child Psychiatry and Allied Professions (IACP&AP) and again in 1978 to the name it has today—IACAPAP. At last, adolescents were incorporated in the official name. However, years later separate international organizations were created for adolescent psychiatry (ISAP in 1984 and ISAPP today) and for infant psychiatry (WAIMH in 1992).

Thus, the movement towards international child mental health began in Europe among medical specialists in child psychiatry. Expedited by the migration of child mental health professionals to the US before and during World War II, North American professionals became involved in this international association at an early stage. Also, from the 1970s, professionals from other parts of the world began to be elected as officers of the Executive Committee of IACAPAP—from South America, Africa, Asia, the Middle East, and Oceania. The IACAPAP constitution says that officers of the Executive Committee shall be drawn with regard to gender, professional background and age, as well as taking into account the principal cultural and geographic regions of the world. Today all parts of the globe are represented through national societies as full members: 58 in 2014.

In 1954 IACAPAP was officially incorporated in Massachusetts, United States of America, as a tax-exempt organization. Currently it is registered in Geneva, Switzerland, as a non-government organization, structured as a corporation, and empowered as a juridical entity.

If networking with likeminded professionals was the initial driving force for IACAPAP, the emphasis soon evolved “to advocate for the promotion of mental health and development of children and adolescents through policy, practice and research. To promote the study, treatment, care and prevention of mental and emotional disorders and disabilities involving children, adolescents and their families through collaboration among the professions of child and adolescent psychiatry, psychology, social work, paediatrics, public health, nursing, education, social sciences and other relevant disciplines”.

To achieve these purposes, one of the main activities of IACAPAP has been the organization of international congresses—to meet with colleagues, to learn from each other, and to promote ethical child and adolescent mental health services and practices. At the beginning, the constitution stipulated that congresses were to be held every four years. In 2008, it was decided that world congresses should be organized every two to four years. Besides congresses, regional conferences devoted to specific topics have been organized regularly. Furthermore, so-called study groups (or seminars) have been conducted since 1954; in recent years especially in low income countries to stimulate the recognition and development of the discipline in these countries. Since 1998 research seminars for young scientists (the Helmut Remschmidt Seminars) and since 2004 the Donald J Cohen Fellowship Programme have been regular events to help younger child mental health professionals, especially from less developed countries, to promote their career development. Publications like the *Bulletin* since 1994, the *IACAPAP Book Series* since 1970, the *e-Textbook of Child and Adolescent Mental Health* since 2012, and the *IACAPAP Declarations*, mostly published in connection with congresses, have all broadened the services that are offered to mental health professionals. *Child and*



More details about IACAPAP's history can be found in the booklet by Kari Schleimer *75 Years with IACAPAP*.

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Adolescent Psychiatry and Mental Health (CAPMH), an open access online journal became the official scientific journal of IACAPAP in 2013. The [IACAPAP website](#) is the portal to access most of this material.

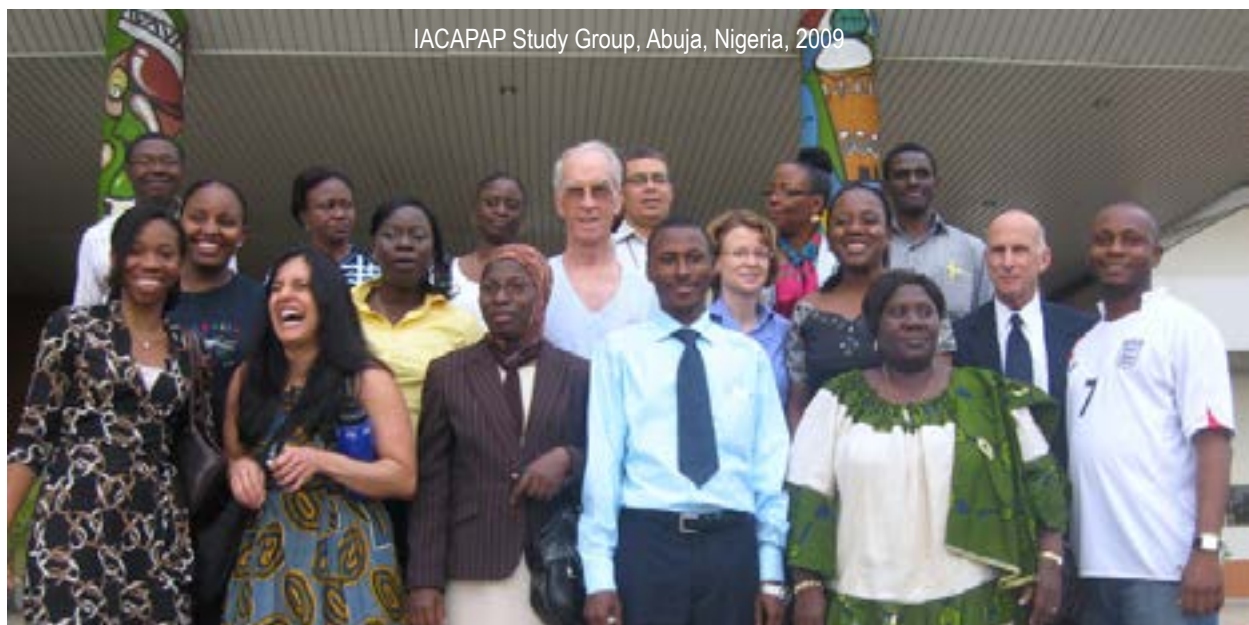
HISTORY OF CHILD PSYCHIATRY IN DIFFERENT COUNTRIES AND REGIONS

AFRICA

Historically, psychiatric disorders of children and adolescents were slow to be recognized in Africa, with those of infants being last of all. As a general rule, child and adolescent psychiatry developed in Africa only in the second half of the 20th century. Invariably, medical professionals established the kind of psychiatric services they were familiar with in the English-speaking countries of the northern hemisphere or in France, Portugal, and Spain. Other than francophone countries in North Africa, this brief history covers Anglophone countries only. The information in this report is largely based on the paper by Robertson et al (2010).

In North Africa, until the year 2000, most child and adolescent psychiatry services were provided by general psychiatrists with an interest in child psychiatry. In countries formerly colonized by France, the French psychodynamic model was predominant, as in day hospital programmes for psychosis or autism. Egypt developed a more eclectic approach. Over the last decade, the situation has changed rapidly, with moves towards formal child and adolescent psychiatry training and services. Tunisia has developed child and adolescent psychiatry as a specialty, independent from general psychiatry, training three to four new specialists per year. Morocco is also following this option.

By 2015, in Anglophone sub-Saharan Africa, outside of Nigeria and South Africa, possibly twenty to thirty psychiatrists would have had some formal training in child and adolescent psychiatry, but only a few would have had more than one year of supervised training in a recognized training programme. In the last twenty years interest in child and adolescent psychiatry in Nigeria has grown significantly,



aided by regular updates organised by the West African College of Physicians. Since 1999 many child and adolescent psychiatry services have opened around the country including some with inpatient facilities. The graduation in 2014 of the first class from the newly established Master of Science programme in Child and Adolescent Mental Health at the University of Ibadan will more than double the number of Nigerian psychiatrists with a child and adolescent qualification, as well as increase the numbers of child and adolescent mental health professionals in other parts of the region.

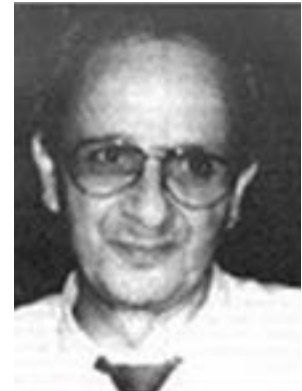
South Africa has provided a complete two-year postgraduate training in child and adolescent psychiatry for general psychiatrists since 1983. There are currently over 30 child and adolescent psychiatrists in the country. Child and adolescent psychiatry services are generally tertiary level outpatient clinics, with some centres providing day and inpatient services. Programs in infant psychiatry are developing strongly in one or two centres. The South African Association for Child and Adolescent Psychiatry established the peer-reviewed *Journal of Child and Adolescent Mental Health* in 1989.

The above-named achievements by child and adolescent psychiatry in Africa represent only a small inroad into the challenges posed by the largely unmet child and adolescent mental health needs on the continent. Neuropsychiatric conditions constitute a significant proportion of these and include the impact of ongoing major environmental hazards like HIV/AIDS and other epidemics, as well as war, among the many difficult circumstances in which children grow up on the African continent. The optimal development of child and adolescent psychiatry services is made more difficult by a steady and debilitating brain drain, a relative lack of good research programmes, and under-resourcing by governments. In the absence of formal psychiatric services, children and adolescents with psychiatric disorders may receive interventions from professionals in other sectors, or from traditional healers or non-governmental organisations. Child and adolescent psychiatry services will not be able to develop adequately until national child and adolescent mental health policies and plans are adopted with dedicated funding and suitably qualified personnel to implement them.

ARGENTINA

Early in the 20th century Argentina was an intellectual powerhouse for child psychiatry. Those were times of affluence and of a thriving cultural life in the country. The first child psychiatry chair in the world (*Cátedra de Neuropsiquiatría Infantil*) was created in 1923 in Rosario for Lanfranco Ciampi, an Italian psychiatrist who had trained in Rome with Sante De Sanctis. This is currently the only chair of child psychiatry in Argentina. Ciampi also created in Rosario an enlightened school for the intellectually disabled using a multidisciplinary approach.

To meet the needs of children, particularly those with intellectual disabilities, a number of Medico Pedagogical Institutes (*Institutos Médico Pedagógicos*) were created following the lead of Carlos Bernad Morales. These were institutions with multidisciplinary staff that sought to address the specific needs of each child. This model is still followed in other South American countries and in Spain. Relationships between health professionals and schools were also developed to deal with children's specific learning disorders such as dyslexia.



Mahfoud Boucebci (1937-1993) was one of the founders of Algerian psychiatry. He authored numerous books and articles and was particularly concerned about helping the intellectually disabled. He was president of the Algerian Society of Psychiatry and vice-president of IACAPAP. He campaigned for a secular democracy and was a founding member in 1985 of the first league for human rights in Algeria. During the Algerian civil war—an armed conflict between the Algerian government and various Islamist groups that began in 1991 and during which many intellectuals were assassinated—Boucebci was stabbed to death at the age of 56 outside *L'Hopital Drid-Hocine*, Algiers, where he was the director. A foundation was established in his name in 1994 to continue his work.

Telma Reca, who had returned to Argentina in 1934 after a period of specialization in the US, was influential in introducing the child guidance model popular in the US at the time. She began working in the old *Hospital de Clínicas de Buenos Aires* treating children with developmental disabilities, motor skills difficulties and behaviour problems. The *Hospital Carolina Tobar García*, which opened in 1968, was the first hospital in Argentina that specifically addressed child and adolescent psychiatric care.

The introduction of concepts such as “minimal brain dysfunction” in the 1960s led to an interaction between psychiatrists, neurologists, teachers and speech therapists. Developmental problems with affective or behaviour symptoms were treated as near-neurosis or adaptation syndromes. Mood and anxiety disorders were not a focus of clinical attention as much as they are today. There was also a great interest in high functioning autistic children, which led to the creation of special classrooms for them, with only a few pupils and staffed by teachers, psychologists and speech therapists.

Psychoanalysis had a very large impact in the evolution of child psychiatry in Argentina. While psychoanalytic ideas had reached South America much earlier—Freud’s works were translated into Spanish in the 1930s—the Spanish civil war, the rise of Nazism, and World War II resulted in several trained psychoanalysts migrating to, or seeking refuge in Argentina, such as Ángel Garma. The creation of the Argentinean Psychoanalytic Association (*Asociación Psicoanalítica Argentina*) in 1942 was an important milestone. The subsequent popularity of psychoanalysis led to many professionals, particularly psychologists, training in the discipline and an overcrowded field. The dominant influences in the 1970s and 1980s were continental European—exemplified by Ajuriaguerra’s 1973 textbook *Tratado de Psiquiatría Infantil*—and Freudian or Kleinian-style psychoanalysis.

The publication of DSM-III in 1980 and subsequent editions, the newfound eclectic approach of North American psychiatry, the evidence-based treatment movement, and globalization have had a growing impact on clinical practice in the last 30 years and there has been a dramatic increase in the use of psychotropic medications. This was compounded in Argentina by economic problems and social strife that created a difficult environment for the practice of the specialty. Nevertheless services for children and adolescents are increasing. The child psychiatry paradigm—and the name of services—has been changing over the years to reflect the ideas prevalent at the time: from mental hygiene, to developmental psychology, to psychopathology, and finally to mental health, although child psychiatry is still used.

The AAPI (*Asociación Argentina de Psiquiatría Infanto Juvenil y Profesionales Afines*), created in 1969, is the main child and adolescent mental health association in the country and a member of IACAPAP. Uruguay, Chile and other South American countries have their own associations. They are all part of FLAPIA (*Federación Latinoamericana de Psiquiatría de la Infancia y Adolescencia*), the South American child and adolescent mental health umbrella organization. Both AAPI and FLAPIA conduct congresses, training courses and advocate for better education of professionals and better services.



Lanfranco Ciampi (1885-1962), held the first chair of child psychiatry in the world, established in Rosario, Argentina, in 1922.



Melanie Klein was very influential in South American child psychiatry.

ASIA

Asia is a conglomerate of very diverse countries, regions and cultures, unique in the sense that mental health was not in the domain of health until very recently. Emotional concerns were seen as the domain of families and communities. It is not as if mental health needs were not met prior to the formal development of child mental health services; they were often provided by existing social and community resources. This could include village elders, medical practitioners who took care of children and social services. In China, the earliest account of mental health related literature was not in medical accounts by physicians but rather in a volume on dreams as early as the late Ming Dynasty (around 1636) (Vance, 2014). The combination of biologic and psychological approaches was emphasised as early as the 18th century (Chen, 2014). In countries that were part of the former British Empire, such as India and Singapore, British-style services gained strong foothold from the 1960s and 1970s. There were child guidance clinics that were

small and poorly staffed. Specific child psychiatric training was not available and most practitioners were trained in Britain. Most of the child psychiatric work was undertaken by general psychiatrists, which often resulted in children being treated like mini adults. Indonesia, Japan, Philippines, South Korea and Thailand were influenced by US practitioners, who promoted the development of local training programs. Most of such services drew from influential individuals who sponsored such development, for example Kusumanto Setyonegoro (1924–2008) in Indonesia. His influence brought South East Asian child psychiatry into the forefront in the region. Most Asian countries had child psychiatry services concentrated in urban centres such as Jakarta, Tokyo, Seoul, Manila, Bangkok and Bangalore.

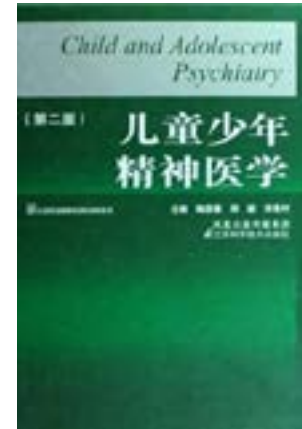
Formal services in Asian countries started in several ways. One was through the formation of professional associations with prominent individuals who advocated for the establishment of services or by influencing national policy development. For example, in China, Tao Guo Tai singlehandedly set up child psychiatric services in 1930 in Nanjing. Through his influence and patronage, the entire country was galvanised to develop this type of services (Hong et al, 2004). Another way was through the development of mental health policies. In Singapore, the government started child mental health services in 1970; children were seen as important in the new country and their physical and emotional health had to be addressed. In 2005, the government moved to improve existing services in response to the tragic suicide of an 11 year old. This resulted in the formation of a National Committee on developing child psychiatric services and subsequent plans (Fung et al, 2012).

Regional review

Because of the diverse nature of the Asian continent, a sample of several regions and countries is provided in Table J.10.1, incorporating data from several sources (e.g., Guerrero et al, 2013; Hirota et al, 2014, Hong et al, 2004; Tan et al, 2008). Most child psychiatry services started between the 1960s and 1980s largely following Western models (McClure & Shirataki 1989; Woon, 1981; Fung et al, 2012). Formation of national and, eventually, regional associations resulted in a more rapid growth of services. IACAPAP held its international congress in Kyoto, Japan in 1990 and the idea of an Asian association was seeded at that meeting. The Asian Society for Child and Adolescent Psychiatry and Allied Professions (ASCAPAP) was formed in 1996 and its membership has grown steadily since then. Because Asia is a mix of high, middle and low income regions and countries, development has been uneven. Even when resources are available, development of services may depend on how well professionals (for example psychiatrists and paediatricians) collaborate in defining the basis for child psychiatric practice. For example, in Japan, child guidance clinics were set up in 1974 but were run by paediatricians with psychiatrists performing a visiting role (McClure & Shirataki, 1989).

International collaborations

Concerns about the mental health of children in Asia only started in the 1970s. The WHO set up an expert committee for third world countries in 1976,



Textbook by **Tao Guo Tai**, the first Chinese child psychiatrist



The Executive Council of the Bangladesh Association for Child and Adolescent Mental Health (BACAMH) at the 2012 Annual General Meeting

which produced a technical report the following year. The findings were consistent but loosely based on a survey of only four countries: India, Thailand, Sri Lanka, and Indonesia (Bartlett, 1980). The finding was that all four countries did not have significant services but were developing them following Western lines, so that in Indonesia and Thailand American influences were prominent. An interesting point in India and Sri Lanka was that although adult mental health was considered to be the domain of clinics and hospitals, child mental health was seen as a matter for the family. Influential paediatric texts did not include child mental health issues. The 1977 report concluded by suggesting the following developments:

- Services should be planned and coordinated because mental health needed multidisciplinary input. In fact, based on the WHO report, the need for cross-sectorial national plans was emphasised
- Development of child mental health centres was needed and models in Jakarta and Bangalore were lauded as examples
- Need for training child psychiatrists, who were divided into two groups, general psychiatrists who do some work with children and families, and specialised child psychiatrists who work only with children. The need for cross cultural training in influential western centres for professionals from countries without local training programs was emphasised. This was the case for many Asian countries in which child psychiatrists were rare or non-existing
- Child psychiatry and paediatrics were seen as complementary and the need for cross training was emphasised. Many paediatricians had little training in managing mental health issues and did not work closely with child mental health services
- Teachers should be trained in areas such as child abuse, mental retardation, learning difficulties and epilepsy. This was akin to suggesting using educational settings as potential primary mental health care delivery points
- Culturally appropriate health education should be used, with proper evaluation before being embraced
- The number of educational psychologists should be increased as they could be the link between mental health care and education.

Table J.10.1 Overview of the status of child psychiatry in several Asian regions and countries*

COUNTRY	POPULATION (millions) % AGED 0-15 YEARS	CHILD PSYCHIATRY ORGANISATION (YEAR STARTED)	YEAR CHILD PSYCHIATRY SERVICES STARTED	NUMBER OF CHILD PSYCHIATRISTS (TOTAL N OF PSYCHIATRISTS)	CHILD PSYCHIATRY TRAINING PROGRAM
Bangladesh	166 30%	Bangladesh Association for Child and Adolescent Mental Health (2008)		2 (814)*	
Brunei Darussalam	0.4 25%		2005	1 (4)	
Cambodia	15 31%		1996	0 (41)	
China	1,400 18%	Professional Committee on Mental Health In Children (1986)	1930	500 (20,500)	3-year
Hong Kong	7 12%	Hong Kong College of Psychiatrists (1948)	1960s	30 (300)	6 year training program in general psychiatry. No specific child psychiatry training.
India	1,300 28%	Indian Association for Child and Adolescent Mental Health (1990)	1937	100 (4,000)	3-year training program
Indonesia	253 29%	Association of Child And Adolescent Mental Health, Indonesia	1978	40 (600)	2 years in addition to 3 years in general psychiatry
Japan	127 13%	Japanese Society for Child Psychiatry (1960). Became Japanese Society for Child and Adolescent Psychiatry	1920s	1,677 (13,534)	3 year of a 5 year training program for psychiatrists
Lao PDR	7 35%			2 (2)	
Malaysia	31 26%	Malaysian Association of Child and Adolescent Psychiatry (MYCAPS) (2014)	1968	25 (289)	4 years of training to be psychiatrists followed by 3 years for child psychiatry
Mongolia	3 27%	Recognised subspecialty 1978		2 (135)	1 year, general psychiatry training
Myanmar	56 25%			0 (80)	2 years training in general psychiatry

*Some of the data are not available. These are best estimates obtained from a variety of sources.

Table J.10.1 Overview of the status of child psychiatry in several Asian regions and countries (continuation)*

COUNTRY	POPULATION (millions) % AGED 0-15 YEARS	CHILD PSYCHIATRY ORGANISATION (YEAR STARTED)	YEAR CHILD PSYCHIATRY SERVICES STARTED	NUMBER OF CHILD PSYCHIATRISTS (TOTAL N OF PSYCHIATRISTS)	CHILD PSYCHIATRY TRAINING PROGRAM
Pakistan	188 34%			2 (342)	
Philippines	100 34%	Philippines Mental Health Association (PMHA) (1950) Child and Adolescent Psychiatrists of Philippines (CAPPI) (1993) The Philippine Society of Child and Adolescent Psychiatry (1996)	1950s	20 (400)	3-4 years of general psychiatry and 2 years of child psychiatry
Singapore	5 16%	Section of Child Psychiatry, College of Psychiatrists, Academy of Medicine Singapore (2014)	1970	25 (208)	4 years of general psychiatry residency and 1 year of child psychiatry
South Korea	51 14%	Korean Academy of Child and Adolescent Psychiatry (1983)	1958	400	4 years general psychiatry and 2 years of child psychiatry training
Sri Lanka	20 25%				
Taiwan	23 14%	Taiwanese Society for Child and Adolescent Psychiatry (TSCAP) (1998)	1953	195 (1,480)	3.5 years of general psychiatry. 1 year of child psychiatry training
Thailand	68 18%	Royal College of Psychiatrists of Thailand Psychiatric Association of Thailand (1950s)	1960s	120 (520)	3 years of general psychiatry. 4 years of child psychiatry training
Vietnam	93 23%			10 (700)	2 years of general psychiatry training

*Some of the data are not available. These are best estimates obtained from a variety of sources.

These ideas were consistent across the various reports that emerged in the last three decades (Belfer 2008; Hong KM 1982; McClure & Shirataki 1989; Woon, 1981). Some of these ideas can be best promoted through regional organisations. ASCAPAP since its inception in 1996 is an example of collaboration between different countries within the region by sharing knowledge and experiences, by the development of training programmes, professional development, and research collaboration.

Asia in comparison with the rest of the world

The WHO Mental Health Atlas gives a good summary of the extent of mental health services globally (WHO, 2005; 2011). Ten countries in the South East Asian WHO region (Bangladesh, Bhutan, India, Indonesia, Maldives, Myanmar, Nepal, Sri Lanka, Thailand and, Timor Leste) were evaluated. The atlas provides information on six domains: governance, financing, services, human resources, medications, and information systems. The key finding was that resources for mental health were insufficient, poorly distributed, and inefficient, with a general trend of reduction in institutional care. For the South East Asian region, the pertinent points were:

- Although mental health is considered in general health policies in 80% of countries and dedicated mental health policies exist in 70% of them (second only to the European region), population coverage was only 30%. Mental health plans were present in 80% of countries in Asia compared with the worldwide average of 70%.
- Asia allocates to mental health the lowest amount of funds, in terms of percentage of the health budget. Even with such a low allocation, most of the mental health budgets in Asia were spent on inpatient care.
- Asia has the highest availability of mental health resource manuals in primary care at 50%. Facilities for mental health delivery (outpatient, day treatment and inpatient) were the lowest in the world
- Mental health workforce is amongst the smallest in the world—second only to Africa—with an average of 0.23 psychiatrists per 100,000 population (world average was more than five times higher at 1.27/100,000). A similar pattern exists for the rest of the mental health workforce.

In 2005, WHO also developed a mental health atlas for child and adolescent mental health (Belfer 2008; WHO 2005) but only three South East Asian countries completed the survey (India, Sri Lanka and Thailand). In comparison with general mental health policies, specific child and adolescent policies were less common (50%). Like in their adult counterparts, the mental health workforce was significantly smaller than in Europe and the Americas.

BRAZIL

Until the mid-19th century, Brazilian medicine was completely dependent on Portuguese medicine as Brazil was not allowed to have its own universities. Those interested in becoming physicians were forced to study in Europe (e.g., Lisbon or Paris). By 1808, with the arrival of the Portuguese court in Brazil (the Braganza royal family and its court of nearly 15,000 people) fleeing from the Napoleonic invasion of Portugal, two pioneer medical schools were established in Rio de Janeiro and Salvador (Bahia). Even so, there was no teaching on mental

illness care, which was only established in 1822. By 1824 the mentally ill had been deprived of political rights and the *Santas Casas* (“Holy Houses of Mercy”, religious institutions of Portuguese origin scattered around the country that ran charity hospitals) assumed their care. Three psychiatric nuclei grew in Rio de Janeiro (led by Juliano Moreira), São Paulo (coordinated by Francisco Franco da Rocha), and Recife (Pernambuco), represented by Ulysses Pernambucano. In relation to child and adolescent psychiatry, the first nucleus developed a special school linked to Hospital Juliano Moreira. The second nucleus originated an “abnormal children’s” section in Hospital do Juquary in 1929, run by Vicente Batista. The third conducted a series of studies on mental retardation and evaluation tests. In 1932 the Russian psychologist and pedagogue Helena Antipoff founded the *Sociedade Pestalozzi* in Belo Horizonte (Minas Gerais), focusing on the multidisciplinary care of children disabled or mentally disordered.

By the mid-1950s, some child psychiatry facilities were set up in association with general hospitals. One of them was headquartered in the *Universidade do Brasil* (Rio de Janeiro) in 1953 and in 1955 another in the *Universidade de São Paulo*. The latter was headed by Stanislaw Krynski, arguably the most influential child psychiatrist in Brazil until the mid-1980s. By the mid-1960s, Krynski linked with the *Associação de Pais e Amigos dos Excepcionais* (Association of Parents and Friends of Exceptional Children, APAE, an association that, in addition to parents and friends of the “special”, sought to prevent and treat disabilities and to promote the welfare and development of people with intellectual disability). He trained several disciples and conducted many studies on mental retardation.

During the mid-1970s child psychiatry in Brazil underwent significant changes under the influence of Argentinian psychoanalysts who migrated to Brazil during Argentina’s military dictatorship, resulting in Brazil losing most of its distinct clinical traditions. This situation remained until the mid-1990s when a new generation of Brazilian child psychiatrists, influenced by North American psychiatry, changed the profile of the specialty, losing the continental European flavour to adopt an Anglo-American empirical-pragmatic approach (Assumpção, 1995).

Even after this shift, child psychiatry in Brazil is currently in difficulties. Whether this is due to the low number of trained professionals (presently under 300 and badly distributed geographically), to the dearth of training programs, or to the absence of child mental health teaching in most Brazilian medical schools’ curricula, is unclear. Moreover, this crisis is exacerbated by a lack of youth mental health policies and of specialist health services for this age group, creating a vicious cycle of lack of services and professional interest. Thus child psychiatry in Brazil is stepping unsteadily into the 21st century.

CENTRAL AND EASTERN EUROPEAN COUNTRIES (CEECs)

The situation in the field of child and adolescent mental health in Central and Eastern Europe deserves special attention. This is a huge region covering 30 new democracies, which emerged after the collapse of the Soviet Union and its then satellites, with a population of around 400 million. These countries have very different cultural backgrounds. Geographically, not all are even located in Central



Salvador Célio (1940-2009) was a leading Brazilian child psychiatrist. He was secretary and vice-president of IACAPAP.

and Eastern Europe—the countries of the Balkan region are in South-Eastern Europe. However, they all have a similar context because, after having been under communism for 50 to 70 years, they have faced a transition from totalitarian regimes to democratic ones. The period from 1990 —when socio-political changes started— has been marked by an impressive combination of successes, challenges and failures in many areas, including in child and adolescent mental health.

Under Soviet rule, CEECs developed a unique system of mental health care for both children and adults different from that in developed and developing countries. Contrary to what occurred in most of the rest of the world, this system was driven by Soviet ideology, which supported health policy and social security with relatively large amounts of financial and human resources. However, compared to western countries, resources were predominantly invested in residential institutions. State policy was based on a model of social exclusion of vulnerable groups. The usual solution was to institutionalise children in cases where families were in crisis or children developed problems. The official indicator of the system's good performance was a high percentage of “organized children” (which meant *institutionalised* children) with any type of developmental or psychosocial problem. Community-based services were prevented from developing by the very fact that Soviet ideology held that psychosocial problems had been successfully solved by the political system, resulting in a lack of development of the psychosocial components of care, and the child and adolescent mental health field being dominated by concepts such as “defectology” and “child psycho-neurology”.

Child psychiatry was initially part of child psycho-neurology and evolved on the basis of a narrow biomedical model represented by the clinical neurology of the mid-20th century. In the 1970s, child and adolescent psychiatry was recognized as a specialty, becoming independent from child neurology throughout the Soviet Union. Since then the specialty has been struggling for independence from adult psychiatry with varying degrees of success in different countries. While adult psychiatry in the Soviet Union was known for its extremely broad criteria for schizophrenia —resulting in psychiatrically-justified political abuses— child and adolescent mental health was looking for other ways of interpreting the possible causes of emotional and behavioural disorders. As a result, diagnoses different from the widely accepted classifications (ICD, DSM) were often used, reflecting the former links with child neurology (such as organic brain syndrome or organic-type consequences of hypothetical mild brain damage during pregnancy, labour or early infancy). It is important to remember that these trends were the outcome of ideological statements by a totalitarian state, according to which the psychosocial causes for disorders had been eliminated. Thus, pharmacological treatment was used extensively in both outpatient and inpatient child psychiatry services. Professional groups of clinical psychologists started to slowly grow only from the 1980s. Social work as a specialty was non-existent until 1990 when the socio-political changes in the region started.

The services for children with developmental disabilities grew under the concept of “defectology”, which was a Soviet equivalent of special education. The level of *defect* was assessed in each disabled child to decide whether it was cost-effective to invest in his or her education as future cheap labour force. As a result mildly intellectually disabled children were usually referred to special schools, while those with moderate and severe intellectual disability were assessed as *uneducable*.



Children in a Romanian orphanage in the early 1990s (Photo: Mike Carroll)

Professionals gave parents the strong advice of abandoning these children, placing them in state institutions for the rest of their lives. Tragically, a large group of children suffering from social and emotional deprivation were also placed in special boarding schools by labelling them as mildly intellectually disabled. In this way the Soviet system was hiding social problems and presenting them as problems emerging in the brain of the child. The Romanian orphanages are an extreme and heartbreaking example of this. Under Nicolae Ceaușescu, abortion and contraception were forbidden in Romania. This resulted in many children being abandoned and placed in orphanages with disabled and mentally ill ones. These vulnerable children were subjected to institutionalised neglect and abuse, including physical and sexual abuse and given drugs to control their behaviour.

Child psychiatry in Lithuania after the collapse of the Soviet Union

Following the collapse of the Soviet Union in 1991 there were dramatic political changes in the CEECs and opportunities for developing modern approaches to child and adolescent mental health. Child psychiatry in these countries emerged in this context. The successes, challenges and failures of the Lithuanian child development model are described as an example. The situation and development in other CEECs may be quite different.

In 1991, a Child Development Centre was established in Vilnius as a demonstration clinic for the implementation of contemporary child and adolescent mental health policies and practices. The centre was affiliated with Vilnius University. Since then, considerable progress has been made in restoring a balance within the biopsychosocial paradigm. However, after 25 years of attempting to change service delivery there is a sobering acknowledgement that the influence of the former ideology is still vast and contemporary approaches to treatment are often losing the battle for funding to traditional services, which still rely on the concept of social exclusion, stigma and institutionalization.

With the help of the international community, more than 50 diagnostic and therapeutic methods have been introduced into clinical practice in Lithuania. The attitude has been to accept all the evidence-based approaches and not to become dependent on one or another school of thought or clinical practice. As there is ideological control no longer, the mass media has begun to highlight the problems that had been hidden from the public during the Soviet era and the Child Development Centre took advantage of this to urge politicians to initiate changes within the system.

The first problem brought to people's attention was the plight of children with developmental disabilities, including intellectual disability and autism. A strong coalition of professionals, parents' organizations, and reform-minded politicians was successful in convincing the national authorities to develop a network of community based services for these children—as an alternative to the traditional system of large residential institutions. The Child Development Centre has been driving this process with professional education and skills, emphasizing early intervention for infants and preschool children with developmental problems and disabilities. This field has grown as developmental (social) paediatrics, with a network of community-based teams throughout the country. Thus, a good foundation has been built for the reintegration of disabled children into the education system and society in general.

The specialty of child and adolescent psychiatry has become well established in Lithuania, with a four-year postgraduate (residency) training program. In 2015 there are 80 specialists in child psychiatry working in outpatient and inpatient services. After long debates with the compulsory health insurance fund, relatively good agreements have been achieved, so that funding of inpatient and day care services allows having teams of professionals working with children in need. A pilot service for an intensive one-week crisis intervention program has been opened, also covered by health insurance despite referred cases not necessarily having a medical diagnosis. It was an important victory to convince national authorities that health insurance funds should be used for the effective and flexible management of urgent psychosocially challenging cases (e.g., suicide attempts, physical or sexual abuse). Outpatient services are staffed by child psychiatrists, psychologists and social workers, who are employed by municipal mental health centres, funded by health insurance on a capitation basis. However, these so-called primary care mental health centres are too weak to perform the mission expected of them since they have an extremely small number of non-medical staff (such as one professional per 30,000 population). Currently, negotiations with government are taking place to develop regional child and adolescent mental health centres with larger catchment areas, which would have a higher number of psychologists and social workers in the team and will be able to better fill this gap.

The ongoing debate indicates that there are many challenges and obstacles for the development of child and adolescent mental health services in Lithuania, which seems to follow the path of what happened in Western Europe 50 years ago. Opponents of change argue that most of the population (and especially families at risk) are not motivated to receive psychosocial interventions, that there is not a large enough workforce (health professionals are not eager to move to work in the provinces; they often chose to migrate to other countries because of better salaries). Further, most child psychiatrists working in existing services are reluctant



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to support the development of new services and there is a popular view among health authorities that the compulsory health insurance fund (the only way to fund healthcare services in Lithuania) should not be used to pay for interventions provided by professionals who are not medical practitioners. It will be known in the future if a breakthrough in the development of child and adolescent mental health services is possible in Lithuania. The outcome of this debate could be important in the broader European and global context as it raises important questions about priorities when developing healthcare systems.

Despite the achievements, 25 years of change have not managed to eliminate fully the Soviet legacy in mental health and social policy. The state of the child and adolescent mental health field is a good reflection of the level of democracy and civil society in a country. While the physical health of children (such as prevention of infant mortality and morbidity, vaccination, prevention of infectious diseases) were already adequately addressed during the Soviet era—and developed further as a priority during the *transition* period—there is still a lack of political will to manage comprehensively many child and adolescent mental health problems.

From 2007 to 2009, a project funded by the European Commission and led by Lithuania (Puras et al, 2010), examined challenges and opportunities for the development of effective and evidence-based child mental health policies in the context of the European Union (EU) enlargement. The large number of countries (16) and organizations (35) from old and new EU member states that participated allowed comparisons between countries and regions. There was a clear difference in the quality, quantity and direction of child and adolescent mental health services. While Northern, Western and Southern European countries (*old* EU member states) had well established services with a large number of allied mental health professionals supporting child psychiatrists in teams, in many newer EU countries (Bulgaria, Romania, Baltic countries) a large proportion of human and financial resources was still employed in ineffective residential settings (such as infant homes and large residential institutions for older children with and without disabilities). The situation in the Baltic countries was significantly better than in Eastern non-EU countries (such as the Russian Federation or Ukraine). The child and adolescent mental health field in Central European countries (such as Czech Republic and Poland) and the former Yugoslavian states has developed more effective community-based services compared with countries that had been part of the Soviet Union. This difference could mean that Eastern European countries had a heavier legacy of the totalitarian mentality than Central European countries, Baltic countries being in the middle. As an example, the project studied the situation of children born to parents with intellectual disability. While countries such as Finland have developed services for such families, Lithuania, Bulgaria and Romania still—as a rule and not as an exception—institutionalise both mother and child.

One of the systemic gaps in many CEECs is the lack of a culture of evaluation and monitoring of policies and services. The Soviet tradition was to focus on statistics that reflected processes and not outcomes. This gap has not been filled thus far; research and evaluation activities in child and adolescent mental health are not funded by governments.

FRANCE

After a long period during which the specific nature of children's mental disorders had been ignored, French psychiatrists became interested in the concept of "idiocy" through the works of Itard about the *Sauvage de l'Aveyron*, a feral child. Jean Marc Gaspard Itard, a student of Pinel—the father of asylum psychiatry—is known for his work on access to language. Until then, only educationalists had studied children and then only from the teaching point of view. Even when general hospitals were created in every major French city by the 1662 Royal Edict, children did not receive special attention. Forsaken with beggars and convicts, children had only one specific feature: abandonment—a widespread practice throughout the middle ages.

“Idiocy”

In 1800, Itard developed the first medico-educational therapy. The result, in addition to an extensive observation on what looked like childhood autism, was a debate about whether mental disorders were inborn or acquired, psychological or organic in nature, a debate that would haunt the 19th century and hindered psychiatric care in the first half of the 20th century.

Idiocy in French was synonymous with mental illness or lunacy, and the only application of asylum medicine concerning children. Edouard Seguin—who worked as a teacher in an asylum—developed a type of care for the *idiots*. He considered that *idiots* had “an infirmity of the nervous system” and needed educative and sensory treatments based on physical activities. Seguin thought that



With the appointment of Bourneville in 1890, and later on, in 1957, of Roger Misès, La Fondation Vallée has been at the centre of innovation and care for children and adolescents in France.

idiots had a preserved intelligence behind their disease. The work of Seguin was not well received by the alienists (physicians working in asylums); half a century and the work of Bourneville must come to pass for real advances in the treatment of *idiocy* to occur. Désiré-Magloire Bourneville, an alienist, recommended the methods of Seguin and led the *Fondation Vallée*. He fought for early treatment and for consistency in punishment in his teaching. He is known for his activism against the deplorable conditions in asylums for the mentally ill. He focused above all on the development of education.

These approaches had the advantage of thinking about treatment despite the ongoing debate on aetiology, which became complicated further with the theory of degeneration proposed by Benedict Morel. According to Morel, *idiocy* and *imbecility* (intellectual disability) were the legacy of madness over several generations. This reflected the eugenic interpretation of man and his destiny popular at the time and reflected in literary works such as Zola's. *Idiocy* started to be considered an incurable condition and not a progressive disease.

The organisation of care: From maladjusted childhood to division into psychiatric sectors

At the beginning of the 20th century, Bourneville saw his work and his desire to create genuine asylum schools somewhat hampered by the work of Binet and Simon, the creators of psychometrics. Alfred Binet, who was director of the psychology laboratory at the *Sorbonne*, defined the *idiot* as a child unable to communicate with language. He wrote in 1908, with the psychiatrist Théodore Simon, *Abnormal Children*. The advent of psychometric testing allowed the development of specialised classes in France, where school had become compulsory by the Ferry Act of 1884. Classification led, on the one hand, to a great improvement in the support provided by state-funded schools to children considered “curable”, but maintained segregation for children considered “incurable”, who were directed towards asylums without any real treatment.

The 20th century thus began with a split between the support offered to some children by schools and the confinement of others in asylums, which became psychiatric hospitals in 1938. Conditions became increasingly precarious in asylums as the theory of degeneration reached its zenith. Debate then became about abnormal childhood—with a distinction between “the abnormal child in asylums” and “the abnormal child in schools”.

Besides this, French child psychiatry became increasingly interested in a variety of other issues such as juvenile delinquency, psychoanalysis, the work of developmentalists such as Piaget and Wallon, not to mention the emergence of phenomenology—the study of psychopathology, broadly defined, including signs, symptoms, and their underlying thoughts and emotions. Outpatient consultation services began to appear in the 1920s. The discipline started to change its concern from the dichotomy educable/not educable, to open up a different perspective on developmental and behavioural disorders in children. The term “child-psychiatry” (*pédopsychiatrie* in French) appeared for the first time in 1912.

Upon the arrival of the Popular Front (an alliance of left-wing groups) to power in 1936, significant work was undertaken to coordinate clinical services. In



Roger Misès (1924–2013) had a major impact on the development of child mental health services in France.

1937 Henri Wallon, a psychologist and politician, began to develop a nationwide network providing psychological care and protection for children. Some hospital services were enhanced, such as Georges Heuyer's at *la Salpêtrière*, in collaboration with the first French psychoanalyst, Eugenie Sokolnicka, and later with Sophie Morgenstern. Meanwhile, universities supported the gradual institutionalisation of French child psychiatry. The creation of the first child psychiatry outpatient clinic by Collin in 1912, the holding of the first international congress of psychiatry in 1937 in Paris, the creation of the first French chair of child psychiatry in 1948 (for George Heuyer in Paris) and the holding of the "Psychiatry White Paper Days" organised by *L'Evolution Psychiatrique* (a journal of phenomenology and psychoanalysis) in 1965, 1966 and 1967, were important milestones.

The clinical care system relied on institutions for "maladjusted" children. This term first appeared during the Vichy regime but it followed work that had started before the capitulation of France to Nazi Germany. The definition of maladjusted children first appeared in 1944 in the *Lagache Report* (Daniel Lagache was a psychiatrist and professor of psychology at the *Sorbonne*): "A child is maladjusted who has insufficient abilities or defects in his/her character putting him/her in extended conflict with reality and the demands of his/her surroundings, according to his/her age and social environment". The provision of a more or less intensive treatment depended on the severity of the disorder: "Overall, we can distinguish between the recoverable, semi-recoverable and non-recoverable". The non-recoverable were placed in institutions. These views, at the height of the German "final solution", reflected the ideology of the Vichy regime. It is still the subject of historical research whether physicians and administrators actually knew the fate reserved for the mentally ill in psychiatric hospitals. The reality is that about 40,000 mentally ill patients died of starvation or neglect in French psychiatric hospitals during the Nazi occupation.

After the liberation, awareness of this carnage stimulated a more humane attitude, to think differently about the provision of psychiatric care. Largely influenced by the Anglo-Saxon and Italian anti-psychiatry ideas (echoed in France by Michel Foucault) and especially by institutional psychotherapy (created by Francois Tosquelles) "psychiatry sectors" were created in the 1960s—each sector catering for a designated population, aiming at ensuring equal access to care whatever the place of residence. His process was, on the one hand part of a democratic regional organisation of mental health care, and on the other the foundation for a better understanding of mental disorders. Psychiatric sectors were put in place in 1960, initially affecting both adults and children. In 1972, sectors specific to child psychiatry were created. The Government Circular of 1972 (*Circulaire Misès*) supported a new organisation of clinical services, more democratic and less rejecting of the severe forms of disease. Roger Misès can be considered the father of child psychiatry sectorisation. He was confronted by an asylum system that in his view made patients worse. Thus, he developed the "new psychiatric clinic" based on multidisciplinary teamwork with educators, psychologists, pedagogues, psychiatrists, and psychiatric nurses working side by side using the theoretical contributions of psychoanalysis and other schools. He drafted the circular of 14 March 1972 that created the child and adolescent psychiatry sectors. This movement occurred in the aftermath of the May 1968 events in France—a period of great civil turmoil punctuated by demonstrations, general strikes, and



Serge Lebovici (1915-2000) was an influential French psychiatrist and psychoanalyst who was president and honorary president of IACAPAP. In 1958, he set up the *Centre Alfred Binet*, an outpatient service in the 13th arrondissement of Paris. In 1978, he was appointed Professor at the *Université Paris Nord* at Bobigny.

the occupation of universities and factories. The same year, psychiatry split from neurology becoming both empowered and emancipated. Day hospitals became the alternative institutional structure for inpatient care to prevent segregation. The CMPs (*centres médico-psychologiques* or mental health centres) became the gateway for the provision of care. Psychoanalytic thinking and institutional psychotherapy played a large role in this reorganisation.

Over time this system has become the victim of its own success. According to some this success has, in places, crystallised treatment around psychoanalytic ideology rather than on a medical model. Recently, child psychiatry services have undergone significant changes in their organisation and therapeutic methods. Since the 1990s, and especially since the beginning of the 21st century, the contribution of the neurosciences and cognitive science has improved clinical practice.

The territorial organisation gave a real impetus to training. No formal child psychiatry education existed until the 1970s. The first training program was started by the “four colonels” (Lebovici, Diatkine, Soulé and Misès) in Paris, which progressively disseminated to the entire country. In the last two decades of the 20th century almost all universities offered PhD degrees in child psychiatry, both for teaching and research. The census of 2014 reported that there were 743 child psychiatrists, more than 14,000 adult psychiatrists and more than 100,000 family physicians (for a population of about 70 million). The number of child psychiatrists does not include psychiatrists without a specific diploma who treat children. Indeed, there is no big difference between adult and child psychiatrists. Unlike in some other European countries, French training does not separate child and adult psychiatry; child psychiatrists must be adult psychiatrists first.



[Click on the image to view Marcel Manheimer's monograph Les Troubles Mentaux de l'Enfance,](#)

The development of psychopathological understanding

In the first half of the 20th century, the issue of child psychosis helped to offset the influence of psychometrics, which had become ubiquitous. In addition to psychoanalytic concepts, other contributions enriched the understanding of mental disorders in children: developmental psychology with Jean Piaget and Henri Wallon and phenomenology.

After the 1950s, clinical descriptions became more refined: “there are two types of maladjusted children: those deficient in intelligence and those unbalanced by character or behaviour”, Heuyer wrote. More and more children received outpatient assessment with psychological tests, rehabilitation and psychotherapy. Drug treatments were emerging, such as the use of phenobarbital for behavioural disorders with violence. Nevertheless, the tradition of institutionalising maladjusted children in boarding schools persisted.

At the International Congress of Paris in 1937, continental European clinicians became aware of the US literature on childhood schizophrenia through a communication by Despert. Subsequently, childhood psychosis began to take a special place in French child psychiatry, whose practitioners rejected the dichotomies between psychogenesis and organogenesis, curability and incurability. The notion of handicap was also considered by child psychiatrists as alienating, perceiving the term as synonymous with loss of hope.

“The *French Classification for Child and Adolescent Mental Disorders* (CFTMEA) was created in 1983 by a task force led by Professor Roger Misès with one major goal: to offer French child psychiatrists an alternative to DSM-III. French child psychiatrists worried that DSM-III was quite different from the clinical process that most of them were using for diagnosis decision making. They also worried that the DSM-III could drastically change clinical practices by focusing all of the clinical and therapeutic attention on isolated symptoms rather than taking into account structural psychopathological configurations” (Mises et al, 2002).

French language publications in child psychiatry have had a significant impact in other European countries, French-speaking African countries, and in Spain and Latin America—mostly through translations into Spanish of influential textbooks (e.g., by Serge Levovici and by De Ajuriaguerra). This influence has been gradually waning (Maldonado-Duran & Helmig, 2001).

GERMANY

The field of child and adolescent psychiatry and psychotherapy in Germany is defined by the German Medical Association as comprising “the diagnosis, non-operative treatment, prevention and rehabilitation of psychiatric, psychosomatic, developmental and neurological diseases or disorders as well as psychological and social behaviour disturbances during childhood and adolescence”. This definition has been modified several times and was first used in 1968, when child and adolescent psychiatry became an independent specialty. At that time, the specialty was called “child and adolescent psychiatry”. Psychotherapy was added to the title in 1993, taking into account the importance of psychotherapeutic treatment methods. This section is a revised version of a chapter in *Child and Adolescent Psychiatry in Europe*, edited by Helmut Remschmidt and Herman van Engeland (Heidelberg: Springer, 1999).

The postgraduate training schedule to become a child and adolescent psychiatrist and psychotherapist requires five years, out of which one year can be completed either in paediatrics or in general psychiatry. Training can be undertaken in all the 16 states of the Federal Republic of Germany and ends with an oral examination at the office of the medical association (*Landesärztekammer*) of each state.

Historical development

German child psychiatry is very closely connected to European and international developments. Its roots go back to several other disciplines, especially paediatrics and psychiatry, but also clinical psychology, pedagogy (therapeutic education) and also, with regard to many regulations, to social sciences and law. These influences, however, did not lead child psychiatry to become a mixture of heterogeneous disciplines but to be an independent specialty that integrates all these influences in order to give psychiatrically ill and disturbed children and their families the best possible support.

An important milestone in the history of German child psychiatry was the textbook by Hermann Emminghaus (1887) entitled *Psychic Disturbances in*



Hermann Emminghaus (1845-1904) was Director of the Department of Psychiatry at the University of Freiburg from 1886 to 1902 and author of the first textbook in child- and adolescent psychiatry.

Childhood, which has been called the “cradle” of child psychiatry (Harms, 1960). In 1899, the term “child psychiatry” was first used by the French psychiatrist M Manheimer who subtitled his book *Les Troubles Mentaux de l'Enfance* as *Précis de Psychiatrie Infantile* (Stutte, 1974). The books by Wilhelm Strohmayer (1910) *Psychopathology of Childhood*, Theodor Ziehen's (1915) *Mental Disorders in Childhood*, August Homburger's (1926) *Lectures on Childhood Psychopathology*, and Moritz Tramer's (1942) *Textbook of General Child Psychiatry* further contributed to the development of the discipline. After World War II, the handbook article by Hermann Stutte (1960), the textbook by Jakob Lutz (1961), and the *Textbook of Special Child and Adolescent Psychiatry* by Harbauer et al (1971) were influential also. These textbooks were followed by several others and by the three-volume *Child Psychiatry in Clinic and Practice*, edited by Helmut Remschmidt and Martin Schmidt (1985, 1988).

As far as journals in German are concerned, three developments were important:

- In 1898, the journal *Children's Faults (Die Kinderfehler)* was founded. It became later the *Journal for Child Research (Kinderforschung)*, which ceased publication in 1944, during World War II, after the 50th volume. After the war, this journal continued as the *Yearbook for Youth Psychiatry* (founded in 1956) and has been running since 1973 under the title *Journal of Child and Adolescent Psychiatry (Zeitschrift für Kinder- und Jugendpsychiatrie)*. Following the change in the name of the specialty, the title was changed to *Journal of Child and Adolescent Psychiatry and Psychotherapy* in 1996.
- In 1934, Moritz Tramer founded the *Journal of Child Psychiatry (Zeitschrift für Kinderpsychiatrie)* which continued until 1984 as *Acta Paedopsychiatrica* and ceased publication in 1994.
- A third journal—initially with a more psychoanalytic and, later, more interdisciplinary orientation—*Practice of Child Psychology and Psychiatry* was founded in 1951 by Annemarie Dührssen and Werner Schwidder. It continues to be published today and has a large readership.

The establishment of a new discipline, however, is only possible if it has a scientific base and if it is supported by professional organizations that drive the discipline forward. The official foundation of a German association for child and adolescent psychiatry took place on September 5, 1940, in Vienna as the German Society for Child Psychiatry and Therapeutic Education. Its first president was Paul Schröder, head of the department of psychiatry at the University of Leipzig. During World War II, under the Nazi regime, some German child psychiatrists were involved in the euthanasia program through which thousands of mentally handicapped and psychiatrically ill children were murdered with their cooperation.

In 1950, the German Association for Youth Psychiatry was re-established as a medical association, with close links with other disciplines such as therapeutic education, law, clinical psychology, psychiatry, and paediatrics.

German child psychiatry has evolved from four traditions:

1. The neuropsychiatric tradition, going back to its roots in neurology and psychiatry, from which child psychiatry has evolved in several places. This tradition was prominent in the former German Democratic Republic where the specialty was called “child



Heinrich Hofmann (1809-1894) was director of the “Hospital for Epileptics and Mentally Sick Patients” and started one of the first departments for child psychiatry. He also became famous as a writer of children's books, especially *Der Struwwelpeter* (Shockheaded Peter), considered the first description of a child with ADHD.

and adolescent neuropsychiatry”. It continues nowadays in the neuropsychological approaches dominant in several fields of child psychiatry

2. A tradition in therapeutic education, which developed mainly in paediatric settings and can be considered a precursor of the departments of psychosomatics in paediatric hospitals
3. The psychodynamic-psychoanalytic tradition, which goes back to the beginning of psychoanalysis. This tradition was responsible for the inclusion of psychodynamic psychotherapy in the curriculum for child psychiatrists as well as for the establishment of “psychagogues” (who later changed their name to “psychoanalytic child and adolescent psychiatrists”)
4. The empirical-epidemiological tradition. This orientation was established in the 1960s and 1970s and was influenced to a great extent by empirical research from the UK and the US.

After the German reunification, a Society for Neuropsychiatry of Childhood and Adolescence was founded in February 1990 in the former East-Germany, which was later integrated into the German Society for Child and Adolescent Psychiatry that in 1994 became the Society for Child and Adolescent Psychiatry and Psychotherapy. This society holds an official meeting every second year in different cities in Germany.

There are two other organizations of child and adolescent psychiatry in Germany: a “professional organization” (*Berufsverband*) which was founded in 1978 and represents child and adolescent psychiatrists and psychotherapists in private practice (with 907 members in 2013), and the Conference of Directors of Child and Adolescent Psychiatric Hospitals, founded in 1990 (in 2014 it had 142 members).

These organizations have established a close cooperation and have joint working groups for quality assurance, training, and research. They have published guidelines for the optimal practice of child and adolescent psychiatry and a memorandum on the current status of child and adolescent psychiatry in Germany (edited by Andreas Warnke and Gerd Lehmkuhl in 2011).

Recent developments

The treatment of psychiatrically disturbed children and adolescents in Germany is funded by (a) the insurance for acute disorders, (b) by the youth welfare organization and (c) after the acute phase of the illness, by the social security system for rehabilitation and reintegration. The social security system is responsible only for physically handicapped and severely intellectually disabled children and adolescents, whereas the youth welfare organization is responsible for psychiatrically disabled children up to the age of 18.

With regard to the progress of child and adolescent psychiatry in Germany in general, four developments during the last forty years have been critical:

- The *Psychiatry Enquête* of the Federal Government (report 1975)
- The model program, *Psychiatry*, of the Federal Government (1980-1985)



Hermann Stutte (1909-1982) was appointed to the first independent chair of child and adolescent psychiatry in West Germany in 1954. He was the child psychiatry pioneer in Germany after World War II and president of the European Union of Child Psychiatrists.

- The *Psychiatry Personnel Equipment Act* (introduced stepwise between 1991 and 1995), and
- The inclusion in 1992 of psychotherapy into the training curriculum and in the name of the specialty.

These four developments have influenced current child and adolescent psychiatry and psychotherapy in a remarkable way. The *Psychiatry Enquête*, initiated by two members of parliament, opened the door for a broad inquiry about the situation of psychiatry and child and adolescent psychiatry across West Germany. After the report of the commission (1975), a model program, *Psychiatry*, was created which was implemented in 14 regions of the Federal Republic, evaluated different types of services and created new ones. One region (Marburg) was devoted exclusively to the evaluation and establishment of child and adolescent psychiatric services. Many newly created services could be continued. The *Psychiatry Personnel Equipment Act* was responsible for more satisfactory staffing of psychiatric hospitals and services, which led to a remarkable improvement in everyday work. The inclusion of psychotherapy into the curriculum for child psychiatrists *and* for general psychiatrists was not only important for the training of each child and adolescent psychiatrist but also improved the status of child and adolescent psychiatry.

Current situation

The population of Germany in 2014 was around 80 million, among them 13 million were children aged less than 19 years—about 16% of the population. In 2014, child and adolescent psychiatry and psychotherapy was represented in 142 child psychiatric hospitals and departments, among them, 25 university departments. Out of the 1,965 specialists in child and adolescent psychiatry and psychotherapy (more than half are women), 907 are working in private practice, i.e., covered by insurance. There is one child and adolescent psychiatrist per 40,979 inhabitants or per 6,644 children less than 19 years of age. The parallel figures for child and adolescent psychiatrists in private practice are 1:88,780 and 1:14,394 respectively. The German Society for Child and Adolescent Psychiatry and Psychotherapy had 1,164 members in 2014; in 1975, there were only 200, among them 34 women. This growth is a remarkable achievement.

Challenges remain. Though the Federal Government of Germany has accepted the proposal of the Expert Commission for the *Model Programme Psychiatry* to establish a department of child and adolescent psychiatry in every university, these are lacking in nine of of 36 universities. There are not enough child and adolescent psychiatrists in private practice and there is an enormous need for research in many areas.

JAPAN

Efforts to raise public awareness regarding childhood mental disorders and delinquency were already starting to be seen in Japan at the turn of the 20th century along with the rapid social modernization. Psychiatrists and psychologists interested in children had been involved in research and treatment of young people with behaviour problems and developmental delay at some public and private child study institutes (there were 33 institutes in 1922). Influenced by the mental



hygiene and the child guidance movements in the US, child guidance clinics were established in Nagoya and Tokyo in 1936, where some 80% of children referred were intellectually disabled. After the interruption caused by World War II, several university hospitals resumed outpatient services and child psychiatric wards were established in the National Kohnodai Hospital and Tokyo Metropolitan Umegaoka Hospital in the late 1940s.

In the wake of the first report of infantile autism at the 49th annual meeting of the Japanese Society of Psychiatry and Neurology in 1952, psychiatrists interested in childhood mental disorders organized a study group from which the Japanese Society for Child Psychiatry was established in 1960 (renamed the Japanese Society for Child and Adolescent Psychiatry [JSCAP] in 1983). JSCAP is a multidisciplinary organization with a membership of 3,592 in 2014—of whom 1,677 are psychiatrists and 322 are paediatricians—making it one of the largest of its type in the world. JSCAP has been a member of IACAPAP since 1962 and hosted the 12th international congress of IACAPAP in Kyoto in July 1990—the first IACAPAP congress in Asia. Furthermore, JSCAP was instrumental in establishing the Asian Society for Child and Adolescent Psychiatry and Allied Professions (ASCAPAP), which held its 1st congress in Tokyo in April 1996.

The focus of research and practice had been on autism spectrum disorders from the very beginning of JSCAP—Hans Asperger gave the keynote address at the 6th meeting of the society in 1966. In the 1970s, school refusal became another major clinical focus, which led to the development of school-based mental health services. Today, school psychologists are available at most public schools. Experience of mental health care for children affected by massive disasters such as the Hanshin-Awaji earthquake of 1997 and the East-Japan earthquake and

From left: Kosuke Yamazaki, Shigeta Saito, Reimer Jensen, Koichiro Shirahashi, Kiyoshi Ogura at the IACAPAP Kyoto Congress of 1990.

tsunami of 2011 made necessary the development of a more systematic mental health support system for victims of disaster. Also, with the surge in reports of child abuse and neglect in the 1990s, childhood trauma has become a focus of child psychiatry and child mental health in Japan.

In spite of the mental health care needs of children and adolescents, education and training of professionals in this field has been far from ideal. Although JSCAP launched an accreditation program of specialist child psychiatrists in 1991, as of March 2014 there were only 206 members accredited. Also, only 16 out of 80 university hospitals have a division of child psychiatry, resulting in a shortage of specialist child mental health professionals. To increase the number of professionals in this discipline the Ministry of Health, Labour and Welfare began to develop a training program in 2005.

RUSSIAN FEDERATION

Child and adolescent psychiatry in Russia started at the beginning of the 20th century as a division of general psychiatry. Long before, from the second half of the 19th century, the first steps were taken toward the organization of medico-social services, asylums and special schools for underachieving children with intellectual disability and epilepsy. K Ushinskij, F Erisman, and Andrian S Griboedov were among the physicians who worked with children with mental disorders at that time. In 1887, the problem of the medical care and education of intellectually disabled children was broadly discussed by psychiatrists such as Korsakov, Serbskij, Yakovenko, and Rossolimo at the 1st Congress of Psychiatrists in Moscow. From the end of 19th century several scientific clinico-psychopathological and patho-anatomical works in child psychiatry were published by Lesgaft, Merzheevskij, S Danilo and others.

At the beginning of the 20th century, several institutes were created to study normal and abnormal child development, such as the Institute of Child Neurology and Psychology of Rossolimo (1911), the Pedological Institute set up in 1907 by V Behterev to study human beings as a subject of upbringing, and the Children's Investigation Institution (1918) headed by A Griboedov.

After the October 1917 Revolution more institutes, departments and clinics for children with special needs and mental disorders were set up, as well as special schools to look after orphans, homeless and mentally ill children. The Educational-Clinical Institution (Воспитательно-Клинический институт) with a boarding school for 100 children, psychotherapy and physiotherapy rooms, psychology laboratory, and workshops was opened in 1919 to examine diseases of the nervous system in childhood and psychoneuroses. The Institution for the Defective Child, which consisted of several schools and sanatoriums, was developed to explore educational and therapeutic interventions for children with abnormal behaviour. In 1921 the Pedagogic Institutes headed by P Kaschenko to train specialists in the education of "defective" children was opened. A department "not for defective children and neurotics, but for mentally ill children" was set up in 1919 within the Psychoneurologic Institute of St Petersburg (now named after V Behterev) under the leadership of R Golant and Mnuchina. In Moscow in 1920 there were three services for children attached to psychiatric hospitals. A system of psychoneurological centres (dispensaries) was set up in the 1920s for case detection,

ambulatory treatment, evaluation for hospitalization, consultation at schools, to provide health education for parents, teachers and paediatricians, and to collect statistics about child mental illnesses. This system was in place until the 1990s. There are efforts in some areas to bring this structure back to life.

The beginning of the 20th century was the golden age of Russian psychology, neurology and psychiatry, with important contributions, among others, from VM Behterev (1857-1927) in neurology and objective psychology (which states that behavior can be studied through observable traits), LS Vygotsky (1896-1934) who developed an influential theory of cultural and biosocial development and on the connections between mind and speech, G I Chelpanov (1862-1936), who developed social psychology, and AF Lazurskij (1874-1917) who developed a classification of personalities. At the same time three child psychiatry schools developed, in Moscow (with VA **Gilyarovsky**, MO Gurevich, TP Simson, and GE Suchareva), Leningrad (NI Ozeretskii and SS Mnuchin) and Ukraine (TI Udin and GE Suchareva).-

T P Simpson and her co-workers focused on disorders starting in infancy and early childhood. In her monograph *The Schizophrenia of Early Infancy* (1948) she described in details 73 cases of early childhood schizophrenia with catatonia and oligophrenia-like symptoms. In Moscow and Leningrad the clinical picture and course of organic disorders in connection with infections, trauma and intoxication were explored.

After World War II interest in behaviour disorders, neuroses, and the development of personality disorders increased in the USSR and interest in schizophrenia and autistic disorders continued. Unfortunately, because of the political situation, ideology began to interfere with science. Contact with international psychological and psychiatric specialists was discouraged from the late 1930s and as result international exchanges diminished significantly or stopped. In 1950 the Pavlovian Session (Павловская сессия) was organized (a joint session of the Academy of Sciences and the Academy of Medical Sciences of the USSR) in order to counter Western ideas, giving a monopoly over psychiatry and psychology to the Pavlovian school. As a result, Soviet child psychiatry repudiated for a long period the achievements of science outside of the USSR and became isolated. It worked as a system of active case finding, medical treatment, and institutionalization. Children with mental retardation or mental disorders were placed in special schools; those with more severe conditions who were considered uneducable were placed in special asylums. This situation began to change in the 1990s when treatment became more humane, with greater respect for human rights, deinstitutionalization began and international contacts resumed.

In 2015, there are some state-run institutions and many more private ones where psychiatrists, psychologists, educational specialists are working together. The children's right to live in a family and to education and social interaction have become national policy.

At the time of publication there is no officially recognised speciality of child psychiatry (although it existed until 1995). Once students complete their 6-year medical degree, they may choose to train in psychiatry (for 1 or 2 years) in adult or in paediatric units; further qualifications are not required to work as a child psychiatrist. There is a Russian Association of Child Psychiatrists and Psychologists



"The relation of thought to word is not a thing but a process, a continual movement back and forth from thought to word and from word to thought. In that process, the relation of thought to word undergoes changes that themselves may be regarded as developmental . . . Thought is not merely expressed in words; it comes into existence through them."
Lev Vygotsky

Lev Vygotsky (1896-1934) highlighted the importance of social environment in the development of higher cognitive functions. His research was preserved (and sometimes distorted) by a group of his students and colleagues, the Vygotsky Circle.



GE Suchareva in 1968 with a patient and a group of her pupils.

Grunya Efimovna Suchareva (Груня Ефимовна Сухарева; 1891-1981) graduated from Kiev's Women's Medical University. In 1919, she was appointed head of the Department of Defective Children and lecturer in Kiev's Medical Pedagogic Institute. Subsequently she combined clinical work in several psychiatric clinics in Moscow and in Kharkov, Ukraine. She published a variety of articles on "schizoid psychopathy" but her main interest was on schizophrenia. In 1937 appeared the first volume of her influential monograph Клиника шизофрении у детей и подростков (течение, прогноз, систематика) [*The Clinical Picture of Schizophrenia in Children and Adolescents (Course, Prognosis, Classification)*]. Suchareva's clinical activities and research were summarised in the three volumes of "Clinical Lectures on the Psychiatry of Childhood" (published in 1940, 1959, and 1965). In 1996 one of her papers originally published in German was translated into English by Sula Wolff with the title "The first account of the syndrome Asperger described?" It would appear that Suchareva's had been the first depiction of Asperger's disorder about 10 years before Hans Asperger's (Wolff, 1996).

(ACPP) that was created in 1992. In 2007 it was estimated that there were 1,400 child psychiatrists for a population of about 32 million children and adolescents (Grebchenko & Koren, 2007).

TURKEY

Child and adolescent psychiatry in Turkey began as a division of paediatrics and, in the late 1950s, of general psychiatry. Before then, there had been only child welfare units within the Ministry of Social Support working in the field of child development. The first child psychiatrists started working with child welfare units to incorporate mental health within these services. The child psychiatry pioneers in Turkey were people working voluntarily with children and adolescents in general psychiatry clinics. Later on, upon the return to Turkey of a very small group of professionals trained in the US, Germany and the UK, the two groups worked together to establish child and adolescent psychiatry units within the paediatrics and psychiatry departments and were finally included formally within psychiatry. They also attracted to their units psychologists and social workers interested in working with children. However, up to the late 1980s there were child and adolescent psychiatry units and clinics only in the three largest cities (Istanbul, Ankara and Izmir), at university hospitals.

Child psychiatry training was accepted as subspecialty training (following four years of general psychiatry training) in the late 1970s. Because of lack of awareness of the importance of child mental health, there were no policies about the issue and thus there was much reluctance to fund positions for child mental health training. Through the efforts of a group of pioneers (such as Atalay Yörükoğlu, Mualla Öztürk, Ridvan Cebiroğlu) the number of formally trained child psychiatrists grew to 25 by 1990.

The Turkish Association for Child and Adolescent Psychiatry (TACAP) was established by this small group in 1991. The first president was Atalay Yörükoğlu. The establishment of TACAP had enormous implications for the development of child psychiatry, of child and adolescent mental health policies, and in increasing the Turkish public's awareness of child and adolescent mental health issues. Along with its focus on professional development, TACAP worked with the Ministry of Health to develop child mental health policy in connection with the national mental health policy program. The Association has always been the core body advocating for child and adolescent mental health and for the development of child psychiatry as a separate medical branch (officially recognised in 1996). As a result of these efforts child and adolescent psychiatry has also been included in medical schools' curricula at the preclinical and clinical levels.

The board of TACAP has seven members: president, vice-president, secretary general, treasurer, and three other members. Within the association, there are 16 committees working on various subjects: infant and adolescent mental health, consultation-liaison, ADHD and learning disorders, autism and other pervasive developmental disorders, mood disorders, inpatient psychiatry, disabilities, ethics, trauma, psychopharmacology, psychotherapy, children's rights, international affairs, public education, and forensic psychiatry. Development of research projects, increasing public awareness and advocating for child and adolescent mental health, publishing books and booklets for professionals and the public, organizing meetings and training courses, and establishing a code of ethics are some of the activities performed by these committees.

The Board for Training in Child and Adolescent Psychiatry, established



Atalay Yörükoğlu was one of the pioneers of child psychiatry and mental health (known in Turkey as “the Dr Spock of mental health”). After receiving his medical degree from the University of Istanbul in 1953, he trained in the US and returned to Turkey in 1964 to assume a full-time faculty appointment at the University of Hacettepe in Ankara. He was an ardent advocate of children's rights and the first president of the Turkish Association for Child and Adolescent Psychiatry.

within the association, coordinates training programs, sets standards—in conjunction with the Union of European Medical Specialties—conducts the board exams for qualification, and establishes continuing medical education programs. The child psychiatry training program consists of a separate curriculum of four years after finishing medical school. Medical graduates enter the program via a centralised examination. Child psychiatry is currently one of the most highly rated specialties in Turkey. The training program has theoretical, clinical and research components that run in an integrated way. Both the biological and psychodynamic aspects of child psychiatry are covered in the curriculum and basic psychotherapy courses are also provided. Since some of the child psychiatry departments have few academic staff, TACAP runs complementary courses three times a year.

TACAP has organized a national child and adolescent psychiatry congress every year since 1990, an adolescent psychiatry symposium since 1996, and a child and adolescent mental health policy workshop since 2004. *The Turkish Journal of Child and Adolescent Mental Health*, published quarterly, is the official journal of the association. During the last few years, eight books have been published, one being a child psychiatry textbook, along with other handbooks and booklets.

Child and adolescent psychiatrists played an active role lobbying the government to include a separate child and adolescent mental health section in the 2003 National Mental Health Policy Program. This resulted in the establishment of the Child and Adolescent Mental Health Division (under the Department of Mental Health, within the Ministry of Health), and the Advisory Council for this division—the primary body for child and adolescent mental health policy development—composed of mental health professionals working with children and adolescents.

Though child and adolescent mental health professionals are working very hard to implement the aims of the profession, inevitably there are obstacles to overcome at times. One of the important issues in Turkey is the small number of child psychiatrists (around 600—the number actually doubled in the past six years) for the number of people aged under 18 (approximately 20 million). There are also difficulties implementing programs, the result not only of political issues but also of a lack of resources. There is a need for more psychologists, social workers, counsellors and other mental health professionals working in the field as well as child and adolescent psychiatrists. Currently, paediatricians, psychologists, social workers, counsellors and psychiatric nurses have their own professional organizations. TACAP is working in collaboration with these organizations to increase the number of professionals working in the field. On the positive side, nowadays financial sources to run projects can be obtained more easily from international bodies or nongovernment organizations, such as the European Union, UNICEF and Turkish Institute for Science and Technology but sustainability of the programs is still a problem.

In 2014, there were 40 university clinics and 35 state hospital clinics for child and adolescent psychiatry in the country. However, only six of the clinics have an inpatient unit and most of the time young patients have to be admitted to either paediatric or adult psychiatric wards. The most frequently treated psychiatric conditions are anxiety, mood disorders and developmental problems. Conduct and substance use disorders are still relatively infrequent.

Child and adolescent psychiatrists in Turkey, although a small group, are highly committed. TACAP is enthusiastic about international collaborations, is a member of the European Union of Medical Specialists, ESCAP and IACAPAP and was the local organiser of the 18th World Congress of IACAPAP in Istanbul in 2008, and the Regional Congress of the International Society for Adolescent Psychiatry and Psychology in 2013.

UNITED KINGDOM (UK)

The history of the research and treatment of children with mental health problems in the UK has been characterized by three historical waves that have had influence and ramifications internationally. Firstly, work in child psychology and child guidance in the 1920s and 1930s established the principle of early intervention in child mental health and collaboration with schools and other health services. Secondly, the work of psychoanalytically-oriented researchers at the Tavistock Clinic in the post-World War II period encouraged greater collaboration with families as well as propagating internationally influential theoretical approaches such as John Bowlby's attachment theory. Finally, the work of researchers and clinicians based at the Maudsley Hospital from the 1960s onwards has influenced the observation and study of clinical syndromes, encouraging epidemiological, statistical and genetic research, and multimodal treatment.

Child psychology, child guidance and the interwar period

In 1913, Cyril Burt was appointed as the first official psychologist in the world, working for the London County Council in overseeing the testing and treatment of all children in that city (Sutherland, 1984). Education was made compulsory in the UK in 1880 and Burt's appointment encouraged the practical implementation of psychological sciences in Britain via the education system. His work was supported by the experimental approaches of Susan Isaacs who later became head of the Department of Child Development at the Institute of

Participants in a "Witness Seminar" 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 child psychiatry in the UK, particularly from 1960 to 1990. From left, 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 (photo: University of Glasgow).



Education. Burt, Isaacs and other educational psychologists lay the foundations for the development of both child psychology and psychiatry in Britain. After Burt's death (1971) it was alleged that he had falsified results on his studies on the inheritability of intelligence but this has not been proven conclusively.

Early treatments for childhood mental illness and psychopathology went through a major growth period in Britain in the late 1920s following a generous donation from the Commonwealth Fund, a US-born charitable venture, to establish child guidance clinics across the UK. These funds encouraged the growth of psychological disciplines and promoted interdisciplinary work by teaming up physicians with psychologists and social workers (Evans et al, 2008). Child guidance clinics gave medical authority to the psychological sciences and also encouraged the development of child psychiatry as a niche discipline.

In 1927, Emmanuel Miller, a formidable figure in the field, established the first child guidance clinic in East London. In 1928, William Moodie established a demonstration child guidance clinic in North London, which taught child guidance techniques to others, and Margaret Lowenfeld founded a clinic for the treatment and study of nervous and difficult children in Central London. These clinics pioneered new techniques such as Lowenfeld's "World Technique" that encouraged children to use toy figures in sand to depict their inner world, and thus to enable therapists to engage with them in thinking through their difficulties (Lowenfeld et al, 1988). Isaacs also worked on the significance of children's play in understanding their motivations, thoughts and dreams. Their work was highly influential to the development of child psychotherapy techniques in Britain and abroad. However, during the interwar period, child guidance clinics did not treat children classed with "mental deficiency" as this section of the population was still held in institutional care under the 1913 Mental Deficiency Act (Stewart, 2013). This meant that the techniques developed within the child guidance clinics were not designed to include the treatment of children who rated poorly on intelligence



Objects used in Lowenfeld's
"World Technique".
Photo: Science Museum,
London

tests and therefore were somewhat limited in their applicability to the whole population.

The late 1920s and the growth of the child guidance movement also saw increasing numbers of child patients being referred to major centres for the treatment of both adult and child mental illness, in particular the Tavistock Clinic, established in 1921, and the Maudsley Hospital, established in 1923. Whilst the former worked primarily in developing psychoanalytic theory and techniques for children, the latter began to work on behaviour management and collaboration with other social agencies such as children's care committees. The Maudsley became known as an institution where very severe cases of child mental illness could be referred. The hospital set up large outpatient and inpatient units for detailed observation and treatment of child psychopathology in the late 1930s, although these were made redundant during the war because of the threat of bombing.

The post-World War II era and the growth of psychotherapeutic approaches

World War II stimulated the development of child psychotherapeutic techniques by providing a lamentable testing ground for psychological theory as many children were separated from their families or experienced other traumas due to the air raids. Isaacs, Anna Freud, Dorothy Burlingham and John Bowlby were amongst a group of psychologists and psychoanalysts who studied the responses of children to these difficult circumstances and the impact that it had on their mental health, culminating in the Cambridge Evacuation Survey—paradoxically, the survey emphasized the distress suffered by adults and downplayed that suffered by children. John Bowlby later went on to develop his theory of “maternal deprivation” in a 1951 report for the World Health Organization that had international impact, making his “attachment theory” renowned across the globe.

The late 1940s and early 1950s saw growing interest in treating whole families rather than individual children. The evacuation surveys had encouraged the enactment of the 1948 Children's Act in Britain, which established a centralized structure to child care. Local authority children's officers oversaw children's psychological development and sought to intervene where they saw necessary. At the Tavistock Clinic, the Children's Department was renamed the Department of Children and Parents in 1953 and psychotherapists aimed to integrate whole families into the treatment process. Melanie Klein's theories of infantile phantasy and Donald Winnicott's work on transitional objects helped to establish British “object relations theory” as a dominant discourse within both psychological and political circles and helped to establish the *Tavi* [Tavistock] *model* of child psychotherapy, in which clinicians employed play therapy and transference models to elicit and expel pathological memories (Rose, 1999).

Throughout the 1960s and 1970s, Tavistock-inspired psychoanalytic models of child development and the management of trauma continued to thrive through the work of the Association of Child Psychotherapists and the *Journal of Child Psychotherapy*. Esther Bick established the Tavistock model of infant observation in the early 1960s, which was later developed by Martha Harris and Margaret Rustin as an essential component in child psychotherapy training. These methods were propagated by Harris and others who went on international lecturing tours as well as publishing widely (Williams et al, 2012).



The Maudsley Hospital child outpatient department, 1938.

Photo: London Metropolitan Archives.

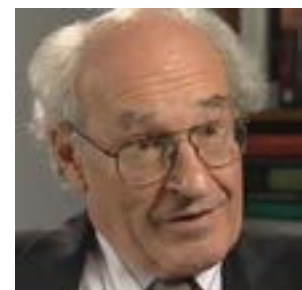
At institutions such as the Maudsley, instead of focusing on family treatment and the observation of “normal” infants, clinicians placed increased emphasis on observing individual psychopathology in great detail and this led to some rifts between the *Tavi* and Maudsley approaches. In 1953 Kenneth Cameron and Elwyn James Anthony established a clinic at the Maudsley Hospital for the rigorous observations of children then diagnosed with schizophrenia and psychosis. They also encouraged a comprehensive vision of the work of child psychiatrists to include intellectual disability, thereby challenging the exclusivity of approach. Their work also challenged psychoanalytic assumptions about thought patterns in early infancy (Evans, 2014).

At the celebrated Great Ormond Street Children’s Hospital in London, Mildred Creak sought to anchor child psychiatry in the field of paediatrics and thus to ward off widespread theoretical divisions. Creak’s method was very practical and she aimed to treat children’s problems with play, speech therapy, discussion, and collaboration with social and educational services. Both Creak and Emanuel Miller, in particular, saw child psychiatry as a discipline that could draw from multiple theoretical models but whose primary aim was to witness improvements in children’s health. They were practice-driven, rather than research-driven, and their work provided a model for practical engagement as the primary object of the profession. Emmanuel Miller established the Association for Child Psychology and Psychiatry in 1966 (renamed Association for Child and Adolescent Mental Health in 2005), a leading British organization later responsible for publishing the journal *Child and Adolescent Psychology and Psychiatry*. Miller later went on to edit the first key British textbook in child psychiatry that covered language development, early experiences, parent-child relations, social factors, psychotherapy, behavioural methods, drug therapy, community services, and crisis intervention (Miller, 1968). Their work provided a blueprint for non-dogmatic and open-minded approaches that drew from the best practices of all workers.

The Social Psychiatry Research Unit and statistical methods

The 1960s saw a flood of innovative methods and approaches to intellectual disability and mental illness in children at the Maudsley Hospital. These were largely stimulated by the termination of the Mental Deficiency Legislation in 1959. The Maudsley’s Social Psychiatry Research Unit, funded by the British Medical Research Council, produced important studies such as Jack Tizard’s work on the significance of quality of care to the cognitive development of children with learning disabilities. This highlighted the importance of intellectual stimulation and a supportive environment to children, no matter what their intellectual level. Michael Rutter is one of the most influential figures to emerge from this historical moment and he went on to systematically rewrite the rules for research in child psychiatry.

In 1970, Michael Rutter, Jack Tizard and Kingsley Whitmore published an epidemiological study of the entire population of children resident on the Isle of Wight, a small island in the English Channel. This report—*Education, Health and Behaviour*—highlighted the multiple environmental factors that could impact on children’s mental growth, including social inequalities, and argued for new approaches to treatment that were based on the findings of epidemiological studies and clinical research trials. In 1975, Rutter and colleagues published a report for the



[Click on the image to access several video clips reflecting an interview with Michael Rutter, his career and contributions](#)

World Health Organization that pioneered the multi-axial model of child diagnosis that took into account intellectual level and associated etiological environmental factors as well as the child's clinical presentation. This multi-axial model was later introduced into the third edition of the US Diagnostic and Statistical Manual of Mental Disorders. Rutter, the first professor of child psychiatry in Great Britain, has since gone on to develop new approaches to treatment, for example supporting a multimodal management designed to treat the different aspect of a child's specific clinical syndrome. This treatment is rooted in empirical evidence, that is, having been shown to be effective in that particular clinical population (Rutter et al, 2008).

Growth in the Maudsley's statistical methods was coupled with an upsurge of behaviouristic and cognitive approaches to treatment. Operant conditioning therapies, where children were systematically rewarded for socially desirable behaviour, began to have an impact on the treatment of intellectual disabilities in the 1960s and 1970s. This was in parallel with a growing emphasis on cognitive treatments, which inspired a new understanding of intelligence and mental abilities via the work of Beate Hermelin, Neil O'Connor, and Uta Frith. Maudsley researchers conducted detailed investigations of the specific cognitive impairments experienced by children who displayed overt clinical symptoms of psychopathology and helped forge a space for the developing field of cognitive neuroscience. Hermelin, O'Connor, and Frith encouraged new methods to enable children with psychological difficulties to learn more adaptive behaviour through speech therapy as well as behavioural techniques. Encouraged by Hans Eysenck (1964), they conducted, along with other Maudsley researchers, trials that proved the effectiveness of structured behavioural methods in generating clinical results.

Maudsley researchers have played a particularly influential role in autism research since the 1970s. In 1977, Rutter published the first genetic study of autism and his definition formed the basis for the description employed in DSM III. Lorna Wing delineated Asperger's syndrome, drawing from the work of the Austrian paediatrician Hans Asperger, subsequently recognized worldwide as a variant of autism—now considered part of the autism spectrum. Other influential autism researchers include Frith and Simon Baron-Cohen, who originated the concepts of executive functions and theory of mind to explain autism (Evans, 2013).

The Faculty of Child and Adolescent Psychiatry

The Faculty of Child and Adolescent Psychiatry of the Royal College of Psychiatrists (RCP) had its beginnings in 1942 when The Royal Medico-Psychological Association (the forerunner of the RCP) set up a Child Guidance Sub-Committee. It was renamed the Child Psychiatry Sub-Committee in March 1943 and became a Section in 1946. It was called the Child and Adolescent Psychiatry Section from the early 1980s until 1997 when it was renamed the Faculty of Child and Adolescent Psychiatry (Bewley, 2008).

Any member of the RCP may apply to be a member of the Faculty of Child and Adolescent Psychiatry. In effect most practising child and adolescent psychiatrists in the UK are members but other RCP members with a special interest in the specialty are also affiliated. The fact that a college member belongs to the faculty does not necessarily mean that they are working in child psychiatry.

Most practising child and adolescent psychiatrists in the UK are consultants or “higher trainees” and the faculty has a major role in supporting specialist training. Child and adolescent psychiatry is a recognised specialty in the UK, and training in an approved training scheme leads to a certificate of completion of training from the General Medical Council and to access to consultant posts in the specialty. The faculty runs a strong academic programme with a specific day in the College’s annual general meeting, a teaching day in the winter, and a three-day residential conference each autumn.

Conclusion

British child psychiatry and mental health research has produced a wealth of innovative theories, methods and approaches that have had worldwide influence. From Lowenfeld’s “world technique” and Bowlby’s attachment theory to Rutter’s multi-axial model of diagnosis and Frith and Baron-Cohen’s work on autism and theory of mind, British research has had a major impact on global understandings of atypical development and mental illness and the use of psychotherapies to treat it. It is perhaps because of the dynamic clashes between the *Tavi* and the Maudsley models in Britain that researchers have been so productive in generating evidence to support their theories and thinking about new ways to put these into practice. Since the 1980s, clinicians have focused on the treatment of particular disorders based on DSM and ICD categories. This is a testament to the work of child psychiatrists such as Rutter and Wing who sought to base treatment methods directly on epidemiological and statistical studies.

UNITED STATES OF AMERICA (US)

Child Psychiatry in the United States, as in other countries, represents an array of services, a body of knowledge, and a profession. The growing field has had to balance challenges encountered elsewhere—whether to evolve as a medical subspecialty or as a multidisciplinary field; whether to focus on the most impaired or on children with varying degrees of impairment; and whether to treat those whose parents seek and can afford psychiatric services or whether to serve a whole population. This section will specifically review the field’s history in the US, both to understand the place of child psychiatry in the US and to anticipate its future evolution.

Services later called child psychiatric began when social workers and other advocates, calling attention to children in the criminal justice system, argued for special courts. Under William Healy, a neurologist, these gave rise to the Juvenile Psychopathic Institute (later the Institute for Juvenile Research) in 1899, then the Judge Baker Guidance Center in Boston. Healy, who spoke of eliciting the “child’s own story”, became one of the first US child psychiatrists (Richmond & Harper, 1996). Years later, child clinicians including psychoanalysts were credited with teaching all physicians to “listen to the patient” (Eisenberg, 2001). The resulting child guidance clinics gave rise to two multidisciplinary associations: the American Orthopsychiatric Association, formed in 1924, and the American Association of Psychiatric Clinics for Children, established in 1948 (Schowalter, 2003). These predated the American Academy of Child Psychiatry, founded in 1953.



While child guidance clinics treated troubled individual children, their work also addressed factors in the family and community. Study of these factors, along with adversities such as poverty, racism, homelessness and refugee status (Eisenberg & Belfer, 2009), was advanced in three fields influential in US child psychiatry: cultural anthropology, family treatment, and epidemiology.

The impact of culture on child development and mental health was studied by Margaret Mead, Ruth Benedict and their colleagues. Erik Erikson (1902-1994) attempted a synthesis of psychoanalysis, history, and culture in his 1950 book *Childhood and Society*. Relevant hypotheses were tested empirically by Whiting and Child (1953). “Transcultural psychiatry” developed as a field with later participation by child psychiatrists (Minde, 2005; Joshi & Pumariega, 2010).

Families were addressed in several ways. Early parent-blaming—by using derogatory terms such as “refrigerator mother” and “parentectomy” (Eisenberg, 2001)—gave way to creative ways of joining with families. Family therapy was developed, among others, by Salvador Minuchin and Jay Haley, physicians and non-physicians (Minuchin, 1974). Parent education and family training sought to teach parenting skills and empower parents, including using the *Triple P* program created in Australia (Sanders et al, 2014). More recently, services have been developed that are designed to create *family-driven* care and to support parents with peers with lived experience (“parent partners”; see below).

A third approach to examine the child-in-context has been through child psychiatric epidemiology. Extending the work in the UK of Rutter and his colleagues, community studies by Felton Earls and others quantified the effects of neighbourhood cohesion on child development and mental health. They developed and measured the role of individual and collective efficacy in mitigating risk and promoting resilience (Carlson et al, 2014).

Past presidents of IACAPAP at the IACAPAP San Francisco Congress, 1994. Forefront: Al Solnit. Middle row, from left: Mary Philips (widow of the late Irving Philips), Colette Chiland, E. James Antony. Back row: Lionel Hersov, Reimer Jensen, Donald J. Cohen.

Clinical services for troubled children in the US until the 1980s were predominantly community-based. In addition, US children benefited from hospital-based consultation, where child psychiatrists recognized opportunities to help children that went beyond the presenting medical illness (Prugh, 1983), and residential services that offered treatment for troubled young people. Residential services were often long-term, provided far from home and with little family participation (Whittaker & Trieschman, 1972; Redl & Wineman, 1957). In these services the child psychiatrist worked with a team, at times as a consultant, at times prescribing medications, but less often as the team leader, in contrast to adult psychiatric services. The services were also predominantly psychodynamic in orientation. While the first academic department was founded by Kanner at Johns Hopkins in the 1930s, most medical centres did not have such departments until the later part of the century.

In the last three decades of the 20th century, US child psychiatry joined other countries in applying approaches to assessment, treatment and evaluation already established in general psychiatry. Eisenberg's study of the use of stimulants in attention-deficient children pioneered the use of the randomized controlled clinical trial (Eisenberg, 2007). With support from governments, foundations, and the pharmaceutical industry, such investigations flourished, introducing new medications to psychiatry and more rigorous approaches to assessment. Many endorsed a new standard of care—evidence-based treatment—with findings based on the results of randomised controlled trials, though often short-term when most psychiatric conditions are chronic or recurrent.

The increasing role of pharmacotherapy reflected an important change in society, a readiness among parents and other professionals, little seen previously, to define children's needs in biological terms (the so-called *chemical imbalance*), and to look at medications for help. Many were not only willing but eager to use pharmacotherapy. For child psychiatrists, such definition of children's needs offered an advantage vis-à-vis other mental health professionals but also a risk. The risk was that the role of the child psychiatrist would be limited to assessment for and prescribing psychoactive medications, the child psychiatrist becoming the "meds-doc".

US child psychiatry became a subspecialty of general psychiatry with its establishment in 1959 as a subspecialty of the American Board of Psychiatry and Neurology. As a result, the base of American child psychiatry moved from the community (outpatient clinics, courts, community centres, and residential treatment) into departments in academic medical centres.

Part of this move was the establishment of the American Academy of Child Psychiatry (ACAP) in 1953. Founded by child psychoanalysts and a few psychiatrically oriented paediatricians, the ACAP, initially a club restricted to invited members, later expanded to include a new generation of child psychiatrists. Full membership continues to be limited to physicians, excluding allied health professionals. In 1986 ACAP changed its name to American Academy of Child and Adolescent Psychiatry (AACAP), at least in part due to the perceived clinical and economic threat from adolescent psychiatrists whose training did not include child psychiatry. Currently, the AACAP has approximately 8,000 members and 58 affiliated regional organizations. Reflecting the influential role of American child



Leon Eisenberg (1922-2009) was the chairman of the department of child psychiatry at Johns Hopkins Hospital after Leo Kanner. Subsequently he was appointed professor of psychiatry at Harvard Medical School. He conducted some of the first rigorous studies of autism, attention deficit disorder, randomised controlled trials and learning delays and became a prominent advocate for children struggling with disabilities. He was described as being a pivotal person in 20th century US child psychiatry.

psychiatry worldwide, the AACAP has established a membership category for non-US physicians, who have increasingly looked to the *Journal of the American Academy of Child and Adolescent Psychiatry* and to AACAP's annual meetings for continuing education.

US government support for child psychiatry grew, but slowly, in the same period. Recognizing the extent of disability due to mental health problems in World War II soldiers, the National Mental Health Act was enacted in 1946, leading to the creation of the National Institutes of Mental Health (NIMH) in 1949. The NIMH remains the dominant funding agency of mental health research, though its support for research in children became important only in the 1970s. The US Federal government has also supported training for paediatricians in child psychiatry.

Since the 1970s there has been increased interest in the *objective* description of disorders and empirical science in child psychiatry. In 1983, the AACAP's *Child Psychiatry: A Plan for the Coming Decades*, written with participation from many disciplines and the NIMH, concluded that child psychiatry was 10 years behind adult psychiatry in biological and epidemiological research. The document supported initiatives in those fields and in the genetics of childhood disorders. There were several consequences of this for child psychiatrists. For one, those in academic settings now grounded their work in the peer-reviewed literature, not just in clinical experience, an emphasis that created a divide between the biologically oriented academic child psychiatrists and those providing clinical services in the community. At the same time, in community-based child psychiatry/child mental health programs, child psychiatrists' roles diversified, with the child psychiatrist serving as school consultant, program consultant, or manager. For another, the increasing emphasis on psychopharmacology—supported by the pharmaceutical industry—influenced child psychiatrists' training and practice. Unquestioning pharmacotherapy is being replaced by discernment and limits on promotion from pharmaceutical companies.

As mentioned, political support for child psychiatric research and training increased with the recognition of mental disability in military recruits and of the disparities between research support for child psychiatry and other medical specialties. The government, acknowledging that the majority of children with clinically significant mental disorders receive no mental health services (Knitzer, 1982), has created a network of *systems of care* to provide services closer to home, with a positive role for parents (supported by *parent partners*—community partners with lived experience similar to the youths' parents), and better coordination of mental health, education, and social services. The role of the child psychiatrist in these innovative services is evolving (Pumariega & Winters, 2003).

In 2015, child psychiatrists in the US remain the diagnosticians but with the expectation of a biological explanation. Psychotherapy with children, once a primary area of endeavour for them, is now often carried out by other professionals. The child psychiatrist may be seen increasingly as the purveyor of medications and their scope of practice is changing as many leave the public sector for private practice. Today's academic child psychiatrist may lack the comprehensive understanding that leaders of an earlier era had, a particularly striking change, in view of the voice given by child psychiatrists in previous decades to the "child's



Yale Child Study Centre

Arnold Gesell (1880-1961), a psychologist and pediatrician established the Yale Child Study Centre in 1911 and was the first director. The Centre subsequently became a leading research hub for child mental disorders, such as autism and obsessive compulsive disorder, and child development.

An intersection with IACAPAP happened early and has been very productive. Al Solnit, the center's third director, was the 10th president of IACAPAP (1974-1978). During his tenure, Solnit oversaw the 9th congress of IACAPAP in 1978, the first of two held in Melbourne, Australia. A year later Solnit organized a study group in Senegal, in close collaboration with IACAPAP stalwarts E James Anthony, Collette Chiland, Gerald Kaplan, and Serge Lebovici. Also in attendance at the Senegal meeting was Donald J. Cohen who subsequently became deeply immersed in IACAPAP's activities and was President from 1992 to 1998.

own story.”

US child psychiatrists, having seen much innovation in the field, now face the challenges of:

- Seeing children’s troubles in terms of *development* or in terms of (relatively fixed) *categorical diagnoses*
- Seeing children’s troubles in terms of processes located solely within the child or in terms also of the *context / ecology* and *relationships* in which the child lives and grows
- Seeing children as the *object* of intervention or as an *agent*, with a sense that they can shape their lives
- Promoting or neglecting the *narratives* of *acknowledgement* and *meaning-making* that support growth and recovery
- Embracing a *comprehensive* range of ways to help children and families as opposed to limiting their interventions to pharmacology.

Child psychiatrists may be seen increasingly as the purveyors of medications

CONCLUSIONS

As shown in this brief historical review, although gestation was slow, progress at the level of clinical services—particularly in developed countries— research and policy in a broadly defined child psychiatry has been outstanding since its inception about 100 years ago. More than in any other developmental stage, psychiatric disturbance in children occurs in the setting of dramatic biological, cognitive and emotional changes and impacts on individuals, families, schools, neighbourhoods, and judicial and education systems. That is, optimal treatment usually requires medical and allied professionals with expertise in all these domains working together, a difficult undertaking that explains some of the tensions and challenges that child psychiatry has experienced over the years, and still faces.

There are also dark pages in child psychiatry’s short history, which should not be glossed over because they may hold the key to avoid making the same mistakes in the future. The darkest one has been the participation of some child psychiatrists in eugenic practices during the first half of the 20th century, particularly—but not exclusively—in Nazi Germany. Unnecessarily blaming parents (e.g., “schizophrenogenic mother”), punitive attitudes towards patients under the guise of therapy, and failure to protect children, particularly those in institutions, have been or still are areas of concern. More recently, prescribing unnecessary medications and polypharmacy, particularly for very young children, and administering treatments which are known to be ineffective or on the bases of ideology and not on the grounds of empirical evidence or sound clinical reasoning, suggest that many ethical issues are still far from resolved.

Child mental health research by psychiatrists, psychologists, paediatricians, social workers, mental health nurses and other allied professionals has blossomed, particularly after the end of World War II, so much so that childhood and adolescence has become the most vibrant area of mental health research largely due to the recognition that most mental disorders have their onset during this developmental period. Advances have led to a much better understanding of normal development, its disorders, the nature of psychiatric illnesses in children, and their treatment.

Progress is likely to continue at an increasing pace due to technological innovations, for example in imaging and genetics. Yet, while societies are becoming healthier (in terms of life expectancy) and wealthier, psychosocial problems in children and adolescents appear to have been increasing in the last 50 years: depression, self-harm, autism spectrum disorders, ADHD, eating disorders, etc. Perhaps the most important challenge that we face is to understand why (Rutter, 2002). The impact on children of significant social changes (such as high divorce rates, increasing number of single parent and blended families, same-sex marriages, children left behind in China's quest for development etc.) are still not well understood.

In spite of the successes, child psychiatry as a medical subspecialty is undergoing dramatic changes, facing new opportunities and challenges as a result of globalisation, the evidence-based movement, the advent of the Internet, and the worldwide political and economic climate. Globalisation is lessening differences in knowledge and clinical practice between western and non-western, developed and developing countries, making it more difficult for ideology-driven or idiosyncratic practices to take hold. However, some lament that globalization may lead to unwarranted homogenisation, to the loss of important cultural nuances, or to forsake ethnic or other differences that could be used to enhance diagnosis and treatment.

The Internet is facilitating the dissemination of up-to-date clinical information and training (this eBook is an example). While an emphasis on evidence-based clinical decision making is increasing the quality of that information, of training and of clinical practice, critics argue that lack of evidence is not necessarily the same as lack of effectiveness—the usefulness of many interventions has not been studied yet—and that most randomised controlled studies examine short term efficacy while many childhood mental disorders are chronic or recurrent. Conversely, the Internet can rapidly spread erroneous or even harmful practices (e.g., the case about the MMR vaccine and autism) while youths' easy access to and reliance on social media is creating its own new challenges (see Chapter H.6).

The sky is bright but some clouds are appearing on the horizon. In spite of the fact that youth mental health problems seem to be on the increase and of the existence of a large pool of unmet need—huge in low income countries—there is growing competition between specialties and professional groups. The demand for child psychiatrists far outstrips supply worldwide. This is compounded by a serious maldistribution, especially acute in rural areas and in low income countries, where most of the children of the world actually live.

The proliferation of associations—country-based, specialty-based, theoretical orientation-based, and illness-based—each with their own agenda and interests is making it more difficult for child mental health professionals to present a unified front and to have as strong a voice as possible in advocating for child mental health policy in global fora such as the WHO, or at country level.

The rapid expansion in the use of medication risks making child-psychiatrists glorified pill-dispensers with shrinking skills in other key areas (e.g., psychotherapy, CBT), which are increasingly delivered by other professionals. This can result also in several experts dealing with a single child's problems—a psychiatrist prescribing medication, a psychologist administering CBT, a social worker doing family therapy, etc. While this could be considered optimal care in

Societies are becoming healthier and wealthier while psychosocial problems in children and adolescents appear to be on the increase.

The impact on children of social changes (high divorce rates, increasing number of single parent and blended families, same-sex marriages etc) are still not well understood.

some contexts, the consequent increase in costs, the risk of families being given conflicting advice or of falling through the cracks, the increased time demands on patients, and the impact on the therapeutic relationship may be more harmful than the benefit obtained.

Political and economic problems are resulting in stagnating, if not dwindling, government expenditure in healthcare in many parts of the world—child psychiatry services often an easy target—and threatening to undermine the very foundations of the welfare state, which has served children well. While the need for more services is almost universally acknowledged, child mental health care is often given low priority by health administrators and policy makers. Lack of funds and the worldwide dearth of professionals with adequate training make the commissioning of new services difficult. These problems are made even worse by ongoing military conflict and terrorism in many regions—with children being some of the main victims—and by the so far unbridled climate change, the consequences of which we can hardly fathom.

Child psychiatry is still looking for its place in the sun in many parts of the world, either because the number of professionals is very small or for their inability to persuade authorities of the value for training and quality of care of its recognition as a specialty. For example, after many years of lobbying, child psychiatry has been recognised as a subspecialty in Spain in 2014. Conversely, the Russian Federation ceased to recognise the subspecialty of child psychiatry in 1995 (the specialty had previously been recognised in Russia from the 1970s).

Child psychiatrists in the 21st century will need to take a proactive role in reshaping their role and showing their worth in a very competitive and rapidly changing environment. Should child psychiatrists continue to evolve predominantly as a medical specialty narrowly focusing on biological treatments? As therapists? As coordinators or managers of the various professionals involved in care, integrating biological, psychological and social aspects of treatment...?

Child psychiatry is still looking for its place in the sun in many parts of the world

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