OCCASIONAL HUNDREDS 1

STRESS IN YOUTH

A FIVE-YEAR STUDY OF THE PSYCHIATRIC TREATMENT, SCHOOLING, AND CARE OF 150 ADOLESCENTS

MARY CAPES
ELISABETH GOULD
MOLLY TOWNSEND

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OXFORD

PUBLISHER'S NOTE

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A five-year study of the psychiatric treatment, schooling, and care of 150 adolescents

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Contents

Preface

During the last few years, there have been public outcries about the lack of treatment facilities for adolescents who are suffering from psychiatric illnesses and maladjustment, particularly about those admitted to adult psychiatric wards because there has been nowhere else for them to go.

The Ministry of Health in 1964 issued a memorandum advising hospital boards on the number of beds required specifically for adolescent care, and recommended further inquiries into the general facilities needed by this group of patients.

This book has been written with those in mind who are responsible (*a*) for psychiatric treatment, (*b*) for 'children in care', and (*c*) for the special educational needs of maladjusted adolescents. This pilot survey shows what is being done to date to help these youngsters, where there are gaps in the services, and how intractable are some of the problems. It should also provide a better perspective of the over-all needs of maladjusted adolescents, and about the relatively few who make headline news.

The information has been obtained through a longitudinal

study of 153 maladjusted adolescents aged 12 or 13 at the start who co-operated over a period of four years in reporting about their progress, the facilities used in helping them therapeutically, and which appeared to be lacking.

Whilst following these adolescents, a careful analysis was also made of any information about adverse experiences in their early formative years, and of whether these appeared to tie up with their later development.

The investigations were of a multidisciplinary nature, and the conclusions are those of a sociologist, a psychologist, and a psychiatrist working together. Needless to say, this involved the co-operation of parents or parent substitutes, teachers and child care officers, with the result that the home and school milieux, as well as the intellectual potential and the nature of the maladjustment or emotional disturbance of the adolescent, were studied *in toto*.

Since the survey was made in an area where opportunities for obtaining help were relatively good, and where the majority of these adolescents made steady progress, this brought into high relief one particular group of behaviour problems which failed to respond to any of the therapeutic measures made available to them. A plea is made for further study of this relatively small group in terms of their inherited constitution and early traumatic environment, and to determine whether the techniques and methods of treatment used to date are really appropriate for this particular group.

These are some of the points discussed. The difficulties of diagnosis, the results of each yearly prediction, and the facilities which were used in the main during the period of investigation are made available in the report, as are some of the unexpected findings.

One of the findings which emerged is that the treatment of the majority of maladjusted adolescents should have been initiated *under the age of 5* by which time many were showing problems. A short blueprint of the facilities which seem to be required in an area the size of Wessex is added as a final constructive gesture, which should at least promote some lively discussion. This five-year survey was supported by the Nuffield Provincial Hospitals Trust, under the aegis of the Wessex Regional Hospital Board. We should like to

express our deep gratitude to the Nuffield Provincial Hospitals Trust for making this five-year survey possible through the generous grant we received in 1965.

Acknowledgements

Without the encouragement of Dr John Revans, Senior Administrative Medical Officer of the Wessex Regional Hospital Board, this project might never have got off the ground, but it took the wise counsels of Professor Sir Denis Hill and Professor Rawnsley to prevent it becoming too much in the clouds, and the programme becoming too ambitious.

Subsequently Professor James Anthony, Dr James Masterson, Jr, Dr Peter Sainsbury, Dr Michael Rutter, and Dr M. Laufer have been more than helpful.

In the actual accomplishment of our task, we must also thank so many people. First, the adolescents and their families who could not have been more co-operative, and many offered to continue with their help should it ever be required. Secondly, the consultants in child and adolescent psychiatry who, with the psychiatric social workers, paved the way for the co-operation of the families; the children's officers and child care officers who gave unstintingly of their time whenever it was asked for throughout the survey; and the head teachers and other teachers concerned who also co-operated so willingly. Our thanks must also go to the

medical officers of health and the chief education officers who generously gave permission for us to use their premises when these were required.

During the course of the survey, many of the adolescent units in the United Kingdom, and a number of small 'homes' for disturbed adolescents, were visited. We were acutely sensitive about intruding on the time of the hard-pressed people who are running these units, but none the less the utmost help and generous hospitality was offered by all the staffs concerned, and we would not like these facts to go unrecorded.

Finally the help of Mrs Mary Gilbert has also been invaluable in acting as our secretary, often at great inconvenience to herself.

Research Staff

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1

Aim, method, and background

AIM

Adolescents who show signs of emotional disturbance may find themselves being helped, if indeed they are receiving any help at all, by a psychiatrist, a children's officer, or a probation officer, or all three at any one time.

Some of them attend out-patient hospital clinics or child and family guidance clinics, others are admitted to psychiatric hospitals in wards with adults, whilst a minority find their way to in-patient units especially tailored for their needs. Many others reside in family group homes, hostels, and boarding schools for maladjusted children and others get sent to approved schools, where psychiatric facilities may be minimal. Often it is purely fortuitous where the adolescent finds himself, depending on the local facilities, and the time that anyone can devote to helping him. Others just drift along, not vocal enough, or not sufficiently antisocial to make their needs felt.

The Ministry of Health in Memo HM(64)4 made a recommendation based on provisional findings that for in-patient care at least 1,000 beds were needed by this adolescent

age-group in England and Wales. There were at that time only 157 beds available to adolescents in these two countries, distributed amongst seven units.

In the same memorandum, it was recommended that out-patient services should be further developed. There was a final plea for a study in depth of the needs of disturbed adolescents, and how these might be met through the combined operations of various authorities and the many disciplines involved.

The present survey was planned as a pilot study, bearing in mind these recommendations.

The Wessex Region where this took place is one in which a number of facilities exist (which will later be described in more detail), provided by both the regional hospital board and the local authorities of the area. In spite of this, the opinion was frequently expressed and by many agencies that much was still lacking. Crises arise from time to time for which there seem no solutions, and pressure of work and the many conflicting demands on the expertise available lead to frustratingly inadequate forms of therapy.

The survey is a study of a relatively small number of disturbed adolescents—seen in relation to their home and school environments. All the children were born in 1953 and 1954 and the final number in the group was 153.

In following these children from pre-adolescence through early adolescence, our primary aim, having established that they were disturbed, was to ascertain how much psychiatric help they were receiving, the nature of the facilities used and where these were lacking. We were also able to come to some conclusions about the varied types of disturbance, their transitoriness or otherwise, and in many cases to study the long-term results of damaging situations in early childhood.

METHOD

It is obvious that no definitive study is possible in an area the size of the Wessex Region, and the present group consisted of children who were receiving psychiatric help, and disturbed children who had come into the care of the children's depart-

ment. The aims of the survey were discussed with the consultants in child and adolescent psychiatry of Portsmouth, Southampton, Hampshire, and Dorset, and with the children's officers and the assistant child care officers of the City of Southampton and of parts of Hampshire.

As a result, lists of children born in 1953 and 1954 were obtained from these agencies. Child guidance children and their parents were asked by the psychiatrist and the psychiatric social worker concerned if they would be willing to participate in the survey—only a tiny proportion of children in the survey's age-group who were in treatment were not approached and of those approached only a small number refused. The child care officers of children in care or under supervision asked these children and their parents, where relevant, for their co-operation—a slightly larger proportion of children's department children were not approached because the parents at best were unco-operative and the officers did not wish to upset an already precarious relationship, or because of a particular crisis at that time. Some of the latter children were picked up later and agreed to join the survey after they had been placed in family group or children's homes.

Preliminary interviews were begun in June 1966 and eligible children who subsequently appeared on the books of child and family guidance clinics and children's departments were accepted until December 1967. Nearly all the children were aged 12 or 13 when first seen, but a few were a little under 12 or just over 13 at their first interview.

It had been our intention to include a group of children of the age we wanted who were on probation, and who, though emotionally disturbed, were not receiving psychiatric treatment. In preliminary discussions with a senior probation officer in one of the cities where liaison was very good with the child psychiatrists, we were assured that any delinquents who showed signs of emotional disturbance or psychiatric illness were always referred for a clinical assessment and that we would be likely to pick them up via the child and family guidance clinic. In another area, a list was made of the children on probation by the officers concerned, and we met with them to discuss the survey and the means of obtaining

the co-operation of the parents and children. Starting with six or seven families, this co-operation was not obtained by their probation officers, owing to the defensive attitudes of the parents, so further approaches in this area of work were abandoned. We had in any case decided by this time that the 150 children now on our books (rather than the 200 originally planned) were the most that could be followed up each year.

Before any child or parent was seen, the research team, consisting of a consultant in child psychiatry, a sociologist, and a psychologist, studied the relevant file in the child and family guidance clinic or children's department and in nearly all instances had talked with the psychiatrist or child care officer responsible. When possible, the child was first seen at the time of an ordinary visit to the child and family guidance clinic or psychiatric out-patient clinic and in a number of cases the parents were interviewed at the same time. Children in care who were not attending a child and family guidance clinic were seen at the local children's office or clinic, and parents or foster-parents who accompanied them were also interviewed. Parents not seen in this way were visited at home either concurrently with the child's interview or a short time before or after.

PSYCHIATRIST'S INTERVIEW WITH THE CHILD

As much was already known about each child from the case-file and preliminary discussions with officers concerned, the main purpose of the first interview was to establish the degree of the child's disturbance, the likely prognosis, and to enlist his or her continuing co-operation. It was carefully explained that the investigators were not offering help, on the contrary they were seeking help which might be of benefit to other children later. It was emphasized that any information they cared to give us about the facilities which were made available to them which they felt to be helpful or otherwise would be of particular interest to us.

Although every effort was made to establish a working rapport, it was necessary to avoid (as much as possible) any therapeutic intervention; this inevitably limited the depth of

some of the inquiries. Information was obtained, however, on the following:

Individual personality characteristics—attitudes to school, leisure, 'pin-ups', work, and growing up. Activities with parents or parent-surrogates, siblings, and contemporaries, and any information they chose to give about their relationships.

Their capacity for tolerance and adaptiveness—the conflictual areas—internal or external, if any information about this was volunteered.

No child refused to join the survey after the first interview, and they were willing to do two tests (the Wechsler and the Modified Junior Maudsley Personality Inventory) subsequently. Further, it was explained that they would be one of a group of some 150 children who would be invited to report annually for the next four years.

Indeed, they were not only willing but seemed eager to take part in a project which might help other children with problems similar to their own.

The final total came to 153 children, of whom 104 were boys and 49 were girls.

SOCIOLOGIST'S INTERVIEW WITH PARENTS OR PARENT-SUBSTITUTES

Again, and for the same reasons, the main emphasis during the sociologist's first interview was to enlist parental co-operation and to explain the purpose of the survey. Parents or parent-substitutes were asked to comment freely on how easily they had obtained help and whether they were satisfied, and those in charge of children's homes were encouraged to express their views on the general set-up of the homes and on anything they felt to be especially helpful or unhelpful for the children in their care.

The interview was not structured, but as much information as possible was obtained on the following:

Environment—including area, type of house, and living accommodation (when parents were first seen outside the

home, this information had to be gathered at a later visit to the home).

Family—including number of people in the home, socio-economic status, family relationships.

Contacts outside the home—including attitude to school, clubs, and visits away from home.

Child's interest and hobbies.

Parents' attitudes and opinions.

In addition, each parent was asked to describe his child as a person.

Here again the parents and parent-substitutes were co-operative about being interviewed (with the exception of six) and were willing to be visited yearly by the sociologist.

PSYCHOLOGIST'S INTERVIEW WITH THE CHILD

An up-to-date intelligence test result was wanted for every child in the survey. Because the Wechsler Intelligence Scale for Children can reveal interesting discrepancies between verbal and performance scores, it was decided that this was the test to use. A number of the child guidance children had already been tested with both WISC and Binet tests so where a recent WISC result was available this was used, but the WISC test was given to the 62 children who had never done it and to 7 others where the result was considered to be out-of-date.

Contact was made by the psychologist with the others of the group as a personality questionnaire (the Modified Junior Maudsley Personality Inventory) and a reading test (the Holborn Scale) were also given in the preliminary stages of the survey. Children of low intelligence, i.e. with an IQ of 70 or less, were not accepted for this survey as they had been studied in another Wessex project and their needs were somewhat different.

PRELIMINARY FINDINGS

1. A description of the group

It was hoped that the design of the project, i.e. the inclusion of nearly all the children born during 1953 and 1954 on the

TABLE 1

CITIES			COUNTIES						
			Towns over 40,000		Towns less than 15,000		Village or country		
CGC	*CD*	*Total*	*CGC*	*CD*	*CGC*	*CD*	*CGC*	*CD*	*Total*
67	34	101	15	12	10	6	7	2	52

books of (*a*) the child and family guidance clinics and child psychiatric out-patient departments and (*b*) the children's department would yield a varied group, and, in terms of environment, social class, range of intelligence, and type of school attended, this in fact proved to be so. The following paragraphs reflect the fairly wide distribution of the children studied.

a. Environment

The children from the two sources, psychiatrists and children's officers, came from two cities (both with populations of over 200,000) and from two counties. The children from the counties were divided into those that came from large towns varying between 40,000 and 100,000 inhabitants, those that came from small towns of less than 15,000, and those from rural areas. Table 1 shows the distribution of the children in terms of environment.

b. Class

Because over one-third of the children in the sample were not living with their own parents, a breakdown of the sample into social classes based on their fathers' occupations was not meaningful. Instead, the general range of social class in the survey was conveyed in terms of the area and type of house in which the children lived. Definitions of the categories shown in Table 2 below are as follows:

Upper middle	Large houses standing in their own grounds.
Middle	Owner-occupied houses in middle-class areas.
Lower middle	Owner-occupied houses in Victorian streets with very small gardens.

Council houses
Back-streets — Rented houses or apartments in somewhat sordid neighbourhoods.

TABLE 2

	CGC	*CD*	*Total*
Upper middle	2	0	2
Middle	19	1	20
Lower middle	30	8	38
Council housing	37	13	50
Back-street	8	7	15
Group homes or hostels	1	25	26
Not known	2	0	2
	99	54	153

c. Early history—the first five years

Whenever possible, a history was obtained from the child care officers, or psychiatric social workers involved, about the children's home background or other environment during the first five years of their life. There were a few (six) where no information could be obtained about these formative years, but for the majority their early home-life could be classified under three headings, as Highly Unsatisfactory, Unsatisfactory, or Assumed Satisfactory, according to the degree of stability, affection, and security they had had. In many cases factual evidence was available indicating just how unsatisfactory or how unstable the early years had been, but the environment was pathogenic for others in a more subtle way, when for example the parents were excessively rigid or restrictive, overpossessive or demanding, or ineffectual and indulgent. These backgrounds, where the criteria were based on attitudes and emotions rather than factual evidence were classified as Unsatisfactory (*b*). For the rest, the criteria used for the Highly Unsatisfactory and Unsatisfactory homes are shown below.

Highly Unsatisfactory

Cruelty to child so evident that the NSPCC involved.

TABLE 3

Highly Unsatisfactory	*Unsatisfactory* (a)	(b)	*Assumed Satisfactory*	*Not Known*	*Total*
54	19	40	28	12	153

Violence in the home.
Gross neglect, for example, mother promiscuous and indifferent to the child's care.
Child moving around from home to home with no established mother figure.

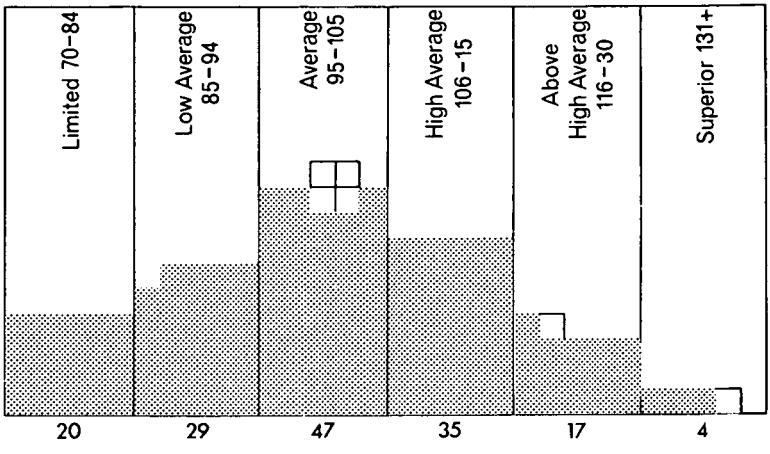
Unsatisfactory
Marital tension culminating in break-up of marriage or divorce.
Death of a parent, in an otherwise satisfactory home.
Parent(s) known to have had a severe psychiatric illness or to have been in prison, with subsequent break-up of the home.
Separation of child from parents for more than four weeks owing to hospital admission, for accident or for illness.

The findings are shown in Table 3.

d. Test findings

Of the original group of 153, 146 had a WISC Full-Scale IQ. These are plotted on the accompanying graph in black. Six white squares represent five Stanford-Binet IQs for the children for whom it was not possible to arrange a WISC and one boy who did only the verbal half of the WISC. One boy had no IQ result at all. A school phobic, he was prepared to accept appointments for testing but in the event did not keep them, and was one of those who later dropped out of the survey.

This distribution approximates to a normal distribution in that 73 per cent of the scores lie within ±1 SD from the mean (taking the mean IQ as 100 with an SD of 15). The fact that no children were accepted for the survey with IQs of less than 70 means that there were no children of inferior intelligence to balance those of superior intelligence.

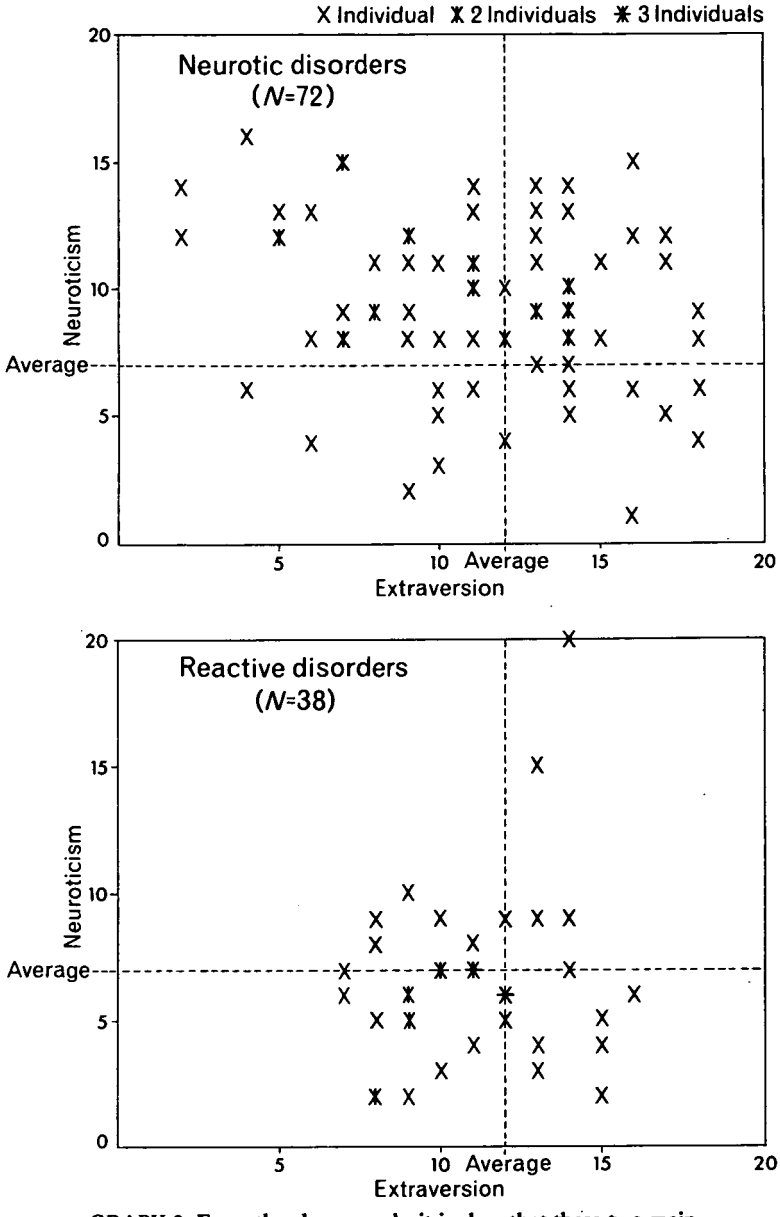


GRAPH 1. **WISC Full Scale IQs (*N* = 152)**

The Modified Junior Maudsley Personality Inventory

The personality questionnaire which was chosen for the survey was the Modified Junior Maudsley Personality Inventory, which measured Neuroticism and Extraversion; it was reasonably short, and it had no 'don't know' category of response. It required a reading age of only about 9 years and had been validated on a clinical sample of 13-15-year-old patients compared with a normal control group from local secondary schools in one of the cities in the region. It seemed particularly suitable for this project, where it was to be given to children of 12-14 years. It was well accepted by all the children, some of whom worked through it at an incredible speed. Even the few to whom it had to be read aloud seemed to respond without embarrassment, doing the underlining themselves.

The Modified Junior Maudsley Personality Inventory is a personality inventory in a very limited sense, in that it measures two factors only, Neuroticism and Extraversion. Previous research has shown that this type of test distinguishes well between certain groups of mental patients, for example, hysterics and dysthymics, or between 'normals' and neurotics. The children's versions have been used to measure differences between school groups in terms of the relationship between neuroticism scores and sex, intelligence, or



GRAPH 2. From the above graphs it is clear that these two main groups are best differentiated by high scores on Neuroticism and low scores on Extraversion in the Neurotic group

attainment. Canadian and English children have been compared for Neuroticism and Extraversion, as have grammar school and secondary modern schoolchildren in England. Many of the surveys have shown significant differences between the mean scores of the groups being studied, not always in the expected direction.

The modification of the Junior Maudsley Personality Inventory by Dr Lokare was tried out on normal schoolchildren and on clinic children and it was claimed that the neurotic sufferers could be distinguished from the rest in the clinic sample. Its 'power to discriminate between diagnostic categories in a consistent way' is of little use in a survey such as the present one unless the scores obtained by *individuals* are an aid to diagnosis.

Four subgroups were differentiated within Lokare's clinic sample, and these accorded with psychiatrists' findings and diagnosis. An inspection of the means and standard deviations of these clinical subgroups and those of the normal group showed a great deal of overlap and it seemed doubtful whether the claim that the Modified Junior Maudsley Personality Inventory could be useful in diagnosis would prove to be sound.

The two diagnostic categories which contained the majority of the children in the present survey were Reactive and Neurotic disorders. These two groups were not differentiated from each other in mean scores of Extraversion, and the mean scores of each approximated closely to the mean score quoted for Lokare's 'normals'. On Neuroticism the children with Neurotic disorders had a group mean of 9·4 as compared with a group mean of 6·5 for the Reactives. This looks promising, till on looking at the range of N scores within the two groups it is seen to be so wide that to use any individual score diagnostically would be unwise in the extreme. (N scores ranged from 2 to 16 in the Neurotic group and from 2 to 20 in the Reactive group.) Subgroups of other kinds, such as school phobics, truants, pilferers, and those with sexual problems showed a wide range of N and E scores.

When the questionnaires were inspected for suggestive clusters of responses, they seemed to show that depression and anxiety came over strongly. The children who were

considered by the psychiatrist to suffer from depression as an initial symptom were listed and their N and E scores examined. They were scattered throughout the four quadrants, neurotic introverts and extraverts. In other words, by no means all the children who showed or complained of depression in history or interview were responding to the sentences designed to identify depression in the questionnaire.

The scores were plotted on a graph for the entire survey group with the names attached so that extreme scores could be quickly related, by means of the record cards, to the diagnosis, severity of disturbance, symptom complexes, and intelligence of the 'fringe' children. No unifying factor was apparent and it was obvious that many of the most severely disturbed of the group lay within normal limits for both Neuroticism and Extraversion.

It was possible, too, to look more closely at the children whose scores were identical and see if there were any points of resemblance. Sometimes there were—two boys who eventually went to approved schools shared a spot, but they shared it too with a disturbed, but mild and inoffensive little girl whose problems mainly arose from having a mother who at intervals was an in-patient in a psychiatric hospital. A school phobic, depressed, clinging, and immature, made identical scores to a small, restless delinquent who was in trouble at school for drawing indecent pictures. A highly intelligent boy who was one of the more mildly disturbed of the group shared his spot with a boy who after in-patient treatment at an adolescent unit continued to have a doubtful prognosis. These last two were stable introverts but the other four were average on both Extraversion and Neuroticism.

Thus it seems clear that, whereas it is possible to make some useful observations about groups in terms of Neuroticism and Extraversion, personality questionnaires of this type will need considerable refinement before they can be safely considered diagnostic for the individual.

The reading test

The Holborn Reading Scale was used to test the children's reading ability. Of the original group of 153 children, 40

were 2½ or more years behind the average for their age and of these nearly half (19) were more than 4 years retarded. The verbal intelligence quotients of the poor readers ranged from Limited to Above High Average. These results will be discussed in detail in a later chapter.

2. Assessing the disturbance

When all the preliminary interviews had been completed, the three members of the team met to discuss each individual child. On the basis of this discussion, and taking into account all the relevant data obtained from the files and from the psychiatrists, psychiatric social workers, and child care officers concerned, an initial diagnosis was then made. The question of deciding whether or not a child was disturbed was largely irrelevant in the case of children already attending child and family guidance clinics, but a decision had to be made for each child accepted from the children's departments. This decision was made easier by the survey psychiatrist first talking over each child with the child care officer who was responsible for him, which enabled us to eliminate those children who showed no signs of disturbance before asking any child to come for a preliminary interview.

It was found that those showing emotional disturbance tended to fall into three main groups. Some were essentially anxious, withdrawn, depressed, and felt inadequate (to be known as Group I), others suffered largely from developmental or physical anomalies with no organic cause (Group II)—these were the children who had tics, and habit disorders such as bedwetting, soiling, and nailbiting—whilst Group III consisted of those whose behaviour disorders were often antisocial, frequently irrational and repetitive, but who were distressed by the conflict between themselves and the adults in their environment, caused by this behaviour. This means that no children were included who had been brought up to steal and behave antisocially as a family pattern of behaviour, nor any whose 'misbehaviour' was an expression of peer-group or group high spirits. The children included in the survey were in conflict and their behaviour disorders were an expression of it—they were 'acting-out'. A much smaller

group, Group IV, included those who had major physical defects with associated emotional problems.

There was at times, of course, considerable overlap of symptoms into more than one group, and no child was accepted for the survey unless there were several symptoms present. For example, enuresis, or nailbiting, or occasional temper-outbursts in isolation did not qualify for inclusion.

The figures for the three main groups at the start of the survey were as follows:

Group I	(anxiety, depression, withdrawal, etc.)	36 boys, 21 girls = 57
Group II	(mostly habit disorders, including tics)	20 boys, 12 girls = 32
Group III	(conduct disorders)	35 boys, 20 girls = 55
Group IV	(physical defects and emotional interactions)	8 boys, 1 girl = 9
		153

There is no diagnostic classification of psychological disorder which has been accepted yet as definitive, least of all for childhood and adolescence. Of the classifications tentatively suggested to date, the one formulated by the USA Group for the Advancement of Psychiatry in reference to children's disorders was used in this survey with certain minor modifications. Based on these categories, the 153 children were diagnosed as follows:

Neurotic disorders	80
Reactive disorders (or 'adaptation reaction')	40
Personality disorders	11
Psychophysiological reactions	11
Brain syndromes	5
Developmental deviations	3
Healthy responses to an abnormal situation	3
	153

The diagnosis was made, of course, in the light of information about environmental factors in the early years, the child's development during these and later years and on

TABLE 4

Predictions after the initial interview ($N = 153$)				
Good	*Hopeful*	*Fairly Hopeful*	*Doubtful*	*Poor*
5	24	40	67	17

the assessment of the personality strengths and the present clinical state of each child.

It will be noticed that none in this particular group was found to be psychotic; one child complained of 'hearing voices' but in no other way appeared to be out of touch with reality.

3. Predictions

Finally, each child was given a prognosis on a five-point scale: good, hopeful, fairly hopeful, doubtful, and poor. Predictions were made at the initial interview based on the clinical findings. If, in spite of a very poor family history and highly unsatisfactory first few years, the child seemed to be making a reasonably good adjustment in terms of relationships, school, and general activities, a fairly hopeful or good prognosis was given.

4. Subsequent interviews and school assessments

The first interviews were begun in June 1966, and the survey ended in December 1970. In the intervening years both children and parents were seen once a year by the psychiatrist and sociologist respectively.

The second-, third-, and fourth-year interviews followed the progress of the child and noted any outstanding events. After each home visit by the sociologist and interview by the psychiatrist, a record was made of the child's current state, and a further prognosis made on the five-point scale. Neither type of interview was structured: as the child matured the psychiatrist added various items (for example, attitude to leaving school, to work, etc.) to the general picture of the child, and during the home visits parents were asked each

TABLE 5

Parents unwilling to co-operate		Child left the area		Death of child		Total	
CGC	*CD*	*CGC*	*CD*	*CGC*	*CD*	*CGC*	*CD*
6	0	4	2	1	1	11	3

year whether various symptoms such as anxiety attacks, bedwetting, pilfering, etc., were still evident, and about over-all progress. In the final home visit every parent or parent substitute was asked seven questions aimed to elicit a general view of their attitude both to the child's disturbance and to any treatment he or she received. In both cases the forms were filled in by the interviewer and not shown to parents or children. These final interviews were made as late as possible and the age-range at these interviews varied between a few at just under 16 and the remainder at 16 or 17 years of age.

During this period the psychologist made contact with nearly all the schools which the children in the group were attending, and a simple report on each child was filled in by the class or form teacher. As these reports became available they were taken into account when the yearly diagnosis was reviewed.

For the great majority a yearly contact was maintained with child and parent over the whole period; there were a few cases where only two or three interviews during the survey were possible. Some families for example moved away from the district but returned after an interval of a year or so, and some children went away into the Services or were away at approved schools for their last year; these were still included in the survey when information about them had been maintained and was comprehensive throughout the four years. The child care officers or the headmasters/mistresses of their approved schools greatly helped us by discussing these adolescents with us.

There were only fourteen children who were not followed through to the end of the survey, and Table 5 shows the reasons.

BACKGROUND

This five-year survey, financed by the Nuffield Provincial Hospitals Trust, was sponsored by the Wessex Regional Hospital Board; all the children who took part in it lived within the Wessex Region, and with a very few exceptions received their treatment and help within the boundaries of this southern area of England. And, since the aim of this inquiry was largely to establish what kinds of facilities were available to help disturbed young adolescents in the Region, and what facilities were lacking, it seems appropriate to give some indication of the existing services, including those of the local authority, and voluntary services as well as those under the aegis of the NHS. Wessex is a relatively small region, with a population of some 2 million people; much of the area is rural but it contains two cities and a number of towns of over 100,000 population.

For convenience of description the facilities can be listed under:

1. Psychiatric, whether at out-patient and child and family guidance clinics, or in-patient units,

2. Special educational, in schools, whether day or boarding schools for maladjusted children, and special tutorial classes,

3. In the care of the children's officer, in units and hostels for the more seriously disturbed, and in family group homes and specialist foster homes.

As has been mentioned already, children who were on probation were not included except those attending child and family guidance clinics and referred by psychiatrists, so the probation service as such is not referred to here.

1. Psychiatric facilities for children and young adolescents

These include out-patient and child and family guidance clinics held in some 22 centres throughout the Region which are attended by 11 consultants in child psychiatry, also helped by a senior hospital officer, a medical psychotherapist, and two senior registrars. Working closely with the

psychiatrists there are three clinical psychologists and some twenty social workers, most of them with special training in psychiatric work. There is inevitably a considerable problem for patients in travelling to some of the more remote clinics, and the psychiatrists in these areas are serving a child population of as much as 55,000 to 70,000 per head.

In regard to in-patient care, two units exist which are under the aegis of the Regional Hospital Board and which serve the whole Region: one is a 35-bed complex consisting of two buildings (one purpose-built) in the grounds of a large psychiatric hospital and a house in a residential area near the sea; these are for children of up to 12 although some older children are admitted. The other unit is for adolescents of from 12 to 18 years, has 30 beds, and is situated in its own grounds in a semi-urban area. At the time of writing a second adolescent unit of 25 beds has just been purpose-built in the grounds of another large psychiatric hospital, for the assessment and treatment of psychotic and very seriously disturbed young adolescents. All these units, to which some of the children of the survey have been admitted (except, of course, the last one which is not yet open) are for both boys and girls.

2. Special educational facilities

It will be noted in later chapters how many of the children in the survey have needed special educational facilities, not because of their limited intelligence since none falling into this category was included, but because they required education in special boarding schools for maladjusted children, or in special small day schools, or in special remedial classes.

These facilities are set up by the local education authorities and the assessment of the children and the work of co-ordination is largely undertaken by the 17 or so educational psychologists of the local education authorities (in the Wessex Region). There are five special day schools in all and one local education authority boarding school for 45 boys, recently built, and largely serving its own local authority. The other special boarding schools (used by the survey children)

are privately sponsored, four being in Wessex, the others elsewhere.

There is one hostel, sponsored by an education authority, for disturbed children and adolescent girls which should also be mentioned.

3. Children's department

Each county and the biggest towns have reception centres (seven in all) for the assessment of children coming into care. These children may then be placed in foster homes, family group homes (of which there are some 65-70) or in specialist units for the more seriously disturbed. There are three of these latter at present. Since the Children's and Young Persons' Act, 1969, came into force, the children's department is also responsible for remand homes and approved schools.

The three remand homes centrally placed in the Region, to which some of the survey children were sent for assessment, cater for boys and girls separately and only one of the three or four approved schools in Wessex (all sponsored by voluntary bodies until recently) was used by any of our children because of restrictions of age or religion.

Hostels for working boys and girls who need special help

Finally, mention should also be made of special hostels for working boys and girls since a number of our children lived in them after leaving school. These are sponsored by local authorities, both by the education and children's department of the Region or by voluntary bodies; seven were known to us but there may well be more.

Summary

This brief outline gives an indication of the facilities in Wessex aimed at helping the disturbed adolescent. Our inquiries over the last five years show how these facilities were used, how effective they appeared to be, and for which cases they proved ineffectual, which inevitably leads on to discussion about the apparent gaps in the Service.

2

Children referred by psychiatrists

Following our first meeting with the children's psychiatrists in the Region, they began to refer us children of 12 and 13 years of age, during 1966 and 1967. They and the psychiatric social workers made it very clear to the families that there was no obligation to become involved but that their help would be welcomed and might one day be very useful to others.

The majority of children had originally been referred to the child and family guidance and out-patient clinics by GPs, paediatricians, school medical officers, headmasters, and probation officers, and their symptoms varied from those specific to certain situations, to others which were leading to a general breakdown in most areas of functioning.

As we were making a separate study of the children who were in the care of the children's department, all those are dealt with in that chapter, leaving us with 88 children to report on here.

NATURE OF DISTURBANCES

Of these 65 boys and 23 girls, 36 per cent fell into the anxious solitary and depressed group (Group I), another 33

per cent showed disorders of behaviour mainly in stealing, truanting, and sex problems (Group III), 19 per cent suffered from physical disabilities without any evidence of organic lesion (Group II), whilst 11 per cent had organic disabilities such as brain damage, diabetes and hemiparesis with associated emotional problems (Group IV).

By far the majority of the 88 had only recently commenced their treatment when the survey was started; a few were in mid-course and none had been discharged. A diagnosis and prognosis was made each year for the purposes of the survey without further consultation with those clinically responsible and the findings were as follows:

Disorders	*Initial diagnosis*
Neurotic	52 (38 boys, 14 girls)
Reactive	14 (12 boys, 2 girls)
Psychophysiological	8 (6 boys, 2 girls)
Personality disorders	6 (2 boys, 4 girls)
Developmental deviation	3 (2 boys, 1 girl)
Brain syndrome	5 (all boys)
	88 total

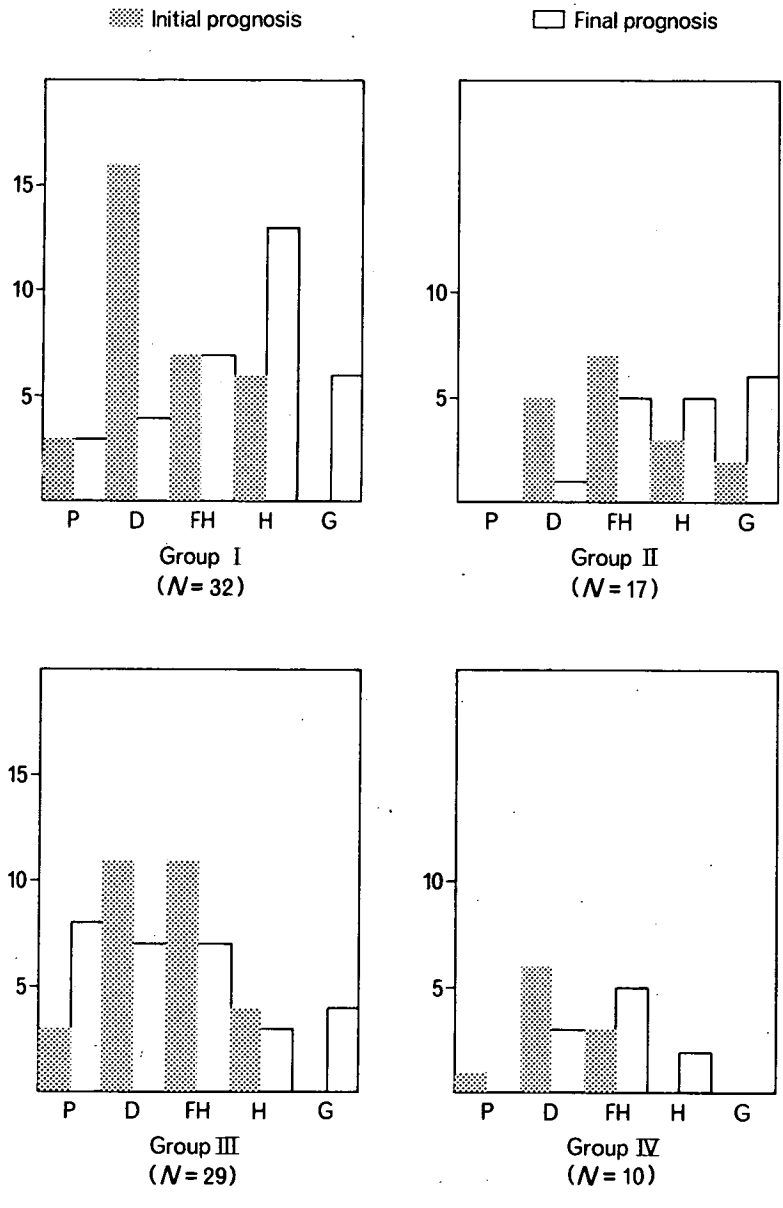
PROGNOSIS

The histograms (Graph 3) show the improvement in the group as a whole from the initial to the final prognosis. Only in Group III is there an increase in the number of 'Poor' prognoses, and these were found to be the most likely to show sudden improvement or deterioration leading to greater difficulty in predicting the outcome.

The results can be quantified if the prognoses are rated on a five-point system:

Poor	= 1 point
Doubtful	= 2 points
Fairly hopeful	= 3 points
Hopeful	= 4 points
Good	= 5 points

The symptom groups can then be compared thus:



GRAPH 3. CGC children (*N* = 88)

Group I	Av. initial score	= 2·7
	Av. outcome	= 3·4
Group II	Av. initial score	= 3·1
	Av. outcome	= 3·9
Group III	Av. initial score	= 2·6
	Av. outcome	= 2·2
Group IV	Av. initial score	= 2·2
	Av. outcome	= 2·9
Total group	Av. initial score	= 2·7
	Av. outcome	= 3·1

This makes it clear that on the whole the initial prognosis was too pessimistic and that in Groups I, II, and IV there was general improvement. Group III, however, was the exception.

INTELLIGENCE QUOTIENTS

The Full Scale and Verbal and Performance IQs of the CG children are shown in Graph 4. Roughly 68 per cent of the Full Scale are in the middle range, i.e. ±1 SD from the mean, as in a normal distribution. There are more children with above average scores on the Performance Scale than in the Verbal Scale but the differences in the distributions are not nearly as marked as in the case of the CD children.

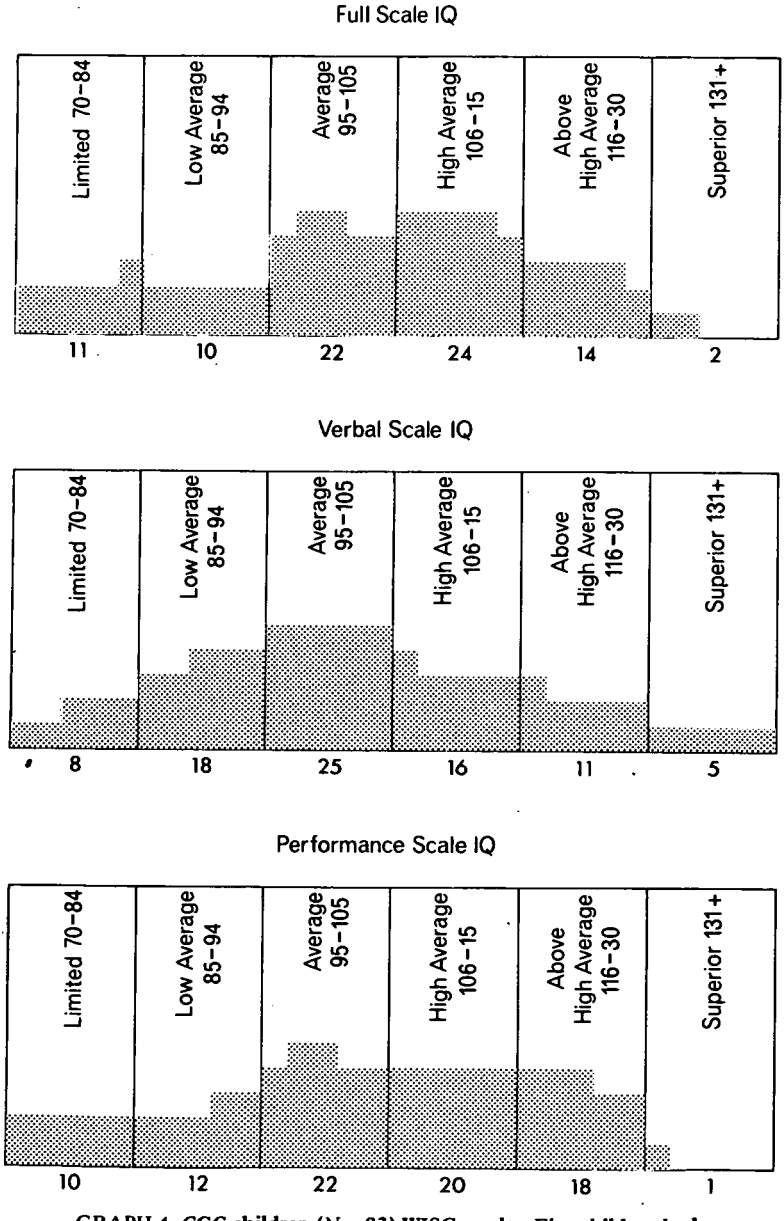
HOME BACKGROUNDS

1. Early experiences

Seventeen of the 88 children had a 'highly unsatisfactory' start to their early years. Forty-four more had 'unsatisfactory' home backgrounds, 35 of these of type (*b*). In the case of 24 there were no obvious factors likely to aggravate an emotional disturbance, and with three children it was impossible to come to any conclusion either way. Table 6 compares the home backgrounds of the children in care with those of the children in this chapter.

2. Known psychiatric history of parents

Three children had one parent who had been a permanent in-patient in a mental hospital for many years, before and



GRAPH 4. CGC children (N = 83) WISC results. Five children had Stanford-Binet IQs only, of 95, 103, 105, 124, and 141.

TABLE 6

	Highly Unsatisfactory	*Unsatisfactory (a)*	*(b)*	*Assumed Satisfactory*	*Not Known*
CGC: $N = 88$	17	9	35	24	3
CD: $N = 51$	35	7	3	1	5
	52	16	38	25	8

during the survey. Five others had one parent who at some time subsequent to the child's birth had temporarily been an in-patient.

Eighteen other parents had had out-patient or GP treatment for psychiatric disorders. In each of these categories, mothers were to be found two to three times as often as fathers. One father committed suicide, however, and two attempted it, whereas there was an attempted suicide by just one mother.

Thus one-third of the 88 children had one parent with a known history of psychiatric disturbance.

3. Age of onset of difficulties

It was interesting to have the parents' opinions as to when they considered their child had first shown symptoms or been difficult to manage. Forty-six of the 88 children were said to be difficult *before* they were 5 years of age—some almost from birth, others at 3-4 years of age; another 22 started showing their difficulties between 5 and 10, and 18 between 11 and 13 (2 we have no information about). The commonest age of first attending the clinic proved to be 10 or 11 years—often because of an exacerbation of symptoms at that time either with school refusal, or other phobic states, or for behaviour disorders such as stealing, arson, truanting, etc.

The parents were also asked at the end of the survey at what age they considered their children had caused most anxiety to them, during their 16 or 17 years. Fifteen parents said it had been continuous since infancy, 14 that there was an improvement by 11; but 29 mentioned 11-13 years as

being the most difficult. The majority were much less worried about their children during the 14-, 15-, and 16-year period—a significant though not altogether unexpected finding in a survey of disturbed adolescents.

4. Environment during the survey

Almost all the children attending the clinic were living at home. Sixty-one of the 88 children were living with both parents, and 10 with their mother only. The homes of the remaining 17 were as follows:

Living with mother and stepfather	9
Living with father and stepmother	1
Living with adoptive parents	5
Living with foster parents	1
Living with private children's home	1

The distribution of the children according to class is detailed in Table 2 (p. 8). Most of the homes were adequately or well-furnished even including some of those in the more sordid neighbourhoods. Expensive model-car tracks, new bicycles, typewriters, and tape-recorders were not unusual presents for teenagers living in lower middle-class or council-house areas, and were evidence of the prosperity and full employment prevailing in the south of England during the years of the survey. Only three of the fathers were out of work for long spells and they all were on sick leave.

Nevertheless there were 14 homes where there were real signs of poverty in the way of dilapidated furniture and very shabby decorations combined in nearly every instance with marked overcrowding. In this group of 14 families, 7 had 7 or more children (the largest being 11), 5 families had 6 children and the remaining 2 families 4 children. The dilemma of parents with large families living amongst more affluent neighbours is illustrated by the father of one of the survey families who decided to send the eldest of his six children on a holiday abroad organized by the school. His wife complained to the sociologist that she feared her husband might break down under the strain of working every evening to pay for the trip and she could foresee no let-up for many years to

come with five children to follow in their sister's footsteps. When a home visit was made a year later, the sociologist found that the father had indeed broken down and had made an unsuccessful attempt at suicide.

CLINICAL STATES OF THE EIGHTY-EIGHT CHILDREN

1. Neurotic (52)

Eighteen boys and 8 girls showed symptoms of anxiety, depression and inadequacy, a number of them being phobic about school attendance (Group I), 12 boys and 4 girls were behaving in antisocial ways resulting from conflict (Group III), and the rest, 8 boys and 2 girls, had symptoms such as bedwetting, soiling, poor sleep, tics, etc., causing distress (Group II).

Twenty of these 52 children diagnosed as neurotic attended for out-patient treatment, an additional 9 went to special day schools whilst continuing with psychotherapy, and 10 others were on probation. Seven were away at special boarding schools and were reviewed by psychiatrists when they were home for holidays, and 6 were admitted for in-patient care to units in Wessex. These were the main features of their treatment during the survey.

Other investigators have found that children by and large who are diagnosed as neurotic respond well to psychological treatment and these were no exception. On the other hand some investigators have suggested that neurotic children frequently improve without treatment, as shown for example in the long waiting-lists from which they sometimes get withdrawn because they no longer have symptoms. There was no question in regard to the parents' opinions about treatment in many of these cases, that there had been a marked improvement (not infrequently requiring several months of attendance) which they closely associated with the help given. In several cases they said their children had changed out of all knowledge. Many of these parents also expressed their appreciation of the help they themselves had received from psychiatric social workers.

In the case of 39 of the 52 neurotic adolescents, progress

was good, the outlook became increasingly satisfactory, and the available facilities seemed adequate.

There were 8, however, whose prognosis continued doubtful and, in the case of 5 others, it was persistently poor. These were the children who apparently lacked the facilities which would have helped them to mature—was this in fact so? What were their case-histories?

In regard to the 5 who were very seriously disturbed, 4 were boys and 1 was a girl. Three of them were illegitimate and had lived in a 'highly unsatisfactory' home for many years.

One of the boys, a big baby, had a difficult birth, and there was no father in the picture as far as he was concerned until he was 3. This one was replaced by another at 7, and the mother was alternately indulgent and neglectful. He also suffered from many changes of address. He was first referred for psychological help at 11, though his mother said he had been difficult to manage all his life. At this stage he was very depressed, apathetic, and lonely, and felt a complete failure. Every effort was made to encourage this boy of rather limited intelligence, to help him to catch up and mature at a special day school which he attended for three years, but there was little co-operation from the mother. When he left school he failed to settle in any job; he became increasingly hostile and demanding at his work. He is now being helped by the mental health officer, with a view to going into a sheltered industry.

The second boy who also had a 'highly unsatisfactory' start was so resented by his 'father' that he tried to strangle him at the age of 3. Both parents came from poor homes and themselves had witnessed a lot of violence; in material ways they kept up a good home. This boy was taken to a hospital out-patient clinic when 5 years old when he first started school-refusing, and some improvement resulted for several years. Later the family moved south when he was 11 years old, the school-refusing recurred, with other symptoms such as sleeplessness and a persisting fear he was going mad. He was so disturbed that he was admitted forthwith to the adolescent unit where he stayed for three years. There was a slow but moderate improvement and finally boarding school

was tried but this proved to be disastrous and he left after a week, as, amongst other things, there was a recurrence of his acute anxieties about his backwardness and his poor writing although he was a boy of average intelligence. He appeared to have been so damaged by the continuing tension in his home life that he was unable to concentrate or derive any permanent benefit from any help given, except on a holding basis.

The third boy came from a more satisfactory home but presented as a school phobic at 12 years of age. He suffered from many obsessional rituals as well, and was acutely depressed and withdrawn. There is a history of obsessional disorders on the father's side—and the mother suffered from depression after his birth. She went to work when he was 2 and he was looked after by several substitutes particularly between the ages of 4 and 5. His problems became noticeable to the family only at 12, when he was seen by a psychiatrist and admitted for in-patient treatment for three years. During this time he regressed to a very infantile state, and needed continuous support, both psychiatric and nursing, for two years before any signs of improvement occurred and, although the prognosis is still poor, he has recently shown definite signs of increasing maturity. He is now in an after-care hostel from which he goes out to work.

The fourth, a girl, who deteriorated seriously during her adolescence, had been adopted at the age of 12 months, having lived in an institution until then. She then joined a strict and punitive adoptive father and an anxious and rigid adoptive mother. The long-standing history of petty pilfering came to a head when she was 13. At this time she was a very lonely girl, and sensitive about her unusual height; later she began making undesirable friends, stayed away from home at night, and finally became more seriously delinquent. The parents regarded her pilfering from a very early age as morally reprehensible and failed to achieve any insight into the girl's needs. In this case later therapeutic facilities were not lacking but institutional care when she was a baby and an adoption which was not a happy one had made the situation chronic. Possibly this girl would have benefited had she been sent to a boarding school with a friendly and understanding

atmosphere. There was certainly some capacity to make good relationships when she was first seen.

None of these four adolescents in our opinion was suffering from a lack of adequate psychiatric help at the time they were seen but, since they had all suffered from very adverse circumstances for many years, the optimum time to help them and their families would clearly have been when they were much younger, as young as 3 or 4.

The fifth had received psychiatric help from the age of 10 for behaviour problems, including arson. His early upbringing had been somewhat unsatisfactory in that his mother left him in the care of his grandmother till he was 4, while she went out to work. His disturbance was said to date from his separation from the grandmother, to whom he was devoted. He responded excellently to in-patient treatment at 10 and made a very good relationship with the sister-in-charge to whom he was similarly devoted. Subsequent to discharge home all attempts to find him the recommended boarding school failed and he gradually deteriorated until he finally ended up in an approved school. This boy certainly went downhill with the lack of suitable follow-up facilities.

In regard to the 8 who were given a doubtful prognosis at their last interview, 4 had improved during the course of the survey, but it was impossible to be confident that all would be well, as they had frail personalities and their success in a competitive world was doubtful. One boy, however, a highly intelligent one, should have done well but didn't. He was sent to an ordinary boarding school at 10 after receiving out-patient treatment from the age of 7, and failed to respond there though he might have done so in a more 'progressive' school where his imagination and a desire to work might have been more stimulated.

2. The Reactive disorders (14)

Here again the children exhibited a multiplicity of symptoms when they were first interviewed but these were more clearly related to specific situations such as bullying at school, or violence from older siblings at home, and, when these were remedied, a marked improvement took place.

There were, however, 2 boys out of the 14 who did not improve, whose problems had been longer-standing and who might have been diagnosed as suffering from personality disorders. But they had had their phases of better adjustment during adolescence, depending on improvements in their circumstances. One boy, for example, had been subjected to a great many moves, he saw little of his own father in his early years since he was away on Service, later the marriage broke up and he found himself living with a very quarrelsome and lazy step-father, only to move again when this marriage was dissolved. This time he was moved to a country area where he attended a relatively small secondary modern school with an outstandingly good headmaster. At last this boy felt he had found a father-figure whom he could trust and to whom he responded extremely well; his truanting and pilfering ceased and he became popular with his peers, only to be moved again back to a town and to a school which he disliked. He then became very resentful and seriously delinquent, and his prognosis is now poor. He had had seven moves in seven years, as well as the relationship problems of an unsettled home to contend with, but he had shown a capacity to respond effectively given the chance. Unfortunately this opportunity was only short-lived.

The other boy had the dice loaded against him from the start. He was illegitimate and lived with his mother until he was 2 years of age when she died; after which he was fostered in seven different homes until he was 12 when his father, who had always kept a contact with him, also died. He then went to live with a young relation where petty pilfering, and homosexual tendencies, increasingly made him unacceptable. He attended the out-patient service for psychotherapy for a year but his deterioration was not halted and he ended up in a remand home after an aggressive outburst, and, absconding from there, was sent to prison. This boy was very attached to his father, and until his death had been relatively easy and friendly when he stayed with his relations. His was not an affectionless character; he had, however, repeatedly experienced the feeling of being unwanted in the homes his father found for him, and finally felt nothing but bitterness and loneliness.

3. Smaller groups

a. Psychophysiological (8)

These children, of whom there were eight, suffered from a serious physical disability with a marked psychological interaction. For example, two boys whose diabetes was diagnosed at puberty had a year or so earlier been referred for psychiatric help because one was suffering from phobic symptoms about attending school, the other was seriously depressed and irritable. Another boy, the fifth child of the family, whose mother had required in-patient psychiatric treatment, suffered from marasmus as a baby and was in hospital at that time for two months. From the age of 9 years following very serious burns, he was re-admitted to hospital for skin-grafting on a number of occasions. At puberty he was referred for psychiatric help because of behaviour problems, and a deep depression over his disfigurements.

In fact, all these adolescents improved during the period of the survey both in their physical state and in regard to their emotional difficulties, except one. He was a boy who had a major heart operation at 3, and had a pacemaker inserted later. For many years he had been subject to aggressive outbursts and to fainting turns; he was just holding his own in a sheltered industry when he was last interviewed but was still very immature.

They had all attended for supportive interviews at out-patient clinics, and three of them required the individual help provided by special day schooling.

b. Developmental deviation (3)

The three children who were listed under this heading might possibly have been included in the group above. But, as the symptoms of depression, lethargy, lack of appetite, and poor sleep had arisen *de novo* probably in association with their stage of pre-pubertal development and seemed likely to be fairly transitory, they were regarded as developmental upsets. The three made good progress over-all, though one went through a bad patch for a few months. Subsequently they

remained equable and able to cope with school and work quite satisfactorily.

c. Brain syndromes (5)

The brain lesions all happened to have been in boys—four of whom showed evidence of damage and had abnormal EEGs—and all had attended psychiatrists for their very disturbed emotional state rather than for neurological reasons. Three went to special boarding schools, and progressed well, one, who had a great deal of special day schooling, deteriorated after leaving to go to the Midlands where he became involved in a drugs charge.

The facilities available for this group seemed to be adequate and were helpful but, largely owing to very real initial handicaps, the prognosis was hopeful or fairly hopeful for only two of them. The others required jobs in sheltered workshops when they left their schools.

d. Personality disorders (6)

This is not a diagnosis to make readily before the age of 17 or 18 years, but there were 6 children (4 of these being girls) whose relationships with adults were shallow, who were behaving in uncontrolled and impulsive ways and whose personalities already seemed so damaged that any great modification was unlikely.

Three of these 4 girls were adopted, and the fourth was the child of a parent who had been brought up in an orphanage and herself received psychiatric treatment when young. Although this girl was restless, unreliable, inclined to pilfer, and was much preoccupied with the opposite sex, she had improved during the years of the survey. She spent two years at a special boarding school and then went to a local day school without any major problems arising but, since leaving school, had within twelve months been in nearly as many jobs (8 or 9). She is likely to continue in this overactive and restless state. The three other girls were all referred to psychiatrists at the age of 8 or 9 for behaviour problems such as stealing, lying, truanting from school, or arson. Two of them during their first years were with mothers who have since become permanent inmates of psychiatric hospitals;

nothing is known about the third mother except that, during the first ten months of life, her child moved around with her to five different addresses and was neglected before the adoption when she was about a year old. It does not seem wildly improbable that the personality development of these three girls was already seriously damaged by the time they were 2 years of age. And none has fitted satisfactorily into their adoptive homes, two of the homes being possibly too 'respectable' and middle class. Every effort was made to help these girls from the time they first attended for treatment, one being found a place at a special junior boarding school where she settled fairly well. After the change to a senior boarding school she began to deteriorate. (It was not a well-chosen school—too lax and indifferent.)

One girl was admitted to the adolescent unit for two months but her sexual proclivities made her too disturbing for the boys and she was finally sent to an approved school where she did better in the more contained atmosphere but there was no radical change in her personality.

The third girl, after being 'withdrawn' from boarding school, was also sent to an approved school, from which she truanted to live rough with a group which was involved with drug-taking. When last interviewed, she was back at the approved school and had settled into an outside job quite well. She was seen at the age of 14 with a view to admission to the adolescent unit but was not admitted as she was incapable of responding to intensive psychotherapy or gaining real insight.

All these girls might have been admitted to the new adolescent unit had it been open since it is designed to assess serious behaviour problems in a more secure and structured environment. Observation of their strengths as well as the weaknesses might have helped in their development.

In regard to the boys, they too had been away to special boarding schools and had derived considerable benefit although both were of somewhat limited intelligence, and, in spite of returning to undisciplined and chaotic homes (one mother had required psychiatric treatment, the other was on probation), they had not deteriorated during their adolescence, though the prognoses were not too rosy.

e. School phobics (17)

As school phobia is a syndrome which has been much discussed and written about during the last two decades, it is dealt with in some detail below. This section demonstrates clearly the interaction and interdependence of the various facilities provided for children who suffer from this problem, and shows rather more encouraging results than have been reported in some earlier studies.

The original child guidance group contained 17 school phobics, 13 boys and 4 girls. All suffered from physical symptoms ranging from poor sleep and poor appetite to headaches, abdominal pain and sickness, associated with panic attacks or obsessional rituals. Many had first attended a GP for these symptoms before being referred to the child and family guidance clinic. One boy had been hospitalized for observation, when he complained of abdominal pain and also ran a temperature. No physical cause was discovered.

Most of these children were also depressed and generally anxious and four of the boys had made suicide threats, one of them as early as 9 years of age. They were a very different group from the truants, whose symptoms included a complex of stealing, aggression, lying, and sexual problems. None of the school phobics showed any overt sexual problems and only four were pilferers. Three of these had done some petty pilfering at home and the fourth, who had been in more serious trouble for stealing, was the one boy who in many ways did not fit into our school phobic group. He was the only one of limited intelligence, his school-refusing had begun as truanting, and he was in fact diagnosed as a personality disorder. One of his parents exhibited phobic symptoms and this boy later suffered from nausea and vomiting and 'went to pieces' when he tried to attend school.

As a group these school phobics were of above average intelligence with a mean IQ of 105. Seven had IQs between 110 and 123 on the Full Scale of the WISC and the one boy who did not do an intelligence test was a school phobic who had passed his 11+ and had broken down with his start at grammar school, which coincided with the death of his father. All in all, therefore, as has been shown in a number of

previous investigations, the school phobic child is likely to be of above average ability. This is not to say that their attainment matches their ability but, though we have little evidence of their general scholastic level, we do know that only four (all boys) had reading ages two or more years behind their chronological ages.

Two boys were lost to the survey by the end, having moved from the area, but we had been able to follow them for a number of years. One appeared to improve markedly on changing from a secondary modern school to a smaller private school—a recommendation made during intensive therapy at the child and family guidance clinic, therapy which the mother afterwards described as very helpful. The other boy who could not be followed right to the end had a more chequered history. His mother seemed willing to co-operate with the clinic but, typical of many of the school phobics' mothers, would then suddenly make decisions contrary to the advice she was receiving. She took the boy from the special day school for maladjusted children which he was attending and sent him first to a private fee-paying school, where he failed to attend despite one master's particular interest and help, and so to a secondary modern school where he immediately refused to go in to assembly. In the end he was officially excused from schooling and reached school-leaving age planning to make up his education by correspondence courses. At this point, the family moved and we do not know if the boy ever found or kept a job.

We were able to follow the remaining 15 children to school-leaving age and beyond, and the details which follow refer to these 11 boys and 4 girls, whose original diagnoses were as follows:

12 Neurotic disorders
1 Developmental deviation
1 Personality disorder
1 Psychophysiological (a diabetic)

More than half the children had been first referred for their school phobia at the secondary stage, aged 11+ to 13. Four others had shown disturbance when first at school, aged 5 or 6. One child, much frightened by the religious teaching at a church school, was reported to have been preaching on

the buses at the tender age of 6. Some of the group said that they had been very happy in their junior schools, but they were in a minority.

Although all 15 children were on the books of child and family guidance clinics, not all were taken on for intensive therapy, as for some of them a change of school to a special day school or tutorial unit was found to bring about so much improvement that occasional reviews by a psychiatrist were enough. The great majority, however (12 of the 15), had a great deal of clinic treatment, regular intensive or supportive therapy over a period of years. Five of these had in-patient treatment for part of the time, 3 in a children's unit, and 2 in an adolescent unit. Schooling was available at both units and the adolescent unit gave two boys all the secondary schooling they had, as they lived there for three years.

Most of the 15 school phobics were considered to be more than mildly disturbed. This is reflected in the initial prognoses: 9 Poor or Doubtful, 4 Fairly Hopeful, and only 2 Hopeful.

How then did they get on? Most of them needed special educational treatment for the rest of the secondary phase. Only one girl remained at her secondary modern school, gradually re-establishing attendance by working up from part-time to full-time with the help and patience of an understanding headmaster. All the others used one or more types of special schooling. Twelve attended a special day school or tutorial unit, at some point.

Five were moved to special boarding schools but only one transferred successfully. Three had to be returned to special day schools and the fourth, after truanting four times from his boarding school, was tried at a secondary modern at the age of 12 and never looked back.

Thus 11 of the 15 school phobics finished their school life at schools or units for maladjusted children. Attempts had certainly been made to encourage a return to ordinary school with a number of others, but their acute agitation at the thought showed them to be quite unready, and even temporarily affected their attendance at the special schools or units. Before attendance at these was established, there were, of course, difficulties for many, but with transport

provided (sometimes taxi, sometimes a member of staff) they were helped into a routine and in the much less stressful environment began to cope with schoolwork.

Reports obtained from the special units they attended show that, though a number were probably underfunctioning (of the 7 children having IQs of 110+ only 3 were rated as of above average intelligence on the school form), most were considered to have average to good concentration. Two others were said to concentrate well when interested and only one to have consistently poor concentration. For 'individual effort' the picture was much the same, with 2 boys whose concentration was average marked 'poor' for effort. All the rest were rated average to good.

Four boys were reported as having no friends despite the smallness of the groups in which they were being taught. Others, who had found it difficult to make friends at a large school, acquired some in the more sheltered situation.

Comments by the special schools, where the children's history was naturally well-known and well-documented, include these: 'Easily upset by teasing by his peers—might consequently become a "work-refusal" '; 'School phobic following death of mother and illness'; 'Parents in their 60's, little rapport'; 'Tenuous ability to make social contact'; and 'Disturbance and depression follows discussion of a return to normal school'. Here we have a selection of the well-known factors in school phobia, the insecure, uneasy relationship with the parents, the frequency of a trauma such as death or illness in the family as a precipitating factor, the inability to mix socially and the likelihood of work refusal following school refusal.

It is in this last respect that our school phobics have proved particularly interesting. All had reached school-leaving age by the end of the survey and only one was still at school, planning to take CSE and GCE examinations. At first sight, this seemed to indicate a great deal of wasted talent despite the time and effort spent in the special units, for here was a group of above average intelligence of which all but one had left school with no paper qualifications whatever. What we found, however, was a high degree of job adjustment once schooldays were over. The boy of limited intelligence is

working as a labourer, but of the more able adolescents seven are doing further education and training, one as an Army Junior Tradesman, two on full-time technical college courses, and four others in jobs which include day release or an evening class at the technical college. An eighth has a printing job and is having weekly home tuition. Three others (all boys) have steady jobs in retail or wholesale firms.

This leaves two boys who have failed to find or keep steady employment. One is near-psychotic, and the other is drifting in and out of unskilled jobs despite his above high average intelligence.

This seems a very high proportion of school phobics adjusting to work. Yet they were a group who displayed all the classical symptoms, some very severe, and they came from families where the relationships were typical of school phobics. Nearly all the mothers were over-protective, over-meticulous, depressed and anxious, or ineffectual. Only two were described as 'competent' and 'dominating' but both of these had very odd marital relationships. One was divorced from her husband, but he continued to spend the shore-leave at the family home, albeit in a separate bedroom, and his son was supposed to be ignorant of the divorce. The other couple were not married, and, despite the father's very difficult and violent behaviour at times, often directed against his child, the mother never took advantage of her 'freedom' although herself bewildered as to why she stayed.

As many as 10 out of the 15 fathers were described as inadequate or ineffectual; 2 others had had psychiatric treatment for depression and a 'nervous breakdown'. In the remaining cases, only a very shadowy impression of the father was obtained, suggesting he was far from being a forceful character. It had been observed before that an ineffectual father is often part of the family pattern and here this finding is strongly confirmed. The fathers, in fact, were found to be somewhat more of a kind than the mothers.

To sum up—for the great majority of the adolescent school phobics in this survey, education in a small specialist school was needed for the whole of their secondary school life, combined with psychiatric help. These special schools and units attended by our group seem to have done a good job, in

TABLE 7. **Child guidance group (*N*=88)**

	GROUPS				RESULTS			
	I	II	III	IV	Steady progress on the whole		Remaining unsatisfactory	
					Good and Hopeful	*Fairly Hopeful*	*Doubtful*	*Poor*
Out-patient treatment only (*N*=40)	12	12	11	5	23	12	3	2
Out-patient + special day schooling (*N*=13)	9		1	3	4	5	2 (2 physical disabilities)	2
Out-patient holiday review and special boarding schools (*N*=14)	3	3	6	2	4	5	2 (brain damaged)	3
Probation (*N*=11)	3	1	7		6	1	3	1
In-patient treatment (*N*=7)	5	1	1		1	1	3	2
Approved schools (*N*=3)			3					3
	32	17	29	10	39	23	13	13
					62			

getting the adolescents to mature enough to face up either to work or further education but at a stage later than their better-adjusted peers.

And, although the possibility of a later exacerbation of symptoms in stressful situations cannot be ruled out, the final prognoses were encouraging. Only two had initially a 'hopeful' prognosis but six were hopeful or good by the end, and five were fairly hopeful, all of them showing a marked improvement. One boy remained doubtful and two other

very seriously disturbed children who showed near-psychotic symptoms continued 'poor'.

THE MAIN FACILITIES USED

To make a diffuse picture somewhat clearer, Table 7 shows the main facilities used by this group of adolescents; there was, of course, some short-term overlap in the use of them (which would only be confusing if detailed here), and, as will already have been noted, a few of the children went through the whole gamut of the facilities.

RESULTS

Thirty-five out of the 40 who attended for out-patient treatment maintained steady progress during the survey, 23 having a good or hopeful prognosis by the end, 3 continued to have a doubtful prognosis, and 2 deteriorated seriously.

Of those who had in-patient treatment, who except for 1 were all seriously disturbed, a poor prognosis was given for 2, 3 were doubtful, and the other 2 were fairly hopeful and hopeful respectively.

Of those on probation, 1 did very well indeed, 5 were given a hopeful prognosis, 1 fairly hopeful, 3 remained doubtful, and 1 was poor.

Of the 2 girls and 1 boy who were sent to approved schools, none had been on probation, but they had all had psychiatric treatment previously before they went to approved schools, and all belonged to Group III. The results of special schooling are discussed in Chapter 4.

3

Children referred by children's officers

Fifty-four of the original group of 153 children were in the care of the children's department when they first joined in this study. Only three of these were lost to the survey by the end: one boy, physically as well as psychologically handicapped, died; one boy and one girl moved right away from the Wessex Region, returning to the care of parents, and their contact with the survey team and with the children's department was broken.

NATURE OF DISTURBANCE

The 51 children, 31 boys and 20 girls, showed of course varying degrees of disturbance. There were 15 who were relatively mildly disturbed but who still had a multiplicity of symptoms. There was some discussion as to whether they should be included in the survey but, in the light of their extremely unsatisfactory early years, the instability of their parents and the fact that their own personalities were rather frail, it seemed highly probable that they might become increasingly disturbed during adolescence. The rest (36) were

more seriously disturbed and 14 of these were so damaged that many difficulties were expected during the ensuing years.

Emotional disturbance was shown in behaviour disorders in 20 cases (Group III), nearly as many (18) were acutely anxious, depressed and solitary (Group I), fewer (12) were in Group II, and only one (Group IV) had problems arising from a mixture of organic and psychological factors, he suffered from poliomyelitis which had required much hospitalization when he was very young, and his family was neglectful.

The 51 were subdivided into diagnostic categories as follows:

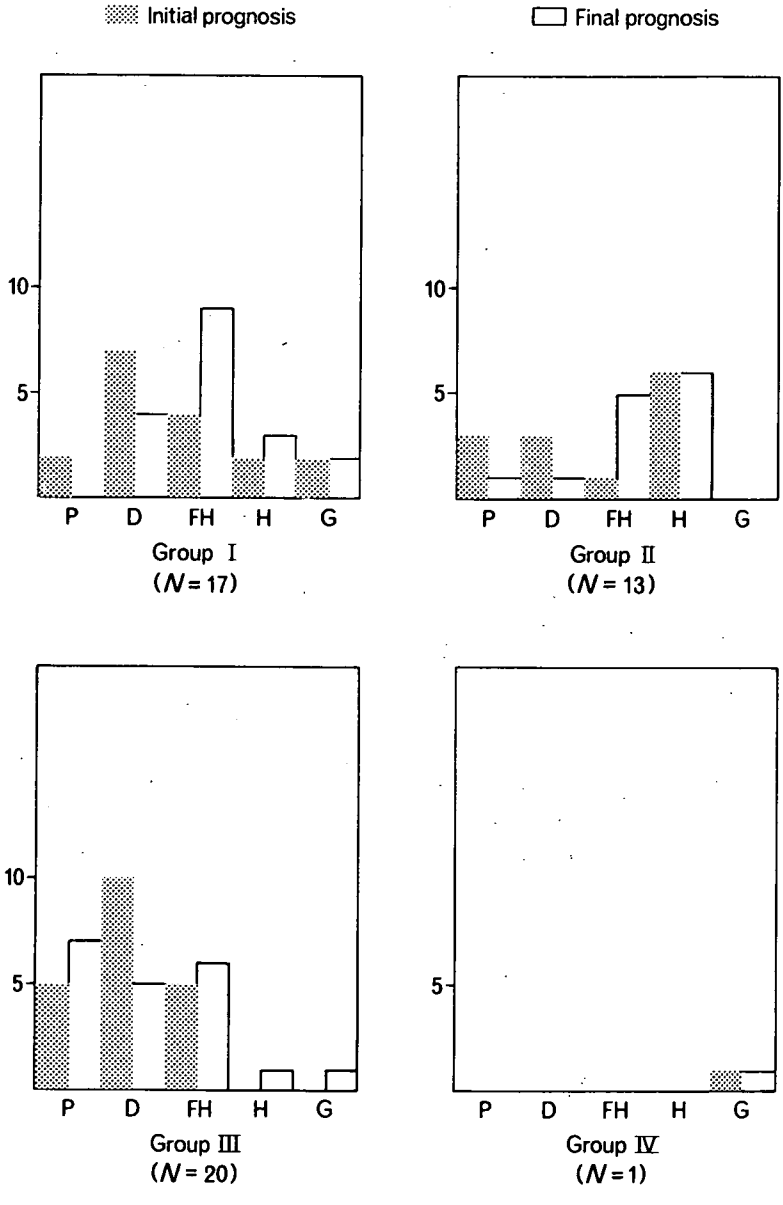
Disorders	*Initial diagnosis*
Reactive	24 (13 boys, 11 girls)
Neurotic	20 (13 boys, 7 girls)
Personality disorders	3 (2 boys, 1 girl)
Psychophysiological	1 (1 boy)
Healthy responses to difficult situations	3 (2 boys, 1 girl)

PROGNOSIS

As in the CGC group, there was general improvement over-all from the first to the final prognosis. Again it was only in Group III that the number of 'Poor' prognoses increased from first to last (see Graph 5).

Quantifying the results, as before, by giving from 1 to 5 points to the prognoses from Poor to Good, the improvement is shown thus:

Group I	Av. initial score = 2·7
	Av. outcome = 3·1
Group II	Av. initial score = 2·8
	Av. outcome = 3·5
Group III	Av. initial score = 2·0
	Av. outcome = 2·2
Group IV	There was only one boy in this group who had a 'good' prognosis throughout.



GRAPH 5. CD children (N = 51)

INTELLIGENCE

All 51 children were tested on the Wechsler Intelligence Scale for Children which makes possible a comparison between their verbal and non-verbal ability. It is generally believed that children in care are backward in linguistic development and, on average, of lower intelligence than the general population.

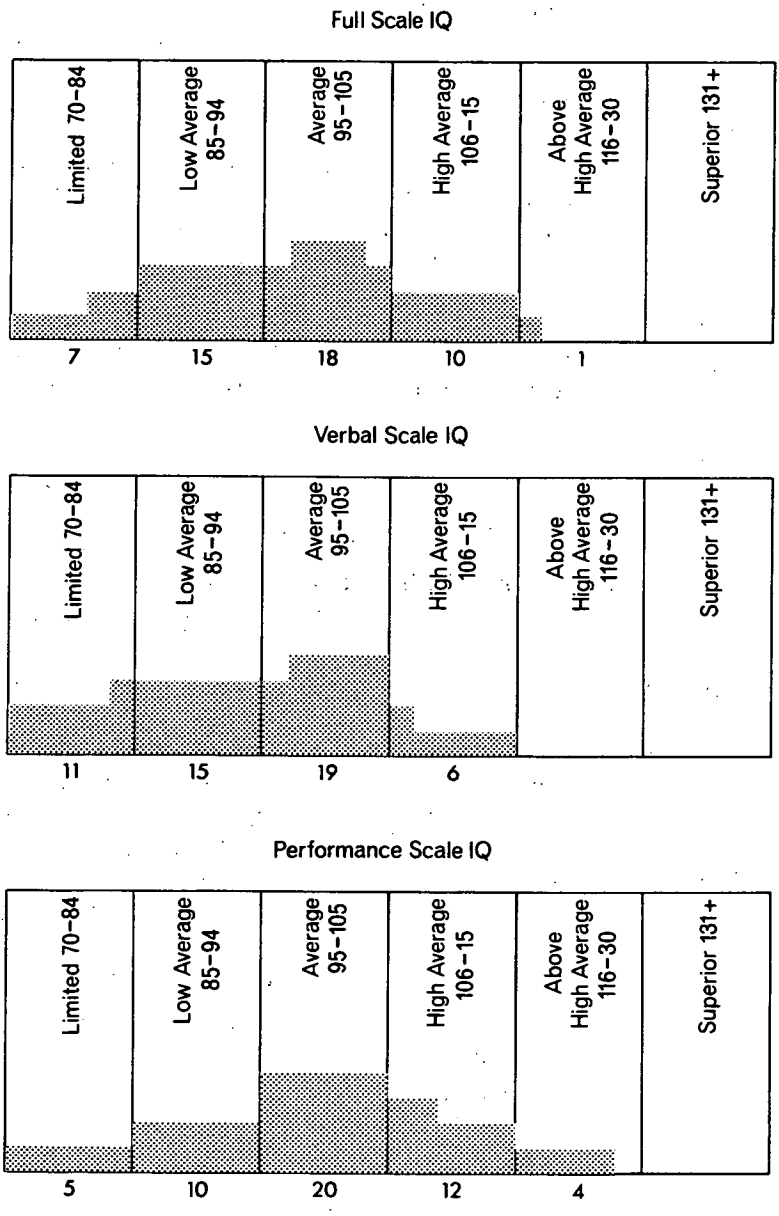
The Full Scale IQs (Graph 6) of the 51 children makes it clear that *twice* as many were of Limited and Low Average intelligence as were of High Average intelligence or above. When, however, the Verbal IQs and Performance IQs were plotted separately, the patterns shown in Graph 6 are seen.

On the Verbal Scale more than *four times* as many children were in the limited and low average range as were in the high average. The Performance Scale, on the other hand, showed an even distribution of scores, 15 below average, 20 average, 16 above average.

The scores were then looked at for each individual, to see in how many cases the Performance IQ was markedly above the Verbal IQ. Exactly one-third of the group of 51 children had a difference of 13 points or more, in favour of the non-verbal tests. In 5 cases the discrepancy was of more than 20 points, the maximum being 38 points. This figure of $33\frac{1}{3}$ per cent compares with a figure of 18 per cent for the rest of the survey group and cannot be related to disturbance as such. Four out of 51 had discrepancies of 13 or more points in favour of the Verbal Scale, i.e. less than 8 per cent compared with 17 per cent for the rest of the survey group. In other words, while the other disturbed children were just as likely to have a much lower Verbal as to have a much lower Performance IQ, the children's department children were more than four times as liable to have a much lower Verbal IQ than to have a much lower Performance IQ. This finding is in common with many similar studies of children who have come into care, and of children whose parents have a limited and very concrete vocabulary.

Poor reading

It was expected that, with their tendency to do badly in verbal tests, these children would prove to be particularly



GRAPH 6. CD children (N = 51). WISC results

backward in reading. This was not the case. The proportion of children in the children's department group with reading ages 2½ or more years behind was very similar to that of the child guidance group (23·5 per cent as against 22·7 per cent). What is more, there were proportionately less children's department children who were severely handicapped (four years or more retarded), the percentages being 5·9 per cent of the children's department children as against 13·6 per cent of those who came from the child guidance clinics. To sum up, no disproportionate number of poor readers occurs in the children's department group despite the large number with unsatisfactory early histories and evidence of verbal deprivation. Poor reading in the group as a whole is further discussed in the school chapter.

HOME BACKGROUNDS

Early experiences and parental state

Table 8 shows the early history of these children, grouped according to the criteria set out in Chapter 1. Ninety per cent of the children's department group had unsatisfactory or highly unsatisfactory early histories, which is what one would expect. Twenty parents had been admitted to mental hospitals, seven for many years. And thirteen had served prison sentences, the reason in some cases being for neglect and cruelty to their children.

Unlike the child guidance referrals, these children were mostly not living at home but were in varying substitute homes, which were as follows:

Living with one or both parents	8
Living in a foster home	18
Living in a family group home	16
Living in special children's department hostels for maladjusted children	8
	51

These are described in some detail as they form to a large extent the facilities available for this group of children.

TABLE 8

Highly Unsatisfactory	*Unsatisfactory* (a)	(b)	*Assumed Satisfactory*	*Not Known*
35	7	3	1	5

a. The nine children living at home

Only one of the nine children living at home with one or both parents had been in the care of the children's departments for any length of time. The rest had come in to care owing to fairly recent events such as a marital break-up, mental illness in the family, or for the child being beyond control of his parents. Three remained at home throughout the period of the survey. Of the remaining 6, 2 went to family group homes, 2 went to approved schools, and 2 went to special hostels for maladjusted children, 1 at 14 and 1 at 16 years of age.

b. The eighteen children in foster homes

Only 3 of the 18 fostered children had been with their foster parents from early infancy. Six remained in the same foster home throughout the survey; 3 of the fostered children went home but one after a short period had to be moved on to a special hostel for maladjusted girls. Seven had to be removed from their foster homes as they were too unsettled to remain, and the other 2 left their foster homes owing to illness in the foster parents.

As would be expected it is among these children that contact with their own parents was minimal. Nine of the 18 had no contact at all, 3 had only very rare visits from one parent, while 6 had continuing contact with one or both parents. Of the 9 children who had some contact with their real parents, 7 of the foster parents thought these contacts upset the children, especially where the contact was only occasional. They thought this made the children very

insecure. And, where contact was more frequent, with a strong likelihood of going home, most foster parents felt that the resulting division of loyalties was a great source of conflict for the child.

Most of the foster parents welcomed visits and advice from the child care officers. The three exceptions all had difficult children and were unreasonably disappointed that there was no immediate improvement in the child's behaviour after the CCOs visit. One point that emerged clearly was the marked preference of foster parents for older CCOs. It should be remembered that all the foster parents in the survey were dealing with teenage children, and this may have contributed to their feeling that a young man or woman must be inexperienced in understanding the problems that arise when children begin to grow up and the generation gap becomes more marked.

Three of the foster parents commented on the financial aspect, feeling the payment was inadequate for a child who had reached its teens and needed so much in terms of food, clothing, and equipment.

c. The sixteen children living in family group homes

The smallest of these homes took 7 children and the largest just under 20. All had a large age-range of both sexes, some having pre-school children and some only children over 5. The smaller homes were run by married house mothers whose husbands went out to work elsewhere, with daily help from outside, and the larger specialist groups were run by married couples, both working full-time, with usually at least one resident staff and daily help. Two of the larger homes were converted houses in middle-class areas; the rest were purpose-built houses sited in council estates. Very few of the group homes had individual bedrooms for the children in care, though many house parents would have liked one or two; the largest 'dormitory' in the group homes used by children in the survey had seven beds but most bedrooms were smaller, sleeping only three or four. A number of the house parents would have liked more play space for the

children both indoors and out, especially in the smaller homes which had only a sitting- and a dining-room as public rooms. Twelve of the 16 children had arrived after the age of 9, and the 4 others had come between the ages of 6 and 8.

Two children only remained in the same family group home throughout the survey. Of the remaining 14 followed through, 6 went home but one later had to be transferred to a working boys' hostel. Three were fostered, 3 went into lodgings or hostels when they left school, and 2 had to be sent to special hostels for maladjusted children. Finally it should be noted that out of the 16 children in this section, 5 had 3 or more different places of residence between the ages of 12 and 16, and 9 had two changes of address.

All except one of the 16 survey children in these homes had fairly constant contact with one or both of their parents and the one exception had had several unsuccessful attempts at placement between the ages of 7 and 12 and he was refostered from the home. Unlike the foster parents, nearly all the house parents welcomed visits from and to the parents, though many complained bitterly of the real parents breaking promises to send presents, forgetting birthdays and Christmas, and cancelling, often at the last minute, plans to have their children home for weekends or holidays.

Many of the house parents wished they were allowed to keep the children in their care for a longer period after they began work. They spoke of the difficulties children faced when they were moved out into lodgings or hostels, for, unlike children brought up with parents or foster parents, these children were unused to hearing ordinary family talk about budgeting and what could or could not be afforded in the way of holidays, clothes, and luxuries. Children in family group homes have little chance of acquiring money sense as all the things they need appear to them to come from an unreal institution which they vaguely refer to as 'The Welfare'. It is interesting that a number of CCOs and house parents in charge of children who seemed unlikely to go home consider the Armed Services and the Merchant Navy the best careers for these children for this very reason that they would find it difficult to hold their own in a less structured environment.

d. The eight children living in special homes for maladjusted children

When first taken on in the survey, 8 children were already resident in special homes for maladjusted children. They were distributed between 3 such homes, 2 of which were run by the children's department: 4 were in a home for boys who were known to be antisocial in their behaviour and unlikely to settle either in foster or family group homes; 2 boys and 1 girl were in a mixed hostel for children needing psychiatric help; and 1 girl was in a special hostel run by a local education committee. Five of these ultimately went home; 1 went to an approved school and 2 to a special unit for adolescents. The girl in the hostel run by an education committee was transferred when she left school to a small hostel for difficult girls.

CLINICAL STATES OF THE CHILDREN

1. Reactive disorders (24)

Sixteen of these 24 became increasingly settled and free from symptoms as adolescence proceeded, 4 of whom were entirely free from any sign of disturbance by the end. In 5 cases the outlook remained somewhat doubtful, and 3 who started with a doubtful prognosis became increasingly disturbed throughout the survey. All 3 of these had lived in appalling conditions of neglect and marital discord when very young and were continuing to live in unhappy environments. One of them, an illegitimate child who was removed from her mother by the NSPCC at the age of 3, had a succession of foster homes, and in the last one was aware of discord leading to a divorce in the home which took place when she was 14. She never had any chance of identifying with any stable adult and certainly during adolescence was proving to be quite beyond any hopeful response to treatment. One can foresee her deteriorating into a frequent inmate of a prison or a psychiatric hospital.

The other two boys eventually went to approved schools and were returned to their highly unsatisfactory homes and broke down into delinquency again. In both cases these boys

would have had a better chance had they lived in hostels and not gone home after leaving school.

2. Neurotic disorders (20)

Twelve of these responded well, 5 having had psychiatric treatment, 3 benefiting from hostel placements. Of the 4 who did least well, 1 boy who was living in the depths of the country urgently needed psychiatric help of some sort but did not get it; 2 others were difficult and unco-operative about the facilities available to them, but they just might have responded if admitted to the new unit not yet open. The story was the same again for them: they had all been brought up in highly unsatisfactory conditions and continued in unsatisfactory environments for many years. The fourth, whose final prognosis was poor, had done well until he became involved in drug-taking when he rapidly deteriorated.

3. Smaller groups

a. Personality disorders (3)

Of the 3 initially diagnosed as personality disorders, 2 somewhat unexpectedly improved and became more stable, but the third rejected all efforts to help him and eventually went to an approved school and has, since his discharge, been involved in more delinquent behaviour. He had many moves as a toddler to nurseries and back home, and then came to live at 2 years with foster parents who were alternately indulgent and harshly critical, and themselves on the defensive about having psychiatric help for the boy.

On looking back, there were at least 5 or 6 diagnosed as reactive or neurotic who by the end of the survey were clearly chronically damaged personalities, and would by then be diagnosed as suffering from personality disorders.

b. Healthy responses (3)

Of the rest, the boy who suffered from crippling after-effects of poliomyelitis did well at a special grammar boarding school. He was an intelligent boy and, although he had conflicts over his family's attitude to him, and was given to

TABLE 9. **Main facilities used. Children's department children (*N*=51)**

	GROUPS				RESULTS			
	I	II	III	IV	Steady progress on the whole		Remaining unsatisfactory	
					Good and Hopeful	*Fairly Hopeful*	*Doubtful*	*Poor*
Out-patient treatment only (*N*=11) (5 seen for consultation only)	1	5	5		5	2	3	1
Out-patient + special day schooling (*N*=4)	2		2			4		
Out-patient holiday review and special boarding schools (*N*=5)			5		1	1		3
Remand and approved schools, attendance centres, etc. (*N*=7)	1	1	5			1	3	3
In-patient treatment adolescent unit (*N*=2)	1		1		1		1	
No psychiatric or special educational facilities (*N*=22)	12	7	2	1	9	9	3	1
	17	13	20	1	16	17	10	8

temper outbursts accompanied by an astonishingly obscene repertoire, he did very well indeed at school and in adjusting to his physical handicaps.

The three adolescents who were showing a healthy response to adverse situations also did well. The three had

been contending with a number of difficulties in their environment and reacted to them with behaviour which was 'normal' and thoroughly understandable. For example, one boy was, when first seen, solitary, friendless, given to outbursts of temper, was very restless and very dependent on his foster mother. He changed markedly on leaving this foster home which was an eccentric one where a lot of nagging went on and to which no child would want to bring friends. He had been in it since he was a baby and it had given him security, but it was stifling him in adolescence.

RESULTS

Of the 51 children in care, it will be noted that 33 made reasonably good progress during the survey, leaving 18 whose prognosis was less satisfactory, 8 remaining seriously disturbed—one of these had no more than a consultation although he was a very neurotic boy.

Of the 22 who had no psychiatric or special educational facilities:

13 were in foster homes (all or most of the time)
6 were in family group homes (all or most of the time)
2 were with one or other parent
1 went to boarding school for the physically handicapped.

The outlook, as will be seen from the above table, was good for all of these except 4, 3 of them having a 'doubtful' and 1 a 'poor' prognosis.

It was of some interest in regard to these adolescents that those who progressed most satisfactorily during the period of the survey were those who remained secure at one address—these numbered 11. This was in part because they were not as difficult or were less disturbed than some of the others, but the very disturbed were moved around many times, each move seeming to lead to further instability and failure.

Some conclusions about these children in care, about the role of the psychiatrist and the available psychiatric facilities will be further discussed in the final chapter.

4

The survey children in school

INTRODUCTION

The survey children attended a variety of schools: state secondary modern or grammar schools; private day or boarding schools; and special schools or units, both day and residential. Those selected for special educational treatment were, of course, known by their schools to be disturbed, but we were interested in finding out if the ordinary schools were aware of a child's disturbance.

To this end, a school form was produced which stated that the pupil named had agreed to take part in an adolescent survey. Straightforward assessments on a three-point scale of intelligence, reading ability, etc., were asked for, together with judgements of the child's concentration and individual effort. Parental encouragement, social ease, and friendships were covered and the form ended by asking whether it was felt that the school catered for the child's particular needs and whether the child had any specific disability or problem.

Where possible, these forms were taken personally to the schools so that the head teacher could be asked about the facilities provided for the 12-18 age-group, particularly on

the social side. Head teachers were immensely co-operative and willingly gave time to answer these questions, often combining this with a conducted tour of the school. In this way, over fifty schools and units (with up to five survey children each as pupils) were visited. Great care was taken not to state or imply that any survey child at an ordinary school was emotionally disturbed or maladjusted, though, where the head was fully aware of clinic attendance or remarked on known behaviour difficulties, this was acknowledged.

All the school forms personally delivered were later returned by post. One hundred and sixteen forms were obtained out of a possible 139, representing 83 per cent of the children. In seven cases, parental permission, which was always asked for first, was withheld (chiefly for the children at private day and boarding schools) and the school was not approached. In a few cases, a school form sent by post to a boarding school at a distance was never returned. The other 'blanks' were because of changes of school, temporary loss of contact with child and family, or a move to approved school. The forms were filled in when the children were between 14+ and 16, as near the end of their time in school as possible, a notoriously unsettled stage.

The emotionally disturbed child is sometimes unable to settle to school work. In other instances, however, the child may feel more settled and secure in school than anywhere else. Just over a quarter of the survey children were said to have poor concentration and the same proportion exactly (though not always the same children) were marked 'poor' for individual effort. A few in each category were said to be extremely variable, according to mood or interest.

Also from the forms it was found that just on 19 per cent of the schools did not give an unqualified affirmative when asked if they could cater for the needs of a particular child. Where the answer was 'No' it was usually for non-educational reasons (9) but in a few cases (4) for educational reasons. In a further 9 cases the answer was a qualified 'Yes' and in all these instances the social and emotional aspects were those about which there was doubt. Only one such reply was received from a special school.

The special schools and units are facilities often used along with or as an alternative to child guidance clinic treatment. The ordinary schools do not aim to cope with real disturbance but various writers, both medical and educational, have pointed out that they could play a greater part in helping children with their problems, as the school is often the most constant feature in the child's life. Ideally this help should come at a much earlier stage than the secondary one and few of our children showed problems first in adolescence but it is still of interest to see what the attitudes of the schools are. As far as the special schools are concerned, the chief interest is in the extent to which they carry out their function.

The different types of school are considered separately in the following sections.

SPECIAL DAY SCHOOLS AND HOME TUITION

For children who are phobic about school attendance or have been excluded from their ordinary schools, there are various types of non-residential special schooling. In this category we include home tuition. Of the two cities in the Region, the first has one day school for maladjusted children, which at the beginning of the survey provided only part-time schooling and about two years later changed to full-time schooling on four days a week. The other city, of comparable size, has a much greater variety of provision, with two day schools for maladjusted, one specializing in withdrawn and phobic children, plus tutorial units for adolescent boys and girls who would not fit into the special day schools. In the county, special day school provision is not generally available—the size of the area and difficulties of transport make this type of unit less easy to provide, although there was one in a county town, attended by a few of the survey children.

Twenty-four of the 139 children made use of these facilities in the course of the survey. Half were school phobics, most of whom spent their entire secondary phase at a special day school or tutorial unit. The section on school phobics has summarized the very satisfactory results. Only three of the school phobics had criticisms of this type of schooling at the end—they complained that the units were

too easy-going and that academically they were allowed to drift, but all were later undertaking further education.

Four boys spent only a few months at a special day school, three until a place was found at a boarding school for maladjusted children. There are usually some temporary placements of this kind in the special day schools. Home tuition, too, is generally used as a temporary measure. Three of our children had some home tuition. One girl had been excluded from two secondary modern schools and proved very difficult in a special hostel where she had been placed by the children's department. Her home tutor despaired after a few weeks and the girl then waited without schooling until she went to an approved school. The two boys who were given home tuition had missed a great deal of schooling because of hospitalization and were very backward in attainment. One had a congenital heart defect and had been at a boarding school for the physically handicapped. The other, a boy with severe facial burns, had many skin-grafting operations over the years. When in school he was very aggressive and abusive. Short though the period of home tuition was for these two, their mothers mentioned it as the most helpful of all that had been done for them.

The remaining six children shared many symptoms. All were given to aggressive outbursts and were defiant of authority. Their aggression was largely in response to provocation, particularly in the case of the three boys, who were rejected children with very unsatisfactory early histories. Only one of them was with both his natural parents, but in his early years he had been left in the care of an ayah and later with relations. Two girls had been adopted by maternal aunts, one having been summarily abandoned by her mother, the other having suffered from her mother's recurring bouts of psychosis. A problem family lay behind the third girl, with her step-father in prison, and her mother having no real affection for her.

All six children were severely disturbed, with Doubtful or Poor prognoses. Three had a final prognosis of Poor—a girl at approved school, a boy on probation for drug-taking, and another boy who was out of work and appealing for help to the mental health centre. The others ended with Fairly

Hopeful prognoses. One girl changed unexpectedly when she attended a tutorial unit for adolescent girls run by a very remarkable teacher. She had been particularly difficult before, having been expelled from three schools. Her improvement became decisive when she entered a hostel run by this same teacher, and lived away from her problem family. Another, a boy, who at an earlier stage had made violent assaults on various house mothers, spent three-and-a-half years at a special day school while living at a hostel for maladjusted boys. He began to show an improvement in his final year and, on leaving school, trained as a chef satisfactorily. He stated that he had found the special school very helpful.

Although a quarter of the children having special day schooling were children's department children, all had been seen at child guidance clinics, where the initial assessment and recommendations were made about their special educational needs. None of the school phobics was a children's department child.

The special day schools are, therefore, in the long term helping the school phobics and the withdrawn neurotic child as well as the acting-out children with behaviour disorders. They seem to be very successful with the former group, taking adjustment to work or further education as one measure of their success. With the aggressive group, too, they do a good job but in a more limited sense. They cope well with these children who cannot be tolerated in ordinary schools and not only contain them till school-leaving age is reached but also teach them something. Unfortunately there is often no lasting effect. Half of our small group of aggressive children broke down on leaving school whereas only one school phobic was unemployable out of the fifteen, and that was because he was pre-psychotic.

RESIDENTIAL SCHOOLS

Residential schooling was recommended for more than a quarter of the final group of children. Places were never found, despite repeated attempts, for five of those for whom the recommendation was made and three of these children

later went to approved schools. We found that places are refused for various reasons apart from the genuine 'no vacancies'. Children can be turned down for being too disturbed, of too low intelligence, or of too great an age. Schools have to maintain a balance by taking only a certain proportion of children with one type of disorder—one experienced head, for example, said that only about half-a-dozen really aggressive children could be tolerated in a community of fifty.

Finding the right school with a vacancy at the right time for a particular child is therefore not easy, and this has to be borne in mind when we consider the results achieved by the twenty residential schools which accepted thirty of the survey children.

Four of these schools catered for physical handicaps—two handicapped children remained happily settled until leaving school; two others improved enough to return to ordinary day school. With all these children, their maladjustment was related to their handicap.

Of the other residential schools attended, all were specifically for maladjusted children, except for four private schools which took a proportion of maladjusted pupils. Twenty-seven children went to these schools, and eight of them did well, finishing their schooling there. Some of these had survived difficulties—one boy was excluded for a time and threatened with expulsion for persistent smoking in the dormitory (a real fire hazard in an old building), but he went back and was later reported to be running a dormitory 'with unquestioned authority'. Another boy was asked to leave one special school for maladjusted as he was considered to need a school with psychiatric help available—on being moved to a school which catered for serious emotional and psychological disturbance, he was greatly helped. Yet another boy who did particularly well was at a school not recognized by the Minister of Education and there was some doubt as to whether the local authority would allow him to remain there. In the end it was agreed that he could stay to sit his O-levels, a remarkable achievement for the school with a boy who had been taken on as of limited intelligence and four years retarded in reading, besides being maladjusted.

So much for the undoubted successes: but less than one-third of the twenty-seven is not a very encouraging proportion. What of the rest? Five children who were sent to residential schools never settled down and were taken away. In a couple of cases of this kind, the schools had deteriorated and the children's complaints of poor standards of food, hygiene, and discipline were justified. The others were just unhappy at being away from home. Three other children were removed because it was felt that the schools were no longer benefiting them, and a different type of schooling was tried.

Eleven children out of twenty-seven, however, were either formally expelled or 'asked to leave'—eleven children who were known to be maladjusted by the schools which accepted them, whose history was known in detail, whose intelligence and attainment had been assessed prior to placement, and whose type of disturbance was well documented. Most had severe behaviour problems and, when seen for the project, the great majority had initial prognoses of Doubtful or Poor.

Two girls who were accepted by private boarding schools were expelled within months for being a disturbing influence, talking sex, threatening violence, and absconding. The other children, all at schools for maladjusted, were expelled or asked to leave for a variety of reasons, all adding up to the fact that they could no longer be contained. Their misdemeanours included pilfering within the school, organizing crime outside it, indulging in bullying and extortion, or in homosexuality. In a number of instances, although the real reason for the expulsion was clearly a failure to cope with the child's disturbance, in formal letters to child guidance clinics or other agencies concerned in the placement, face-saving explanations were given.

One boy was said not to be suited by the four-term system of his boarding school, as the school's work was undone by his lonely drifting in the holidays, while both parents worked and local children were at school. Another school regretted its lack of specialist teachers in science and mathematics for a boy who needed O-levels in those subjects to enter his chosen career—earlier complaints about the hostility shown by his parents to the school, his obsession with sex, and the fact

that he constituted a fire risk because of his perpetual smoking had not led to his removal, but the 'educational' gambit worked. In two other instances the same excuse was offered and the children asked to leave—a girl who was being very difficult, with sex problems, in a mixed school, was told that there were 'no facilities for her age-group' because of reorganization; a boy, whose constant pilfering had so enraged his peers that he was felt to be in danger of being beaten up, was not removed until the school added that their academic standard had proved to be too high for him.

It is difficult to see how selection can be improved. As with many of the other groups, there is often nothing to distinguish between those who do well and those who do badly. Children with similar problems, coming from equally bad backgrounds are to be found at the end among the successes as well as among the failures. Residential schools for maladjusted children earn a reputation for dealing with a certain type of child, a reputation which can be quickly lost by overloading the school with such children, or merely by changes in the staff, for the personal element in their success is paramount.

Where the children did well at the residential schools, they and their parents commented enthusiastically: 'the school did wonders', 'it was excellent', 'very helpful', 'great', 'I loved it'. Even one or two who had been asked to leave were generous enough to praise what the school had done for them, and not all the 'failures' were given poor prognoses at the conclusion of the survey. Nevertheless, the proportion of placements which succeeded seems unsatisfactorily low.

THE APPROVED SCHOOL GROUP

Nine children during the course of the survey were sent to approved schools, 5 aged 14 and the rest aged 16. There were 5 boys and 4 girls. Six of them were from the children's department group but all of these had been referred to the child guidance clinic by the age of 12, so all the approved school children had been already seen by a psychiatrist.

As would be expected, they all showed behaviour problems of an antisocial nature with the girls in particular

becoming sexually involved which made earlier placement difficult. Two boys had persisting problems of homosexuality and another was interfering with small girls.

They had, with one exception, had Highly Unsatisfactory home backgrounds in their early years. To list them makes appalling reading—two violent fathers, a psychotic mother, a mother who was prosecuted for keeping a brothel. Four sets of parents were separated or divorced by the time the child was 4, one father died when the child was 2, and in two other cases the child was permanently fostered or adopted by the age of 2. This leaves only two boys who were living with both natural parents beyond the age of 2 and one of these was with a violent father who beat his wife and his son for years before finally leaving home. The other was the only child whose home background was not Highly Unsatisfactory in the objective sense but it was rated Unsatisfactory in terms of the family relationships—this boy had a father who quite openly showed his dislike for his son, and a mother whose relationship with him had been unsatisfactory from the start.

After consultation at the child guidance clinic, very few of these children were taken on for treatment as they were not felt to be accessible to therapy. Two of the group had spent three months in a children's in-patient unit at age 11, and another at 13 had spent two months at an adolescent unit, but only one other had regular therapy for any length of time.

Four of them, however, had been tried at boarding schools in the course of the survey, two boys at a residential school for maladjusted, and two girls at private schools which accepted a number of maladjusted pupils. Both boys were asked to leave before they had reached school-leaving age. The girls stayed for even shorter periods before being expelled. Two others, a boy and a girl in the care of the children's department, had been removed from home to hostels at the age of 11 or 12 and from these attended ordinary day schools until sent to approved schools.

In nearly every case the approved schools were used as a last resort, more to contain the child than help him. An exception was one boy whose child care officer said that the real help given by the approved school had been wasted

because he returned to a very unsatisfactory home and quickly deteriorated. For all the others, too, the outlook seems poor. Four are still at their approved schools but one boy is not at all well placed and is not getting the psychiatric help that was recommended. Another, who had been sacked from four jobs in quick succession before going to approved school at 16, remains seriously retarded in spelling and arithmetic and has fears of going mad.

Of those who have left their approved schools, one girl is about to bear the illegitimate child of a drug-peddler; two boys have been involved in stealing or housebreaking since they returned home; a third is out of work.

These children make a particularly difficult group. Their parents, if they are still with them, mostly fail to co-operate in treatment. Milieu therapy is more liable to be used than psychotherapy, but even special schools for the maladjusted seem unable to cope with the behaviour problems these children present. An adolescent psychiatric unit found one girl too disruptive of the community to keep. Ordinary schools quickly reach the stage where, in the interests of the majority of their pupils, they feel that these disturbed children cannot be tolerated. It is possible that, if removed sooner, the children might have benefited more. All these children had reached the age of 11 or 12 before residential placement was provided but, as has been shown, they had all suffered emotional damage and shown disturbance at a much earlier age.

STATE DAY SCHOOLS

Ninety children were at ordinary schools throughout the survey, 7 at private schools and 83 at secondary modern or grammar schools. It is with the latter that we shall concern ourselves in this section. They represent nearly 60 per cent of the survey children.

At the time of the survey, the state secondary schools in the Region were many of them involved in a change-over to a comprehensive system but our children were old enough to have been selected throughout the Region by the 11+ examination and almost exactly 10 per cent had qualified for a grammar school place.

School forms were completed for 76 of the 83 children, just over 90 per cent. Forty-seven were children referred by psychiatrists and 29 were children's department children.

In the school forms 14 children were mentioned as behaviour problems and not surprisingly all but three of these had been classed as having Group III symptoms. It has long been realized that the aggressive, disruptive and antisocial child is an obvious problem in school because his behaviour affects others, whereas the inhibited, withdrawn child is often a problem only to himself. This, however, has now been said often enough to have alerted teachers to the quiet, anxious child. Eight children altogether were described as 'extremely reticent', 'secretive and withdrawn', or in similar phrases. Five were stated to be truanting, all but one of whom were children's department children. (There were in fact many more truants than this.)

For two-thirds of the children's department children, no problems in school had arisen. For 13 out of the 29, however, a mention was made of the fact that they were fostered, in care, or had difficulties at home, though the section on the form was not phrased to imply that information about out-of-school problems was sought. Seventeen out of 47 child guidance clinic children were said to have problems at home, ranging from 'an abnormal and unhelpful home situation' to a mere mention of the parents' unco-operative attitude to the school. This lesser proportion of home problems is balanced by a higher incidence of school problems—only half the child guidance children had shown no problems or disabilities worthy of mention.

The school forms were, of course, completed towards the end of the survey when many of the children were felt by the survey psychiatrist to be improving and the great majority of those who were said to have no problems had final prognoses of Fairly Hopeful, Hopeful, or Good.

What did seem surprising, however, was that in very few cases was a child stated to need remedial help—the number of backward readers among the survey children was startling, and the following section considers this problem in detail, together with the assessments of intelligence given by the schools.

POOR READERS AND THE ASSESSMENT OF THEIR INTELLIGENCE

By any reckoning, the number of poor readers in the survey was extremely high at 32, i.e. 23 per cent of the final group, who were 2½ or more years behind the average for their age in reading. (This proportion was even higher in the original group as half of the 14 children lost to the survey were 3 or more years retarded in reading.)

Of the 32 poor readers, 20 were in the child guidance group and 12 in the children's department group, almost identical proportions of each. Boys were as usual in the majority, making nearly three-quarters of the total.

Only 4 of the 32 children had IQs in the Limited range on both scales of the WISC. A further 8 were not above Low Average on either scale. This means that 20 children had an Average IQ (95 or over) on at least one scale of the WISC and 8 of these (one-quarter of the poor readers) were Average or above on both scales. These 8, the most intelligent of the backward readers, were all boys and included one who was Above High Average on both scales of the WISC and 3½ years retarded in reading.

On looking more closely at the discrepancies between scores on the Verbal and Performance Scales, it was found that three-quarters of the poor readers had a higher score on the Performance Scale and it is tempting to relate their reading backwardness to poor verbal ability. Despite the general trend, however, most of the discrepancies were not of a significant size, and where they were, the child guidance and children's department children showed very different proportions.

Fifty per cent of the poor readers from the children's department group had significantly higher Performance IQs, but this was true of only 15 per cent of the child guidance poor readers, and it was the child guidance group which contained most of the really severely backward readers.

It appears, then, that, as the high proportion of reading disability cannot be explained either in terms of low IQ or more specifically in terms of low Verbal IQ, we are left with what the two groups have in common—emotional disturbance

or maladjustment. There was no obvious relationship with type of disorder or with symptom groups. Month of birth was checked to make sure there was no preponderance of children who might have been summer entrants.

All the poor readers were already attending secondary schools at the time they were tested and, as nearly half of them were as much as four or more years behind at this stage, they simply did not have the reading ability to cope with a secondary curriculum. A number of them were very unhappy about their reading and would have welcomed more help than was provided.

From the school forms, we find that seven of these children were wrongly considered to be average readers. All the rest were correctly classified, so on the whole we can be sure that the poor readers will be picked out. What is of more concern is that in only two instances were children who had been rated Below Average for reading rated higher than that for intelligence. Reading failure at the secondary stage seems to cast a shadow, so that the poor reader's general ability is underrated and he is not thought to be under-achieving to a marked extent.

The schools' intelligence ratings were compared with the WISC results and were found in most cases (22 out of 32) to agree more closely with their Verbal IQs, which, as has been emphasized, were below the Performance IQs of most of them. Is it lack of general verbal ability which colours the judgement rather than poor reading? There was an equal number of children with similarly discrepant results on the WISC who were not retarded in reading. When we look at how their intelligence was assessed we find that they are much more likely to be credited with a level of intelligence midway between the discrepant Verbal and Performance IQs, or with intelligence at the level of the higher, non-Verbal IQ. So it does seem that, if a child can read adequately, deficiencies in his general verbal ability are not nearly so noticeable and intelligence in the more practical sphere is more readily noticed.

This finding seems very important and we did feel that the really backward readers were not given adequate individual help. Children of high intelligence could spend years in a

remedial class at the secondary stage where, grouped with the dull non-readers, their special difficulties were not identified, far less solved. Teaching reading at the secondary stage is a very hard task and as by that time most children have a sense of failure the emotional element complicates matters.

Poor reading may well have increased the maladjustment of some of the children in the survey—after all, nearly a quarter of them were suffering in this way.

The recommendation we would make is for reading failure to be taken very seriously indeed at a young age. Money spent on intensive and individual remedial help at the age of 7 or 8 would be money well spent, not only enabling the child to benefit from his education at the secondary stage, but also helping his general adjustment and self-confidence. The fact that so many of our disturbed adolescents had reading problems makes us wish to emphasize strongly the emotional aspects of reading failure, which can aggravate emotional disturbance and be thereby aggravated.

5

The whole group discussed

The aim of this survey, as has been already stated, was to follow a group of disturbed or maladjusted adolescents aged 12 or 13 for a period of four years, mainly to find out what treatment facilities were available for them, what use was made of them, and where there were gaps. In the course of the study information was obtained about their early formative years, the attitudes of their parents, at what age their disturbances had caused most distress, and whether adolescence as applied to this group was a particular period of turmoil or not.

Other points of interest also emerged, some quite incidentally, which raise more general issues about adolescent attitudes and needs. The subsections will deal first with physical aspects, then schooling, and finally the emotional factors.

CERTAIN PHYSICAL ASPECTS

As has often been commented upon by other observers, we found the years between 12 and 17 seemed to be quite

remarkably healthy. Even at the height of an influenza epidemic, few of our youngsters caught it, and then only very mildly. Three of five boys who had undescended testicles were operated on during adolescence, and four were circumcised between the ages of 10 and 15.

Of the girls, all but one were menstruating by the end of the survey, the average age of onset being 13 years, and only two had complained of any discomfort. Four girls became pregnant, one had an abortion. None was married.

Many of these adolescents had taken part in discussion or had talks about physical development and sex in their senior schools which they accepted quite equably. In almost every case, however, they were given this too late for most of the facts, however garbled, were well-known to them already, especially by the age of 14 or 15 years.

At the beginning of the survey 22 children, 12 boys and 10 girls, were reported to be having sexual problems; several of the boys were preoccupied with female attire or were homosexually seductive—by the end some of these preoccupations had apparently been grown out of, but the girls remained promiscuous and at least 4 boys were continuing to be homosexual.

At least 5 others had been known to have been interfered with sexually before the age of 11, with subsequent ill-effects on their attitude and behaviour.

There were undoubtedly many more with sexual problems, but questions on this topic were not asked during the survey since it was unlikely on a once-yearly interview that accurate replies would be given.

The majority were at co-educational schools, and preferred this—'it was more natural'.

Twenty-five of the 139 were enuretic and/or encopretic at the start (16 of these being child guidance cases), only 3 remaining so by the end. This is considerably above the figure of 5 per cent by the age of 10 which Meadow stated as the norm for the general population.

At least 50 per cent were smoking by the time of their final interview, some from the age of 10; rather more children in care were smoking than those referred by the psychiatrists. It was also reported that more of the former

group had abnormally hearty appetites, suggesting oral deprivation—and 75 per cent of these children had bitten their nails as against 50 per cent of the child guidance group.

In regard to recreational activities, the sea and swimming baths were fairly accessible in Wessex and 93 of the 139 got a great deal of enjoyment from swimming. Twenty on the other hand actively disliked the thought of it, 2 or 3 being phobic about the water. About 40 per cent of the total group complained in no uncertain terms about boredom and longed for more sports, swimming, and dance centres. With the exception of those living in the two cities, these facilities were not easily available or there were great difficulties in transport which prevented them from being normally enjoyed in the evenings. Those who were not bored were mostly taking higher exams. In discussing sleep habits, it was surprising how many complained of their inability to get to sleep, and almost as many of frequent nightmares. At least 90 out of the 139 complained of these sleep disturbances at their first interview.

EMOTIONAL DISTURBANCE AND MALADJUSTMENT IN TERMS OF ENVIRONMENT AND RELATIONSHIPS

One of the most frequently debated questions since man first began to think intelligently about man is how much his behaviour results from an interaction with his environment, and therefore how modifiable it is, and how much he is born with a constitutional make-up and a type of personality which largely conditions his responses to his environment. One of the problems in the study of human behaviour is that it is a dynamic process, in which all the years that have gone before have inevitably left their mark. In medical terms, the surgeon usually sees the results of his efforts in a matter of weeks, the obstetrician in months (nine at the most to be precise) but the psychiatrist needs to follow his patients for a lifetime to get any logical clues as to cause and effect. And to continue the medical analogy, it is known that the distorted limbs in rickets cannot be straightened after a certain degree of deprivation, however much sunshine and vitamin D are made available later. Does this also apply in non-physical

terms to the development of the intelligence and of emotional responses? If the appropriate stimuli and interactions are not forthcoming at the appropriate developmental stages, does this lead to irreversible damage? Evidence is accumulating that this is so in regard to animals, and a number of writers have maintained the same for man. We inevitably had questions such as these in mind as we conducted our survey. What was the nature of the disturbance? How damaging had been the environment and for how long? Did it ever appear that a time had come when the psychological vitamins and sunshine were being offered too late or was the personality shown to be somewhat more adaptable in this way than the body in which it housed itself?

1. The background to the first five years

It will be remembered that this was classified as either Highly Unsatisfactory, Unsatisfactory, Assumed Satisfactory, or Not Known, as detailed on pp. 8-9.

For the 139 children who were followed through:

52 had a Highly Unsatisfactory start to their lives,

54 had an Unsatisfactory start, 16 falling into group (*a*) and 38 falling into group (*b*) (33 being CGC cases)

25 were assumed to have lived in a Satisfactory environment.

In the case of 8 there was no evidence either way.

2. Satisfactory first five years

Taking the 25 who were known to have had a reasonably good start in life, only one child was in care—her difficulties started when her mother left the home when she was 9 and her father attempted suicide, but the break-up of the home was only temporary and there was no reason to suspect there had been earlier traumatic events.

For the rest, the 24 largely suffered from emotional states of anxiety, depression, phobias, sibling rivalry (i.e. were in Group I) or had difficulties over bedwetting, stammering, abdominal pain (Group II), and 6 had physical abnormalities such as brain damage associated with their emotional problems (Group IV). Only 4 belonged to Group III with problems associated with aggression, truanting, pilfering, and

sex, and only 3 out of these 25 ended up with a doubtful prognosis, none was 'poor'; these 3 had severe physical handicaps, all the rest were given an encouraging prognosis by the end, 9 of these adolescents being very well adjusted indeed.

These results make one justifiably hopeful that having a good start in life leads to less serious disturbance at a later date.

3. Highly unsatisfactory first five years

Turning the coin over, did we find that those from highly unsatisfactory homes were the most disturbed? There were 52 children who had experienced highly unsatisfactory situations under the age of 5 and of these 16 had developed well with a good or hopeful prognosis and for 15 more the prognosis was fairly hopeful. Well over half therefore were *not* permanently damaged. On the other hand, there were 13 in this group who had a very poor prognosis and 8 more were given a doubtful one.

This brought us up against the question of constitution or the genetic inheritance again. Were those who did well of tougher fibre than those who remained disturbed? Or had an improved environment been provided earlier for those who responded well, before the pattern of behaviour or the emotional disturbance had become chronically ingrained? Or was the psychiatric treatment more effective? No answer can yet be given as to which type of personality can best survive in adverse circumstances; in so far as everyone is an individual possibly this answer may never be forthcoming but it was clear that the adolescents whose prognosis was worst, though they were not necessarily similar in personalities, belonged in the main to Group III. They were pilfering, truanting, had violent tempers, sexual problems, and not infrequently were fire-raising. Most of them, however, were still living in very unsatisfactory conditions when at home whereas those of Group III who did well in spite of a very unsatisfactory start were living in much happier and healthier environments. Either the whole family had been helped as in some cases or the child had been removed to better conditions.

4. Adoptions

Five children were legally adopted, and one other was virtually adopted by her mother's sister at age 4. It is not without significance that everyone of them had Group III symptoms and was still highly disturbed by the end of the survey except for one who had improved surprisingly and whose prognosis became fairly hopeful. Not one of them was adopted under 5 months of age and four were known to have had a highly unsatisfactory start for as long as three years before the adoption was legalized—as was mentioned in an earlier chapter.

5. Results in terms of early upbringing, end prognoses, and symptom groups

a. Highly unsatisfactory homes (*N*= 52 (23 in Group III))

End results

Poor	*N* = 13, 10 being Group III
Doubtful	*N* = 8, 4 being Group III
Fairly Hopeful	*N* = 15, 6 being Group III
Hopeful	*N* = 10, 2 being Group III
Good	*N* = 6, 1 being Group III

b. Assumed satisfactory homes (*N*= 25)

End results

Poor	*N* = 0
Doubtful	*N* = 3 (all physically handicapped)
Fairly Hopeful	*N* = 8 (3 being in Group III)
Hopeful	*N* = 5
Good	*N* = 9 (1 being in Group III)

Those in Group III from the satisfactory homes, four in all, also had parents who were co-operative about the psychiatric treatment that was given.

These findings strongly suggest that the child is largely a product of the interaction with his environment, given a healthy physique and normal intelligence, and that, whilst he remains in a situation where the interactions are negative, none of the facilities offered him are likely to be effective. In order to test out this hypothesis further, the total number of

adolescents whose prognosis remained poor was then examined.

6. Final prognosis—'poor'

There were 19 adolescents in this group at the end of the survey, 8 of these were children in care and 11 were referred from the psychiatrist (i.e. 16 per cent and 12 per cent respectively of the two groups) and 13 of these 19 came initially from highly unsatisfactory homes. Fifteen of these 19 were presenting with behaviour disorders, i.e. were in Group III, the 4 others were in Group I. One of the latter group (an illegitimate boy whose mother had been imprisoned by the NSPCC for neglect) said in his first interview: 'I'd like an army of my own to protect me, and to own 'planes and boats and live in barracks—everywhere it's dangerous.' Three years later he began running away all over the country to Kent, Wales, Birmingham—free-footing—always ringing up his child care officer and secretly making contact again with his mother—suicide attempts and arson as well as fights were reported. His symptoms changed from those of Group I to Group III, making 14 out of the 19 by the end.

7. Initial prognosis—'poor'

Looking once more at the other side of the coin, what about those whose prognosis was initially poor but who improved during the survey? There were 10 of these, 4 from child guidance clinics and 6 from the children's departments, but only three of these belonged to Group III. None had ended up so well adjusted that one could be entirely confident, especially as 6 remained in somewhat unsatisfactory homes, but they were given a fairly hopeful prognosis and had certainly improved during the years. Again the prognosis was shown to be more hopeful when the symptoms were of Groups I, II, and IV. Finally, as was mentioned in an earlier section, the children in care who did best were those who remained in the *same* satisfactory environment throughout the period of the survey, whether this was in a family group home, a special group for maladjusted children, or a foster

home. Although they were disturbed, a number of them had had no psychiatric treatment, their secure environment had proved effective.

Clearly these facts have a bearing on the type of facilities which should be provided but, before discussing them, there are other points of general interest which might be mentioned here.

ROLE OF THE PARENTS

In the case of the 88 adolescents referred by the psychiatrists, these parents were generally speaking co-operative and spoke warmly about the help received. They were particularly appreciative for themselves of the support from psychiatric social workers. Of the 60 parents who said they found the facilities helpful, 17 picked out for mention the special educational facilities provided and 6 the probation service. Fifteen parents remained somewhat critical and, in the case of 13, there was no comment.

These criticisms were almost equally divided amongst the various facilities used. Five parents thought the visits to the clinics were ineffective in helping their children; 5 criticized the boarding schools, some thinking them too strict and others too lax; the remaining criticisms were directed against an in-patient unit (1), a remand home (1), an approved school (1), lack of follow-up after treatment (1), and too many changes of probation officer (1).

In regard to the children in care, the policy was for the children to maintain a contact with their parents whenever possible, which proved possible for most of them. There were four cases where this contact produced an aggravation in the symptoms and when one doubted the wisdom of the policy—but the majority (whatever distress they had experienced at the hands of their parents) wanted to maintain their link. At the initial interviews, there seemed to be much more fantasy than reality—when asked what their three wishes were, time and time again they said they wanted to be back with their parents, one child said 'to be in a cottage near Snowdon with Mum and Dad'—quite unrealistically, knowing as one did the parental situation. Was this in part due to the

feeling these children had that they were different from most others—determined by the cultural norms of family life? Or was there a positive feeling towards their parents in spite of everything? It was remarkable how many, in spite of all their early experiences of rejection, cruelty, or indifference, still refused to accept this as any reason for permanent separation, though some resentment was expressed initially against their parents. Resentment was also felt about 'them' in the shape of the local authority, but, as affection and trust in their child care officers and foster parents developed, and as they found them consistently ready to help over the years, so they themselves improved. Frequent changes of child care officers or foster parents, on the other hand, served to reinforce acutely the original feelings of rejection.

By the end of the survey in a number of cases links with parents had grown stronger, some adolescents had returned home, some parents were clearly more stable and settled themselves, and the attitudes of their children were much more realistic. There was less fantasy and more acknowledgement of the parents' shortcomings, but withal a preference to be with the family again.

SUMMARY OF FACILITIES USED

1. Schooling

One in three of our adolescents used special educational facilities in the course of the survey—even more if we count approved schools. One of the two cities was particularly well provided with day facilities but this did not seem to reduce very much the proportion of children sent to residential schools. On the other hand, it was easier to place a child in a day unit in an emergency than in the other city, where those excluded from their ordinary schools sometimes had to wait for months without schooling of any kind

The special day schools did well with our children, particularly with the school phobics. Providing separate schools for the withdrawn or phobic child and the aggressive, acting-out child seems the ideal. It worked very well in one of the cities, whereas the number of aggressive children admitted to the one special day school in the other city had to

be kept very low as they are too disturbing for the quiet, inhibited children.

The chief criticism we would make of the day schools known to us is that, after all the good work done in maintaining links between school and home (much appreciated by the parents), too little effort was made to help pupils into their first jobs. One boy said he would have liked to feel he could go and discuss his job and later his job failures with the staff at his special school. No doubt he would have been welcomed and helped had he gone, but an occasional 'club' evening for ex-pupils such as is in operation at one of the educationally sub-normal schools, together with some overseeing and support in the first job, if wanted, again as is done at the educationally sub-normal school, might make all the difference in the big step from school to work.

The special residential schools were, unhappily, much less successful with the children in our survey. Although it is true that they are often used where there seems no alternative, and certainly have some of the most difficult children, there were too many which, having put up with a boy in the years from 11 or 12 to 13+, suddenly decided that (perhaps because of his increasing size and strength) he was beyond them at 14 or 15. A number of those expelled or asked to leave before school-leaving age had to be returned to ordinary secondary schools in their home town at this age, and it was hardly surprising when another expulsion then followed. Apart from two special residential schools where the standards were so poor that one felt they should have failed any ministry inspection, our criticism would be neither of the provision nor the staffing but of the selection procedure. Many of the schools attended by survey children had great successes as well as sad failures. If only something could be learned from a hard, analytical look at the failures; maybe an idea of the type of boy or girl who does not do well at that particular school. Many of these residential schools are housed in beautiful country mansions, with acres of ground, a swimming-pool, and excellent provision for games. In some cases, the contrast between this and the child's home is too great; there is difficulty with holidays when a child has to return to overcrowding, child-minding and even, as with one

of our boys, malnourishment for many weeks at a time. There is difficulty, too, if there is no room at home (or no home) and he has to be accommodated in a hostel for the holidays. The hostels find it difficult to keep places for these 'holiday children'. We felt that some children would have been better placed in a special day school, attending from a hostel from which they could also visit their homes if they had them.

The ordinary State schools proved to be aware that many of the children were disturbed, and a sizeable number felt that they could not cater for their non-educational needs. This was despite the fact that all the schools we visited felt that they had adequate provision in the way of tutors, counsellors, careers masters, or social workers—people to whom pupils might be expected to take their problems. We found that children are just as likely to talk to ordinary staff—perhaps the master who runs the chess club, or the teacher who takes their favourite subject. Very few schools as yet have full-time trained counsellors and we are not in a position to judge whether a counsellor in every school is the ideal to aim for.

Even during the years of the survey, the improvement in communication between school, clinic, and parents was noticeable. Parents became less nervous of letting the school know about the child's difficulties at home; schools created stronger links with the home, not waiting till a child was in trouble to make the acquaintance of the parents. As in so many other fields, any improvement in communication has immediate effects and the fact that the whole subject is much written about and discussed at present is a good sign.

This section must contain a last word about reading failure. The amount of retardation in our group was staggering. Again, reading is a subject much discussed, and much researched. Hardly a year passes without a new set of figures for the amount of reading failure, and suggested new methods of dealing with it. A determined onslaught is yet to come. Reading backwardness should begin to be taken seriously at the age of 7 or 8. Adolescents who are virtually non-readers are very difficult to help because of the large emotional element in their failure by that age.

2. The combined facilities

In Chapter 1 are described the facilities available in Wessex for helping and caring for disturbed children and adolescents. It was noted during the course of the survey that on the whole these facilities were fairly well integrated and that satisfactory treatment of many of these disturbed and maladjusted teenagers consisted in the use of appropriate facilities at the appropriate time as part of a continuing process—a process whose aim of course was the development of independence, trust, and satisfying relationships at home and at work.

Table 10 gives details of the facilities which were used in the main by each adolescent.

Comments have already been made about the 19 whose prognosis was still poor by the end of the survey. Fifteen of the 24 who were given a 'doubtful' prognosis were child guidance children and not 'in care', so we were able in their case to ask their parents when they first showed signs of difficulty. Nine of them were reported to have been difficult under the age of 5 (2 of these having major physical handicaps) and their problems had continued since with the exception of two who showed some improvement.

The other 9 were children in care, 4 who came from highly unsatisfactory homes when young, 3 having had the intervention of an NSPCC officer.

There is one other facility which was used in a few cases at school-leaving age and when jobs were first obtained. These were specialized hostels or ordinary houses where small groups of teenagers lived together with a highly experienced adult in charge, and went out to work.

Seven girls and 3 boys were followed up in these 'hostels', only, of course, for a relatively short period of the survey. The girls appeared to settle in better than the boys, especially where they were given the responsibility of sharing in the running of the place, shopping, cooking, etc., as well as working. A dramatic improvement was observed in 4 of these girls, as if becoming part of a normal household with a very understanding adult present in the background brought out the best in them.

TABLE 10

	GROUPS				RESULTS			
					Steady progress on the whole		Remaining unsatisfactory	
	I	II	III	IV	*Good and Hopeful*	*Fairly Hopeful*	*Doubtful*	*Poor*
Out-patient treatment only (*N*=51)	13	17	16	5	28	15	5	3
Out-patient + special day schooling (*N*=17)	11	0	3	3	4	9	2	2
Special residential schooling and holiday psychiatric reviews (*N*=19)	3	3	11	2	5	6	4	4
In-patient treatment (*N*=9)	6	1	2	0	1	2	4	2
Probation (*N*=11)	3	1	7	0	6	1	3	1
Remand home, approved schools, etc. (*N*=10)	1	1	8	0		1	3	6
No psychiatric links (*N*=22)	12	7	2	1	9	9	3	1
Total (*N*=139)	49	30	49	11	53	43	24	19

ADOLESCENTS AS IN-PATIENTS— NOT IN THE SURVEY

It was mentioned earlier that none of the 153 children when first seen was psychotic, and none became so during the course of the survey. But, since one of the major outcries about the treatment of adolescents has been about their admission to adult psychiatric wards, and its unsuitability both for child and adult and the nursing staff, we decided to

TABLE 11

Age	*12*	*13*	*14*	*15*	*Total*
1968	0	0	6	5	11
1969	0	0	9	16	25
Half-year 1970	0	0	1	9	10

ask for information about any children of our age-group (though not in our survey) who had been admitted to Wessex hospitals during the years 1966-70.

There are five main psychiatric hospitals in the Region. No 12-year-olds were admitted to adult wards during the period of the survey (January 1966 to June 1970) and only four 13-year-olds. These four were all admitted to the same hospital which is in an area of the Region distant from any adolescent facilities.

Table 11 gives the figures for those aged 12-15 who were admitted to these five hospitals in the last 2½ years of the survey. From these totals it appears that a problem remained for those in their middle teens which appeared to be on the increase. In looking over the reasons for admission, one might expect to find more drug-takers. Although this was true of the 16 and 17-year-olds, it does not explain the rise in 14 to 15-year-olds admitted, since none of these 14-year-olds was treated for this problem and the number of 15-year-olds involved with drugs was 1 in 1968, 2 in 1969, and 2 in the period January to June 1970. Of the other 14 to 15-year-olds admitted in 1969, 5 were suffering from depressive illnesses, 7 from schizophrenia, and 6 from personality disorders, giving some idea of the nature of their illnesses.

Inquiries were also made about admissions to the adolescent unit during the period of the survey and for the same age-group, excluding those in our study. Four pre-psychotic or psychotic children were found to be schizoid or schizophrenic, 11 were suffering from depression, 18 were neurotic, being acutely anxious or phobic, and another 3 had predominantly physical symptoms with emotional disturbance. There were another 13 admitted for behaviour disorders, making a total of 49 (20 boys and 29 girls) in all. Possibly

most of these 13 children would have been admitted to the new unit had it been open, thereby lessening the waiting-list for the present one, and allowing for the appropriate admission of those requiring and responding to intensive insight therapy in this more relaxed environment. The second unit will be for those requiring greater security in a more structured environment.

GAPS IN THE SERVICES

1. In-patients

In Chapter 1 is given an outline of the facilities available in Wessex for helping emotionally disturbed and maladjusted adolescents.

When the second adolescent unit opens, there will be 55 beds per 2 million population for treating the mentally ill and seriously maladjusted. Certainly this second unit is required as already stated to obviate admissions to adult wards, and to relieve the pressure on the existing unit. There is also a need for a half-way hostel in close association with a sheltered industry in the vicinity of the two adolescent units. Some of the adolescents in the unit stayed there as long as three years with the risk of becoming institutionalized and failing to be discharged as soon as they might. This would have been avoided if the only alternative had not been to return to a highly unsatisfactory home environment.

2. Out-patients

The gaps in this part of the service were more acute in the rural areas than in the two cities. Nine of the adolescents we saw, particularly those living in the north of the Region, required more treatment and it was noticeable how many of the parents also wanted help for themselves. There was considerable scope for family therapy.

3. Gaps in after-care facilities

Two young boys, after receiving helpful treatment, lapsed because they could not leave their adverse home environ-

ments. No boarding school vacancies in schools for maladjusted could be found. They might alternatively have benefited from living in a hostel attached to a day school, had such been available, possibly to return home for weekends. One of these boys had experienced living with a violent father until he was 4, who was twice jailed for manslaughter, his mother married in all three times, and was given psychiatric treatment herself when the boy was 10. The headmaster of his secondary school and his staff took a lot of interest in this intelligent boy and got him involved in the Duke of Edinburgh Awards, but he lapsed after leaving. The jobs he chose were not satisfactory, although he had the potential to develop well given a more supportive background. Discussion about the pros and cons of residential and other special schooling is found in Chapter 6.

4. Liaison with the children's department

Six of the 22 children who never saw a psychiatrist urgently needed this psychiatric help. In the case of two they returned prematurely to their own parents and we were able to follow them and unfortunately observe their deterioration; in the case of four others, they lived in rural areas with clinic facilities not easily come by. Since these children who came into care were all maladjusted or at least highly vulnerable, they should all have been given a psychiatric and psychological assessment before their more permanent placement. The fact that this did not happen was in no way due to lack of good liaison between child care officers and psychiatrists in Wessex, but was entirely due to manpower problems.

UNEXPECTED FINDINGS

1. Co-operation

When planning this survey, we felt as if we were about to embark on a voyage where at times the seas would be pretty choppy, and the final arrival at port might find us rudderless and with few of the passengers still left on board. Such is the 'image' of the adolescent, particularly when emotionally disturbed and maladjusted. But, thanks initially to the careful

approach and explanations by our clinical colleagues, the parents and children co-operated excellently. It also appealed to the adolescents that *they* were offering the helpful information, adults were turning to them rather than the other way round. It was a tribute to them too that, when they were enjoying their first earnings, they one and all brushed aside any offer to have their fares reimbursed although these previously had naturally been accepted–their pride in their first independence completely overruled any material gain.

In regard to the children in care, there was possibly less option about their co-operation since those *in loco parentis* told them when their next appointment was due and they were expected to keep it, but again there did not appear to be any obvious resistance. The only adolescents (four) who flatly refused to be seen at the end had very real anxieties about their mental state and were paranoid about being interviewed; we had details about them through their parents or other sources.

2. Age of onset of the difficulties

It came as a considerable surprise to us to know how many parents had already found their children difficult before the age of 5. This was so in the case of 46 (they were all toddlers), and another 6 of the 88 started being difficult at 5. This is well over 50 per cent. Even allowing for the fact that most toddlers are difficult to cope with, clearly an unfortunate interaction between these parents and their children had been continuing for longer than advisable before any positive steps had been taken. Only 30 out of 139 were referred for psychiatric help under the age of 10.

In regard to the children not living with their parents, or 'under supervision', what they had had to suffer and endure made a shocking impact. Twelve of the 51 had had an intervention by the NSPCC. Many had witnessed much violence in the home, three were known to have found a parent in a suicidal coma, and others had experienced the eccentricities of schizophrenic or seriously depressed parents for some years. The surprising thing about many of these

children was their resilience; most of them lacked the spontaneity and 'aliveness' of the child who has known security, but they were at least holding their own in jobs, and with their peers.

In regard to those who had not survived these traumata and whose prognosis was poor, it was discouraging to find what little effect the various facilities had on them. Some of these points have been brought out in the brief case-histories in earlier chapters.

3. Diagnosis and predictions

Certainly the headaches in regard to diagnosis were always with us. The attempt, using the USA Group for the Advancement of Psychiatry classification, helped in certain ways, but it was found that the neurotics, the reactives, the developmental deviations were all treated with varied facilities apparently regardless of diagnosis and with varying degrees of success. On the other hand, the symptom categories gave a much better picture of the ultimate prognosis, especially when taken in conjunction with the experiences of the early years.

The expectation at each yearly interval of reports of fluctuations in mood, swings from one extreme of behaviour to another, and evidence of general turmoil as adolescence progressed was not borne out. Most of these 139 teenagers made steadier and better progress than was initially predicted, as has already been illustrated in the histograms. Those who did badly, with three exceptions, were already seriously disturbed at the start of the survey and continued in this state. It has been clearly shown too that by far the majority of these had problems of an antisocial nature and in almost all the cases where pilfering occurred there were also sexual problems and in eight cases fire-raising.

These findings tally with those of Masterson who in *The Psychiatric Dilemma of Adolescence* found that 'adolescent turmoil was at most an incidental factor subordinate to that of psychiatric illness in the onset, course, and outcome of the various conditions of our patients. Adolescence was but a way station in a long history of psychiatric illness which

began in childhood and followed its own inexorable course. . . . The decisive influence was psychiatric illness, not adolescent turmoil.' A number of the adolescents in Masterson's group, which extended into the ages of 22 and 24 for some, were more seriously ill than the teenagers in this survey, but our experience was the same. We observed that it was hard to assess the outcome in the more seriously disturbed of our group at the age of 17. One longed to follow them through for another five years, but, as stated before, it would take a lifetime to draw final conclusions. How many of those showing emotional disturbance such as depression, anxiety, insecurity, etc., who improved steadily will continue to hold their own through the stresses of rearing a family, working in an unsatisfying job, or coping with the major responsibilities which come with middle age? The best prognoses seemed to occur for those in Group II whose problems viewed retrospectively were largely of a developmental kind.

An interesting corollary is that Offer in *The Psychological World of the Teenager* followed for five years a group of adolescents who were selected initially on the evidence of their normality. It was a highly selected group, but they certainly progressed steadily through adolescence without any apparent turmoil (almost to a boring degree). He found too that they were able to stand up to the trauma of the death of a parent, or other adverse circumstances, during the period of his observation with a commendable fortitude. Their home-life had always been stable and secure and relationships with their parents had been easy.

4. Summary and conclusions

In studying these 139 disturbed and maladjusted adolescents for four years, the most striking fact which emerged was their long history of disturbance—in the majority it had started under the age of 5—either with highly unsatisfactory home conditions or with a difficult relationship between parent and child.

This indicates that the assessment and treatment of many disturbed adolescents should start *under* the age of 5 and *not* over the age of 14 or 15, and that this is not even preventive,

for the difficulties have actually become established at this early age.

The second fact which emerged clearly was how resilient and modifiable the majority were given a healthy environment, in terms of receiving affection and understanding. In this connection a psychiatric team can probably help most in assessments of strengths and weaknesses and recommend what is an appropriate environment. They can further help supportively with the aim of maintaining the milieu at all costs in order to allow security and confidence to develop, in spite of the major crises and difficulties which may occur.

This, of course, means that many adults are needed with special knowledge and skills to rehabilitate these children in the community. As Clegg and Megson have shown in *Children in Distress*, teachers in ordinary schools do a remarkably good job when *properly* trained in helping difficult children. We found the same with teachers in the special day schools dealing with maladjusted children, who could not be contained in the ordinary schools. For those children who were unable to remain within their family, it was also noted how much was achieved in a good foster home or family group home provided the child's difficulties could be understood and he was not rejected and then moved again.

One of the most encouraging findings was the discovery that there are so many men and women prepared to devote themselves to the apparently unrewarding job of the day-to-day care of children in need. The goodwill shown by foster parents in taking a strange child into their home, often knowing that its real parents might well claim it back when it reached earning age, is matched by house parents in charge of a family group home.

In a similar way, to have the same child care officer, the same probation officer, the same psychiatrist, is a major ingredient of helping successfully. For those impossibly difficult, especially at adolescence, it was the rare individual with a strong personality, interested, warm, and adequately trained who was most successful in helping a residential group and that withal a very small one of about six. Anything institutional, except for the relatively few who are very sick, is contra-indicated in adolescence since this is the time when

the surge forward to independence should at all costs be fostered, everything should be done to encourage it; all adolescents long to achieve this, however inadequate they may feel, and they are most likely to respond given adequate understanding and support. At this age particularly they want to feel that their lives are relatively like those of their peers. The adults who achieve the successful running of these small groups, the Aichhorns of this world, are few but the value of their work, which is almost inestimable, should be recognized in terms of salary as well as status.

The number of children who required insight therapy for internalized conflicts in regard to their repressed aggressive feelings of sibling rivalry, ambivalence to parents, or their sexual guilts was not more than about a third of the children being seen by psychiatrists.

Many of the adolescents by the age of 17 began at last to verbalize more freely their anxieties, their longings, and their problems, and it is clearly more than chance that it is at this age and onwards that the 'walk-in' clinics come into their own, and have the greatest demands made of them.

The communication between all those involved in the different facilities needed to be much closer; there were times when setbacks occurred just through a failure of communication or when the right facilities were not available at the right moment. Would not a better solution be to have one authority with health, education, and welfare service all co-ordinated under one umbrella?

In view of the poor results in some of the group, most of whom had used a number of different types of facility without any improvement and who all caused a disproportionate amount of trouble in the community, more research is still required (*a*) into the nature of their personalities and their disabilities, and (*b*) into how to provide an environment stable in human terms despite the enormous difficulties entailed. This might produce more positive results. It was evident that moving these disturbed children around from one facility to another in a vain hope of finding something somewhere that worked was in itself a cause of further disturbance.

6

Planning for the future

This chapter consists of a shortened version of a report which was made by a working party in Wessex for the Regional Hospital Board. All the consultants in child and adolescent psychiatry in the Region gave their views, as did all the children's officers in Wessex and the known needs of paediatricians were also taken into account. The recommendations of the working party were based on these reports and on the facts which emerged from this Nuffield adolescent survey, and are included in these final pages as possible guidelines for planning in child and adolescent psychiatry.

SUMMARY

The small working party was set up by Dr Revans, the Senior Administrative Medical Officer, to study (1) the changes in child and adolescent psychiatry in the Region during the last decade, and (2) to make recommendations about the establishment and the improved facilities required to ensure an adequate and reasonably comprehensive service in Wessex. The last recommendations were made in 1959.

This inquiry served to highlight the increasing association of child psychiatrists with paediatrics, with special schools for maladjusted children, and with the children's department of the social welfare services.[1] It was noted that links were also growing with the services for the mentally handicapped and with adult psychiatry. These developments, occurring as a natural growth of the service, have put great strains on the existing staff and facilities have now become inadequate in a number of areas.

It was with these points in mind that the working party made the recommendations in the following sections, both for immediate and long-term improvements. In the light of growing experience recommendations were also made for certain changes of emphasis and for careful evaluations of established techniques which might lead to further modifications and improvements in the decade ahead.

POPULATION SERVED

Wessex now has a population of just over 2,000,000 and this is expected to increase, particularly in the north with overspill from London, during the next ten years. The following blueprint, therefore, is for a population of at least 2,000,000 in an area which contains three cities, a number of sizeable towns, but also tracts of rural country in which are dotted small isolated villages. The cities have comprehensive services, but these are harder to provide in country districts where travel facilities are limited for patients and consultants cannot spend time visiting widely scattered clinics. It has, however, been recommended that one full-time consultant should be responsible for 30,000 of the child population (to include those under the age of 5 and up to 15 years) with the *caveat* that during the next ten years the aim should be to reduce the figure to one consultant per 20,000, although this is still nearly twice that considered advisable by the European Office of the World Health Organization (1970). The figure of one per 12,000 of the child population has been achieved in Sweden, but a number of other countries whose practices

1. Since 1 April 1971 absorbed into local authority social service departments.

are somewhat similar to ours such as Norway, Switzerland, and Holland have not managed more than one consultant per 20,000-30,000 school population to date. On the basis of one per 30,000, the Wessex Region should have at least 16 consultants in child and adolescent psychiatry. At present there are 10 full-time consultants, another works 6 sessions weekly, there is 1 part-time senior hospital medical officer (9 sessions), and 1 medical psychotherapist (full-time).

NATURE OF PSYCHIATRIST'S PRACTICE

1. Out-patients

The work is mainly community-based at local authority child and family guidance clinics (there are seventeen of these) but out-patient sessions are also held at the regional children's and adolescent psychiatric units and in association with five paediatric departments.

All the consultants allocate part of their time to advisory and consultative work in the welfare department for children in care (on average one session fortnightly per consultant), and they also work closely with the staff of day schools for maladjusted children, in particular whilst the children are attending the clinics for treatment at the same time; there is on the whole a more tenuous link with the smaller number of children at boarding schools for the maladjusted who are mostly seen just once during the holidays. The exceptions are two of the boarding schools within the boundaries of Wessex where child psychiatrists attend regularly.

Other activities undertaken by the child psychiatrists include attending joint assessment clinics with other specialists for advising on physically handicapped, deaf, spastic, and brain-damaged children; visits to some of the hospitals and the new hostels for subnormal children also take place. There are, of course, emergency calls for attempted suicides, and from paediatricians and GPs for problems associated with the 'battered baby syndrome' and for acute adolescent crises.

Other community-based activities include consultations and reports for magistrates and probation officers, and the training of students, medical, sociological, and psychological.

Requests from GPs or health visitors for seminars are always complied with since they are key figures in detecting the development of tension and anxiety in families at an early stage.

2. In-patients

In regard to in-patient facilities, reference has already been made in earlier chapters to two units for disturbed adolescents, totalling in all 55 beds. These are situated centrally and serve the whole Region. The Wessex Unit for children (a complex of units also previously described) has beds for 45 children. The most recently built 10-bed addition is so designed that parents can be admitted as well.

The nursing staff of two of the units are associated with those of the adult psychiatric hospitals with which geographically they are closely linked, but have considerable autonomy in regard to their staffing arrangements, and the third unit is staffed completely independently. The consultants at these units also hold sessions at local authority clinics, thereby keeping in touch with community facilities.

FUTURE REQUIREMENTS

The future needs in the Wessex Region might be summarized under the following headings:

1. Under 5-year-olds

There is a great need for increasing the facilities to help young parents who are under stress and live in very cramped circumstances. Parents who come from less socio-economically deprived groups are more able to verbalize their anxieties about their toddlers now, and to ask their GPs for help. They are referred to child and family guidance clinics fairly promptly or may even come directly themselves to the clinics. There is a steady increase in number of referrals of this age-group.

But, as shown in this adolescent survey and in other research findings, some of the most intractable problems begin under the age of 5 and are only dealt with by psychiatrists, child care officers, or teachers a number of

years later by which time it may well be too late to modify the emotional disturbances and behaviour problems, or to catch up on the lack of verbal skills which so much handicap schoolwork. That a great deal can be achieved if intervention and help are offered early enough has been shown by Hunt in the work done at the Parent and Child Centres at Illinois and similar centres.

There is at the Wessex Psychiatric Children's Unit one wing equipped with paddling pool and sand play facilities and a room for the mothers to meet as a group, and another small centre in a county area has been organized by a children's officer for mothers and toddlers at risk. The indications are that such facilities should be available at most of the district general hospitals in the Region, in close association with the paediatric departments.

Special nursery schools with a very high pupil-teacher ratio of the order of 5:1 should also be provided. The staff problem might be eased, as at York, with the help of interested students from the University and teacher-training centres.

The best means of finding and treating these vulnerable children sufficiently early is through an effective communication network between the medical, social welfare, and educational personnel of each district, enabling a three-pronged approach.

2. Paediatric departments

Out-patient and day hospital facilities

These require development for children of all ages in four of the district general hospitals in association with paediatric departments.

Increasing in-patient beds for children

Based on the recommendations in the memorandum of the Royal Medico-Psychological Association, about 100 beds are needed in this Region. Two small psychiatric units for short-term observation and treatment should be established at the western end of the Region, possibly at the two district general hospitals when they are built; these should possibly

be planned as 'domestic type units' each consisting of 10-15 beds. The most severely disturbed children will continue to be admitted as in the past to the 45-bed Wessex Children's Unit where all the specialist facilities exist for investigations and for some long-stay cases. Other beds for which the children's psychiatrists are responsible, closely associated with paediatric departments, already exist at two hospitals but are also needed in the north of the Region with the building of the district hospital there (approximately 20 in all).

3. Links with adult psychiatrists

Research has shown that a considerable number, possibly a third of the children seen by psychiatrists at child guidance and child psychiatric clinics, have parents who have also required psychiatric treatment. At times the treatment of the parents, particularly as in-patients, may be concurrent with the child's treatment, involving at least two consultants. Clearly it is to the benefit of the family that there should be joint discussion and case conferences between the consultants in the child and adult departments concerned and it has been recommended that opportunities for this should be fostered. It is already occurring where the two departments are geographically close together but is less easy when this is not so.

4. Adolescent patients

It has been recommended that the present number of 55 beds for adolescent patients should be given a fair trial before any others are planned.

A much more urgent need is for *day hospital* facilities for adolescents, in at least five or six areas, one or two of which should also provide hostel accommodation and sheltered workshop facilities. In this way the two regional units for adolescents can increase their intake and the risk of institutionalization is minimized.

5. Children in care

It has long been recognized that the children's officers, child care officers, and those caring on a day-to-day basis for

deprived children are responsible for some of the most disturbed children, but it has not been fully appreciated that, however disturbed, these are children by and large who do not benefit from clinic attendance for psychotherapy; what they need is to build up security and trust on *a long-term basis* in the right milieu. The adolescent study served to show (although the numbers were small) that those children who stayed throughout the four years in the one suitable environment did best whether it was in a foster home or a special group for maladjusted children.

Some of the responses were also quite dramatic when adolescents with severe behaviour problems were moved into small groups, living their lives as much like those of other 'normal' adolescents as possible, provided an exceptionally understanding adult was in charge.

The Wessex Children's Committee[1] of the department of social welfare have been making plans for a main central day and residential assessment unit, with an associated residential 'adjustment' unit probably consisting of several small 'family' groups for children too disturbed for ordinary foster home placement; in all some 80-90 children will be resident. Other smaller reception and adjustment units are, of course, being maintained elsewhere. It is accepted that all these children (except for the short-term admissions) should initially have full psychiatric and psychological assessments before placement. Psychiatric advice and support should also be available when asked for by those who are responsible for looking after the most disturbed of these children. Those who 'care' for these children, apart from requiring the right personalities for this work, are now beginning to get specialist training so that the pooling of experience with psychiatrists and psychologists is really constructive. These residential units will also relieve pressure on the psychiatric in-patient units.

It is increasingly recognized that these children can only achieve stability and happiness when they at last learn to trust one individual, and that many problems are likely to arise before this trust is established. To move them around from one milieu to another as shown in the adolescent survey in the hope of finding somewhere appropriate just leads to a

1. Set up under the Children's and Young Persons' Act, 1969.

steady deterioration in the child with the inevitable increasing sense of failure and of being unwanted.

6. Special schooling

As will have been noted in earlier comments on schooling for maladjusted adolescents, the day schools, where the psychiatrists, psychologists, and teachers work closely together, frequently proved most helpful and therapeutic, especially for school-phobic children. The results were less consistently satisfactory with the boarding schools, partly because most of the children sent to them came from home backgrounds where adverse attitudes showed little hope of modification. But, when good communication with the psychiatrist and psychologist who initially referred the child was maintained by the school (which in fact meant where the boarding schools were fairly close at hand), there was usually a better outcome. This, for example, obviated sudden exclusions. The psychiatrists of the Region, whilst appreciating the need for boarding schools for maladjusted children, were generally more in favour of *many* more day schools or special remedial units, particularly, of course, for the younger schoolchildren. In this way years of persisting maladjustment could be cut short. Some excellent special school facilities which exist in one city in the Region consist (among others) of centres for emergency attendance when the ordinary day school suddenly cannot cope, and a small local residential unit, but with weekends always spent at home. In this way the social workers are able to help more effectively with the parents than when the children are right away from them for a whole term.

7. In-service training

Time must be allocated for the in-service training of the various disciplines, casework students, educational psychologists, and psychiatrists, who make up the team for the assessment of emotionally disturbed and maladjusted children and adolescents. The Underwood Committee's recommendations that a team should consist of one psychiatrist, two educational psychologists, and three psychiatric social workers is still felt to be the right one, but

these numbers have rarely been achieved in the Region to date. When, however, there has been opportunity for training, the students have tended to remain in the area afterwards, a general experience throughout the country.

8. Research

The need for evaluation of the services offered (and for money to be allocated for research) is also to be stressed. In particular the results of in-patient treatment and residential schooling, which involve some of the most intractable disturbances, should be studied.

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