Twenty-five years ago, in an address entitled 'Facts and Fictions in the Study of Child Psychiatry', Emanuel Miller made a plea for the objective study of child development. Referring to psychoanalysis, he called for a 'moratorium on interpretation', declaring that 'Science cannot live by metaphor alone'. Since then many apparent fictions have been turned into facts and the essential challenges our specialty faces have changed. The main problem is no longer how to give substance to theory, and modify theory to accord with the facts, but how scientific knowledge can be translated into better practice. This paper will focus on the gap between rapid advances of research in child development and child psychiatry on the one hand, and the fluctuating trends in the practice of child psychiatry and its related disciplines on the other.

Eisenberg, in a splendid analysis of the relationship between research and public policy in psychiatry, wrote: 'When discoveries come in the form of more effective new drugs and procedures, they are readily introduced into practice. When they come in the form of remedies which counter deeply held beliefs, or are costly and manpower-intensive, they compete in the political arena with other values'. How the lessons from research are applied, and even what research is done, clearly depend on the social climate of attitudes, values and fashions, on public policies, and on individual professional practice.

Two preliminary points
First, research must influence policy but, particularly in psychiatry, it can do no more than guide personal practice. Policies for a community should follow from research based predictions, but statistically significant research results can never be applied across the board. The outcome of a particular intervention is rarely the same for everyone. Increasingly, exceptions to the rule are being studied, and policies need to promote a variety of options, in the proportions suggested by research findings. In clinical practice, when decisions have to be made for a unique individual, prediction in terms of statistical probabilities is less helpful. The clinician must choose between alternative interventions for which, with luck, the probable outcomes are known; there are no clearer directions.

Secondly, more than scientific evidence is needed to bring about change in public attitudes and policies, at times even in clinical practice. Emotionally charged features of the activities and writings of professionals and the prevailing demographic and political movements are also at play. Yet now, as in the past, doctors seem powerfully placed to alter public opinion.

Lawrence Stone attributed the reserve and even brutality of family life in England prior to the late 17th century at least in part to the high death rates, not only of young children but of young parents, with consequent disruption of family ties. Children were regularly boarded out to wet nurses, he thought, to shield their parents from the pain of broken attachments when the children died. As many children then suffered parent loss and step-parenting through death as do now through divorce and separation. But it was the mother who more often died, in childbirth, whereas today it is the father who leaves or is extruded from the family and replaced within it.

Yet the change towards what Stone called 'affective individualism' came before the control of smallpox and other pestilences and was due to ideological shifts for which the growth of literacy, following the invention of the printing press, was held to be responsible. John Locke, philosopher, experienced educator and physician, whose ideas appear to have been as powerful as Freud's 200 years later, was foremost among the writers of the time to change child-rearing patterns. In his book Some Thoughts Concerning Education, first published in 1693, he deplored the self-defeating nature of excessive physical punishment then used at home and at school, encouraging parents rather to praise and shame their children and set them good examples. He stressed the importance for education of children's individual temperaments and 'rhythms of development' and suggested educating through play. He aimed to encourage 'A mind free, and master of itself and all its Actions ...', rather than the stocking up of knowledge, and advised building on children's natural curiosity '... a great Instrument Nature has provided, to remove that Ignorance they were born with ...'. He wrote: '... pray remember that Children are not to be taught by Rules, which will be always slipping out of their memories ... one can improve and modify but should not attempt to change children's "natural genius" ...'; and he considered childhood 'the Time most susceptible of lasting impressions ...'.

Stone describes oscillatory historical shifts, attributing a decline of the liberalization of child care and family life, to which Locke contributed, to the fears inspired in the wealthy by the French revolution 100 years later. This ushered in the Victorian era of sexual repression and renewed paternal authority which was followed by a 'second intense phase of permissiveness' beginning once more among the middle classes but this time spreading to all sections of society, a liberalization of attitudes to which Freud contributed profoundly.

While research results affect professional practice directly through training and recognized avenues of continuing education, the climate of opinion, influencing both practice and policies, depends also on how such results are publicised. Here the charisma...
of individuals and the nature of the communication media may be as important as the intrinsic merit and appeal of new knowledge and ideas. Three topics will be used to illustrate the relationships between research, policy and practice: child development, delinquency, and treatment interventions.

The effects of research in child development
Important knowledge about child development has sprung from the work on parent-child attachment, encouraged, summarized and propagated by John Bowlby. The baby watchers, using ethological methods, began to substantiate and correct psychoanalytic ideas about the earliest human relationships. They operated with a cognitive-developmental model based on Piaget's theories\(^5\). One feature of this is the assumption of progressive changes in internal cognitive structures so that the world is apprehended differently at different stages; another, that there are biologically determined similarities in the structures of all individuals corresponding to similarities in their environments, so that universally present patterns of development can be seen; and a third, that development depends on transactional processes during which both child and caregiver are changed.

Bowlby's powerful writings\(^6,7\) have had two major effects: to stimulate research into the nature and vicissitudes of children's early attachments, of the varieties of early deprivations, and of their differential later effects; and to set in train major shifts in child care policy and practice. One of these has been entirely beneficial: the introduction of parents as daily visitors, often as residents, into children's hospital wards. Although James Robertson's moving film: 'A two-year old goes to hospital' was widely shown in the early fifties\(^8\), and the Committee on the Welfare of Children in Hospital reported in 1959\(^9\), and despite an active parent organization, it was only in the 1970s that policies began to change nationwide. Yet the revolution in the care of children in hospital could not have been costly. Parents sleep in side rooms or in, and even under, their children's beds. What the effect has been on child psychiatric morbidity has not been charted. The picture will be clouded by the simultaneous shortening of children's hospital stays and the changing patterns of paediatric illnesses and their treatment.

The impact of research into early social development on social work policy and practice has been as profound but more problematical, in that the findings about the harm done to very young children by residential group care, have been used as if they applied also to day care for young children and to residential group care for adolescents. The Curtis report of 1946\(^10\) had already documented the barren and regimented lives of children brought up in children's homes and initiated the development of family group homes to provide more affectionate and individualized care. Bowlby's work and the Robertson's films\(^11\) vividly demonstrated the destructive effect on the developing social and linguistic skills of very young children of even brief spells in residential group care. But, as Tizard\(^12\) has recently suggested, these findings may inadvertently have contributed to the lack of development in the UK of day care facilities for pre-school children.

Tizard had shown earlier\(^14\) that with good resources and a degree of autonomy for child care staff, the intellectual and language development of young children in residential care can be preserved. But, even when such children are later placed in stable and affectionate families before the age of four years, their emotional and social development suffers, and residual difficulties, especially in peer relationships, persist to adolescence\(^15\).

It was Row and Lambert's study however, entitled *Children who Wait*\(^16\) which gave impetus to radical changes in child care policies. Residential nurseries closed; every effort was made to place children under four years with foster parents rather than in children's homes; and to seek adoption for those unlikely to return to their families. But the new child care policies, of the greatest benefit to young children, then came to be applied also to children of all ages, without adequate research backing.

By now illegitimacy was less of a stigma; more single mothers kept their babies; divorce and remarriage had increased; as had the number of older and often disturbed and delinquent children from disharmonious families who needed substitute care. Evidence had accumulated that being in care was associated with psychiatric disorder in childhood and later life, and that the residential treatments then available for delinquents did not reduce recidivism\(^17\). This, it seems, was the basis for the policy of keeping as many youngsters as possible at home or integrating them into new families. Yet the apparent effect of institutional care was shown to be intimately linked to chronic family discord and hostility rather than to the in-care experience itself\(^18\), fostering often breaks down; and many young people with strong ties to their parents, however disturbed these may be, do not want to join other people's families.

Community care for older children, in foster or adoptive homes, or with their own disturbed parents, is of course cheaper than good residential care and it is well to be aware of what Floud in a different context has called 'the systematic self-serving character of government policies'\(^19\). The fact is we do not know what the benefits of really good residential care or education for adolescents from grossly disturbed families might be. To suggest that children of all ages do best at home, is certainly erroneous.

Research into the first human relationship, the child's tie to his parents, especially the mother, has been universally acclaimed and acted upon, largely as a result of Bowlby's polemical writings. A unifying idea, like 'maternal deprivation', has great appeal. What is, underemphasized, to the detriment of our approach for example to antisocial conduct, is that attachment is not all. As important are the child's entry into group relationships and the development of morality. The contribution of Dunn's studies of siblings and parents\(^20,21\) is well recognized. But Kagan's work\(^22\) demonstrating the manifestations in the second year of inner standards of right and wrong and of self-awareness of competence; Hoffman's studies\(^23\) linking empathy to the development of prosocial behaviour; and Turiel's explorations of young children's ideas about morality and conventions\(^24\) are all too little known. The achievements and vicissitudes of the stages of childhood in which group relationships, social identifications and morality first emerge have yet to find their publicists\(^25\).

Changing views of antisocial conduct
Childhood aggression and delinquency are the most worrying child psychiatric disorders. Over 20 years
ago, Robins showed an excessive risk of sociopathy for seriously antisocial children26. More recently she established that, while of course such children tend to have a background of multiple disadvantages, adult outcome is more dependent on the children’s actual behaviour than on their environment, presumably because of the reinforcing responses such behaviour tends to elicit from others, and that early use of alcohol and drugs considerably increases the risk of later sociopathy27. Yet the implications for preventive action are far from clear. The apparent lesson: that conduct disordered boys should be advised to postpone drinking till they are older ‘not now, but later’, has not been put to the test.

The causes, operating at home and at school, of childhood conduct disorders have been greatly clarified by Rutter27. Moreover, specific qualities of school life have been discovered, which promote learning and also reduce delinquency28-29. But there is a big gap between discovering possible preventive influences and evaluating their effects; and the efficacy of interventions shown to work under optimal conditions cannot be assumed to transfer readily to less enthusiastically pursued action30.

The American ‘Head Start’ programmes of the 1960s, supported by the US ‘war on poverty’, and designed to equip disadvantaged pre-school children better for learning at school, were at first disillusioning because the children’s early IQ gains washed out over time. Yet at adolescence, perhaps because of transactional effects between greater competence and self-esteem of the children on the one hand, and higher teacher expectations and approval on the other, children in the programmes were not only educationally more competent, but significantly less delinquent than controls31. By this time the political climate had changed, and in the UK, where pre-school education has, for many years, been woefully inadequate, economically disadvantaged children, who have most to gain from good nursery programmes, are known to have the least access to available resources32.

Enormous shifts of public attitudes, policy and practice in relation to criminal behaviour have taken place over the years. Bottoms33 outlined three philosophies underlying Western penal systems: first, the traditionalist, linked to religious beliefs, with punishment of wickedness, retribution and deterrence as the aims, and the widespread use of execution and transportation even of the young and even for minor crimes; second, the classicist, derived from the 18th century enlightenment, in which punishment was seen as utilitarian rather than retributive, and which aimed at the least deprivation of freedom of individual offenders needed to maintain public order (but which, as Ignatieff has shown34, was hardly more humane in practice); and third, the positivist, developing in the late 19th century, which took a determinist view of human nature, put its faith in prediction and sought to eliminate crime with scientifically derived methods.

Child psychiatry as we know it was born during this stage, from a union forged in hope, between criminology and psychiatry with the aims of unravelling the causes of juvenile delinquency, treating offenders early and preventing later criminality.

The positivist phase, in which the rehabilitation ideal pervaded penal policy35,36, collapsed when treatment patently failed to prevent juvenile delinquency37, and a penal system, based on reform, did not reduce recidivism38. Jones describes how into the psychodynamic and humanitarian climate of thought ‘the critique of deviance theorists came as novel, abrasive and searing39. Now, since the early eighties, in a phase of ‘moral panic’ fuelled by politicians and mass media portrayals of crime39, a further radical change in penal policy has come about. Ideas of ‘just desserts’ and ‘the right to punishment’, in fact a return to the old retributive model of justice, have captured the public imagination.

The justice viewpoint focuses on past behaviour as a guide to action: the sentence must reflect the crime, not a possible outcome. Prediction in the individual case is always uncertain and could, it is now held, open the door to grave injustice, for example, unnecessary detention for ‘dangerousness’. Outcome research is not now on the agenda. Doctors, in contrast, intervene with their eyes firmly on the future: to prevent catastrophe is possible, and to attempt to make things better. We are used to acting amid ambiguity, and we do rely on research to guide clinical practice.

It is paradoxical that, just as the causes, social, psychological and biological, of aggression and delinquency have come to be better understood38, the penal system operates as if, except in a minority of insane offenders, criminal acts are freely chosen. While child psychiatrists are less at risk in the present climate of opinion, of withdrawing their interest from antisocial people, we face the danger that in cases of child abuse we too may be caught up in the panic generated by the media, to accept too readily that we have a public duty to involve the criminal law. Instead, our primary task is to safeguard the children from further harm, and their parents from further harmful actions; and our secondary task to discover why, in our present era, so many parents mistreat their children. It is my view that all psychiatrists have a duty to help the public understand what is known about the causes and development of antisocial conduct; and to promote those penal systems least likely to be destructive of the personality functioning of offenders and their families.

Treatment interventions

Psychiatric treatments for children as for adults are more influenced by fashion and belief than facts, and facts in this area are hard to come by.

Individual psychotherapy for children and social case work for parents were universal treatments in the early child guidance clinics although there was little evidence that they worked39. Professor Kolvin, in his presidential address to this Section39, made clear that in the past, researchers into the outcome of child psychotherapy were often as indiscriminating as the therapists. The apparent finding that, with or without treatment, one third of children improved, one third partly improved and one third did not get better, spread gloom among practitioners. While, fortunately, it did not stop them treating their patients, it may well have caused them to turn their backs on outcome research.

Since then there has been progress both in clinical practice and treatment research, although the two have not often gone hand in hand. Child psychiatric treatment has become more varied and more interesting. Behavioural methods increased the range of effective techniques; and, coincidently with increasing family disruption and multiple parenting,
the family therapies have taken root in child psychiatry departments, despite the paucity of research evidence for their effects. Kolvin’s major experimental venture, which showed group psychotherapy and classroom behavioural treatments for conduct disordered and emotionally disturbed children, to be better than social case work for their parents or no treatment at all, has increased our confidence in the effectiveness of child psychotherapy. Yet this was a school based study of non-referred children treated with methods not generally in use.

We are on surer ground when we turn to the evaluation of specific treatments for specific clinical syndromes such as drug treatment of hyperkinesia, behavioural approaches to sleep disorders, or family therapy for childhood asthma. Here new procedures and remedies scientifically judged to be helpful are, as Eisenberg suggests, readily applied in clinic or hospital settings. Patterson’s recent work on family based behavioural treatments for seriously disturbed, aggressive and delinquent children from economically deprived, coercive families, raised hopes for effective interventions for those children most at risk of a poor adult outcome. But these treatments are ‘labour intensive’ and, because of high drop out rates, require much optimism and stamina on the part of clinical staff. They may be less readily adopted on a wider scale.

There is one example, however, of research which has been almost universally translated into practice. Some 15 years ago, Rutter and Bartak demonstrated that autistic children exposed to a consistent and repetitive teaching style based on behavioural principles, improved more than autistic children whose teachers provided mainly warmth and opportunities for self-expression. A parent organization, the National Autistic Society, has ensured that all professionals concerned know of the sort of teaching to which autistic children can best respond. Yet the recent move towards the integration of children with learning difficulties into ordinary schools, and the emphasis on ‘special educational needs’ rather than specific handicaps, has had the effect that some autistic children are no longer being diagnosed, and do not get the educational treatments now available for them.

Conclusions
Enormous progress has been made in the scientific understanding of child development and child psychotherapy, and treatment in child psychiatry has become more varied and probably more effective. The relationships between research on the one hand, and practice and policy on the other is, however, complex and the use or misuse of research findings depends on many interconnected trends of fashion, opinion, resource availability and political expediency, but also on the persuasive powers of individual experts.

As doctors we need constantly to bear in mind, and not accept unquestioningly, the political and ideological currents which are bound to affect our own outlook and professional activities. As psychiatrists especially, we know that good clinical practice and helpful advice to policy makers as well as the information we impart through the media to the general public, must be based on objective research evidence when this is to hand, but also on an informed, experiential understanding of human nature.

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