

Correspondence

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CHILDHOOD AND ADULT PSYCHIATRIC ILLNESS

DEAR SIR,

In the December 1973 issue Dr. Mellsoy reported on his study of psychiatrically ill adults known to the psychiatric department of the Royal Children's Hospital in Melbourne before the age of 14. He compared his results to our follow-up of child guidance clinic patients in St. Louis (Robins, 1966). While he noted agreement on many points, he also noted a disagreement with our conclusions with respect to the relation between schizophrenia and conduct disorders of childhood and between neurosis in adulthood and childhood. The disagreement he thinks we have about schizophrenia is, I believe, a misreading of our work. We did find that antisocial behaviour in childhood was associated with adult schizophrenia, but it was largely limited to behaviour on the home scene and was usually accompanied by multiple neurotic symptoms. This seems to be what Dr. Mellsoy found as well, namely referral for behaviours at home (Table 6) and a host of non-antisocial symptoms, speech, eating, etc. (Table 7).

The disagreement between his conclusion that childhood neuroses are associated with adult neuroses and our failure to find such an association is a genuine disagreement and warrants further consideration. Dr. Mellsoy warned, however, that his own results varied with his raw data types, i.e. depending on whether he looked at childhood diagnoses, reasons for referral in childhood, or symptoms elicited in childhood. There are even more crucial differences between his study and ours in their raw data, differences which make it difficult to compare results from the two studies. We did not use the clinical diagnoses from the childhood records because we felt they were inadequate. We did find that both reasons for referral and elicited symptoms predicted outcome. Dr. Mellsoy, however, found almost no relationship between elicited symptoms and adult diagnosis. Thus we are left with reasons for referral as the most viable matching childhood data in the two studies.

The St. Louis study excluded mental defectives (by requiring an IQ score of 80 or higher on clinic psychological tests). There is no way to eliminate

mental defectives from the Melbourne sample on the basis of reasons for referral, since the defectives were seen for various reasons. However, we can eliminate almost all of them by dropping the adult diagnosis of subnormality, since 90 per cent of the children diagnosed subnormal got this diagnosis as adult (Table 5).

Another important difference between the data of the two studies is that the St. Louis study made adult diagnoses by interview and a search of non-psychiatric as well as psychiatric records on a consecutive series of clinic children and matched controls, while the Melbourne study reported only on treated children who came to psychiatric treatment as adults and based diagnoses entirely on psychiatric case notes. Some of the St. Louis sample were found to be well adults, and many of those considered to be psychiatrically ill had had no adult psychiatric treatment. Indeed, psychiatric treatment was common only for schizophrenics. Sociopaths and alcoholics were usually handled by legal rather than medical institutions; neurotics by general practitioners and internists rather than psychiatrists. As a result, the Melbourne and St. Louis cases with the same diagnoses are not necessarily comparable in severity or presenting symptoms. Add to these difficulties the fact that categorization of both adult diagnoses and reasons for referral in childhood differed between the studies, and one sees just how problematic comparisons can be.

Nonetheless, curious as to whether the difference Dr. Mellsoy noted would exist if differences in the two data sets were minimized, I have tried to make the closest comparison possible. The accompanying table eliminates the mental defectives in the Melbourne study by dropping subnormality as an adult diagnosis. It combines two reason-for-referral categories in the Melbourne study, 'behaviour at home' and 'behaviour in society', as the closest match to what we termed 'antisocial' referral. It uses personality disorder as the adult diagnosis in the Melbourne study most comparable to the diagnosis of sociopathic personality in the St. Louis study, and drops three groups from the St. Louis study: healthy ex-patients, ex-patients with diagnoses corresponding

Reason for childhood referral

| | Melbourne* | | | St. Louis† | | | |
|------------------------|------------|--------------------|---------------|---------------|----------------------|---------------|-----|
| | | Behaviour problems | Other reasons | | Antisocial behaviour | Other reasons | |
| <i>Adult diagnosis</i> | | | | | | | |
| Schizophrenia | (26) | 42% | 58% | Schizophrenia | (25) | 64% | 36% |
| Personality disorder | (47) | 45 | 55 | Sociopathy | (94) | 95 | 5 |
| Neurosis | (24) | 21 | 79 | Neurosis | (84) | 52 | 48 |

* Recalculated from Table VI.

† Recalculated from Table 6.1.

to those dropped by Dr. Mellsoop because they occurred in fewer than 20 cases, and controls.

The table shows that once these efforts to obtain comparable data sets were made, the disagreement Dr. Mellsoop pointed to has disappeared. The St. Louis study shows as much association between childhood neurosis and adult neurosis as his study does. (Of course, the overall rate of referrals for antisocial behaviour in St. Louis is higher, reflecting the fact that the children were older at referral, since we defined childhood as under 18 and Dr. Mellsoop defined it as under 14, and that the St. Louis clinic served as a facility for the juvenile court. But this should not affect comparisons between diagnostic groups.)

The important point is not that Dr. Mellsoop's data and ours agree, but rather that the data he used to show that 'neuroses in childhood were prominent precursors of adult neuroses' are similar to data which constituted a part of the results from which we drew quite different conclusions. Was our interpretation wrong? I don't think so. Indeed, I believe the cases we had to discard to make our data set comparable to Dr. Mellsoop's are essential to deciding the role of childhood neurosis in adult neurosis. When one is limited to subjects who are sick both as children and adults, the most one can say is that neuroses in childhood are more prominent in adult neuroses (and schizophrenia) than they are in adult personality disorders. But to say that childhood neuroses play a prominent part in adult neuroses in general, one needs the ex-patients we had to discard to obtain a match with the Melbourne cases, i.e. the healthy adults and those with other diagnoses, as well as the controls who were normal children. It was especially our failure to find a difference in rates of neurosis between ex-patients and controls that convinced us that childhood neurotic symptoms were not important precursors of adult neurosis.

Actually, Dr. Mellsoop has only 13 cases of neurotic adults for whom childhood records of neurosis were found. Certainly these 13 cases do not constitute a prominent part of however many neurotics aged 25

to 29 there may be among the more than 100,000 names he found in the central patient registry.

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SELF-POISONING IN ADOLESCENTS

DEAR SIR,

I was interested in Dr. White's article (*Journal*, January 1974, 24-35), because over the past four years I have been collecting details of Bradford school children admitted to hospital following self-poisoning. The age group of the children is largely 10-15, that is just preceding the age group studied by Dr. White. Nevertheless, many of his observations seem to apply to this younger group of children. Although he states that most patients had the drug immediately available, he does not indicate how this came to be so. In my group the majority of children took sleeping tablets or tranquillizers that had been prescribed for a parent. In two cases, the parents actually threw the bottle of tablets at the child with the advice to take the 'bloody lot'. It might be that in other cases a similar suggestion was made in a more subtle way. This suggests that we are dealing with a pre-selected group of children and certainly strengthens the observations already made as to the importance of parental tone.

Dr. White's observations about Jamaican children are confirmed by our experience in Bradford, and we now regard this situation as the 'Jamaican Syndrome'. Like him, I feel that the plight of these children calls for a more responsible attitude on the part of the Jamaican Government.