1 Historical aspects of mood and its disorders in young people

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Introduction

The last 20 years have witnessed rapid expansion of clinical and theoretical interest in affective disorders in children and adolescents. Extensive historical examination of the subject has however been minimal. The primary aims of this chapter, therefore, are to assemble evidence about the wider historical background and to set some current clinical and research issues in perspective. The methodology and interpretation of historical research on affective disorder in young people need to take into consideration a number of factors.

Growth of interest in juvenile mental disorder

Prior to the mid nineteenth century, little systematic attention was given to juvenile lunatics and the existence of insanity in early life was disputed or denied. A picture of their disorders and care has to be assembled, therefore, from diverse sources, mainly reports of unusual cases (Parry-Jones, 1993). Subsequently, insanity in children and adolescents featured increasingly in asylum practice and in textbooks and journals, although it was not until the 1920s and 1930s that a recognizably separate discipline of child psychiatry emerged. The multidisciplinary speciality that took shape was the product of the confluence of expertise from paediatrics, asylum medicine, the training and custodial care of the mentally retarded, psychoanalysis, psychology, psychiatric social work, remedial education and criminology. Later, influenced by the new medical psychology and by psychoanalytic thinking, the developing speciality moved away from asylum-based psychiatry, with its concepts of organ pathology, heredity, phenomenological syndromal description and physical treatments, towards psychosocial and psychodynamic models. In the process, it distanced itself from the most severely disturbed juveniles, particularly adolescents.

Following the Second World War, there was rapid growth of hospital-based outpatient clinics, first inaugurated in the 1920s and 1930s, and the develop-

ment of inpatient wards. From the mid-1960s, increasing acceptance of the need for separate services for adolescents arose out of concern about their care with adults in mental hospitals. The last 30 years have seen the emergence of British child and adolescent psychiatry as a well-established, scientific speciality, accompanied by the slow expansion, from the 1970s, of academic departments.

Changing theories of child mental development

The theories of Locke and Rousseau continued to influence concepts of child development in the first half of the nineteenth century. Darwin's theory of evolution, however, raised new problems concerning development and variation that were alien to the older psychology. By the last quarter of the century, major new interest in child study was developing rapidly in Europe and the USA, associated with biographical accounts of infant development. Such interest had clinical implications; for example, Clouston (1891) catalogued disorders associated with development up to the end of adolescence (interpreted as occurring between the ages of 18 and 25) when reproductive functions were developed and full growth attained. A recurrent theme at this time was ancestral recapitulation whereby, an individual when developing passed through stages which characterized those of his or her race. Early twentieth-century theories of child development were principally influenced by Sigmund and Anna Freud and subsequent child psychoanalytic theorists, and by Claparëde, Piaget, Kohlberg, Vygotsky and Erikson.

Theories concerning the nature, development and expression of emotion

Accounts of the history of the psychology of emotion are fraught with difficulties, since 'the field is replete with theory and scantily covered with relevant experimental evidence' (Mandler, 1979). Consideration needs to be given to the influence of concepts arising from a number of different theoretical viewpoints (Gardiner et al., 1937), including: theological and philosophical perspectives; psychoanalytic and experiential theories; ethological concepts; physiological and neurobiological explanations and behavioural and cognitive interpretations. Darwin's observation (1872) that there was universal similarity of facial expression of emotions and that expressions of sadness and stress had an adaptive function was highly influential, until the advent of the James–Lange theory of emotion in the late 1880s and its subsequent critique by Cannon in the 1920s. In order to elucidate the psychology and physiology of normal emotional life, Thalbitzer (1926) drew upon the study of 'mood–psychoses', suggesting that, in children and 'very naive, primitive and uncivilised people', these states tended to be simple and uncomplicated. For many years, theories

of emotional development (Bridges, 1932) indicated that emotional expressions change and become more complex and differentiated until about 2 years of age. Relatively recently, there has been an upsurge of human, and animal-based research into emotional development (Strongman, 1987; see Chapter 2).

Changing conceptions of childhood

Historical studies illustrate the changing role and status of children in the family and society (Parry-Jones, 1993). The principal issues bearing on the recognition and classification of childhood mental disorders concern the extent to which children were regarded as miniature adults, the awareness of the psychological component in children's lives and interest in the deterministic significance of early life experiences.

Terminological and conceptual confusion

A wide variety of words have been used, over the centuries, to describe and define emotional experience, expression and disturbance, generating a confusing array of theoretical concepts. 'Mania', for example, has been used for diverse excited states. In addition to the core term 'melancholia', a range of alternatives have been used to refer to depressive states, such as 'the vapours', hypochondriasis, spleen, 'hip', 'lypemania' and 'tristimania'. During the nineteenth century, the situation was complicated by inconsistent use and definition of the terms 'affect', 'mood', 'emotion' and 'feeling'. In particular, application of 'affect' and 'mood' has suffered from sustained confusion because of variation in the reliance placed, in definition, on the duration of an emotional state or the distinction between subjective and objective components.

History of affective disturbance in adults

In view of the limited consideration given to childhood disorders until the mid nineteenth century, the field is dominated by issues concerned with affective disorders in adults. Although the extensive history of this subject is receiving increasing notice (Jackson, 1986; Berrios, 1992), aspects relating to children and young people, before the mid twentieth century, have attracted minimal attention.

Diversity and variability of source material

There is only sporadic survival of heterogeneous manuscript material before 1800 and little in the way of consecutive patient-related records. With the growth of theoretical interest in childhood insanity, the availability of printed source material expanded progressively during the nineteenth century.

Primary sources, including patient records, are increasingly available from the second half of the century.

Limited historiography of child and adolescent mental disorders

Historical accounts of child and adolescent psychiatry have been mainly concerned with its development as a medical speciality and with innovative therapeutic techniques. Very limited attention has been given to the history of clinical syndromes or to the wider implications of childhood insanity (Parry-Jones, 1992).

Pre nineteenth century

Despite copious discussion of the phenomenon of melancholia from Hippocratic times onwards, the condition was very rarely alluded to among juveniles. An exception was the Greek physician, Rufus of Ephesus, in the opening years of the second century AD, who stated that melancholia 'did not occur in adolescents, but it occasionally occurred in infants and in young boys' (Jackson, 1986). Before the nineteenth century, the term 'melancholia' was used to refer to 'a rag-bag of insanity states', not necessarily including sadness and low affect, and was a subtype of mania (Berrios, 1992). Depressive states without delusions were designated by terms such as 'hypochondria', 'vapours' and 'spleen'. Although there were occasional references in the seventeenth century to 'depression' or 'defection' of spirits and 'depressed', it was only in the latter part of the eighteenth century that such terms began to feature more specifically in discussions of melancholia.

Specific references to childhood insanity and its treatment are elusive and outwardly relevant early texts covering the topics of 'melancholy', 'frensie' and 'madness', such as those by Bright in 1586 and Willis in 1683, contribute little of relevance. Burton's comprehensive work on melancholy, first published in 1621, was not primarily concerned with depressive disorders in the modern sense, but he made some observations that were pertinent to childhood. He referred to education, for example, as a source of melancholy, especially when conducted by parents. In this context, he criticized parents who were both 'too sterne, always threatning, chiding, brawling, whipping or striking; by means of which, their poor children are so disheartened and cowed, that they never after have any courage, a merry hour in their lives, or take pleasure in any thing'. At the other extreme, he criticized parents who were too indulgent. Among the other causes of melancholy in relation to children, Burton referred to melancholic parents producing offspring who inherited their characteristics. In the

case of the mother, this could occur even during pregnancy and, similarly, a wet nurse could transmit melancholic tendencies to the infant. Finally, Burton emphasized that severe terror and fright could cause melancholy in the young, describing two little girls near Basle, frightened, respectively, by a body on a gibbet and a corpse in an open grave; these girls 'could not be pacified, but melancholy died' (Burton, 1827).

In the eighteenth century, neither Sauvages' seminal nosology nor Arnold's detailed account of classification and causation afforded examples of childhood melancholy, apart from a passing reference by the latter to the vulnerability of young people to 'nostalgic insanity', when away from their homes (Arnold, 1782). This condition was first described clinically in the late seventeenth century by Hofer, whose cases included a young peasant girl, pining in hospital from parental separation. Whytt (1767) described a 14-year-old boy, who become low-spirited before the onset of an eating disorder. Perfect (1791), a private madhouse owner in Kent, England, provided a comprehensive account of an 11-year-old boy treated without admission to the madhouse. He displayed 'depression and lowness', alternating with confusion and acutely disturbed 'obstreporous' states, in which he was irrational and furious, behaving like a 'raving maniac'. The disorder, which Perfect thought had no clear causation, lasted for 4–5 months and was treated with the customary polypharmacy of the period.

Nineteenth century

Melancholia and depression

Changes began to take place in the classical usage of the term 'melancholia', with its connotations of humoral physiology (black bile), leading to its emergence more specifically as a primary disorder of the emotions, which, in turn, became referred to as mental depression or simply depression (Berrios, 1988). Early nineteenth-century classificatory developments in France were particularly influential in defining new disorders. Esquirol (1845), for example, coined the term 'lypemania' for a condition characterized by 'delirium with respect to one or a small number of objects, with predominance of a sorrowful and depressing passion', although this term did not gain widespread European popularity. Esquirol considered lypemania to be 'rather the lot of adult age' whereas 'in youth, mania and monomania burst forth in all their varieties and forms'. In Germany, classifications by Griesinger, Kahlbaum and Krafft-Ebing remained influential until the publication of Kraepelin's seminal work (1921). In Britain, by the end of the nineteenth century, melancholia was clearly defined

as a disorder characterized by 'a feeling of misery which is in excess of what is justified by the circumstances in which the individual is placed' (Mercier, 1892). Numerous forms were recognized, broadly grouped into those with and without delusions, including a hysterical form 'occurring principally in young girls' and a pubertal variant in which 'the patient often evinces a listless and moody apathy and perverseness of conduct' (Tuke, 1892). By the close of the century, the term 'depression' had gained greater currency, becoming a synonym for melancholia.

The growing number of case reports of juvenile lunatics in the first half of the nineteenth century rarely included melancholia and it was not until the second part of the century that there was consistent evidence of the identification, description and discussion of abnormal mood states in children and young people. Crichton-Browne (1860) made the significant observation that although melancholia 'appears incompatible with early life . . . it is so only in appearance, for the buoyancy and gladness of childhood may give place to despondency and despair and faith and confidence may be superseded by doubt and misery'. He recognized a range of disorders, principally 'pure, abstract indefinite depression' and also religious melancholy. Other forms, including hypochondriasis, were less common before puberty, 'as their existence implies subjectivity of thought'. Finally, 'simple melancholia, a mere exaggeration of that feeling of depression to which we are all at times liable, may, in youth, as in mature life, exist without at all involving the intellectual faculties'.

Maudsley (1867) included melancholia among the seven forms of childhood insanity. In his view, depression occurred in children 'with and without definite delusion or morbid impulse'. In some cases, depressive symptoms marked 'a constitutional defect of nervous element whereby an emotional or sensational reaction of a painful kind follows all impressions; the nervous or cyclical tone is radically infected with some vice of constitution so that every impression is painful'. Maudsley went on to suggest that this was often due to inherited syphilis. Deep melancholic depression was associated in older children with delusions and could lead to suicide. The concept of moral insanity, first described by Prichard (1835), was quite widely applied to young people and Maudsley referred to it as 'affective insanity' to convey 'the fundamental condition of nerve element which shows itself in affections of the mode of feeling generally, not of the special mode of moral feeling only' (Maudsley, 1879). In fact, he used the term 'affective derangement' to comprise both moral insanity and mental depression. Maudsley's principal contribution lay in the elucidation of the early onset and forms taken by childhood melancholic states

and in his attempt to relate the type of melancholia to the level of development reached by the child at the time of onset. In infants, 'Feeling going before thought in the order of mental development', melancholic expression was by a 'primitive language of cries, grunts, exclamations, tones of sounds, gestures and features'. Older children aged 4 or 5 years might have 'fits of moaning, melancholy and apprehensive fears' and, later, features of typical melancholy could occur, sometimes with suicidal ideas (Maudsley, 1895). This developmental sequence differed from that of many other writers, which generally only included melancholia from the age of 10 or 12 years (Hurd, 1895). The form taken by melancholia after puberty was generally thought to resemble that in adults including, for example, the commonly occurring presentation with hypochondriacal delusions relating to bodily conditions. According to Mills (1893), delusions commonly occurring in adults, 'as of self condemnation, of the unpardonable sin, of coming to want, or of fatal organic disease' were often absent, although children brought up 'in a morbidly religious, or in distressing surroundings, sometimes exhibit a delusional state of a religious and painful character'.

In Europe, similar references to affective disorders in children began to be made. Griesinger (1867) stated that all forms of insanity occurred before puberty, albeit infrequently, including 'melancholic forms in all their varieties'. He drew specific attention to the occurrence of hypochondria, 'especially where the parents manifest excessive care of the health of the child', and to 'simple melancholic states . . . whose foundation is a general feeling of anxiety'. Later, in his influential work on 'psychic disturbance of childhood', Emminghaus (1887) demonstrated a clear understanding of the difference between child and adult disorders and identified four forms of childhood melancholia, including juvenile suicide.

Growing interest in childhood insanity in the mid nineteenth century was slow to be reflected in paediatric literature. Although West (1854), for example, referred to hypochrondriasis, malingering and moral insanity in children, no specific mention was made to mood disorder. In the early twentieth century, however, notable paediatric authors began to devote attention to functional nervous diseases of childhood, reflecting increasing awareness of the effects of emotional health, the problems of neurotic children and possible consequences in adulthood. Guthrie (1909), for example, drew attention to manifestations of fretting and home-sickness and to the effects of 'hospitalism', later studied by Spitz (1946), and Cameron (1929) recognized recurrent depression in children, including *folie circulaire*.

Mania and manic-depressive insanity

During the second half of the nineteenth century, there was increasing clarification of the concept of mania as an emotional disorder, characterized by elated affect, and its separation from general madness. By the end of the century, Maudsley (1895) divided mania, or 'insanity with excitement', into a simple form (without delusions), acute and chronic mania and 'alternating recurrent insanity'. The association between melancholic and manic states had a long history: an intimate connection between these conditions had been made as early as the second century AD by both Aretaeus and Soranus. In the medieval period, melancholia and mania were usually listed together under diseases of the head (Jackson, 1986). The position was clarified, in the mid nineteenth century, by two French alienists, Falret and Baillarger who, respectively, described and named the alternating sequence as *la folie circulaire* and *la folie à double forme*. When Kraepelin (1921) correlated the various forms, he confirmed that adolescence carried a predisposition for manic-depressive insanity, as well as dementia praecox, and observed that 0.4% of adult manic patients experienced their first episode at 10 years of age or younger.

Throughout the nineteenth century, a steady stream of published case reports recorded the occurrence of mania in children and young people, usually portrayed as early-onset examples of the 'adult-type' disorder (Morison, 1848; Mills, 1893; Fletcher, 1895). Down (1887) gave examples of infantile mania and cases 'where the various phases of insanity in the adult has been well represented'. In many of the reported cases it is difficult to distinguish primary affective disorders from states of excitement and confusion forming part of other psychotic disorders. For example, Greves (1884) gave a detailed account of 'acute mania' in a 5-year-old child, with a history of 2–3 weeks of acute disturbance but, in fact, this condition was more likely to have been a symptomatic psychotic state rather than an affective disorder.

During the last quarter of the century, many cases of *folie circulaire* in children were described. Ireland (1875), for example, reported a 13-year-old German boy, who 'had been so often punished at school . . . that he became deeply melancholy and tried to kill himself. The melancholy alternated with mania, in which he whistled and sang day and night, tore his clothes and was filthy in his habits'. Such a case was regarded as 'very rare at such an early age'. Hurd (1895) was in no doubt, however, that most cases of *folie circulaire* began at puberty, 'due to an original unstable state of the nervous system as is shown by the mental failure which follows an attempt to take on the second stage of physical and mental development'.

Pubescent and adolescent insanity

Puberty became accepted as an important physiological cause of mental disturbance and pubescent or adolescent insanity was frequently referred to during the second half of the nineteenth century. Generally, the disorders of children over the age of 12 years were thought to differ little from adult manifestations. The diverse 'insanities' of this period included abnormalities of feeling and conduct, with impaired self-control, waywardness, irritability and irresponsibility. In his entry on the 'developmental insanities' in Tuke's *Dictionary of Psychological Medicine*, Clouston (1892) detailed the special characteristics of pubescent or adolescent mania and melancholia. In summary, 'the mania of adolescence is acute, but seldom delirious; the melancholia is stuperous, and not very suicidal. Each maniacal attack is short in duration while the melancholic attacks are longer, the mania recurs from 2–20 times while the depression also recurs but not so often. The chief complications are masturbation in the males and hysterical symptoms in the females'.

Theories of causation

Melancholia and mania in juveniles have always attracted a wide range of causative explanations, generally reflecting contemporary clinical and scientific interests. Prevailing ideas of causation in the nineteenth century fall into four groups.

Physical causes

Causes thought to act primarily on the brain and nervous system included disorders such as epilepsy, febrile episodes, infections including meningitis, scarlet fever, typhoid fever and measles, intestinal parasites and trauma, particularly head injury and overexposure to the sun.

Psychological (or moral) causes

Severe shocks and frights, anxiety and distress, disappointments, bereavements, jealousy, faulty education, excessive study, religious excitement and parental brutality were the most commonly cited psychological causes. Actual or perceived loss was a recurrent theme, the consequences being particularly related to depressive states, with frequent reference to the effects of bereavement, separation and other adverse life events, such as failure in relationships and in school. Such adverse influences could be mediated by the parents. For example, Spitzka was reported to have seen 'constitutionally melancholic children in whom no other predisposing cause could be discovered than that the mother was struggling with direct or indirect results of financial crisis. In

several cases the death of the father was a contributory cause of maternal depression' (Talbot, 1898). Over the last two decades of the twentieth century, earlier object loss and life stress explanations have been complemented by more specific models based on behavioural theories, the concepts of learned helplessness and cognitive distortion and, most recently, limbic-diencephalic dysfunction.

Early experience and education

The consequences of adverse early experiences, especially during child-rearing, and faulty educational practices, generated increasing comment during the nineteenth century and the role of parents and families was of special concern to many writers. Parkinson (1807), for example, drew attention to the potentially harmful effects of both 'excessive indulgence' and parental inconsistency on children. He argued that the overindulged, manipulative child could later discover his shortcomings and become depressed: 'Suffering under an accumulation of real and fancied ills, his misery becomes so great and insupportable, that sullen or furious insanity or dreadful suicide may soon be expected to succeed'. Harsh educational methods, overemphasis on scholastic attainment and the dangers of excessive 'mental exertion' in school also attracted increasing attention, especially in relation to suicide.

Hereditary transmission

The established belief in the connection between heredity and mental disease in children and adolescents was reiterated in the eighteenth century and was an enduring feature of nineteenth-century lay and medical writings and case material, with considerable preoccupation with concepts of degeneration. Distinction was made between connate disorders and hereditary susceptibilities, which could generate either disposition to disorder, for which hopes for prevention were poor, or predisposition, where the disorder was triggered by external causes and, therefore, carried the best prognosis. The role of hereditary predisposition in melancholia was recognized widely by notable alienists, including Esquirol, Heinroth, Bucknill, D. H. Tuke and Mercier.

Juveniles in asylums

Throughout the nineteenth century, severely disturbed children and adolescents were treated routinely in adult asylum wards. Mania and melancholia were common diagnoses. For example, among 592 young people admitted to Bethlem Royal Hospital, 1815–1899, who were given definite diagnoses, 345