PART I
I. THE NATURE OF CHILDHOOD AND THE CLINICAL SERVICES NEEDED TO DEAL WITH THE PROBLEMS OF THIS PERIOD.

Child Psychiatry is a development within the field of general psychiatry of comparatively recent origin. With the shift of major emphasis from the laboratory to the study of man himself, dynamic psychiatry began. In this early period, the symptoms and character traits of adult patients were correlated with memories of early interpersonal experiences. This synthesis resulted in formulations of theories regarding child development. But attempting to understand the child out of such retrospective material, useful as it was for a dynamic reconstruction of adult problems, was unsatisfactory because it kept the focus on adulthood and not on childhood as an important period in itself. This finally made it desirable to study the child at first hand. The major motive for this direct approach was the hope of wholesale prevention of difficulties in later life, but it soon became evident that such a broad goal, although understandable as an ideal, was unattainable in practice. Furthermore, it was found that focusing attention mainly on potential difficulties of the future tended to obstruct therapeutic efforts in the present. The prophylactic objectives of mental hygiene thus recede as immediate goals to be realized by clinical attention to the problems of childhood. Clarity on the important differences between clinical and mental hygiene objectives is resulting in more effective efforts in each, in fulfilling their different objectives.

The therapeutic needs of disturbed children stimulated further growth in the field of child psychiatry. As knowledge accumulated out of direct observation by psychiatrists, child analysts, social workers, psychologists and pediatricians, there emerged a better understanding of the laws of psychological growth and development. The child began to be thought of as a child and not as a miniature adult. He was seen to be an individual whose thoughts, feelings, relationships and means of expression differ from those of adults. The field of child psychiatry took shape out of the recognition of these differences and out of the needs to develop clinical skills to help children with emotional disturbances.

Many divergences in methodology and clinical practices have emerged as the field of child psychiatry developed into a recognized clinical specialty. Underlying these differences in theory and practice, certain basic principles have been accepted generally in the understanding of personality development. First there is common agreement in stressing the importance of early stages of development in shaping the personality; and, second, that an important dynamic in personality development is contained in the interaction between biological and cultural forces. This group agreed that certain differences in emphasis should be included in this statement.

One viewpoint is expressed in the genetic dynamic concepts of psychoanalysis. Personality development is a historical continuum as the biological forces interact with forces of the cultural setting in which the child develops as an individual. Successive stages are understood in their relation to preceding ones. Early experiences, as well as the processes elaborating them, continue to exert their influence without being available to conscious recall or conscious perception.

Biological forces express the vitality of the organism (Id). They are manifested in the individual's needs for intake, for elimination and retention, for muscular and sensory activity. These instinctual needs are perceived as urges to discharge tension through the exercise of physiological functions. By maintaining homeostatic balance, gratification of instinctual needs helps to preserve the biological integrity of the organism.

Instinctual tendencies follow the general principle of growth, proceeding from simple to higher forms of integration and differentiation. In the course of growth, physiological functions assume supremacy in typical sequence. While the maturational sequence is common to the entire species, individuals vary in the intensity of their needs and in the rate and rhythm of growth.

Compared to the newborn of other species, the human infant is insufficiently equipped to survive by inborn automatic reflexes alone. His physiological functions have to be perfected before they can adequately serve his vital needs. The ministration of others is essential for his survival. Protection, stimulation and vital supplies must be provided in the care he receives. In fulfilling the functions of maternal care, the mother mediates between the infant and the outer world. After the symbiotic uterine existence, the mother as the source of gratification, protection and limitation becomes the first representative of external reality.

While the newborn requires immediate gratification of his instinctual needs, physiological growth increases his tolerance for inner tension and external stimulation. The benign impact of a predictable reality on the maturing organism leads to the structurization of the initially undifferentiated discharge-movements. Perception, motility and anticipation of environmental response permit the individual to scan increasing sectors of the external world in terms of his instinctual needs. Thus maturational processes and environmental direction (specifically, the shaping of instinctual tendencies through maternal care), lead to the establishment of the psychological functions of the ego, which mediates between inner need and external world.
Instinctual needs undergo further modification through development of self-critical attitudes which become part of the personality-structure. In the early stages of development, anxiety is the physiological response to excess tension. As the child begins to recognize the separate existence of those on whom he depends, the fear of losing their love (affection, support, protection) becomes an important source of anxiety. When the capacity to judge and to anticipate approbation, anxiety becomes a danger signal. The child who has already achieved some mastery over inner needs and external reality attempts to avoid danger situations by establishing mechanisms of defense as self-set modifications of instinctual needs.

The nature of the self-critical attitudes is determined by personal experiences with those who inflict frustration and limitation on instinctual gratification. The nature and intensity of the child's reaction to frustration depends on his maturational need and on the environmental response to this need. (Typical fears correlated to the various stages of instinctual development determine persistent phantasies.)

Because the child experiences frustration as well as gratification in relationship to his parents, they become figures of great power to him. To maintain his security and to avoid retaliation, he has to remain in good standing with them. Therefore, he renounces wishes and activities which the parents have prohibited or such as he has directed against them. This interaction is not restricted to the child's conscious response to explicit parental attitudes. Intent and motivation implied in parental behavior determine the child's need to modify his impulses in the way which becomes characteristic for his personality structure.

The need for security and the fear of losing parental love thus lead to the formation of the superego which functions as conscious and unconscious self-critical attitudes derived from the child's experiences with the original parent figures.

Early experiences with meaningful figures of power become elaborated and in their internalized form determine the individual's psychological structure. This explains the persistence of inner dependency beyond the biological and cultural need for support from parent figures.

The way in which these experiences have become integrated into a coherent personality structure determines the adult's ability to balance inner needs with the cultural requirements of his environment.

Derivatives of unresolved needs, fears and resentments retain their dynamic force and influence the adult's motivations. Factors of this kind account for undue vicissitudes of the parent-child relationship. They have to be dealt with by the clinician who attempts to regulate the mutual adjustment between parents and children. In this sense, genetic-dynamic considerations become the rationale for the collaborative approach to the emotional disorders of children.

For some of the Committee the genetic dynamic viewpoint of infantile psychosexual development, previously expressed, has certain values and points of emphasis which are not fully satisfactory. The members consider that ego organization in the child takes place in the interaction between parent and child, the critical point being the dosage of frustration to the child's impulse as it occurs spontaneously rather than in a studied fashion. Out of the frustration of the child's impulses emerges a sense of self as differentiated from object. Feeling (as affect) is developed which is a product of the frustration. The nature of the feelings (as to whether more positive or negative) is determined to a large degree by the conscious and unconscious feelings of the parents. Broadly speaking, these feelings color the ego distinctively and become effective concomitants of impulses toward unity with parent figures and for separation from them (the parents).

In an ideal situation the developing ego should be able to harmonize and accept the instinctive needs of the organism for a balance between unity with the parent and separation impulses largely seen as aggressive moves toward the mastery of reality tasks. It is necessary for the child to identify with the parents as powerful figures in order to feel supported in the task of mastery of reality. Where the developing infantile impulsive for mastery of reality and aggressive self expression is threatening to parental ego integrity however, the nature of parental feelings directed toward the child no longer allows the parent identification to support the ego of the child and impulses toward mastery of reality are withdrawn from acceptance by the child's ego. The child turns toward the parent, not only repressing hostile and aggressive feelings, and courting the approval of the parent, but the child may also be seen as striving to master the parents by compelling the wanted feelings from them.

In the course of such a struggle with the parents, the instinct for mastery is expressed as attempts to control the action and feelings of the parents. Further, since in this instance there is no support for mastery in the reality sphere, uniting and libidinal feelings become too identified with the parental ego; balance between self and object can then only be maintained by the repression of uniting impulses. Thus it may be seen that interpersonal vicissitudes are the critical factor as to whether the forces of the total personality move toward the mastery of reality or continual conflict in relationship.

Motivations for growth cannot be understood as arising out of the need to renounce wishes prohibited by the parents in order to retain their love and remain in good standing. For some this represents too great an emphasis on the negative motivation for growth. In many emotionally disturbed children this emphasis is in the ascendency and represents a barrier in a process of self actualization which is the goal of the biological forces. Cultural forces, in the normal process, support this goal while defining how individuality can be harmonized with social realities. When viewed with this emphasis, frustrations become positive motivators for development. This is not an attempt at the expression of a completely different point of view, but only a different emphasis on directional dynamics.

Development of Clinical Method.

The earliest clinical efforts were educational and "preventive"; they aimed at educating parents to
make children "good." Gradually there emerged a
tendency to work with children directly. The latter
move was enhanced by a general, cultural trend which
pointed up the importance of recognizing the inher-
ent capacity of a child to grow and develop as an in-
dividual and not as an automaton. This trend was
exemplified in the child welfare and progressive edu-
cation movements that found new vitality through a
greater realization of children's capacities to change
and learn under favorable conditions. The psychi-
atric experience of World War I stimulated the de-
velopment of psychiatric clinics for children and in-
creased the interest inside and outside various schools
of psychiatric thought in work with children. How-
ever, understanding of the relative effort that should
be applied to parents or to direct interpersonal
attempts to influence the child, was slow in devel-
oping.

Child analysts devoted their major efforts to the
study and modification of conflicting trends within
the child, drawing the parents into the treatment
tsituation in a widely variable way, often through
the parents' personal analysis. A specifically Ameri-
can contribution to child psychiatry was the Child
Guidance Clinic, a structure which developed out of
the interest of psychiatrists, psychologists and social
workers in how to help disturbed children and their
parents. The professional knowledge of these groups
gradually fused and made clearer the concept that a
child is in a dynamic relation to significant people in
his environment. Out of this concept evolved a
therapeutic philosophy which included modification of
both environment and child in ways most favor-
able for his psychological growth. This philosophy
was implemented in the team or collaborative ap-
proach, which provided for active participation of
parents in a therapeutic process focused on the dis-
turbances in the parent-child relationship. Parent
participation was felt to be a necessity since, in most
instances, the child is brought for help because the
parents are concerned about him—a child does not
seek help because of his own insight. Experience in
guidance practice demonstrated also that a child
can sustain a change in his personality only with the
support of his parents or their substitutes. While it
is clear that child guidance clinics did not discover the
important influence of the parent on the emotional
development of the child, the fact remains that the
collaborative work of these clinics has refined the pro-
fessional skill needed to include parents in the clinic
service designed to help a child with his emotional
difficulties.

Different Settings for Child Psychiatry.

The practice of child psychiatry has developed in
many settings. Those services which have developed
out of the concern of society rather than that of the
parent, have tended to be most variable in nature and
differ in the manner in which the help of the parent
figure is enlisted. Thus the school develops a service
out of its concern not only for the particular child,
but for the group as well. Services developed in con-
nection with courts tend to be diagnostic. Some
social agencies have incorporated psychiatric service
for children or have sought psychiatric consultants
for carrying out the work of the agency. Other
services have been developed in general and pediatric
hospitals. Where these services have been in connec-
tion with teaching hospitals and medical schools,
there has been an increasing influence on medical edu-
cation and pediatric practice.

Recently resident centers have developed where the
child is admitted for the purpose of providing psy-
chotherapy in a controlled environment. A skillful
handling of the daily living medium must be coordi-
nated with the child's use of therapy. Resident
training programs have taken the form of psychi-
atric wards in hospitals or community units. They
usually operate in association with outpatient or child
guidance clinical services.

II. TRAINING FOR CHILD PSYCHIATRY.

As the differences between adult and child psychi-
atomy become clear and accepted, it follows that the
professional training required for the development of
clinical competency is the most important problem
confronting this field. This competency requires
special training.

The foundation of this training is in medical edu-
cation and in the training in basic psychiatry. Some
clinical experience with well and physically sick chil-
dren is also desirable. The present policy adopted by
the American Board of Psychiatry, and the Ameri-
can Association of Psychiatric Clinics for Children,
that requires two years of training in adult psychi-
atomy before fellows are accepted for training in child
psychiatry, is sound in theory. Whether this policy
is sound in practice depends upon the quality of
training provided in these basic years. Too fre-
quently this basic training has been inadequate, par-
ticularly in the development of psychotherapeutic
skill. It is unusual to find a student entering the
children's field who has had real supervision during
the years he has devoted to the psychiatric care of
adults. His professional development suffers from
this serious gap in psychiatric training. Competent
individual supervision is essential for the develop-
ment of psychotherapeutic skill, and, in the opinion
of the Committee, there can be no substitute for this
essential part of psychiatric training.

This Committee is and will be concerned with the
quality of the training and service programs offered
in the clinical resources developed to treat emotion-
ally disturbed children. In our contacts with other
professional groups concerned with standards, such
as the American Association of Psychiatric Clinics for
Children, the sub-committee on Training of the
National Institute of Mental Health, the section on
Child Psychiatry of the American Psychiatric Asso-
ciation, we can assist in determining and raising the
standards in new clinics developed to meet the rap-
idly expanding need. This expansion accelerated by
the funds allocated to states under the National Men-
tal Health Act, has created a situation that threatens
these standards. Some clinics today are being started
with personnel who have had inadequate
training in this field. Too frequently psychiatrists
are drawn into positions in child psychiatry without
any specific training. This Committee wishes to
state that the practice of starting clinics with un-
trained personnel is jeopardizing the standards that have been established and which are essential for a clinical service that can be helpful. Starting a poor clinic just because funds are available and because there is a need for a clinic, will result in a lowering of standards and a consequent impoverishment of the clinical field where needs are great.

Training programs should be built around three interrelated facets—clinical experience, competent professional individual supervision of this experience, and seminars on various aspects of the clinical work.

Clinical responsibility requiring the fellow in training to fulfill a therapeutic role, provides the heart of the training. Here he is not a mere observer learning about children, but an active participant in a process designed to help an emotionally disturbed child. Competent supervision of the fellow's clinical work by a well trained child psychiatrist is an essential part of training. This supervision aims both to teach therapeutic skill and to guide the professional development of the fellow who is learning what is demanded of him in becoming a therapist. While some members of the Committee feel that a personal analysis should be an integral part of training, all agree on the dynamic importance of supervision in the training of the child psychiatrist. However, some training centers require analytical training either before or during training. There is little question in the minds of the Committee that basic personality modification is a necessary part of acquiring skill as a child psychotherapist.

Organized seminars in various aspects of child psychiatry under competent professional leadership are essential parts of a training program. We are not ready to make a detailed statement on the scope and content of these seminars but agree that they should be built around the essential features of a clinical service designed to deal with the unique features of child psychiatry. These seminars should grow out of and be focused on the clinical program in which the student is having a training experience. They are not designed to cover the whole field of psychiatric education or to make up for deficits in the preliminary training of the student. Important seminars in a training program should cover at least the following:

1. Growth and Development—Normal and Deviate.
2. Psychotherapy.
3. Interrelated Movement of Parent and Child in a Clinic Service.
4. Psychological Services in a Clinic.
6. Community Resources—Schools, Courts, Social Agencies, etc.

The best training can be provided in clinics having two or more fellows at the same time and at the same level of training. While we realize this is not always possible at present, adequate training in child psychiatry requires two years.

Since the structure of a child guidance clinic and all other psychiatric services for children has been built and refined by the use that parents and children have made of the developing skills of the professional staff who provide this service, it follows logically that this type of clinical facility provides one of the most important training resources. Also, it is apparent that the major developments in this field will come through the expansion of this type of facility as communities throughout the country awaken to the need of developing more clinical resources to provide therapy for the emotionally disturbed child.

In view of these developments we believe the clinic structure which includes professional collaboration between psychiatrists, psychiatric social workers and psychologists, should be regarded as the best training resource for psychiatrists who want to develop competence in child psychiatry. A more selective training is developing in psychoanalytic institutes where competent child analysts are available. It is important to stress that psychoanalytic experience solely with adults or with two or three children does not give the analyst competence in the child's field. Psychoanalytic training programs now being planned to train child analysts regard clinical experience in a qualified psychiatric clinic for children as a prerequisite for this training.

Knowledge about the nature of childhood and the growing up process has been incorporated into current practices in the various types of clinical programs developed to help the emotionally disturbed child. All of these services—whether developed in a child guidance clinic, in private practice, in psychiatric facilities associated with pediatric clinics and hospitals, in residential programs providing psychotherapy—have recognized the importance of parental participation in the services, both in planning for help and in the sustaining place they can have in the service. When parents act on a decision to seek help for their child and make the first appointment, the structure set up to provide the service takes on life.

Importance of the Intake Process.

When a parent makes a move to get the help of a psychiatric service for his child, the emphasis shifts from a consideration of the problem itself to what they can be helped to do about the problem. Thus a new element is introduced into the problem for which help is sought. That element is the process that helps parents to plan with the clinician how the clinical service they have chosen can be developed and used effectively. The clinical person who helps the parent as he takes this first step to plan for psychiatric service for a child, will need to be sensitive to a number of principles, all of which apply in varying degrees to every case. These are:

1) The decision of the parents to ask for psychiatric help, generally if not always, is the outcome of some degree of crisis within the family, the nature of which is not always easily discernible. It is important, therefore, for attention to be directed to the conscious or unconscious motivations that impel a father and mother to action at this particular time.

2) The parents are, in some degree, emotionally disturbed.

3) The behavior pattern of the child represents his efforts to make an adaptation to himself and to a family situation in which he lives and is related to.
and an outgrowth of elements in the interpersonal relations in the family. There is conflict both in the child and in the family in which the problems arise. This behavior, which can be an expression of the parental disturbance and an adaptation to it, becomes a focusing factor in the first and the parental involvement frequently is marked by shifting responsibility on the child or assuming all responsibility for creating the child's problem.

4) The clinician (in most cases a social worker) who is assisting the parents to make a plan to get help for the child, must be sensitive to the way pathogenic parental patterns contribute to the child's disturbance and how their anxiety is displaced by focusing all attention on the child. This often takes the form of an objective description of the child's problematic behavior which serves to hide their own anxiety.

5) Whether the decision of the parents to enlist the assistance of a psychiatric service is or is not the result of advice, suggestion or insistence of friends, relatives, physician, school, court authority, or social agency, it always involves varying degrees of anxiety arising from shame, guilt about their feeling of failure, etc. These emotional reactions, focused by their positive decision to seek help, will be disguised in varying degrees of denial, suppression and repression, projections and rationalization and represent the negative defensive reactions of parents who are asking for help.

6) In reacting to these emotional disturbances, parents may place the entire problem on the child or assume the entire responsibility and leave the child no place in the problem nor in the plan to help him. In helping the parent to test out the validity of their decision to seek a recognized children's service, skillful use can be made of defining the nature of this service and how it can be effective.

7) Depending upon the degree of their awareness of their feeling about themselves in their present dilemma and their acceptance of their need for help in a crisis, and upon the skill of the clinician1 in recognizing the relation of the emotional disorder of the child to that of the parents, there will remain varying degrees of difficulty experienced by the parents in accepting whatever part they will need to take in a therapeutic program. This difficulty, present in some degree in every case, will in no small measure be modified by the skill, judgment and experience of the clinical person, and by his conviction on two essential points: a) on the intra-familial nature of the disorder and hence of the need to help both father and mother take a real part in this service, if the service is to have significance and be durably helpful to the child; b) on the structure of the service as it is then defined, while respecting the parents' responsibility to decide whether or not they can move on to use it.

Difference in Clinical Procedures That Develop Following the Intake Process.

It is about these latter principles that a considerable disagreement still exists among psychiatric prac-

1 Throughout this report, the word "clinician" refers to the professional person with an assigned responsibility in a clinic service.
In the first pattern, the more concisely formulated plan of working determines the division of responsibility; in the second, it is the clinical judgment of the staff that determines procedure. In the first, the parent can be given a clear picture of how the clinic service operates in the application interview, and can use that clarity in making a decision to use the clinic. In the second plan, it is the staff making this decision after the application interview that determines the way the clinic operates. In most clinics operating on either plan, the application procedure is developed by the social worker.

A great deal can be developed about the relative values of these two main differences in child guidance practices. The Committee has not reached any agreement on these important points and hopes to render a more detailed discussion of the principles underlying them in a subsequent report. The deliberations of the Committee on Psychiatric Social Work will have a most important place in our discussion on this.

Some Principles Essential in Helping a Parent Reach a Decision to Use a Clinical Service.

It is the opinion of some child psychiatrists that if the parental emotional involvement in the problem which the child presents to himself and/or to others, is clearly and sensitively recognized and accepted by the clinician (i.e., with neither subtle blame of parents nor with conscious or unconscious over-identification with either the child or the parents) the initial anxieties of the parents at the outset are more likely to be reduced sufficiently to permit them to go on with a therapeutic service that includes parent and child. Such work may tend towards a further re-definition of roles within the family, which tendency the crisis has often already initiated and which eventually may result in their common greater comfort in living together. This does not mean that in the field of child psychiatry anyone more than in any other medical field, even those most experienced will not meet with failure in his or their efforts. In fact, such experienced professional people realize that the parents and the child may find it necessary, and have the right, to reject not only their most considered judgment but their offer of therapeutic work with them individually or collectively. This very absence, or relative lack, of any authoritarian trends in clinical attitudes towards the family, is one of the best therapeutic means at their disposal. This does not mean that they are ever hesitant or less than frankly authoritative with respect to their opinion and judgments. Such firmness is the real support they can offer to the vacillations of the family. Their willingness to try to be of help along with such firmness and confidence as to what can be of help to them is often steadying to their conflicting feelings even in the event they decide not to accept help over a longer period in the more regular and systematic meetings known as psychotherapy.

A Broader Concept of Diagnosis in Child Psychiatry and the Avoidance of Nosological Schemata.

It may be noted that the word diagnosis has been omitted from the above discussion, because the emphasis has been on the operational elements that make diagnosis a dynamic rather than a static concept. Nosological schemata, describing as they do fixed entities, are neither satisfactory nor valid—at least in the clinical attitudes of some psychiatrists and clinical teams who are interested primarily in therapy. This means there is less interest in merely classifying or categorizing a child's symptom complex or behavior disorder by a nosological title, than in exploring suitable possibilities of therapy, whatever the severity, chronicity or characteristics of the disorder. It is also an indication that in the opinion of those professional people providing a clinical service, the nosological title does not do justice to the close, although often subtle, interrelation between the frequently less obvious disorder of each of the parents (as well as of the conflict between them) and the disorder of the child. Classifying or labeling the disorder of the child as one or another sub-category of neurosis or psychosis, or of behavior disorder, not only tends to emphasize the apparently solipsistic nature of the child's problem but often also carries with it a subtle prognostic implication which in itself may be an expression of extremes of therapeutic pessimism or optimism affecting unfavorably what might be accomplished in therapy. All this, however, in no way implies any neglect of a clinical evaluation of the probable difficulties to be encountered in therapy. Close scrutiny of the genesis of the crisis as well as of its less troublesome antecedents is essential in order that the nature of the events, feelings and persons involved are thoroughly understood. In addition to this, the skill and time available within the clinic staff or of the private practitioner which may be required, is also surveyed and estimated. Bearing these points in mind, diagnosis in the etymologically correct sense of "knowing the situation through and through" is more nearly achieved.

Among the possible measures of therapy, separation of the child from the home and offering the psychotherapeutic influence of a psychiatric hospital ward for children, or of a special school, or a residential treatment center, can be considered by the clinician where the total family situation as well as the condition of the child makes this more advisable. The decision to take such a step, mutually arrived at with the parents (as a phase of total therapy), is guided by the same dynamic principles previously discussed. The difficulties of many parents in arriving at this decision are often greater and more acute and (at times) require a great skill on the part of the clinicians.

Development of New Ways of Dealing with Heavy Caseloads in Clinics.

In the case of the psychiatric clinic for children, in view of its relation not only to individual families of its community who support it and may seek its assistance, but also to other community agencies and authoritative persons, there are additional problems with respect to intake. It is a common experience that almost no matter what the size of the clinic staff and the skill of its personnel, there is generally a much greater demand for its services than can be supplied. This immediately raises questions as to policies of selection of cases for therapy, as well as to
what, if anything, can be done for those families referred but for whom there is no available time for, (a) psychotherapy, or (b) a brief consultation service. The relations of the clinic psychiatric social worker with workers of other agencies, as well as her skill in dealing helpfully with the pressures upon such other agency personnel, are often of critical importance. The reservation of some of the clinic's staff time for shorter consultation services which include a subsequent conference with the referring agency or individual, is helpful in arriving at some understanding and at some tentative decision as to future action by such agency in regard to the crisis. Such consultation service—always offered with a clear statement at the outset as to the actual possibility of longer therapy—is more frequently helpful than might be expected. Although such consultation services generally are not included in the discussion of the intake procedures, their availability to the intake worker to offer them to parents and to such community agencies frequently affects beneficially the pressure of the crisis upon everyone concerned, especially when therapy in the systematic prolonged sense is not available. In this sense the offer of consultative review, even when not used, can be, in a sense, "therapeutic" as well as "diagnostic" in a more dynamic sense.

In summary, the initial interviews stress the significance of the place of the parent in initiating, planning and then sustaining the child's experience in psychotherapy.

DISTRIBUTION OF THIS REPORT

American Psychiatric Association, Request List from Members (approx. 3,100)

Request List from Psychiatrists, Psychiatric Nurses, Psychiatric Social Workers, Psychologists, Medical Libraries, etc., United States and Foreign Countries

State Mental Hygiene Organizations of United States

State Mental Authorities of United States

Provincial Directors of Mental Health Services in Canada

Member Organizations of the World Federation for Mental Health

Professors of Psychiatry, Professors of Preventive Medicine, and Professors of Pediatrics of Medical Schools of United States and Canada

American Orthopsychiatric Association

Member Clinics of the American Association of Psychiatric Clinics

Members of Section on Mental Growth and Development of the American Academy of Pediatrics

Steering Committee, American Academy of Pediatrics

GAP
Group for the Advancement of Psychiatry

The Group for the Advancement of Psychiatry has a membership of approximately 150 psychiatrists, organized in the form of a number of working committees of about 10 members each, which direct their efforts toward the study of various aspects of psychiatry and toward the application of this knowledge to the fields of mental health and human relations. GAP is an independent group and its Reports represent the composite findings and opinions of its members only, guided by its many consultants.

Collaboration with specialists in other disciplines has been and is one of GAP's working principles. Since the formation of GAP in 1946 its members have worked closely with such other specialists as anthropologists, biologists, economists, statisticians, educators, lawyers, nurses, psychologists, sociologists, social workers, and experts in mass communication, philosophy, and semantics. GAP envisages a continuing program of work according to the following aims:

1. To collect and appraise significant data in the field of psychiatry, mental health and human relations;
2. To re-evaluate old concepts and to develop and test new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

Committee on Academic Education
Dana L. Farnsworth, Cambridge, Chr.
Grace Baker, New York
O. Spergon English, Philadelphia
Clements C. Fry, New Haven
Herbert J. Harris, Boston
Edward J. Humphreys, Trenton
Frank J. O'Brien, Brooklyn
William M. Shanahan, Chicago

Committee on Child Psychiatry
William S. Landis, New York, Ch.
Frederick H. Allen, Philadelphia
E. E. Landis, Louisville
J. Franklin Robinson, Wilkes Barre
John A. Rose, Philadelphia
Mabel Ross, Washington
Emmy Sylvester, Chicago
Stan Szurek, San Francisco
Adrian Vander Veur, Chicago

Committee on Clinical Psychology
Paul Huston, Iowa City, Chr.
Daniel W. Bade, Cleveland
Norman Cameron, Madison
George E. Gardner, Boston
James G. Miller, Chicago
Fritz Redlich, New Haven
Committee on Co-operation with Government Agencies
Calvin S. Drayer, Philadelphia, Chr.
Norman Q. Brill, Washington
John M. Caldwell, Jr., Washington
Dave Cameron, Washington
T. E. Dancey, Montreal
Malcolm J. Farrell, Waverley
Thomas A. Harris, Washingon
Gordon H. Hutton, Vancouver
Lauren H. Smith, Philadelphia

Committee on the Family
John P. Spiegel, Chicago, Chairman
Sidney Berman, Washington
Wilfred Bloomberg, Framingham
Milton Kirkpatrick, New Orleans
Henry C. Schumacher, San Francisco
George S. Stevenson, New York

Committee on Forensic Psychiatry
Philip Q. Roche, Philadelphia, Chr.
Vernon C. Bransham, Washington
Walter Broomberg, Reno
Hervey Cleckley, Augusta, Ga.
Frank J. Curran, Charlotteville
Manfred S. Guttman, Baltimore
LeRoy Maeder, Philadelphia

Committee on Hospitals
Harvey J. Tompkins, Washington, Chr.
Walter Barton, Boston
Kenneth E. Appel, Philadelphia
Walter H. Baer, Peoria
Brian Bird, Cleveland

Committee on Military Education
Milton Rosenbaum, Cincinnati, Chr.
Spafford Ackerly, Louisville
F. G. Ebaugh, Denver
F. J. Gerty, Chicago
Alan Gregg, New York
Ives Hendrick, Boston
Henriette R. Klein, New York
Maurice Levine, Cincinnati
William Malamud, Boston
Karl Mensinger, Topeka
Thomas A. C. Rennie, New York

Committee on Preventive Psychiatry
J. S. Gottlieb, Iowa City, Chr.
John W. Appel, Philadelphia
Ivan Berlien, Detroit
Hugh T. Carmichael, Chicago
Arthur M. Doyle, Toronto
David M. Levy, New York
Erich Lindemann, Boston
Norman Reider, San Francisco
Leon Saul, Philadelphia
Milton J. E. Senn, New Haven

Committee on Psychiatric Nursing
Harry Solomon, Boston, Chr.
Helen R. Gilmore, New Haven
Wilbur H. Miller, Iowa City
Elvin V. Semrad, Boston
Francis H. Sleeper, Augusta, Me.
Lloyd J. Thompson, Winston-Salem
David A. Young, Raleigh

Committee on Psychiatric Social Work
Jules Coleman, Denver, Chr.
A. Z. Barbaeh, New York
Irene Josselyn, Chicago
Marion Kenworthy, New York
Hyman Lipman, St. Paul
Joseph J. Michalski, Boston
Don P. Morris, Dallas
Lewis L. Robbins, Topeka
Exie E. Welsch, New York

Committee on Psychiatry in Industry
Ralph T. Collins, Rochester, N. Y., Chr.
Lew H. Bartemeier, Detroit
Temple Burling, Ithaca
Frederick R. Hanson, New York
William E. Keller, Louisville
Alexander Leighton, Ithaca
Hewitt Varney, Washington
Walter D. Woodward, New York

Committee on Public Education
Paul Lemkau, Baltimore, Chr.
Edward G. Billings, Denver
Carl Binger, New York
Robert H. Felix, Washington
John D. Griffin, Toronto
John F. Lambert, Rochester
Robert T. Morse, Washington
Howard P. Rome, Rochester, Minn.
Julius Schreiber, Washington
C. G. Stopfili, Ottawa
Harry W. Weinstock, New York

Committee on Research
Jacob E. Finessinger, Boston, Chr.
George L. Engel, Rochester, N. Y.
Thomas M. French, Chicago
Edwin F. Gildea, St. Louis
Merton M. Gold, Stockbridge
Roy E. Grinker, Chicago
Joseph Hughes, Philadelphia
Lawrence C. Kolb, Rochester, Minn.
I. Arthur Mirsky, Cincinnati
Jorgen Ruesch, San Francisco

Committee on Social Issues
Helen V. McLean, Chicago, Chr.
Nathan W. Ackerman, New York
Charlotte Babcock, Chicago
Viola Bernard, New York
Sol Ginsburg, New York
Gerhart J. Piers, Chicago
Janet Riech, New York
Arthur H. Ruggles, Providence
Rutherford B. Stevens, New York

Committee on Therapy
Maxwell Gitelson, Chicago, Chr.
Bernard Bandler, Boston
M. M. Frohlich, Ann Arbor
M. Ralph Kaufman, New York
Lawrence S. Kubie, New York
Theodore Lidz, Baltimore
Alfred O. Ludwig, Boston
Sydney Margolin, New York
William C. Menninger, Topeka
PRESIDENT
Henry W. Bronin, Chicago
SECRETARY
April, 1959