THE CONTRIBUTION OF CHILD PSYCHIATRY TO PEDIATRIC TRAINING AND PRACTICE

Formulated by the Committee on Child Psychiatry of the Group for the Advancement of Psychiatry

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I. INTRODUCTION—NEED FOR A STATEMENT

For some years many pediatricians and psychiatrists have been keenly aware of the importance of incorporating into general medical practice with children some of the insights and skills developed in psychiatric practice with children and their parents. As child psychiatry emerged as a sub-specialty within the broad field of general psychiatry, forward looking pediatricians turned to it for knowledge which might help them in their daily practice, not only to assist them in evaluating and helping children presenting symptoms of emotional disturbance but also in the preventive job to be done. Child psychiatrists have been brought into pediatric teaching and training centers; they have been invited to present papers and to participate in discussions at professional society meetings: they have been asked to advise about and to take part in well-baby clinic activities. An increasing number of articles dealing with topics related to child psychiatry have appeared in pediatric journals. This interest seems to have been spurred on by an awareness of the broader implications of pediatric practice as well as by a heightened interest in mental health in the community at large, which has resulted in more demands being made for attention to the emotional aspects of child rearing and child health practice.

The rapprochement between psychiatry and pediatrics has been slow. Its development has been hampered in the past by a certain amount of mutual suspicion and distrust with, at times, outright hostility. While many factors have been involved in these unfortunate attitudes, there has without doubt been a good deal of confusion with regard to what child psychiatry has to offer pediatrics. Over a period of years sufficient experience has now accumulated to make the Committee on Child Psychiatry believe that the time has come to outline that contribution more precisely. Most of the Committee members have been actively engaged in cooperative work with pediatricians, and this statement is based on our own experiences as well as on the experiences of others.

II. HISTORICAL BACKGROUND

Both medical specialties—pediatrics and child psychiatry—are relatively young and have undergone considerable change in their orientation and mode of practice during the past quarter century. The recent survey of the Academy of Pediatrics reveals that a little over half of the visits to pediatricians, and almost a third of the visits of children to general practitioners, are concerned with health promotional activities—immunizations, feeding advice, physical checkups, counseling and the like. Early in its history pediatrics was concerned primarily with keeping children alive and curing their ills. Knowledge about the causes of some of the infectious diseases and those due to nutritional deficiencies led to effective measures for the prevention of many illnesses. Pediatricians then became concerned not only with therapeutic and preventive efforts but saw as a field of practice the fostering of normal growth and development through the positive promotion of health. This trend was evident even before the advent of modern chemotherapeutic and antibiotic agents took much of the terror from many childhood illnesses. An interest in the mental health aspects of pediatric practice then logically followed. As would seem almost inevitable in any truly medical field because of its tradition and history, attention was initially focused on the treatment of the emotional disturbances of children. This interest soon was followed by one of prevention, and then of mental health promotion involving all aspects of day to day pediatric practice. Although the physician continues to have as a most important job that of healing illness and curing defect, in pediatric practice these other aspects are perhaps more important at present than in other fields of medical activity.

Psychiatrists early recognized the importance of the childhood period in the development of emotional disturbances in later life, and the role of the pediatrician in affecting child-rearing practices was seen as important. Child psychiatry began with a goal of prevention of adult disturbances through the treatment of childhood disorders but soon began to concern itself with the development of effective means of treating children in the present. The body of knowledge was limited at first but has developed rapidly. As long as child psychiatrists were primarily concerned with building up a body of knowledge about childhood personality, its development, the factors which influence it positively and negatively, and therapeutic methods, it was perhaps premature to expect them to be entirely clear about what they could contribute to pediatrics. This lack of clarity, based on lack of knowledge, was important in the confusion. Pediatricians were urged by psychiatrists to do more to prevent disturbances, without there being, as yet, a well defined set of working principles. Spock tells, for example, about learning that toilet training should not be done "too early" but no one could tell him just when was "too early." At the present time, although our knowledge is far from complete and although full agreement is still lacking among all in the field as to many details, there are certain basic principles which are generally accepted. These basic principles, which have been derived out of clinical practice with disordered children and leavened with contributions from other fields concerning normal growth and development, would seem to afford a sound basis for outlining what child psychiatry has to offer pediatrics.
III. STOCK TAKING OF PREVIOUS PROGRAMS

Almost all of the earlier programs in which child psychiatry and pediatrics found themselves related have been distorted to a greater or lesser degree by a lack of clarification concerning the unique features of each setting. Psychiatric clinics for children when established in hospital out-patient department settings have tended to reflect a vague concept of their potential contribution to pediatric practice. They tended to become preoccupied with the rendering of clinical psychiatric services and were used by pediatricians as places to which to transfer patients. There is apt to be little or no free communication or interchange between the two services. There is no doubt that clinical child psychiatry made its greatest progress when it clearly differentiated itself from pediatric practice and from adult psychotherapeutic practice. However, it would seem that in this differentiating process a point of unhealthy isolation was reached. The greatest errors in teaching seem to have been made when the nature of pediatrics and the nature of child psychiatry were represented as similar or as completely unrelated; actually a common set of principles is utilized differently according to the nature of the setting in which practice takes place.

The child psychiatrist, secure in the setting of his own practice and with the clinical tools he had developed, was too apt to say, "Do it our way." His lack of familiarity with the nature and setting of clinical pediatric practice contributed to this attitude. In his teaching to the pediatrician he was too prone to stress the more severe psychopathological problems of childhood and the skills needed in their therapy. He was fearful lest the pediatrician attempt to deal with the problems which he was not equipped to handle, yet the psychiatrist strongly believed that some knowledge from child psychiatry was important to the pediatrician. The fear that the pediatrician, inadequately trained in child psychiatry, might attempt to do deep psychotherapy led to an expressed belief, by some in the field, that the pediatrician had no place in the emotional problems of childhood. This fear was intensified at times when interested pediatricians, consciously undertaking to influence the emotional lives of children and parents, borrowed techniques from the clinical setting of child psychiatry and attempted to use them in the pediatric practice. The failure of these techniques to work as expected contributed to the rejection by many pediatricians of what psychiatry had to offer. Some of the older, clinically seasoned pediatricians, who had in the course of their practice developed more or less effective methods of dealing with the milder emotional problems of children and of helping parents, expressed their doubts about the direct contributions from child psychiatry. The confusion was made somewhat worse by attempts to deal with this question, of who should influence the emotional lives of children and parents, as a prestige problem. In these efforts at cross purposes one finds evidence that, on the one hand, it was assumed that in order to do child psychotherapy it was necessary to be a qualified pediatrician and that, on the other hand, in order to do clinical pediatrics it was necessary to be qualified as a child psychotherapist.

During the past twenty years a number of programs have been set up in pediatric teaching centers for the purpose of orienting or training pediatricians in child psychiatry, usually at the resident training level. These have taken various forms. At times a child guidance clinic has been established administratively in pediatrics, and at others, administratively in the department of psychiatry of the hospital or medical school but with what is hoped to be a close working relationship with the pediatric service. Pediatric residents have been assigned to some of these clinics for varying blocks of time. On occasion the assignment completely removes them from the pediatric setting and in other centers their activities remain primarily pediatric but with the psychiatric assignment existing for orientation and supervisory purposes. In some settings psychiatric consultants are assigned to the pediatric service. In others, a pediatrician acceptable to the pediatric group has been trained in child psychiatry and then returns to the pediatric setting; here it is hoped that his familiarity with the nature of pediatric practice will obviate some of the confusions. In at least one instance a clinical psychologist has been brought into the pediatric setting. At times a psychiatric team of psychiatrist, clinical psychologist and psychiatric social worker has been added to a well-baby clinic. All too often in such endeavors as these the child psychiatrist is utilized mostly for clinical service and finds himself treating cases rather than contributing more broadly to the pediatric service or to the education of pediatricians. At times he has seemed to prefer it this way, feeling more comfortable in his own clinical setting, and the never ending stream of referrals makes this easier. Often where there have been attempts at teaching, as stated above, there is unclarity of goal, too much stress on psychopathology as such, and a tendency to leave it up to the pediatrician to cull out from the assembled psychiatric knowledge and techniques what is applicable to his own practice.

There has been going on, however, a determined effort to gather the constructive principles of child psychotherapy and to apply them to pediatric training programs. In the training programs where full psychiatric competence has been brought to bear on training in the pediatric field as opposed to a primary function of giving clinical service, there seems to have been less confusion, less unclarity of goal and fewer prestige conflicts. The pediatrician sees the validity of his job as a pediatrician and of the application of sound psychological principles in the pediatric setting. There is less tendency to rejection of child psychiatry or to wholesale, uncritical taking over of psychiatric techniques with a concomitant lessening of effective pediatric functioning.

Senn’s program of training pediatricians in child psychiatry, although it was at the post-residency level, illustrates many of the principles involved in training men who would be contributors to pediatrics and not those who would leave the field and go into the clinical practice of child psychiatry. In the light of Senn’s experience it would appear that

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1 There are now about 20 such programs in the United States.
2 This Committee defines child psychotherapy as including efforts toward modification of both the child and his environment in ways most favorable for his psychological growth; it includes the active participation of parents in the clinical service designed to help children with emotional difficulties.
clarification of principles and procedures of training came from sound selection of candidates and as the setting in which the training took place became more pediatric and less psychiatric. It would also appear that one may take even a soundly motivated individual and confuse him by offering a disproportionately large percentage of training time in a setting which is essentially non-pediatric. When this was the case the individual was more apt to leave the field of pediatrics.

It is now accepted that the major emphasis of training must take place in a pediatric setting and that the child psychiatrist contributing to it must understand and respect the unique nature of this setting. Then the effectiveness of the teaching program is enhanced and prestige conflicts are minimized. Where an effective program is in operation one can expect to see changes in the general functioning of the hospital—such as the gearing of admission procedures, visiting hours, or nursing care to meet better the psychological needs of children and parents—and changes in the attitudes of all hospital personnel, both professional and housekeeping. It should be emphasized that the child psychiatrist stands to learn a good deal about doctor-parent-child relationships in the pediatric setting. Each specialist can learn that there are certain principles of practice and administration which may be transferred from one setting to the other as principles, even though not as actual methods of practice.

IV. RELEVANT KNOWLEDGE FROM CHILD PSYCHIATRY

The working inter-relationship between pediatricians and child psychiatrists has helped to define those aspects of child psychiatry which are applicable to and useful in clinical pediatric practice. The body of knowledge which can be drawn into pediatrics from child psychiatry is conveniently grouped around the following topics.

1. Knowledge of personality growth and development.

Maturation in the emotional, social, intellectual and physical spheres is affected by the interplay of a variety of forces, somatic, hereditary, cultural and interpersonal. There are now available considerable data about growth in behavior as well as changing needs of the child at various developmental stages. Child psychiatry has accumulated much knowledge about parent-child relationships and their effects on the developing personality of the child. There is also understanding about the genesis of unsatisfactory parental attitudes, and methods of helping parents to change are available. Some of these clinical tools are adaptable to pediatric practice.

With this knowledge of growth and development and the factors influencing it positively and negatively, the pediatrician is able to gear his practices in such a way that he better meets the changing psychological needs of his child patients and their parents. He is able to guide and advise parents in a helpful way and to discover early in the game deviations which are then more easily corrected.

2. Knowledge of interviewing techniques.

In this area child psychiatry can contribute much to help the pediatrician and make a more effective use of his time in history taking and to aid him in his contacts with children and parents, both in health and illness. Improved interviewing techniques help the pediatrician as he deals with anxious, argumentative, or dictatorial parents. These skills include the art of showing respect for a patient or parent, the art of listening, the art of directing an interview without dominating it, the art of ending an interview without leaving the patient or parent with a sense of rejection or confusion, the recognition of both verbal and non-verbal communications, the problems of semantics and the importance of attitude.


Psychiatry has paid special attention to the relationship between physician and patient; in child psychiatry the parent-child unit is included. This knowledge is particularly helpful in day by day pediatric practice. As the pediatrician is aware not only of parent-child interactions, but also of his interactions with them, he is able to be more helpful in his counseling and advisory efforts. The meaning of the pediatrician to the child or parent may bear little relationship to his concept of his role in the situation. As these meanings, and the feelings involved, are understood and a capacity to deal with them developed, practice becomes more effective, whether physical illness, emotional disturbance, or health supervision is involved. The knowledge involved here has to do with the art of medical practice. It is usually developed in the course of clinical experience; such knowledge, however, has been systematized in clinical psychiatric practice and can be taught. A psychological approach to practice consists of much more than indiscriminate use of reassurance, lollipop or a "palsy-walsy" attitude. It involves an understanding of interpersonal relationships in the setting of clinical practice. It involves the attitudes and feelings of the child, the parent, and the physician.

4. Knowledge of the psychological reactions of children and parents to physical illness and convalescence.

Child psychiatrists, especially those working in pediatric settings, have made contributions to this area. The meaning of illness to a child or parent may include a sense of being punished, a feeling of self-blame, a sense of failure or even a sense of contamination. These psychological concomitants may affect the course of the illness or convalescence. The satisfactions which parents or children can gain from illness, particularly the dependency gains, are important. Child psychiatrists can learn much from pediatricians about the emotional regressions which take place in physical illness. From clinical practice child psychiatrists can be helpful in pointing out the iatrogenic factors in illness, physical and psychological, which stem from overtreatment or from pseudo-diagnoses such as a "touch of," "be careful, it might develop into," or "it might be."

5. Knowledge of psychopathology and symptom formation.

Child psychiatry has much understanding to contribute in regard to the development of psychopathological disorders and psychosomatic relationships. With an understanding of these the pediatrician is better able to deal with the mental health aspects of his practice. Along with this knowledge child psychiatry can give an understanding of the clinical psychiatric treatment measures; this will help
the pediatrician to determine those problems which should be referred for specialized help and those with which he, himself, can deal adequately. The limitations as well as the potentialities for psychotherapeutic work with children in pediatric practice are better understood at the present time than they were a few years ago. Further exploration of this area must be done by pediatricians and psychiatrists working together. The child psychiatrist and pediatrician together can arrive at an appreciation of childhood which neither overlooks serious disturbance when it is present nor sees it in every child. The tendency to do either connotes too little knowledge of psychopathology or of healthy children. As more has become known about the causes of emotional disturbances in children, child psychiatry is in a better position to impart to pediatrics sound knowledge about preventive measures to be taken. Such preventive efforts are based on a thorough understanding of normal personality development as well as a working knowledge of the psychology of interpersonal relationships in medical practice.

V. GOALS OF TRAINING

It is in the application of this relevant knowledge in pediatric practice that child psychiatry can contribute most effectively to the education of pediatricians by furthering the practice of "comprehensive pediatrics." Such practice would include constant alertness on the part of the pediatrician to the emotional implications of all he sees and does; understanding of the facets in the relationship between child and parent, between child and physician, and between parent and physician; the inclusion in histories of psychological data relevant to emotional development and to the problem at hand; knowledge of community resources and the ability to use them; the capacity to differentiate between problems which should continue to be handled by the pediatrician and those which should be referred to a child psychiatrist or elsewhere; and the ability to prepare properly both parent and child for such a referral. The practitioner of comprehensive pediatrics is comfortable about seeking psychiatric consultation because he has clearly defined to himself the areas of competence of the specialties (e.g., he does not practice direct psychotherapy). He knows that in his practice he makes as great a contribution to the emotional health of his patient as does the psychiatrist.

The comprehensive pediatrician views parents as potential collaborators rather than as intruders, and much of his effort is directed at lessening the anxiety which is ever-present in both parents and child. For example, he can conduct routine procedures (such as venipuncture, physical examination and hospital admission) as to minimize their anxiety-producing potentialities. Knowledge of one's own emotional responses and the capacity to control them are essential for a feeling of security in this type of practice.

At the November 1950 meeting of GAP it was the good fortune of this Committee to hear a description of one program, developed without the help of a psychiatrist, which exemplifies the philosophy of comprehensive pediatrics as we have attempted to outline it. The originator is Dr. James Spence, the Professor of Pediatrics, The Medical School, Newcastle-on-Tyne, and the account of his work was given by one of his assistants, Dr. Donald Court, who was our guest.

Newcastle is a relatively isolated industrial town, of homogeneous Anglo-Saxon population, whose strong sense of family and community responsibility was solidified by an economic depression. The guiding ideas of Dr. Spence's project seem logical developments from this social situation. They are: that medical practice should be centered on the family and should promote a feeling of competence therein, that the activities of hospital and clinic should support those of the family doctor and that the imparting of a proper attitude to medical students is more important than formal clinical knowledge. This philosophy permeates every phase of pediatric care at Durham University. In pre-natal clinic the pregnant woman meets the nurse, who discusses with her the hygiene of pregnancy, the advantages of breast feeding, and her own questions and concerns. The nurse then takes her to the hospital for a friendly visit with the chief resident pediatrician and the chief obstetrical nurse. So far the fathers have not shown up in this preparation, but this omission is rapidly to be made good. Some deliveries may occur in the hospital, but confinement at home is the rule. In the hospital rooming-in has always been the practice.

The pediatric out-patient department functions as a consultation service to help the family physician. It is conducted in a house with French windows which open on a lawn where the children play while they wait. In case-discussions with medical students, evaluation of the total situation is emphasized rather than the formal diagnosis.

It is felt too that young children with chronic diseases, including tuberculosis of the spine, often do not thrive in hospitals, and so where the home circumstances, parental attitude, and family doctor cooperation are favorable, a number have been treated at home with encouraging results. For premature infants born at home, Dr. F. J. W. Miller of the same department, has created a home service with a rate of survival over sixteen hundred grams which is equal to that obtained in hospitals. Here the primary function of the trained maternity nurse is to mobilize the family, and support the mother in the exacting task of rearing a tiny infant. If a child patient is admitted from the out-patient department, the family is conducted to the hospital by someone whom they know. If she wishes, the mother may share her young child's room and his nursing care. If she stays at home, she is asked to assist during her visits.

The program described presents obvious advantages, chiefly those of bringing the entire family into the picture in any clinical situation which concerns the child as a patient and of providing a prophylactic setting which should benefit all but the more serious psychological disturbances. Whether these advantages overbalance the limitations necessarily imposed on a thorough evaluation of the somatic problem is a question which cannot be answered without more extended observations.

VI. METHODOLOGY

The broadening of the training program of the future pediatrician to include pertinent principles and practices from child psychiatry can be achieved only when the pediatric personnel of the hospital (both administrative and clinical) really wish it. The support of the pediatrician-in-chief is particularly
important since all decisions regarding the teaching scope and function of child psychiatrists and the allotment of time of the resident to this instruction are in the last analysis made by him. Naturally a certain amount of ambivalence to these viewpoints and practices in child care is to be expected, but a genuine sympathy and enthusiastic approval on the part of the administration—and this demonstrated particularly in the initial stages of proposed expanded or enriched programs—will minimize antagonisms and hostilities. It is of equal importance that the child psychiatrist himself shall not assume the role of the aggressive evangelist, but rather shall appreciate that there are many aspects of the practice of pediatrics about which he knows very little and from which he can learn much of value in the practice of his own specialty.

Ideally, in the education of emerging pediatricians, the content regarding the emotional life of the child, interpersonal relationships, etc., outlined above, should be taught by a well-trained pediatrician in collaboration with a child psychiatrist familiar with the pediatric setting and integrally a part of it. However, in most instances the program can not be carried out in this way and the instruction—both individual and staff—will probably become the task of the child psychiatrist.

The opportunity for actual individual instruction, for consultations and for case discussions is best offered in the pediatric out-patient service. This is a most natural setting in that both child and parent are present and problems referable primarily to emotional relationships and only secondarily to the presence of physical disease are more apparent. The pediatric resident can obtain help and advice from the psychiatrist just as he would from any other specialist. Time must be allotted to the resident for individual supervision and consultation as well as the additional working time which a comprehensive case study demands. Hurried, routinized schedules imposed on either the supervisor or the resident will make instruction inadequate and ineffective.

Such instruction can be carried out also on the in-patient pediatric wards, and here again it is best centered in pediatric activities themselves. The medium includes (a) consultations with residents on specific cases; (b) the attendance of the child psychiatrist on ward rounds with the visiting pediatrician; (c) conferences with residents and ward nurse. The discussions can include points arising out of ward observations, physical examinations, medical and surgical procedures, effects of visits on particular patients, the effect of one child patient and the progress of his illness on the sense of security in other children, physical conditions of the ward, as well as the psychological effects of illness on children and parents. All such data are of instructional value and can be used to advantage in the training of the comprehensive pediatrician.

In addition to out-patient and in-patient hospital settings, the well-baby clinics (hospital or community sponsored) offer great possibilities for instruction in mental health principles. The great difficulty in using these facilities effectively in the past has been due to the large numbers of child patients and parents who are rushed through such clinics in the course of a two- or three-hour clinic session. More time should be allotted to the attending pediatricians and the residents-in-training if the significant emotional aspects of well-baby care are to be considered and possible preventive measures instituted. And by the same token, only under more leisurely conditions of work can adequate instruction of residents take place in the well-baby clinic. Here again, the instruction should center about usual pediatric activities rather than emphasizing possible psychopathology.

Where and by what means, administratively and pedagogically, can this instruction best be carried out? The most favorable opportunity for the expansion of the teaching role of the child psychiatrist in pediatrics is offered in those out-patient settings where (a) a clinic in child psychiatry has been established: or (b) where child psychiatrists have been added to the out-patient staff as consultants. In even rarer instances the teaching hospital may have both an out-patient child psychiatric clinic and a small in-patient psychiatric unit. This does not mean that the bulk of the instruction of the pediatrician will be done in these units. On the contrary, it is best done on the pediatric services. But the presence of a functioning child psychiatric unit—preferably in the out-patient department—is the most logical first step to take in the eventual desirable expansion of the residents’ instructional program. It lends prestige to the field of child psychiatry itself and can through its own work make the area and function of this specialty more meaningful and acceptable to both visiting staff and resident pediatricians. The personnel of such a child psychiatric unit in addition to being soundly grounded in child psychiatry should have the attitudes toward the teaching of comprehensive pediatrics discussed previously.

Certain direct pedagogical approaches can be used in the pediatric resident’s program, all of which should be related to his day-by-day functions as a pediatrician.

1. Direct supervision.
   Direct supervision in individual conferences dealing with problems arising from the professional experiences of the resident with children is of first importance. In the supervision of the resident’s treatment of a particular case or group of cases it must be borne in mind that such individual supervision is not aimed at making the pediatrician a psychotherapist, but rather it is aimed at enabling him to appreciate those methods, techniques and devices that he can use as a genuine and integral part of his own practice with children and with their parents.

2. Consultations.
   All consultations answered by the child psychiatrist should be used as media for instruction, and not merely as diagnostic sessions with an outline of opinions and advice.

3. Staff conferences.
   The inclusion in the hospital conference schedule of a certain number of staff conferences devoted to pediatric-psychiatric problems is desirable as a teaching device. The instruction in such conferences is of great value not only to the resident, but to the staff pediatricians, nurses and medical students who

3A community child psychiatric clinic, serving a broader need, can achieve its purpose more effectively if it is established and maintained as a separate organization.
usually attend. All of the hospital personnel who are concerned in the total care of the child must be reached at some point in the hospital program and the staff conference would seem to be the most logical setting in which to accomplish this.

4. Seminar instruction.

Case-oriented seminar instruction of residents in mental health principles should be included in the teaching program. These seminars should cover personality growth and development, the dynamics of human behavior, parent-child relationships and the other topics indicated above. In such there should be a minimum of "lecturing" and a maximum of discussion. Not only should such seminars include a review of the psychiatrist's role in child care, but they should also allow for participation and instruction by the social worker, the clinical psychologist and the recreational worker, with a view to familiarizing the resident with the contribution which these fields can make in the over-all care of child patients and the members of their families.

5. Extra-mural visits.

Lastly, it would be well to include in this program the opportunity for the resident to make extra-mural visits to the most important child-serving agencies in the community, such as child guidance clinics, placement of agencies, courts, and schools, including nursery schools and custodial institutions. Visits to the homes of a certain number of patients should also be encouraged. In all of these extra-mural visits to agencies, a regular and definite program of instruction should be arranged beforehand in order that the resident will actually become acquainted with the day-by-day work of the agency personnel. Such visits, to be of lasting value, should not all be of the "come-and-see" variety, but should be definitely educational in nature. Whenever possible the resident should spend some time working in some of these agencies under the supervision of instructors who emphasize comprehensive pediatric training.

SELECTED BIBLIOGRAPHY

The Committee believes that the following selected references should be helpful. The list is not intended to be a complete guide to the past and present experience in this field. It illustrates some of the changing emphases and some of the material which should be included in a psychiatric orientation program for pediatric training.


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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, gathered by its many consultants. The Group for the Advancement of Psychiatry has been working closely with various specialists in other disciplines, but the emphasis is on psychiatry, with working principles. Since the formation of GAP in 1946 its members have worked closely with various 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:

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2. To re-evaluate old concepts and develop new ones;
3. To apply the knowledge thus obtained for the promotion of mental health and good human relations.

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