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PEDIATRICS *and the*  
EMOTIONAL NEEDS OF  
THE CHILD

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THE COMMONWEALTH FUND • NEW YORK

**PEDIATRICS AND THE  
EMOTIONAL NEEDS OF THE CHILD**

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PEDIATRICS *and the*  
EMOTIONAL NEEDS OF  
THE CHILD

*As discussed by pediatricians and psychiatrists  
at Hershey, Pennsylvania, March 6-8, 1947*

*Edited by* HELEN L. WITMER

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## AGENDA

Thursday, March 6, 9 A.M.

Moderator: Lester J. Evans

*What have we learned about emotional growth and development?*

What we have learned about emotional growth and development from clinical observation and from common pediatric practice—Dr. Milton J. E. Senn

The clinical aspects of parent-child relationships—Dr. William S. Langford

Possible contributions to our understanding of emotional development from a study of human growth—Dr. Alfred H. Washburn

Some basic theoretical concepts of emotional growth and development—Dr. John M. Murray

Thursday, March 6, 2 P.M.

Moderator: Benjamin Spock

*What can the pediatrician in practice do in the field of mental health?*

In what way do the opportunities for contact with children and parents and the range of professional responsibilities inherent in pediatric practice determine the role of the pediatrician with regard to mental health?

What modifications in practice are indicated?

Is there a natural boundary between the function of the pediatrician in this field and that of the child psychiatrist and where does it fall?

Friday, March 7, 9 A.M.

Moderator: F. H. Wright

*What are pediatric departments now thinking and doing about problems of mental health?*

Discussion of the reports of special mental health programs in pediatric services.

What is the optimum program in the pediatric department?

What special personnel and set-up are needed for this?



AGENDA

Friday, March 7, 2 P.M. Moderator: Milton J. E. Senn  
*What are the next steps in pediatric teaching and training toward a better understanding of the emotional life of the child?*

How, when, and what should medical students be taught?

What special training is indicated for pediatric interns and residents?

What can be provided, on a postgraduate basis, for the pediatrician in practice?

How can the techniques of teaching be improved to simplify and clarify the presentation of basic concepts of emotional development and disturbance?

What training and experience qualifications are desirable for a special mental health consultant in pediatrics?

Saturday, March 8, 9 A.M. Moderator: A. A. Weech  
*What are the next steps in furthering comprehensive pediatric service?*

What hospital and other community facilities are needed to give effect to both pediatric and psychiatric functions in this field?

What facilities or services should be available to the pediatrician in private practice?

What are the possibilities of research in which pediatrics and child psychiatry can function jointly?

What should be the direction and scope of future experimental programs?

Saturday, March 8, 2 P.M. Moderator: Charles A. Janeway  
*Summary of the discussion.*

## PREFACE

Of all the problems that perplex the thoughtful physician at the moment none is more difficult or more important than the problem of relating the whole of medicine to its parts. We are at or near the climax of a wave of specialism which has produced spectacular gains at a definite cost, the cost being a significant and sometimes tragic diminution in the capacity of the physician to meet the human need of the patient—that is, to practice medicine comprehensively. One specialty of medicine in which a considerable measure of comprehensive thinking has been preserved is pediatrics, but even here specialism, as indicated by too complete a preoccupation with the physical aspects of the child, has gone so far that leaders in the profession have begun to call it in question.

Some of them have felt that the first step in righting this situation was to bring the psychiatrist into the pediatric department to offset over-specialization on the organic side. When this was done, the question arose as to how he should be used. Was he just another specialist to whom certain bothersome problems could be referred? Or was he a teacher whose point of view was germane to all pediatric practice? Some years ago the Commonwealth Fund began to give fellowships for the training of pediatricians in psychiatrically oriented pediatrics, in the hope that men with this experience might have a leavening and integrating influence in their own profession. This and other experimental approaches to comprehensive pediatrics have involved so many questions of both theory and technical procedure that the time seemed ripe last year for a conference at which they could be explored; this conference was held at Hershey, Pennsylvania on March 6–8, 1947, with 44 pediatricians, psychiatrists, and psychiatric social workers as guests of the Fund. This book is a selective report of that conference; the Fund presents it in the hope that it may serve to strengthen in some slight degree the integrative forces in medicine.

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**APPENDIX**  
**TEN HOSPITAL REPORTS**

## CHILDREN'S HOSPITAL, BOSTON, MASSACHUSETTS

The traditions of older hospitals have a considerable influence upon the new techniques which interest their staffs. At the Children's Hospital the tradition works in favor of doctors who, regardless of special training, confine their interests to children. Thus general pediatrics, laryngology, orthopedics, neurology, general surgery, plastic surgery, neurosurgery, and so on are practiced by men who have offices in the hospital and see relatively few adult patients.

Every one of the physicians in charge of services, and most of their assistants, hold appointments in the Harvard Medical School and are therefore subject to responsibilities as members of the Faculty of Medicine and by the same token are able to call on colleagues in all departments for help.

Under this arrangement it is natural for new ideas to develop in a rather unconventional way. It so happened that specific interest in psychiatric problems followed the founding of a neurological ward. The neurology of childhood is a sterile field if educational and social implications are ignored. The logical consequence of adding psychological appraisal to physical studies was interest in psychiatric implications.

The team of psychiatrist, psychologist, and social worker did not meet our particular needs, or perhaps it would be fairer to say, did not fit in with our prejudices, at the start. Instead we started and have continued with a pediatrician, reasonably competent in neurological situations and constantly interested in psychiatric situations, at the head of a team in which a psychologist, a social worker, and a head nurse did much of the actual supervision of so-called "behavior disorders."

As time has passed, a neurosurgical service has developed to a high degree of competence and a special unit for the study of epilepsy has also been fitted into the hospital framework.

Finally the question was raised whether the complex problems arising from all other causes as well as from disorders and diseases of the nervous system could be effectively handled without a trained psychiatrist. The answer, by staff and managers, was in favor of the appointment of a psychiatrist with adequate assistants.

The evolution, as we see it, has been logical and, we believe, reasonably sound. By long experience we have learned to seek effective psychiatric advice from other clinics and have been able to repay our debt by arranging consultation service for them. The pediatric house officers have passed through the neurological service and many of the surgical house officers through the neurosurgical service. The psychologist and the psychiatric social worker have entered every ward of the hospital and know the people there.

Under these circumstances the staff of the hospital is confident that a psychiatrist will begin his work, as all the rest of the varied individuals in it have done, with a fair chance of being allowed to work out his plans without rigid limitation. Obviously he will have to define his field, and in defining it he may well cross lines into medicine, surgery, and orthopedics. It has been the experience of all of us that pediatrics modifies every specialist who has entered the hospital on a full-time basis; each of them has become convinced that growth and development can confuse most of the preconceptions of a specialist trained in hospitals for adults.

It is the general opinion that a psychiatrist working inside a hospital of this sort will find the demands of the staff so insistent that he will have to devote most of his attention to children who are referred directly by doctors and will have to develop attitudes and techniques of a type which are unfamiliar to psychiatrists whose clientele comes through social workers and courts.

In any case, the proposed set-up involves placing psychiatry on a level with neurology and neurosurgery in a special unit, with full freedom to develop according to the psychiatrist's decisions.

The experience we have gained in absorbing other specialists may be comforting or it may be harassing to the newcomer. However we have no question that each competent specialist so far has found no difficulty in proving that children provide exciting material for full-time special study.

One of the major differences between the Children's Hospital and many other institutions is the geographical area from which children are drawn. Boston, as everybody knows, is an odd community. The suburbs are extensive and the hospital is rather inaccessible from some of the most populous areas of the city. For many years the hospital, as the oldest children's hospital in the

community, drew consultation material from most of New England and the Maritime Provinces of Canada. Thus the hospital has never established itself on the basis of a neighborhood service alone.

The emphasis on consultation service has developed so strongly that it has become a fixed policy. Under these circumstances inpatient facilities, preferably in a special ward, have been provided for one specialist after another. It is reasonable to assume that the psychiatrist will find that ways will have to be found to adapt methods to this situation. In addition, of course, neighborhood practice will be available.

The geography of the medical school and its varied psychiatric hospitals is relevant.

The Boston Psychopathic Hospital is a half-mile away. The other major psychiatric unit is at the Massachusetts General Hospital several miles distant.

The independent psychiatric units are the Habit Clinic one half-mile distant, the Judge Baker Center three miles distant, and the Children's Center two miles away.

Obviously geography militates against close cooperation and the present flow of local children with psychiatric problems to established clinics will continue.

### CHILD GUIDANCE CLINIC CHILDREN'S HOSPITAL, BUFFALO, NEW YORK

#### HISTORY

The Child Guidance Clinic of the Children's Hospital was started in 1930. At that time it was the only resource for psychiatric treatment for children in Buffalo, a city of 600,000. It functioned primarily as a community clinic and received some financial support from a local philanthropic foundation until this past year. In 1936 another clinic, the Guidance Center of Buffalo, was set up by several social agencies for psychiatric treatment and diagnosis of both children and adults. This clinic devotes itself largely to children and is the only other resource for children available in this city.

In 1946 the Children's Hospital Child Guidance Clinic became a definite section of the OPD and a real part of the hospital's

teaching program. The clinic was then functioning with a director who could only give half time to the clinic, a full-time psychiatric social worker, and two part-time psychologists whose total time amounted to one and a half days a week.

#### PRESENT STAFF

*July 1946:* Pediatric-psychiatric consultant appointed on full-time basis (half time for clinic, half time for teaching)

*October 1946:* Full-time psychologist obtained

*January 1947:* One full-time social worker and one volunteer part-time social worker

The Child Guidance Clinic offers psychological and psychiatric diagnostic and psychotherapeutic service particularly to the OPD, wards, and private services of the Children's Hospital but also to the community at large. It is conceived to be one aspect of good pediatric care which rounds out the hospital's service to the community. It is now entirely supported by general hospital funds.

#### TEACHING AIMS

To further develop in medical student, house officer, and attending physician an awareness and understanding of the importance of emotions in children's development. This includes the fundamental role of emotional growth in individual adjustment and behavior; the relationship of emotions to physical symptoms and disease states; and the tremendous amount of preventive mental hygiene which can be accomplished by the physician functioning within the limits of general and pediatric practice. In other words, we are trying to help make good doctors and not develop specialists in child psychiatry.

#### TEACHING METHODS

It is our feeling that effective teaching can be done only with case material currently under the care of the medical student, the house officer, or the attending physician. With this in mind every effort is made to facilitate formal and informal consultation.

#### *Informal procedures:*

Rounds are made on all wards throughout the hospital. Because of lack of available time these are irregular and not made with the house staff. On each ward the nurses and house staff are asked



about their patients, and willingness to see or discuss any case is expressed. This results in a regular flow of ward consultations. The attempt is made to help the house officer do as much as he feels he can rather than taking over the case.

*Formal procedures:*

1. Two afternoons a week are spent in the OPD reviewing medical cases with the medical students and house officers. Time is about equally divided between seeing routine medical cases and cases selected from a previous visit presenting possible emotional disturbances. It is frequently possible to demonstrate significant emotional difficulties in cases otherwise considered routine medical problems. The student can be helped to recognize, to evaluate, and to treat all difficulties within the framework of pediatric practice. The physician-parent relationship is stressed as an invaluable aid to reliable history and especially as a fundamental to any preventive mental hygiene endeavor.
2. Weekly seminar conference with the medical students to discuss theory and methods of helping with emotional growth problems.
3. Monthly conference with house staff for discussion of cases which illustrate by their psychosomatic or behavior symptoms some of the principles of emotional growth and its distortions.
4. In addition, there are four formal lectures to the third-year medical students—two in pediatrics and two in psychiatry.

DIFFICULTIES. Too much to do.

NEEDS

More complete and regular rounds on all the wards in the hospital. At the present time one hour a week is spent making rounds in the cerebral palsy department. There are always problems here. These take more time because of the frequent inability of the patient to communicate by appropriate word, gesture, or look. The problems of the epileptic are being approached by attendance at the neurological clinic but the surface has hardly been scratched.

A few cases have been seen from the allergy clinic but here, as in the diabetic and skin clinics, is interesting and important material which at present cannot be adequately handled. Pre- and post-

operative problems, the chronically ill, and the like are vistas of the future.

Three full-time people could be kept busy. This does not even include the three months' waiting list of children needing active psychotherapy in the Child Guidance Clinic, children whose treatment is an important part of a complete program.

#### DEPARTMENT OF PEDIATRICS UNIVERSITY OF CALIFORNIA MEDICAL SCHOOL

The children's psychiatry program was initiated in the Department of Pediatrics in <sup>1914</sup>1911 by Dr. William Palmer Lucas, then head of the department, who envisioned the need of a psychologist. He obtained the part-time services of Dr. Olga Bridgman, who was on the teaching staff of the Psychology Department in Berkeley. Dr. Jean Walker Macfarlane became associated with the clinic on a part-time basis in 1921 to do child guidance work. In 1929 she was replaced by Dr. Louise Morrow, who continued the child guidance work though much of her attention has been given to the psychiatric social phases of the program for which she had had special training at Smith College and Worcester State Hospital. Later a full-time assistant psychologist was added to do the psychometric testing.

Dr. George Schade, on completion of his training on the pediatric house staff plus six months in the Children's Psychiatry Clinic, was granted a two-year fellowship by the Commonwealth Fund to continue study in child psychiatry in the Philadelphia Child Guidance Clinic. He returned in 1940 to carry out the mental hygiene program in the department but this program was interrupted by the war and in 1942 it was necessary to draft him to direct the children's outpatient department. Now with our staff back to normal status Dr. Schade is able to devote his entire time to our mental health program for children.

It has been the design of the chairman of the pediatric department to coordinate the work of Drs. Bridgman and Morrow more closely with outpatient and inpatient problems relating to socio-psychiatric aspects of selected cases. This has been effective with the hospital and teaching staff, but the limited time they can give

to the program reduces the effectiveness of their influence, particularly on students.

Our present organization consists of Dr. Bridgman, who is on duty two half days and one full day every week, Dr. Morrow on duty two half days, Dr. Schade now available for full time, a full-time psychologist, and the services of a social worker as needed.

Cases are referred to the Pediatric-Psychiatric Unit by students and staff from the children's outpatient department and by the house staff on the inpatient services. A diagnostic survey is made through an initial interview with parents and child. Psychometric and other diagnostic tests are made. A conference is arranged with the student or members of the house staff and the problem is evaluated. This conference results in a decision as to whether the patient is to continue with psychological therapy in the pediatric department or is to be referred to the Division of Child Psychiatry of Langley Porter Clinic. A medical social worker's services are utilized in both inpatient and outpatient care. Each section of twelve students of the senior class has a two-hour seminar regarding the emotional as well as the mental development of the child.

A combined pediatric-obstetric departmental service offers a series of planned discussions with the prenatal group. These concern preparations for the birth of the baby, his feeding, comfort, and feeling of security while in the hospital, his regime after discharge from the nursery, and the first year of life at home with his family.

The psychiatric division in pediatrics attempts to interrelate and correlate the emotional components of pediatric cases to promote a positive constructive element of mental hygiene related to the program of growth and development of the normal child.

One of our difficulties is the lack of cooperation of some of the pediatricians on the consulting staff, who are aware of the psychological and emotional features of their patients but because of their own feeling of inadequacy follow a laissez-faire methodology hoping that nature taking its course will prove adequate for the problem.

A number of pediatricians in private practice in California are asking for further orientation and understanding of ideologies that can be utilized to meet these problems. This may lead to the development of a seminar or postgraduate course through the efforts

of the Division of Child Psychiatry of Langley Porter Clinic and the Department of Pediatrics with the assistance of the State Department of Child Welfare and Mental Hygiene.

I believe the contributions of Drs. Bridgman, Schade, and Morrow will make a well rounded program. It is not our plan to train specialists in "pediatric psychiatry," but rather to include in the teaching of pediatrics to students, staff, and possibly practitioners, sufficient information in the socio-psychological area to make it possible for them to recognize the importance of this aspect of the child's problem and thus be prepared to handle it more adequately.

### PEDIATRIC PSYCHIATRY UNIVERSITY OF CHICAGO CLINICS

#### HISTORICAL

Although no formal program integrates pediatric psychiatry with the Department of Pediatrics, a close relationship has evolved from the free exchange of ideas and from increasing recognition by the pediatricians of their need for knowledge of human behavior. Pediatric psychiatry was established as a unit within the Division of Psychiatry some fifteen years ago by the School of Social Service Administration. At first a psychiatrist and a social worker divided their time between pediatric referrals (mostly for diagnosis) and teaching in the School of Social Service. The next step was taken by establishing a student unit for the training of psychiatric social workers. The second psychiatrist-director was interested in research and teaching, so a seminar for medical students was started, while the student workers were given the opportunity to treat disturbed children.

#### PRESENT ORGANIZATION

The present regime has existed for seven years. The fact that pediatric psychiatry has no administrative connection with the Department of Pediatrics has been no bar to close cooperation. The psychiatric clinic occupies six offices on the first floor of the Children's Hospital. The staff consists of a chief psychiatrist, a resident psychiatrist, a chief social worker, an intake worker, a treatment worker, a student supervisor; and twelve student workers. Psychol-

ogy is a separate unit situated just across the hall. Pediatricians are encouraged to bring parents to the unit personally and to introduce them to the intake worker. Despite this procedure, we have noted that refusal of service is more frequent among cases referred from within the clinics than among those who apply directly from outside. This fact reflects the pediatrician's tendency to refer a case as soon as he recognizes the necessity for psychiatric care without evaluating properly the parents' readiness for this step. Hospitalization of psychiatric patients is carried out on the service of one of the attending pediatricians, but the psychiatrist then controls the management of the case.

#### TEACHING

About twenty formal lectures are given to the medical students in their second and third years; six hours allocated from adult psychiatry, fourteen from pediatrics. Once a week the third-year students assigned to pediatrics gather for a seminar with the psychiatrist, in which they discuss hospital or clinic patients. This group of students rotates every six weeks. A diagnostic staff conference is held once a week at which one new case is presented in full. The social worker gives the history and the psychiatrist reports his interviews; through general discussion the student social workers then formulate the psychopathology of the parents and its relationship to the child's disturbance, to prognosis, and to treatment. This conference is primarily for teaching within the unit but pediatricians, medical students, and others often attend. Cases of psychiatric interest are also presented occasionally at the weekly pediatric "grand rounds." Recently we have experimented by taking one of the pediatric residents into the unit on a half-time basis. Contacts of inestimable value for informal teaching occur in the hospital living quarters, which the resident in child psychiatry shares with the pediatric residents, and many fruitful discussions have taken place at the luncheon table. Over the years, it has been gratifying to see the pediatricians absorb, not the specific therapeutic techniques of child psychiatry, but rather its general point of view.

Within the unit, the emphasis is on intensive psychotherapy. All the workers carry parents and many of them treat children also, by techniques suited to their various skills. In 1946, 389 pa-

tients were referred; 176 were accepted for full service. Also, 2,775 interviews were conducted, of which 2,155 were for treatment.

#### AIMS AND DIFFICULTIES

Our present goals are: better teaching of the pediatric residents, better teaching of the medical students, the training of pediatric psychiatrists and the modification of routine hospital procedures so as to make them less anxiety-producing. Our difficulties, aside from the usual lack of staff and space, are inherent in the several conflicting demands made upon the unit: teaching of social workers, doing research, writing, teaching in pediatrics, and caring for an ever increasing service load.

#### FUTURE PLANS

Extension of our activities is contingent on our ability to increase space and staff faster than our case load; then time will be available for pediatric ward rounds and for a separate inpatient service, which will help in the training of medical students and nurses. All the pediatric residents may be rotated through the psychiatric service and may be given tasks that are within their capacities. Also, a psychiatrist may be asked to share the responsibility of a general pediatric ward with one of the attending pediatricians so that the viewpoints of both will determine the treatment of the hospitalized children. Such a program will make the pediatrician into more of a psychiatrist and the psychiatrist into more of a pediatrician.

### BABIES HOSPITAL COLUMBIA-PRESBYTERIAN MEDICAL CENTER

In 1934 an appeal was addressed to the Commonwealth Fund to support a program at the Babies Hospital for the study and treatment of behavior difficulties, personality disorders, and functional nervous disturbances of children. This was based on a belief that pediatric progress had been uneven, with greater emphasis on somatic disease and a relative disregard of psychic factors. It was felt that the pediatrician would, as a rule, be the first point of contact for the parent seeking aid for a child with a behavior difficulty and that he ought to be able to recognize and deal with many of the

psychogenic disorders as well as to give help in a prophylactic sense. It was felt that the establishment of a special clinic as an integral part of the clinical service in a teaching center for pediatrics might well be the best method to give to the younger men on the attending staff and to the house staff a working knowledge of what psychiatry had to offer in the handling of these problems. Previous attempts to introduce into the pediatric clinic a part-time liaison officer from the Department of Psychiatry had not resulted in satisfactory working relationships. It was proposed that some member of the hospital staff be sent for special training. This was done.

The pediatric-psychiatric clinic of the Babies Hospital was opened in October 1935; "pediatric" because of the administrative auspices, "psychiatric" to give it its right name and not resort to a euphemistic synonym. The program is administered by the Babies Hospital, not by the school; at present it is an integral part of the hospital organization. Since 1939 it has been financed entirely by the hospital; before that the Commonwealth Fund contributed, at first completely and later partially, to its support. The staff consists of the psychiatrist, psychiatric social worker, clinic secretary and a half-time dictaphone operator typist (added after the first year). There has been no psychologist attached to the clinic. The psychological facilities of the departments of neurology and psychiatry in the Medical Center have been utilized by the clinic and by the other pediatric services as well. The psychiatrist holds a clinical appointment on the pediatric staff of the hospital and an academic appointment as Clinical Professor of Psychiatry (assigned to pediatrics) in the Columbia University Medical School. The psychiatric social worker does not come administratively under the medical social service department but works closely with it. There have been no changes in the staff except for a thirty-three-month period when the psychiatrist was in military service. Then his place was taken by a succession of four different psychiatrists, all part-time.

In its services to patients and their families the pediatric-psychiatric clinic has never attempted to function solely as a service clinic for the Babies Hospital and its outpatient department. The extent to which it should so function remains a matter deserving further clarification. The clinic staff has put its main emphasis on

the education of the pediatric staff and of others in the hospital's adjunctive services. This goal has been approached in a variety of ways—by informal discussions including those centering around symptoms and their development; by consultation on concrete clinical situations, the pediatrician retaining primary responsibility for the management of the problem; by conference and seminar (beginning in 1943 at the request of the house staff); and finally, by the selection of cases from the hospital and dispensary populations for psychiatric study and treatment. The psychiatrist participates in pediatric ward rounds, conferences, and history meetings. The psychiatric social worker does so occasionally by invitation.

Through the years certain difficulties have been encountered:

1. Facilities for the psychiatric treatment of children—both clinic and private patients—within the Medical Center and in the community have been meager. It has, at times, been difficult to withstand pressures for service and consistently to maintain a teaching perspective in clinic intake policies. The teaching process, in orienting pediatricians in the matter of selection of those patients definitely requiring the specialized services of a psychiatrist, has been handicapped. Pediatricians become alert to the need and have too little experience in having the need met and in following through on cases.
2. There has been inadequate social case work with mental hygiene orientation available from the medical social service department. There has been a recent addition to that staff, at the request of the chief of the outpatient department.
3. There is a pull between the respective advantages and disadvantages of teaching opportunities in the hospital and in the outpatient department.
4. There is a relative gap between giving the pediatrician an understanding of factors involved in a case and imparting an ability to deal successfully with them in his relationships with child and parent.
5. Pediatric interest in psychiatric study and treatment of the so-called "psychosomatic" conditions in childhood is increasing. Our present ability to meet the demands for this type of service is limited.



For the future certain changes might be made as considered:

1. Further clarification is needed regarding the service function of the pediatric-psychiatric clinic in relation to the pediatric and other departments in the Medical Center which request service. (There have been times when the pediatric-psychiatric clinic has been the only psychiatric outpatient department service in the Medical Center admitting children. The number of children which Vanderbilt Clinic Psychiatry and the Psychiatric Institute outpatient department can accommodate has been minimal in relation to the 4,500 children admitted annually to the Medical Center via the pediatric clinic.)
2. It would seem desirable to have a psychologist attached to the pediatric-psychiatric clinic who would also have responsibility in relation to the extensive psychological services in the hospital and outpatient department.
3. Training of the individual house officer would be enhanced if there could be full-time assignment to the psychiatric service for a period when he had no clinical responsibilities elsewhere in the hospital.

## CHILDREN'S PSYCHIATRIC SERVICE THE JOHNS HOPKINS HOSPITAL

### WHY AND HOW THE PROGRAM STARTED

Begun in November 1930 under the auspices of Josiah Macy Jr. Foundation. Stimulated by Drs. Adolf Meyer, Edwards A. Park, and Stewart Paton. Aim: "Investigation of the rank and file of patients in the pediatric clinics for the formulation of psychiatric problems, the mastery of which should be made accessible to the pediatrician to serve him as the psychological principle in dealing with children."

### DEVELOPMENT AND CHANGES TO DATE

Steadily increasing demand for clinical service, teaching, and research called for continued expansion. Progressive integration with pediatric service was made dependent on the readiness of the pediatricians. No innovation was demanded of them but introduced

when they were ready to request them. In 1932 the Rockefeller Foundation took over the financial support.

#### PRESENT ORGANIZATION, STAFF, AND PROCEDURES

The clinic is located on the premises of the Harriet Lane Home. Though relatively self-dependent administratively, its staff is a part of the psychiatric department. At this time, the personnel consists of a director, a full-time assistant, five full-time trainees, one psychiatric social worker, one psychologist, and three secretaries. The clinic limits its intake to a maximum of three new patients per day. Parent and child are examined and followed mostly by different members of the staff. All cases are presented and discussed at a daily noon conference. Afternoons are devoted to therapeutic sessions. Friday mornings are given over to seminars, in which new publications, selected topics, the work of other outstanding people in the field, and contributions made by related sciences are taken up; the topics are assigned sufficiently in advance to warrant a thorough preparation. The clinic also has the services of a speech therapist and a remedial reading instructor.

#### CLINICAL AND TEACHING ASPECTS

About 10 per cent of all pediatric patients are referred to us. Members of our staff are, in rotation, on call to the wards and dispensary to advise the pediatricians. Psychiatric interns spend two months and pediatric interns one month full time at the Children's Psychiatric Service. Third-year medical students are divided into groups of not more than three, each group receiving a six-hour orientation. Elective courses are available to fourth-year students in their free quarter.

Fellows are sent for training for not less than one year by foundations and by governments of foreign countries. So far, the following countries have been represented: the United States, Hawaii, Argentina, Brazil, Chile, Peru, Cuba, Canada, the Philippines, China, Siam, Switzerland, England and Scotland, France, Belgium, and Sweden.

The trainees are given opportunities to attend pediatric and psychiatric staff meetings. At stated intervals, children's problems are presented by members of our group at conferences of Dr. John C. Whitehorn's psychiatric group.

Education of the pediatricians has succeeded in introducing a warm personal relationship among the patients and the physicians and nurses. Two qualified full-time persons entertain the children in the wards and those waiting in the dispensary.

#### AIMS AND GOALS

Further integration of psychiatry and pediatrics. Intensified research. Improvement of therapeutic methods. Establishment of a children's psychiatric ward. Additional social workers.

#### DIFFICULTIES

Budgetary limitations. Pressure of clinical demands leaves less time than desirable for research activities. Space much too limited for a staff the size of ours. Pediatric interns at present much too busy to follow their patients through our clinic. Inadequately focused enthusiasm about psychiatry tends to reduce efficiency of pediatric interns' physical examinations.

#### INDICATIONS FOR FURTHER CHANGE

A plan to come soon into operation calls for ward facilities for children with psychiatric problems; greater opportunity for the house staff to work actively at our clinic; the addition of a pediatric psychiatrist attached to our clinic, participating in pediatric ward rounds and other regular pediatric activities; interns to continue following their patients after referral to our clinic. These plans are part of a program, approved by the board and worked out by the head of the Department of Pediatrics, which will involve an architectural, clinical, and teaching reorganization of the Harriet Lane Home.

The Children's Psychiatric Service is scheduled to participate in the teaching program of the United States Public Health Service in accordance with the Mental Health Act.

### PSYCHIATRIC SERVICES TO CHILDREN UNIVERSITY OF MINNESOTA MEDICAL SCHOOL

Psychiatric Services to Children at the University of Minnesota Medical School began in July, 1938, with the three-fold purpose of providing teaching, service, and research in the field of children's mental and emotional problems. The impetus to develop such a

program resulted from the realization that many children referred to the University Hospital were not responding to the usual medical management.

Initially, the psychiatric clinic for children was established and maintained as a semi-autonomous unit in the Medical School and University Hospital. Its budget was provided for several years by the Commonwealth Fund and the Stevens Avenue Home of Minneapolis. During this period the university provided offices and maintenance services. As the University Medical School assumed responsibility for the total budget, the Child Psychiatry Unit became an integral part of the Department of Pediatrics administratively. Coordination of the program with the Department of Psychiatry is made possible by a joint academic appointment of the director in the two respective departments.

The present staff consists of a psychiatrist, who serves as director, an assistant psychiatrist, a psychiatric social worker, a clinical psychologist, a part-time speech clinician, and a full-time secretary. The director of the unit is responsible to the head of the Department of Pediatrics and the dean of the Medical School.

In accordance with the hospital policy, any child in the state of Minnesota in need of psychiatric consultation will be seen upon acceptance by the University Hospital's Admissions' Office. With but few exceptions, all children are referred to the pediatric outpatient department, where the preliminary psychiatric evaluation is made. At this time, plans for the patient are made which may be one of the following:

1. Admission to the pediatric inpatient service
2. Admission to the adult psychiatric inpatient service
3. Referral to the Child Psychiatry Unit for intensive work on an outpatient basis
4. Clinical treatment in the pediatric outpatient department

In addition, any child admitted to the pediatric inpatient service for other reasons who, in the opinion of the resident pediatric staff, requires psychiatric evaluation and management is served.

As indicated above, any child accepted by the Admissions' Office of the University Hospital will receive diagnostic study and when possible psychiatric treatment.

Members of the staff in child psychiatry assume much of the re-

sponsibility for over-all supervision of recreation, occupational and play therapy, and special teaching of patients on the pediatric service of the hospital.

A comprehensive teaching program is formulated as follows:

### I. Medical Students

#### A. Juniors

1. Twenty didactic lectures in Child Psychiatry
2. Five ward rounds during inpatient service

#### B. Seniors

1. Teaching is done in outpatient department around patients seen here
2. One elective course, Psychosomatic Problems in Pediatrics, is offered one quarter of each year

### II. Graduate Students

A. One graduate fellow in Pediatrics and one in Psychiatry spend a three months' period, full time, in the Child Psychiatry Unit

B. From eight to ten lectures on Child Psychiatry are given to the residents in Psychiatry

C. Resident rounds with the pediatric staff are held weekly

D. One or two psychiatric social work students spend periods varying from three to six months with us

### III. Nurses

Several lectures are given to student nurses each quarter

Our aim is three-fold: teaching, service, and research. It is our hope to stimulate in medical students, nurses, and others an appreciation of the importance of normal child growth and development and deviations as well as the importance of the mental and emotional factors in children's illness. For graduate students in pediatrics, psychiatry, and psychiatric social work, we hope to develop a broad interest in the diagnosis and management of children's behavior problems, to provide an opportunity for firsthand experience with well selected cases to enable the student to become acquainted with and to know how to use social resources of the community. Much of this is done through clinical service provided. Up to the present time, our investigation efforts have centered largely in the clinical field.

Present difficulties center largely in the demand for teaching and service exceeding the available staff supply and time. Lack of an inpatient service for children with severe psychiatric difficulties presents many problems. Serving such a large area as the state of Minnesota means inadequate contact with families and agency workers in too many cases. Frequently there is too great a distance and too little time available for investigation and intensive work with parents and children.

Indications for further change:

1. Provision of an inpatient service for children with severe psychiatric problems. This is already planned in connection with our new building program
2. Further expansion of the teaching program to include training of child psychiatrists and to provide for training of clinical psychologists interested in the children's field
3. Further integration with referring doctors and agencies
4. More time and staff for investigation and research

### CHILDREN'S CLINIC

#### NEW YORK HOSPITAL—CORNELL MEDICAL COLLEGE

##### ORIGIN OF PROGRAM

*1933:* An experiment in the application of psychiatric principles to pediatric practice and to the teaching of pediatrics, sponsored by the departments of pediatrics and psychiatry.

**STAFF:** One child psychiatrist, working part time in both the pediatric and psychiatry departments. One psychologist in the psychiatry department available for testing children in the pediatric department. Social workers in psychiatry also available. One full-time secretary.

**FINANCED:** By Commonwealth Fund grant as nucleus.

**PATIENT CASE LOAD:** Limited to parents and children in pediatric outpatient department.

**STAFF TEACHING:** Informal and individual with all pediatricians working in the OPD; concerned with particular cases referred for diagnosis and therapy.

**PSYCHIATRIC TREATMENT:** When needed for pediatric patients, carried out in psychiatry department with intensive therapy; on-

the-spot guidance of parents and children carried on in pediatric clinic as part of diagnostic survey by psychiatrist; occasional guidance by pediatrician under direction of psychiatrist.

#### DEVELOPMENT AND CHANGES TO DATE

*1935-1939:* Informal contacts between psychiatrist and pediatric staff members complemented by regular monthly pediatric-psychiatric conferences for all members of pediatric department. The number of cases referred for psychiatric-diagnostic study as well as those requiring psychiatric treatment increased rapidly so that an additional full-time child psychiatrist and social worker were added to staff giving diagnostic and guidance service in pediatric OPD; a small amount of time spent in research, increasing amount spent in treatment of children in child psychiatry clinic.

*1939:* Staff comprised of two part-time child psychiatrists and one full-time psychiatric social worker working as consultants to pediatric clinic and as therapists working in psychiatric treatment clinic. Staff increased by one pediatrician trained in psychiatry whose services were limited to diagnostic observation of inpatients in the pediatric clinic and who served as full-time liaison physician between the departments of psychiatry and pediatrics with focus primarily on teaching pediatric resident staff members through informal group teaching, during pediatric ward rounds, and through regular monthly staff seminars with emphasis on the emotional growth and development of infants and children and on the psychological needs of physically sick patients temporarily confined to inpatient department of hospital. Part-time services of psychologist supplied by the Department of Psychiatry.

**FINANCES:** Increasingly provided by New York Hospital—Cornell University Medical School through budgets of departments of pediatrics and psychiatry, with diminishing assistance from the Commonwealth Fund.

#### PRESENT ORGANIZATION

**STAFF AND PROCEDURES:** Project continues to be jointly sponsored by departments of pediatrics and psychiatry, with the chiefs of both departments in general supervisory and administrative roles and with the liaison officer a pediatrician trained in psychiatry.

Financial support solely from budgets of both departments. Additional staff made up of two part-time child psychiatrists, a part-time psychiatric social worker, one or more part-time medical social workers, and one part-time psychologist. Psychiatric service continues chiefly to be diagnostic in both inpatient and outpatient departments of the pediatric clinic while intensive psychiatric treatment is carried out in psychiatric clinic of the hospital or through other community resources. Guidance of parents continues in pediatric clinic as integral part of pediatric-psychiatric diagnostic service and in the management of problems where pediatrician by necessity or by nature of his therapeutic role is the logical person to assume such function.

**TEACHING:** Provided at three levels:

1. For undergraduate medical students in second year, lectures on emotional growth and development presented as part of course on infant feeding; in third year, lectures and case presentations illustrating common psychological problems of pediatric practice; in fourth year, in seminar teaching about patients cared for by students as clinical clerks
2. For pediatric house staff through ward rounds and staff seminars with current cases the focus for discussion
3. For graduate pediatricians who, as Commonwealth Fund fellows, spend two years' intensive training in both departments of pediatrics and psychiatry in order that they may integrate both disciplines and become teachers of pediatricians or public health personnel in centers of pediatric or public health teaching. Other postgraduate teaching is provided for pediatricians working in pediatric OPD through individual conferences about cases referred for diagnostic appraisal, and for occasional fellows in child psychiatry in seminar and individual teaching.

**RESOURCES** for teaching emotional, intellectual, and social growth and development, mild and severe psychopathology, parent guidance and individual psychotherapy of parents and children around physician-patient relationships are provided in psychiatric OPD, pediatric OPD for sick children, the pediatric well-baby clinic, pediatric endocrine-adolescent clinic, and a community day nursery and a nursery school for healthy preschool children.



AIMS AND GOALS: To provide psychological insight and to teach techniques which can be applied in pediatric and child care practice by physicians caring for well and sick infants, children, and their parents, in the hope that better treatment may ensue and that some of the psychological problems seen in our culture may be prevented.\*

The difficulties lie in teaching the pediatricians and other physicians who care for children in a way which will be sound and practical, which will enrich both pediatrics and psychiatry without detracting from either, and which will help make pediatricians better physicians without fashioning them into psychiatrists. The need for accumulating more knowledge about emotional growth and development, about personality structure and function, and the genesis of psychological problems, as well as the necessity for learning more exact techniques for the prevention and treatment of emotional difficulties in children and their parents, along with the urgency for disseminating trustworthy knowledge as soon as possible to as wide a professional audience of physicians, nurses, and other child care specialists as possible, indicate that expansion of the present experiment in pediatric psychiatry is in order.

#### PEDIATRIC-PSYCHIATRIC UNIT STANFORD UNIVERSITY MEDICAL SCHOOL

##### I. Development of the unit

##### A. A child guidance service was established in 1927

1. Staff: Pediatrician, especially interested in the mental hygiene and guidance of children, volunteer, part-time, director; assistant pediatrician, part-time, after 1932; volunteer assistance of pediatric social worker
2. To take part in the teaching and clinical activities of the pediatric services

##### B. Expansion of unit in 1939

1. Made possible by financial grant of the Commonwealth Fund

\* See Milton J. E. Senn: "Relationship of Pediatrics and Psychiatry," *Am. J. Dis. Child.* 71:537-549, May 1946, and "Role of Psychiatry in a Children's Hospital Service," *Am. J. Dis. Child.* 72:95-110, July 1946.

2. Addition to staff in 1939: psychiatrist, full-time, executive director; psychiatric social worker, full-time; secretary, full-time
3. Present staff: psychiatrist, full-time; assistant psychiatrist, half-time; two psychiatric social workers, full-time; psychologist, full-time; one full-time and one half-time secretary
4. Function of unit: "To conduct a child guidance clinic as a part of the Stanford University Hospital outpatient clinics, and to coordinate the teaching of the mental hygiene of childhood and child guidance problems into an orderly teaching program for undergraduate medical students, members of the resident staff in pediatrics and neuropsychiatry, and for those desiring special training in the field."

## II. Clinical activities

From about 240 to 280 new cases are seen each year. Sixty-five to 85 per cent of these each year have been referred from the pediatric services. In 1945 of 417 applications for clinical service, 240 were accepted and made into cases. Of the 240 cases, about 67 per cent were referred from hospital services or staff physicians, 20 per cent were referred from outside practicing physicians, 7 per cent were referred from social agencies or schools, and 4 per cent were self-referred. Applications are made to social workers; intake interviews with the parents are required; and acceptance for diagnostic study or treatment is made at a weekly intake staff conference. Exception to this procedure is made in ward cases for which consultation is sought.

## III. Teaching activities

In 1945 approximately 210 hours of clinic staff time were devoted to teaching, distributed as follows:

Instruction of senior medical students	140 hours
Instruction of resident staffs	46 hours
Instruction of nurses	18 hours
Instruction of sophomores	6 hours

### A. Undergraduate instruction

1. Lectures to sophomores 6 to 8 hours
2. Clinics in child psychiatry for seniors 10 to 12 hours
3. Meeting with seniors in pediatric outpatient clinic  
2 hours with each group, 16 hours

4. Seminars for seniors (optional) 12 to 24 hours
  5. Outpatient work in child psychiatry (optional)
    - In 1944, 34 students, 308 student hours
    - In 1945, 10 students, 168 student hours
    - In 1946, 12 students, 146 student hours
  6. Participation in public health course
    - supervise case work of 6 students
- B. Training of pediatric residents
1. Child guidance staff attends "grand ward rounds" once a week. Clinic psychiatrist usually also attends ward rounds with the resident staff once a week
  2. Staff meetings in child psychiatry once a week
  3. A seminar for pediatric residents is given at the beginning of each residency year, sixteen hours
  4. Pediatric residents are encouraged to work in the child guidance clinic under supervision. In the past, about two out of every three residents have availed themselves of this opportunity, spending usually one afternoon a week in the clinic for one or two quarters. Last year there was more evidence that the resident staff was applying its child guidance knowledge in routine outpatient and inpatient work.
- C. Instruction of nurses 9 hours for each class
- IV. Difficulties
- Budgetary limitation has made it difficult recently to keep well trained staff members and has prevented expansion of clinical service to meet recognized needs.
- V. Aims and goals
- A. Enlarged teaching program, especially in the first two years of the medical curriculum. More basic knowledge concerning the normal, the factors affecting personality development, and the dynamics of behavior in childhood should be given in the preclinical years.
  - B. Development of the research program
  - C. Additional professional staff
    1. Another full-time psychiatrist for intensive therapy
    2. Provision for group work with kindergarten and first- to third-grade school children

3. Psychologist trained in reading and speech remedial work as well as psychometrics
- D. Use of the clinic for training of personnel—fellows in psychiatry, students in psychiatric social work, postgraduate students in psychology
- E. Freeing the executive from routine for teaching, research, and participation in the development of community mental health programs

DEPARTMENT OF PEDIATRICS  
YALE UNIVERSITY SCHOOL OF MEDICINE

Since January, 1927, Dr. Grover F. Powers, chief of the Department of Pediatrics, Yale University School of Medicine, has had a psychiatric consultant for the department. Dr. Marian C. Putnam served in this capacity from 1927 to 1938, seeing both ward and clinic patients and conducting a weekly seminar for the pediatric staff.

In 1936 Mr. Erik Homburger Erikson and Dr. Edith B. Jackson were appointed in the Department of Psychiatry to work with Dr. Putnam on children's problems in consultation with Dr. Ruth Washburn, psychologist and director of the Yale Clinic of Child Development nursery school, and with the Department of Pediatrics. In 1938 Dr. Putnam, Dr. Washburn, and Mr. Erikson left New Haven; there was lack of immediate support for the proposed expansion of preventive clinical and research work in the field of child psychiatry and mental hygiene. Dr. Jackson remained as psychiatric consultant to the Department of Pediatrics and was assisted by Dr. Helen G. Richter, also a member of the Department of Psychiatry (both on half-time appointments). In 1938 Dr. Dorothy P. Marquis was appointed as part-time psychologist in the Department of Pediatrics to work with Dr. Jackson and Dr. Richter. Their clinical work consisted of diagnostic appraisal of behavior problems from the pediatric ward and clinic and psychotherapy for selected cases. Dr. Richter taught the fourth-year medical students in pediatric psychiatry, Dr. Jackson the third-year medical students, both using

the current clinical cases when possible (six hours for each group of students).

In 1939 Mrs. Alice E. Howell, educator, was appointed in the Department of Pediatrics as liaison worker between the schools and the pediatric-psychiatric consultants. This contact with the schools through an experienced educator was an important aid in diagnostic and treatment work in child psychiatry. During the following years this educational liaison work was strengthened by a cooperative venture with the New Haven State Teachers College. Selected students of Teachers College served as tutors for children needing special work under the combined supervision of the psychiatrist and liaison educator. Dr. Richter was working out this program and had charge of the psychiatric consultations and referrals from the pediatric clinic. Dr. Jackson took the consultations for the ward and undertook as special interest work in the field of the newborn.

In 1945 Dr. Richter's work was interrupted by causes incident to the war. Since that time psychiatric treatment facilities have been minimal; there have been no child psychiatrists in the Department of Psychiatry. Diagnostic and supervisory consultation service within the Department of Pediatrics has, however, been maintained. Dr. William Boyd Curtis, director of Psychiatric Service in the Community, has served as consultant to the pediatric clinic for three-quarters of a day weekly from 1945 to date. Since September, 1945, Dr. Mildred Hartshorn January, child psychiatrist in Hartford, has given her services one day a week. During the past two years she is the only psychiatrist who has carried cases under intensive therapy.

Dr. Helen Richter Gilmore returned to New Haven in 1946 and renewed her liaison work between the pediatric clinic and Teachers College.

Dr. Jackson, in addition to the pediatric ward consultations, has given time to the development of the newborn nursery as a teaching focus for staff and students in preventive mental hygiene and in the last year to the development of a rooming-in project on the maternity ward of the Grace-New Haven Community Hospital.

There has been a full-time psychologist in the Department of Pediatrics for the psychological evaluation of both clinic and ward pa-

tients. She has students from the Department of Psychology working under her who assist in testing as part of their training. The psychological appraisals of preschool children are done by staff members of the Yale Clinic of Child Development.

The pediatric-psychiatric consultation unit has been able to use the resources of the hospital's medical social service, and in 1940 and again in the academic year 1946-1947 one worker was assigned to this unit.

The carrying out of an integrated program has been hampered by the lack of physicians trained to do psychotherapy with children.