
PEDIATRICS *and the*
EMOTIONAL NEEDS OF
THE CHILD

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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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SESSION I

What have we learned about emotional growth and development?

In the first session Dr. Lester J. Evans acted as moderator. The following papers were presented.

WHAT WE HAVE LEARNED ABOUT EMOTIONAL GROWTH AND DEVELOPMENT FROM CLINICAL OBSERVATION AND FROM COMMON PEDIATRIC PRACTICE—*Dr. Milton J. E. Senn*

In an effort to appraise what has been learned about emotional growth and development through clinical observation and common pediatric practice, one attempts first to survey the literature. When this is done, one is baffled as to the source material which should be used. The physician who treats children, whether he be general practitioner or pediatrician, has unquestionably made many observations of growing infants and children. However these usually have been incidental observations, often made at random in the course of providing care for a sick child. Even in the less frequent attempts at longitudinal study of infant and child during periods of illness and convalescence, clinical observations including psychological data as a rule have not been recorded and reported in the literature. This has been decried by such well known physicians as L. E. Holt, Sr. and Sir James McKenzie. Pediatricians have much more readily exchanged their common clinical experiences verbally, possibly feeling restrained from writing because of the unscientific character of their data. Pediatric literature, although still dominated overwhelmingly by accounts of diseases of infants and children, methods, physical and laboratory techniques of diagnosis, and discussions of therapy, has begun to include material about emotional growth and development, and this

knowledge is slowly finding its way into modern textbooks of pediatrics. The contributors of this information, however, have usually not presented material gathered by clinical observation in common pediatric practice, but rather as a result of planned studies, such as those of Dr. Washburn.* Then, too, the observers of the psychological data have been as uncommon as their studies, being either pediatricians with special training in other areas, such as psychiatry, psychology, psychoanalysis, education, and social work, or pediatricians by title only, having actually had very little training or clinical experience in the care and treatment of infants and children.

In appraising the literature one is caught in the dilemma of limiting himself narrowly to a consideration of the contributions of the "pure clinical pediatrician" or of widening the field to include those of his colleagues whose training or experience beyond clinical pediatrics enables them to make contributions which are more complete. A bibliographical survey of the field of emotional growth and development yields little data from clinical pediatrics in comparison to that from the fields of education and psychology; and in passing, it seems appropriate to suggest that a closer alliance of pediatrics with education and psychology might enrich each discipline. The meager amount of reliable and useful information about psychological growth in pediatric literature should be disquieting to the leaders of American pediatrics. Since the topic assigned to me specified the source to be limited to common clinical observations, I have confined myself to that part of pediatric literature.

The merits of considering physical growth and development of an individual in a longitudinal instead of a cross-sectional manner have become apparent to the pediatrician. Fluctuations and wide limits of differences have become increasingly accepted in the realm of the physical. Less apparent has been the concept that emotional growth and development proceed longitudinally, regularly yet deviously, and have a wide range of so-called normality before the pathological is approximated. Physical growth experiences have become accepted as being related, one episode with another, one developmental phase with another. Less apparent has been the fact that personality development proceeds in a progres-

* See pages 16-26.

sive manner, with one life experience (whether physical or mental) related to the other, and that what has come before helps to decide what will follow. The psychologist and psychiatrist have come to this realization through retrospective retracing of life histories. The pediatrician has the advantage of contemporary observation in a prospective study. He is able to obtain biographical records of infants and children in developmental continuity. Yet such accounts do not appear in pediatric literature.

A longitudinal appraisal of emotional growth might well begin with a consideration of the individual at conception, or as soon thereafter as possible. The pediatrician has long said that pediatric practice consists of treatment of child and mother, but he has usually not had an opportunity to help the mother until after the birth of the baby. Those pediatricians who have been consulted by women before the birth of their babies have frequently seen advantages to this arrangement in that guidance and instruction in child care could be given when a woman was very receptive and not yet caught in the problems of normal infant care which seem almost insurmountable to a recently delivered woman who, by reason of her fatigue and apprehension, feels unable to cope with them. The pediatrician is aware that these feelings of the mother are somehow related to the kind of behavior the newborn infant shows, but as a rule he considers that the so-called hypertonic or hyperkinetic baby acts as he does because of physical (neurological) reasons rather than psychological ones. The pediatrician is aware that the psychoanalytic school believes in psychological birth trauma and that maternal influences react psychologically on the baby, but he has not satisfied his scientific curiosity in these matters and is therefore skeptical as to their validity. The pediatrician makes assumptions as to what kind of person the hyperkinetic individual will become, but he thinks in physical terms instead of both physical and psychological terms. Such emphasis on neurogenic factors, to the exclusion of the psychogenic, appears throughout pediatric literature.

Infant feeding presents an area where the physical and the psychological elements should be considered together, yet the nutritional and physical factors seem to predominate in the minds of most clinicians. The feeding of babies has become simplified through the advances of modern scientific pediatrics, yet on occa-

sion the newborn has difficulty in accepting one food after another. In time a satisfactory diet is usually found. Sometimes a pediatrician suspects that the problem is not one of food alone, but also of feeding techniques, and he begins to wonder if breast-feeding might not have its advantages.

Food and feeding are considered important elements in the formation of a good nutrition pattern, but the importance and necessity of such elements as sucking and chewing in setting up a good feeling tone between infant and mother have not been readily understood by the pediatric practitioner. The concept that feelings of security hinge on the mother's practices with respect to feeding, toilet-training, and discipline, also, has not been proven through clinical observation in pediatric practice. Through the stimulus of such able clinicians as Brenneman, Powers, Aldrich, and some of you in this audience, pediatricians have become aware of the fact that many problems of eating rest on a psychological basis: for example, that anorexia in the infant or child may be caused by a solicitous mother who for some reason feels urged to force the child to eat. The feeding problems which result are annoying to the pediatrician as well as to the parents because the parent who seeks help expects the physician to do an act of magic in one session by examining the child and by giving advice or tonics. The pediatrician wants to help and feels called upon to give some kind of tangible assistance because of both the urging of the parents and the press of time. Too often the help given does not solve the problem, and the parent and child return to take up more time of the pediatrician, who feels increasingly frustrated and even angry. The feeding problem persists and in time may lead to other problems in sleeping, behavior, even learning, which the pediatrician may not see as related, yet all of which stem from the same psychogenic factors. The pediatrician at this point may feel that the problems belong to the realm of the psychiatrist, while both parent and physician may accept this conclusion reluctantly. Even should psychological treatment be sought, the likelihood is that none is available, at least not as soon as one would like it to be, and the problem continues to rest with the pediatrician.

Brenneman favored the policy of letting nature take its course in healing physical ills and in promoting physiological function, particularly in eating and gastrointestinal functioning. He fos-

tered the early self-demand feeding experiments of Dr. Clara Davis. Other pediatricians have not felt as able to let nature take care of things either physically or psychologically. The traditional methods of feeding infants continue to prevail over feeding practices which permit self-gratification, although the clinical studies of Davis, Aldrich, Montgomery, and a few others are prompting pediatricians to experiment with new methods in the hope that feeding problems will be to a large degree prevented. The belief is commonly held by pediatricians that feeding problems result from deliberate acts of negativism: attempts at thwarting or brow-beating the feeder, usually the mother. The psychiatrist, psychologist, and educator have suggested that the motives may also be engendered on an unconscious level, that the negativism may be more than one simple trait of balkiness, or that it fits into a pattern of personality development which is ever changing. These mechanisms have not been acceptable to the pediatrician, however. He prefers to believe that there are simpler and more rational reasons for children's behavior.

The notion of individualization of patient care was also fostered by Brenneman; other pediatricians have had similar beliefs and have encouraged the mothering of infants and children both within and without hospital walls. Queries have arisen, however, as to the amount of mothering and the form of mothering which the child should receive. Rocking and holding infants have been recommended by modern child psychology, but these suggestions often conjure up in the minds of pediatricians and parents alike fears of harmful consequences in the form of "bad habits" or "spoiling." Does this kind of mothering weaken the character of the child and preordain the development of an adult who is immature, weak-willed, even homosexual? The psychoanalytically oriented psychiatrist, on the one hand, answers this question in the negative. He believes that the satisfaction of psychological needs during infancy and childhood is necessary to the nurture of the growing personality. Equally as assured, on the other hand, are psychiatrists like Strecker and psychologists like Blatz who believe that mothering represents coddling, that frustration in infancy is needed to toughen the child. Which group can the pediatrician believe? What is the evidence of each? The pediatrician has his

choice, and since he is aware that his own biases determine his choice, he feels uneasy. One may ask if this is the kind of problem that the pediatrician can help to solve by long-term clinical observation in pediatric practice.

Although the period of infancy and early childhood appears to have yielded relatively few facts to the pediatric practitioner concerning emotional growth, the period of later childhood up to puberty has been still less productive. This lack of information about psychological development is evident in all literature dealing with children, even in the literature in the field of general education. The work of Butler and his associates is one of the few studies made of the emotional growth and development of the school-age child. These workers, studying malnutrition in children from four years of age upwards, found a relationship between emotional factors and a poor state of nutrition. It was believed that psychogenic factors might be so powerful as to produce faulty nutrition, and that this condition might lead to a fixed state of malnutrition due secondarily to pathology in the endocrine system which could be overcome only when sex hormones were used.

Beginning with puberty and adolescence, the pediatrician for some reason or other has become aware of the emotions in his patients, or at least has recorded more of his observations. It may be that the adolescent, less removed from the adult than younger patients, sets up a feeling of kinship in the pediatrician which permits him to pay greater attention to the psychological concomitants of physical disease, or that the increased incidence of disease, especially metabolic and endocrine, at this period brings the patients to him more frequently, even more regularly, than in the preceding school-age period.

The pediatrician caring for adolescent patients has been impressed by their feelings of concern regarding health, body build, genital size, and physical prowess, and with their anxieties about many things—some recognized and some merely felt in an uncomfortably unconscious manner. Pediatricians (like Scott Smyth, Guest, Talbot, and Butler) have become cognizant of the emotions in their patients with diabetes mellitus, and have concluded that much of patient resistance to insulin and the diabetic diet is due

to these feelings. When diets were adjusted to the emotional state of the adolescent as well as to the diabetic state, rebellion against physician, parents, and disease lessened appreciably.

A variety of physical conditions investigated by physical and laboratory study has yielded no clues as to their etiology or treatment, and so by exclusion the pediatrician has designated these entities as "nervous habits" or "psychological difficulties." Included in these conditions are tics, habit spasms, and compulsive acts; somatic complaints, especially abdominal and head pains; and symptoms such as diarrhea, soiling, enuresis, and constipation. The pediatrician realizes that there are tensions and other feelings involved in the production and precipitation of these complaints and symptoms, but what is not clear is how the tensions are related to emotional development and how they may be prevented or dispelled. For example, the pediatrician does not see the relationship which the child psychologist points out to him between coercive toilet-training in infancy and adolescent soiling and diarrhea.

The pediatrician has recognized the adolescent's striving for independence, his attempt at emancipation from his parents, and in this emancipation, his identification with the physician, in whom he hopes to find a more suitable parent substitute. The physician has not always found it easy to accept this role, however, especially when the parents were unwilling to be thus replaced. Basically the psychology of all physician-patient relationships has never been quite clear to the pediatrician. Such things as the dependency feelings which the patient invariably develops toward the therapist during treatment have at times been fostered unconsciously to a point where the patient has become confused, even apprehensive.

The management of the hospitalized child is a case in point. Psychiatrists have pointed out the manifold emotional elements stirred up in children and parents by physical illness and hospitalization. In pointing out the psychotherapeutic benefits which come from psychiatric treatment and which should follow all medical care, the psychiatrist has talked about reassurance, ventilation and catharsis, desensitization, persuasion and re-education, suggestion and attitude therapy, and guidance. The pediatrician, believing

that it lies within his province to prevent emotional dysfunctions and the physical disabilities which result from them, is sure that he is a psychotherapist, yet he cannot define his powers in these directions. If he attempts to describe his methods of psychotherapy, he does not think in the psychiatric terms just listed; he credits his treatment to common sense. Yet even as he does this the pediatrician has the feeling that he may be oversimplifying the genetic mechanisms and treating patients superficially instead of fundamentally. Concerned, frustrated, desirous of getting greater insight and better therapeutic tools, he turns to modern psychiatry, not with the desire of becoming a psychiatrist, but rather of becoming a better pediatrician who can share learning and experience with the psychiatrist.

It is believed by many pediatricians that psychiatry has not been helpful to pediatrics because, for some reason or other, psychiatrists have isolated themselves from the rest of medicine and have thereby continued to keep their specialty unscientifically metaphysical and philosophical. Pediatrics has made groping advances to psychiatry but has too often felt rebuffed and has therefore felt the need to develop its own psychiatry. One is again drawn to the writings of Brenneman, particularly since he has titled one paper, "The Menace of Psychiatry." Analysis of the factors back of the sequestration of both pediatrics and psychiatry is pertinent to the discussions proposed for this conference, and it is hoped that here together we may air our views and opinions so that psychiatry and pediatrics may get a clearer definition of their relative roles in the common enterprise of health.

To those pediatricians who have also had training in psychiatry, it is apparent that a vast body of knowledge is accumulating in the field of medical psychology which should be available to the clinician. Each of us is faced with the problem of how to share our psychiatric experiences with our colleagues in pediatrics so that all of us may obtain greater information in these matters. Another challenging problem is how in pediatrics we can collect as accurately as possible (even if it is not always scientific), data which would verify and enrich the findings of psychology, psychiatry, education, sociology, social work, and the related disciplines dealing with human behavior. It seems to me that all of us gathered here by invita-

tion of the Commonwealth Fund are charged with the responsibility of discussing teaching methods and planning research and patient care in order to benefit the individuals in whom we are most interested, namely, children and their parents.

THE CLINICAL ASPECTS OF PARENT-CHILD RELATIONSHIPS

Dr. William S. Langford

The child's physician, whether he be pediatrician or psychiatrist, has no choice. He must, if he is to help his patient, deal with his patient's parents unless he is practicing in that Never Never Land of Peter Pan where parents dare not go. The child rarely comes to the physician for help alone or of his own accord, whether his problem is one of physical illness or of emotional disturbance; he is, as they say in the South, "carried" to the doctor by his parents. The alert, observant physician is aware of the potent effects on the developing child of the parents' attitudes, of their ways of feeling, of acting, of thinking. He sees parent-child relationships and their effect on the unfolding pattern of social and emotional growth and development in the child. Disturbances in the parent-child relationship often become highlighted in behavior and personality symptoms in the child; they may also be reflected in physical disturbance and the reaction of the child to illness, operations, hospitalization, immunization procedures, and convalescence. In trying to help a child with a purely physical disorder the physician finds that the quality of the parent-child relationship may influence the course of the illness. In the early months and years of life when the pediatrician is guiding the parent closely in her care of the physically well child, parent-child relationship factors are of especial importance in the success or failure of his guidance procedures.

In pediatric practice the contact with parents begins soon after the birth of the infant with the mother's anxious question "Is he all right?" and continues until the child has grown beyond the pediatric age range. The parents are seen when things are going well and when the child's illness precipitates anxiety and feelings of self-blame in the parents. The pediatrician visits his child patient and the parents in the home and also sees them in his office. He is consulted by the parents on a variety of problems, some having to do with physical health, others concerning emotional well-being.

The amount of time he can spend at any one contact may be limited, but he has rich opportunity for observing parent-child relationships in action and his contacts are spread over a period of years beginning with infancy. He also has contacts with large numbers of children and their parents.

The child psychiatrist rarely has professional contacts with children and parents throughout the period from birth through adolescence. His contacts with the child and his parents are over a relatively brief period of childhood. His emphasis on health is usually part of the treatment relating to personality and behavior difficulties. Ordinarily children do not come to him for a health check-up. The psychiatrist as a rule sees his child patients and their parents only in an office setting, rarely if ever in the home (although he is interested in the home life of his patient) and never in the middle of the night when an acute illness threatens the life of the child and releases acute anxieties and tensions in the parents. On the other hand, the setting in which he practices gives the child psychiatrist more opportunities than the pediatrician has for exploring the underlying factors in parent-child relationships through planned interviews. Physicians practicing in either field are able to learn a great deal about parent-child relationships. The observations and conclusions of the practitioners of one discipline are a valuable contribution to the practitioners of the other.

Too often the child's physician, and I include both psychiatrists and pediatricians, is prone to let his understanding of the dynamics of parent-child relationships rest at the level of recognizing the importance of parents, without accomplishing anything more than a dermatological type of descriptive classification. Parents are called various names: "overanxious," "overprotective," "doting," "ignorant," "stupid," "impossible," "grim," "hyperthyroid," "hopeless," "punishing," "compulsive," "rejecting," "neurotic," and sometimes "nice," to mention only a few of the terms used from time to time. Some of these words directly express the physician's irritation with the parent whose attitudes and actions interfere with the child's successful growing up or with the physician's attempts to help the child; others are a pseudo-learned jargon which adds nothing to the basic understanding of parent-child relationships and how they get that way.

Most faulty parent-child relationships are not due to stupidity, ignorance, or a puckish perverseness, but are related to the parent's own personality structure, emotional conflicts, biases and prejudices, and past experiences. A willingness to try to understand the role of the child in the psychic economy of his parents is essential at times and always helpful in the successful practice of medicine with children. It is only through such an understanding that the child can best be helped to pass through the successive stages of physical, emotional, and social development to assume his responsibilities as a mature adult.

In clinical practice with children in both pediatrics and psychiatry, information about parent-child relationships is obtained largely through interviews with the parent (usually the mother) about the child and, to a lesser extent, through observing the parent-child unit in action. Regardless of the nature of the problem which brings the child to the physician, the parent reveals a great deal of her feelings, her ways of doing things for the child, her attitudes, and (to the educated ear) many clues as to why she reacts as she does. It takes little clinical skill to recognize the insecure, anxious parent who must protect her child from all sorts of real and fancied dangers; who cannot let her child play actively lest he become overheated and catch cold; who must make sure he eats enough through feeding him; who lies down with him at night so that he will get enough sleep and then tiptoes in frequently to make sure that he remains covered; who in every way infantilizes her child and tries to keep him in a baby-like state, dependent on her for all his needs. As she talks, such a mother may reveal her feelings about keeping her child a baby, her feelings about being a slave to her child, her feelings about her need to protect him from everything, and her husband's attitude toward her concentration on the child. One mother who had attempted several times to abort the pregnancy which served to seal her marriage to a man with whom she was unhappy, said to a medical student in the course of a routine history, "Every time I think of that I feel so upset inside that I've got to make up to her for not wanting her." The patient, a twelve-year-old girl who had been brought in for recent acne and lifelong enuresis, was fed and dressed until eleven years of age and was still accompanied in the block-long trip to and from school.

Another mother who took rectal temperatures of her ten-year-old son three times a day, had his urine checked at the corner drug-store, and contributed in a large measure to the hypochondriacal complaints with which he was brought to the clinic, when asked what she did, said, "Only housework." An inquiry brought out a flood of resentment toward her more fortunate brothers and sister who had received professional educations as lawyer, doctor, and social worker, with equally strong resentment of her own position as a lowly housewife and mother. In her relationship with her child she was trying to satisfy her "professional" yearnings.

Given a chance to talk to an attentive, nonjudgmental listener, the parent will reveal much that will help the physician to understand the basic factors operating in the parent-child relationship. If he does not listen the physician may well find himself in the embarrassing position of a fourth-year student who had spent the best part of two hours taking a history and examining a child brought to the clinic because of "nervousness." He had written a long history and had asked numerous questions without learning what the instructor brought out with one statement: "I understand that your little girl is nervous." The mother replied, "Small wonder—I'm nervous too. Everywhere I go it's wired to the church, I never have any peace." Her paranoid psychosis had already led to hospitalization and shock treatment. The student, red-faced, said, "I forgot to ask about that. Perhaps I should have let her tell me about things."

The parent who brings in her child for a physical disorder is often equally as revealing regarding the concerns, worries, and pre-occupations which have emotional significance for her and for the child. One mother plagued the house staff with queries about her child's moment-to-moment condition, sure that he was going to die and unable to accept reassurance that all was progressing satisfactorily. When time was taken to understand why she had to look for the worst possible outcome, it was learned that she had lost her first-born son, that two brothers had died in infancy, and that she was sure that all males in her family were doomed to early death. She felt responsible for this child's illness and the possibility of his death was a trigger that released overwhelming anxiety. Another mother unduly prolonged her son's convalescence from pneu-

monia. Her behavior was not understood until it was learned that her father had developed pulmonary tuberculosis following pneumonia and she was anxious to prevent history from repeating itself.

Before going on to relate some of the ways in which unhealthy parent-child relationships can be influenced and the child and parent given a better chance to grow and develop emotionally, I shall give a few excerpts from a planned series of interviews with a parent in which the role of the child patient in the mother's psychic economy was revealed in detail.

The mother of a two-year-old girl hospitalized with a severe feeding problem could not accept negative physical findings nor the assurance that it was all right if the child did not eat for a time. Since the child's birth she had ruthlessly forced food, leaning on the chance statement of her obstetrician, made because the child had gained weight poorly in the neonatal period, that she "must get food into that child." Excerpts from interviews follow.

If I look at her and she is eating, my heart is glowing. If she is not, it just gnaws me. In my mind if I did not force her, I starved her.

The very thing I was annoyed at in my mother is what I am doing to my child (getting angry and swearing at her). I'd be hitting my mother if I bashed Florence.

My mother asked me to have a baby and give it her name. She has my mother's name. If something happened to Florence I might feel my mother didn't get her wish.

I feel as though she is taking my mother's place—very often. God took my mother and gave me the baby. She is almost as dear as my mother, maybe dearer.

I assumed the baby would be a reincarnation of my mother. If the baby had been abnormal, if she had not had a foot (maternal grandmother had lost her foot with diabetic gangrene), it would have been more like a reincarnation.

I feel the baby is suffering just like my poor mother.

I think we are closer if she called me Rhea—I would rather be her friend. I don't think there is so much reserve. I thought she might be closer to me if she called me Rhea—that she would not think "mother" is so much older.

The mother carried over into her relationship with her child unresolved conflicts in her relationships with her own parents. She was not experiencing healthy satisfaction in her role as a mother

nor was the child able to gain from her the support and security necessary for normal emotional development.

From such detailed study of the meaning of a particular child to his mother (or father) it is seen that the parent's relationship with the child represents one element in a constellation: grandparents, parents, sibling, spouse, and child. Conflicts in feelings in early relationships are reflected in the parent's relationship with the child. Patterns in the parent's behavior with the child—overmeticulous care or neglect, rigid standards of obedience or relative lack of any limitations, specific pressures, preoccupation with feeding, education, and the like—are related to those patterns which figured conspicuously in the parent's own home. As the parent is helped to understand and resolve the conflicts of feeling in her earlier relationships, there is a concomitant decrease in pressures on the child and in the parent's inconsistency in behavior with the child. As the mother becomes more accepting of, and less guilty about, her hostile feelings, there is greater freedom in the expression of positive feelings in all her relationships. There is often an increased sureness, a lessened uncertainty in her maternal role.

It should be stated that displays of hostile feelings toward a child by the parent in an interview, even though devastatingly cruel and punitive, may be deceptive as to her relative capacity for positive feelings toward the same child. The term "rejecting parent," it seems to us, has been applied too loosely. It characterizes only the less mature part of the parent's personality. Rarely have we met a parent who at no time shows some positive feelings toward the child.

Insecurity in parenthood is common in our culture. The newspapers, magazines, radio, and books on child-rearing are all apt to make the mother feel that she is to blame when things go wrong in the child's development. One recent book suggests that the great all-American "mom" was the cause of our almost losing the last war. Also, the conflicting and confusing rules laid down by various "experts" on the best ways to raise a physically healthy, mentally sound child are apt to fan the latent fires of partially resolved conflicts of the past and prevent the mother from assuming her maternal role in a confident and casual manner. Even the setting in which we see our patients and their parents is one which detracts from security in parenthood. To acknowledge the presence of a

problem in the child and to seek professional help from the pediatrician or psychiatrist is tantamount to acknowledging failure as a parent. Then, too, the mother looks upon the physician as someone who knows a good deal about scientific child care and hence as one who is able to judge her as a parent. It is inevitable that the parent should feel that she is being judged, as often she is, but the physician can speed his progress by counteracting this attitude.

Fundamentally, the key to progress is the relationship of the parent with a noncritical, accepting individual who at the same time is in a position of professional authority. In all instances the over-all goal is to encourage a person to be a "parent." It is not telling a parent; it is helping a parent. The experience a parent may have in elaborating her early relationships and the knowledge the pediatrician, the psychiatrist, or psychiatric social worker may gain from this is not essential to provide help which is meaningful to the parent and significant in the parent-child relationship. The parent may always get a certain amount of therapeutic help if the physician has in mind the goal of helping her, whenever possible, to increase her security as a parent. The opportunity that the parent is given in her contacts with the medical advisors to assume her natural responsibilities and to exercise her prerogatives as a parent is a therapeutic process in its own right. The parent's effectiveness as a responsible parent, from the pediatrician's or psychiatrist's standpoint, is obviously a separate consideration. The parent can be permitted to feel her importance in helping the physician to know and understand her child. Suggestions and advice can be given with an awareness of the difficulty for an outsider, and one not on the spot, to know just what to do or not to do in a given situation. The physician must recognize that, for all of his scientific knowledge and feelings of responsibility for the child, it is the parents who are in a position of unique importance for the child. Attention to the parent's fears and anxieties in her job as a parent, consideration and tolerance, coupled with any means the physician can use to show confidence in the parent's ability, increase the parent's self-confidence, self-esteem, and courage to try again.

At times a parent needs to be encouraged to elaborate her earlier relationships and helped to verbalize her frustrations, feelings of deprivation, the hostility for which she has felt guilt, and the like. Whenever a parent makes an association between how her parents

handled her and how she felt about it, and what she is doing with her own child, one has usually helped the child as well as the parent. These procedures, which build on the inherent strength of the more mature part of the parents' personalities, can be followed with all parents. But the parent who presents symptoms suggestive of clinical psychopathology, the parent who is weighed down with physical or difficult social problems, the parent who shows a fatalistic attitude about changes in the child, or the parent who does not recognize a problem and brings the child for help only at the insistence of someone else is not apt to be helped by any method short of a series of interviews with special attention to his or her own intrinsic personality needs.

Thus far we have stressed untoward parent-child relationships and their interference with normal physical, emotional, and social growth and development in the child. Before closing we should at least mention some of the healthy patterns in parent-child relationships which permit the child to grow and develop according to his own innate pattern, which provide a setting in which the child can move from one stage of development to another with a minimum of disturbance to himself and others, which establish conditions that permit the child to accept the limitations imposed by training, which provide for the child satisfactions in daily living appropriate to his age and the stage of development in which he finds himself, and which give the child the necessary warmth, security, and support to go ahead in life. These patterns imply a capacity on the part of the parent to deal with the child without undue anxiety, tension, or preoccupations in all the aspects of day-to-day living, feeding, toilet-training, sex education, health and illness, obedience, school progress, and the like; a capacity to perform effectively in the maternal or paternal role and to gain satisfaction from it.

POSSIBLE CONTRIBUTIONS TO OUR UNDERSTANDING OF EMOTIONAL DEVELOPMENT FROM A STUDY OF HUMAN GROWTH—*Dr. Alfred H. Washburn*

In contrast to the two previous speakers I have had no formal training in psychiatry, nor can I possibly pose as an authority concerning any of the psychological aspects of the growing child. Whereas Dr. Senn is a pediatrician who has become a psychiatrist

as well, I am merely a pediatrician who has become absorbed in a study of growth. I shall assume, therefore, that my essential function here is to talk about growth.

The Child Research Council program has developed into a study of growing human organisms throughout their life cycle. So far it has been centered largely on physical, physiological, and psychometric changes during growth from birth to twenty years. The only specific approach to gaining a clearer insight into emotional development has been a rather intensive Rorschach study started six years ago. I do not mean to imply any lack of interest in each child's emotional responses as we visit the home or school or as we observe his reactions to examinations, x-rays, blood counts, or to the many other tests and observations which we do routinely at regular intervals throughout his life. But I do mean to imply that the emotions *per se* have not formed a separate study as, for example, our study of basal metabolism or of plasma protein levels.

Since I have chosen to talk about growth as a whole at a conference on emotional growth and development, it seems wise to start with some rather simple and possibly naïve statements.

The human organism, like any other biologic unit, is an individual, that is, an indivisible entity. Thus the significance to the individual of the peculiar characteristics of any part or function is to be understood only in relation to the whole person. All parts and functions are related to one another in a more or less well integrated fashion. The young adult is as he is because of, first, the patterns of structure and functioning which he has inherited via the genes or chromosomic substance which is passed on from the original germ cells to every single cell in the developing organism; and, second, the interplay between this basic pattern and factors in his environment during growth from conception through adolescence, the many environmental factors playing either a permissive or a directive part.

Thus an understanding of the young adult should imply:

Some knowledge of the nature of the environmental factors which may alter the orderly development of the embryo or fetus *in utero*.

Familiarity through experience with the characteristics of human organisms at birth in all their many variations within the general human pattern.

An understanding of the human pattern of progress from birth to

adulthood and of the almost endless expected variations within the limits of that human pattern: that is, the possible changes in size, shape, and proportions in the morphological sphere and the changing picture of functioning which accompanies the maturing process and which is so striking an attribute of growth. And here I refer to functioning at all levels.

Some knowledge concerning the effects of these growth changes on the whole individual and his reactions at different age levels or at different stages of maturity.

A thorough knowledge of the environmental factors, animate as well as inanimate, which may alter the orderly progress of growth and hence lead to a different end product than might have been reached under other conditions.

I take it that this is an ideal which none of us has approached too closely. It is, however, the ideal which serves as the chief stimulus for such a study of the growth of individuals as the one with which I am fortunate enough to be associated. Furthermore, any hope of helping to produce healthier, happier, or more adequately adjusted young adults implies a better understanding of both the potential patterns present at birth and the possible effect of almost innumerable environmental factors upon their development.

If my premises are essentially sound, then the emotions may be understood most adequately by a study of the child himself, within his environment, as he grows from infancy through childhood to the adult level. We know that emotion not only appears in the explosive episodes which can be called by some such specific name as "anger" or "fear" but also pervades all thought and action in varying degree.

I think of an emotional response as involving subjective feelings, impulses, physiological changes, and physical action. In my present stage of ignorance I am still trying to observe the emotional responses experienced during the successive stages of growth by different individuals in different environments. I must confess to having as yet no clear-cut picture of any such definite pattern of emotional development as we recognize for the progress of height or weight increases or for improving function on a bicycle ergometer. However, if physiological as well as physical patterns are characteristic of the individual, if growth changes in different parts and functions are interrelated in an orderly fashion in that

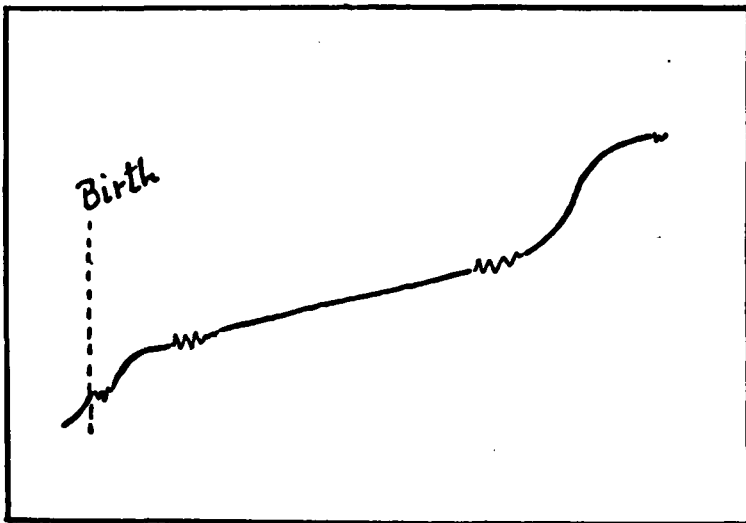
individual, and if emotion pervades all thought and action, then it seems apparent that an understanding of emotional development will be facilitated by a well rounded study of individuals as they grow up.

And so this morning I should like to present rather briefly illustrations of:

1. The general human growth pattern
2. The consistency of the individual's own growth patterns
3. The integration of different parts, aspects, or functions of the individual as he grows and matures
4. Evidence in support of the thesis that certain patterns are so well established in early infancy as to afford predictive value for a later age period

1. *The General Human Growth Pattern*

In spite of the possible wide deviations from the mean, the growth of any healthy individual will follow the general human pattern. By drawing on the blackboard a crude and somewhat idealized copy of the curve of weight increase I can point out a few well known characteristics of the pattern. I could just as well have used the curve for changes in the basal metabolic rate, or the curve for



Curve of weight increase

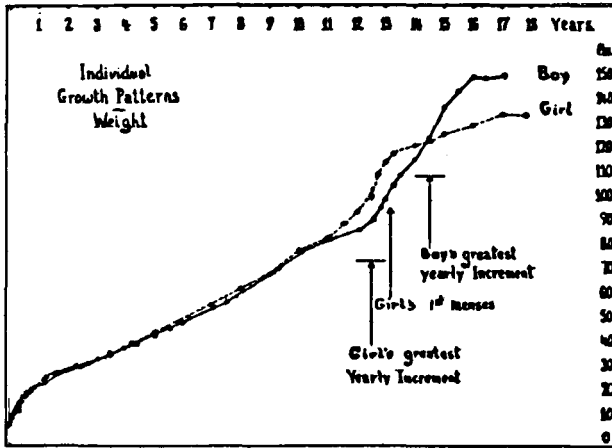
femur growth, or even the curve for the changes in IQ's. I picked this merely because weight increases are very simple and easy to tie to, and it does give a chance to point out just the high spots of the changes going on, starting with the transition period from prenatal to postnatal life with its disturbed period, its difficulty in stabilizing physiological functions, and its known responses to stimuli. We notice next the remarkably smooth curve representing the infant growth cycle, to which I shall refer later, and the transition period from infancy into the preschool age with which we are all so familiar, a period of many physiological, psychological, and emotional instabilities and upsets as the child is beginning to explore his world; then the relatively smooth period through the preschool and school years; then the marked upset at the beginning of adolescence; and frequently the secondary upset period toward the end of adolescence.

Slide 1. The first slide merely shows the curves of weight increase in an unusually healthy boy and an unusually healthy girl whom we have followed from birth up into the late teens. I put it on merely to show that the somewhat idealized curve I drew on the blackboard is pretty well borne out by the actual curves representing increase in weight in a healthy boy and in a healthy girl, showing the relatively smooth period in the infancy cycle of growth, and again the tremendous spurt during adolescence of these children, both of whom are large individuals.

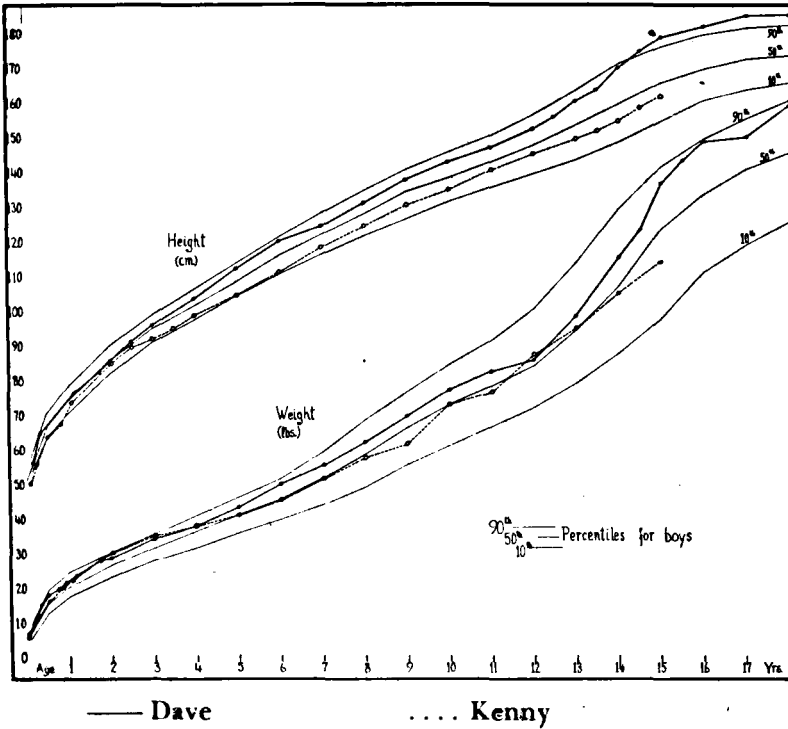
2. *The Consistency of the Individual's Pattern*

That individuals have their own peculiar characteristics—so uniquely their own that you can pick out your friend from amongst thousands of fellow humans—is, of course, an accepted fact. The concept that the pattern by which these characteristics developed may be as uniquely their own is not so generally accepted. And yet, if one accepts the first statement, it would be strange indeed if there were not truth in the second concept. While one can imagine different developmental pathways reaching the same or similar end-points, one can hardly picture identical pathways reaching different end-points. And so my next six slides illustrate individual patterns of progress.

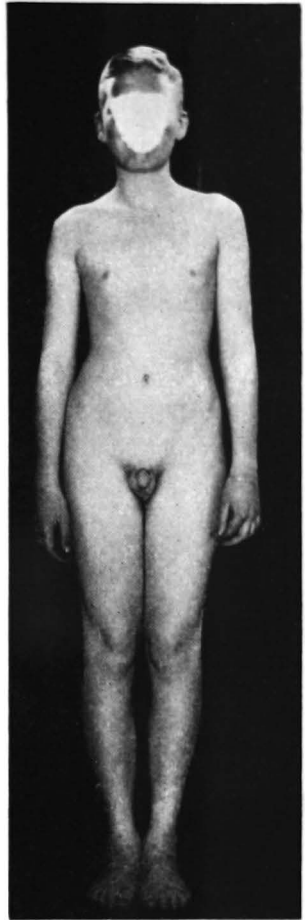
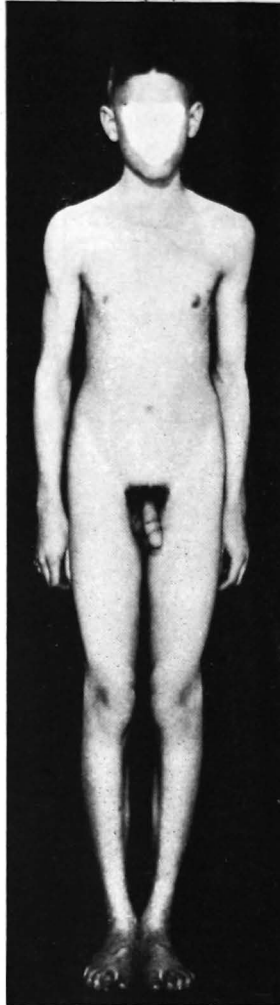
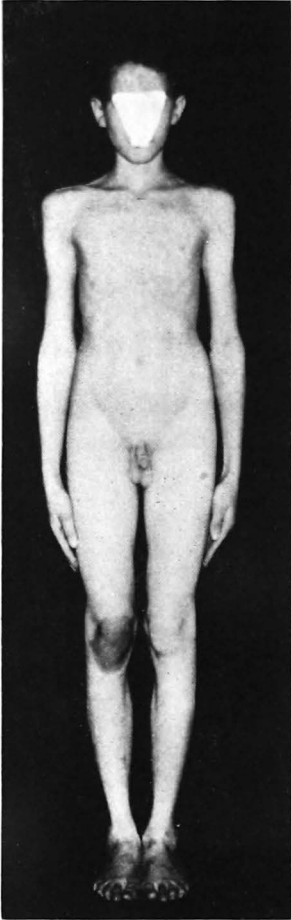
Slide 2. On this slide I have shown, above, the height curves and, below, the weight curves of two boys, John and Kenny, who are brothers. John is the older brother. There are three boys in the family, John be-



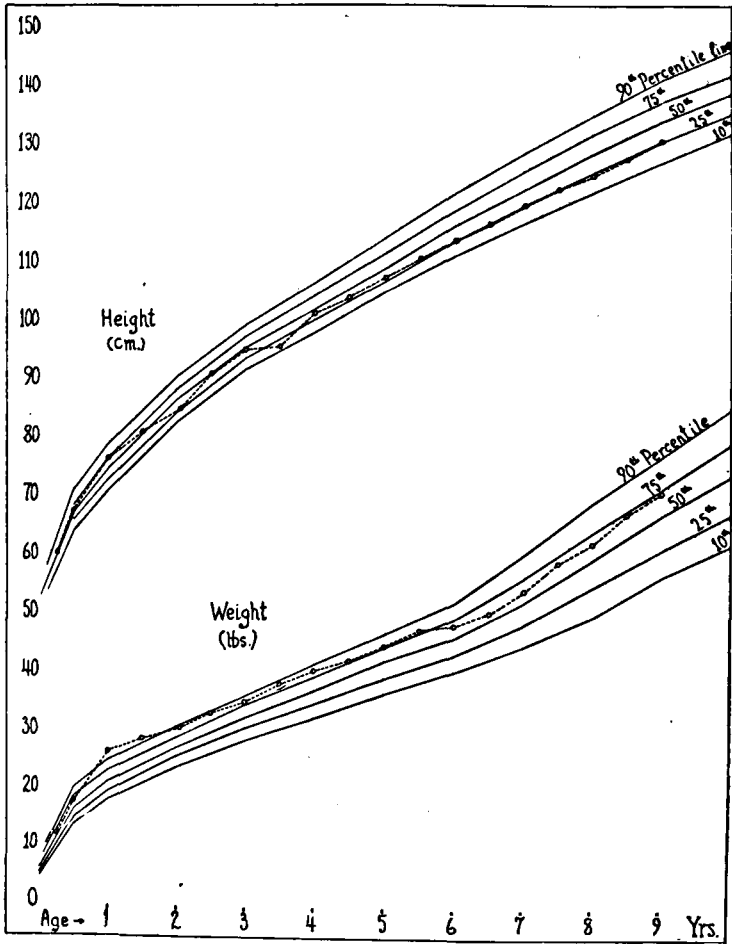
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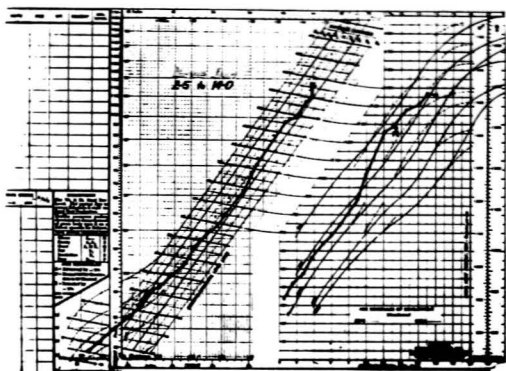
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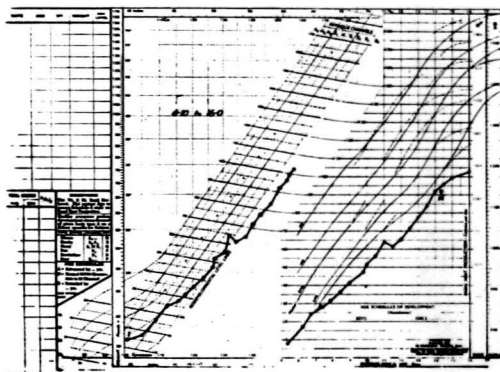
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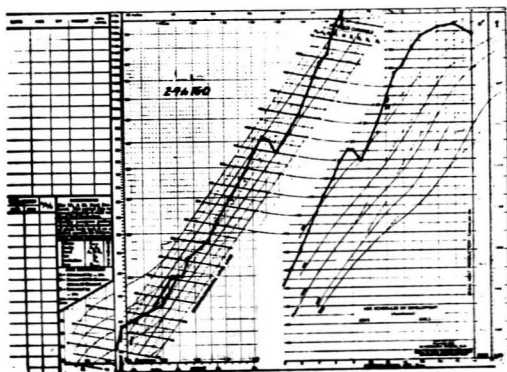
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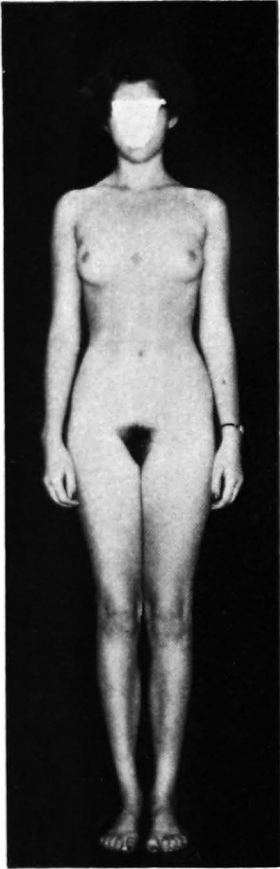
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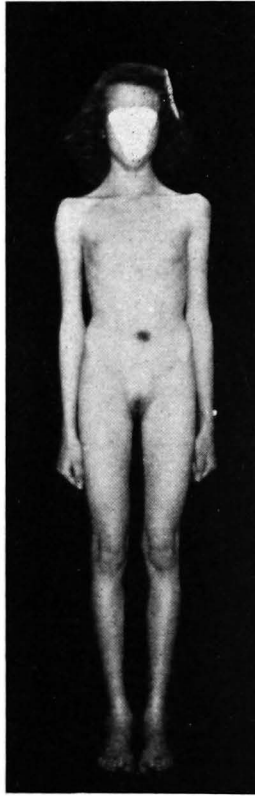
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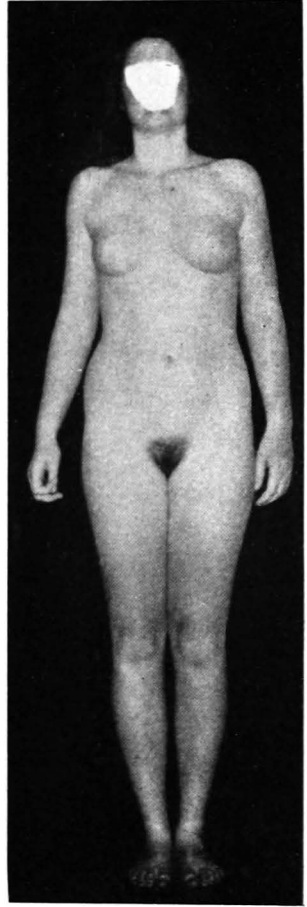
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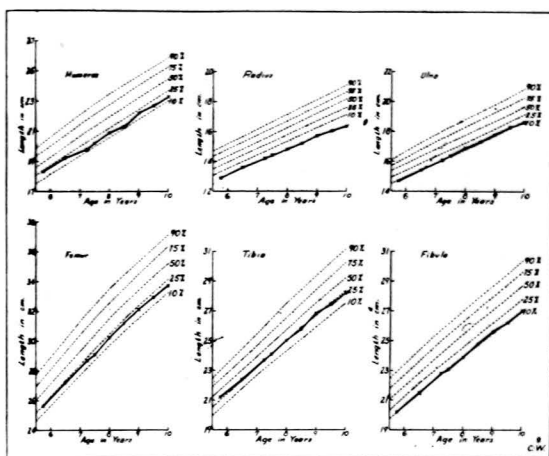
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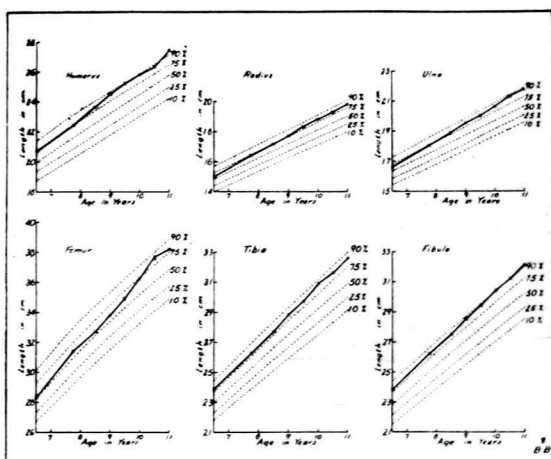
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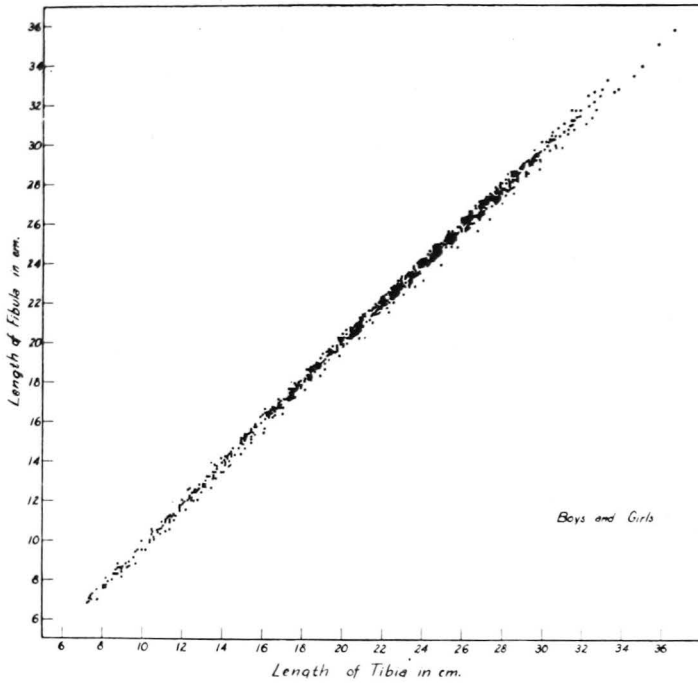
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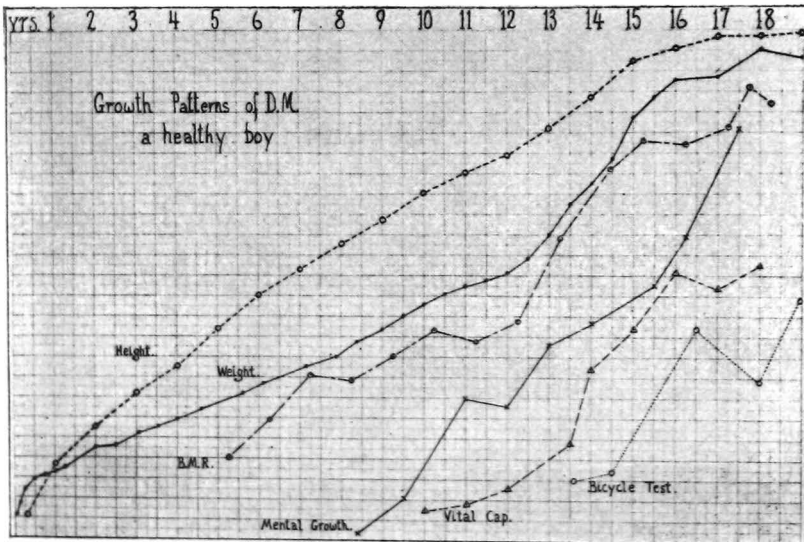
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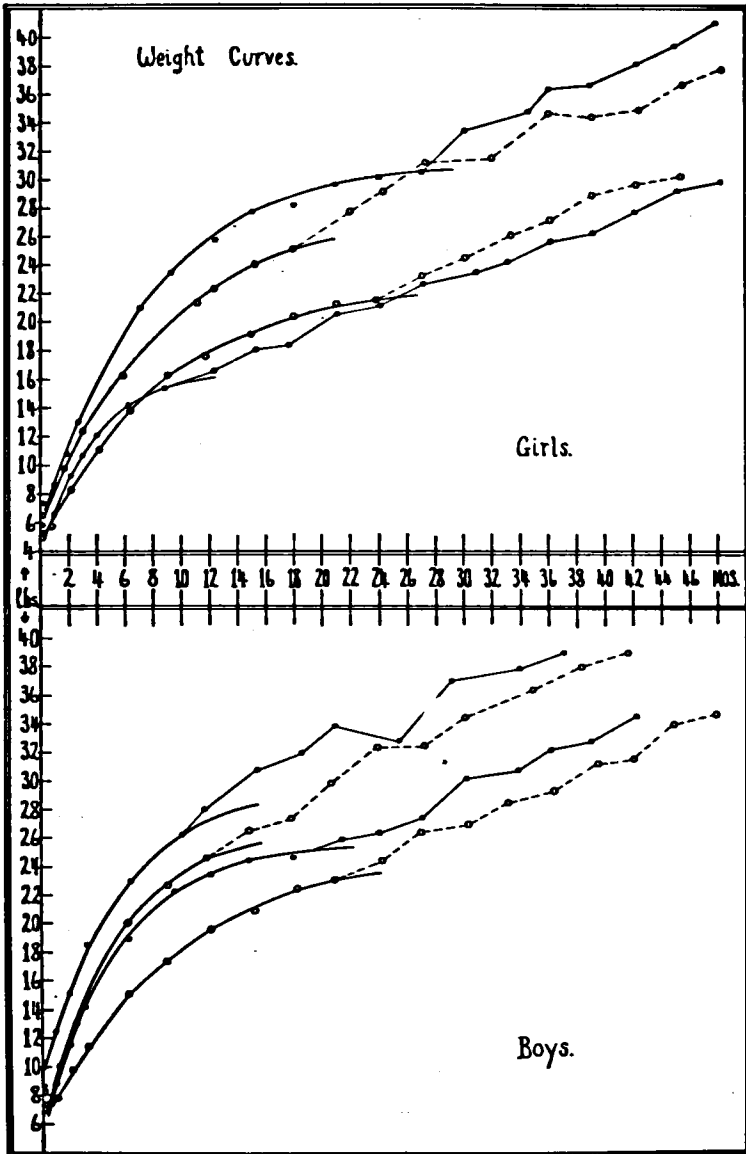
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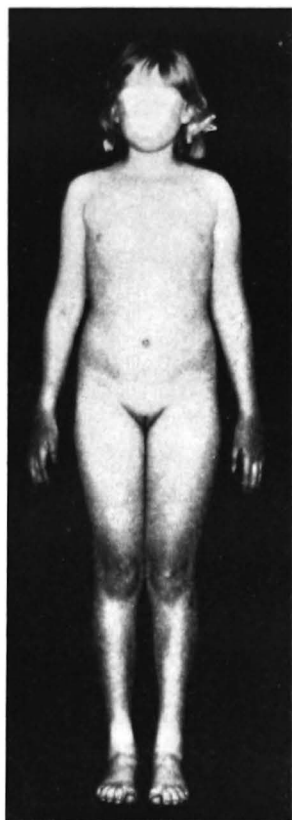
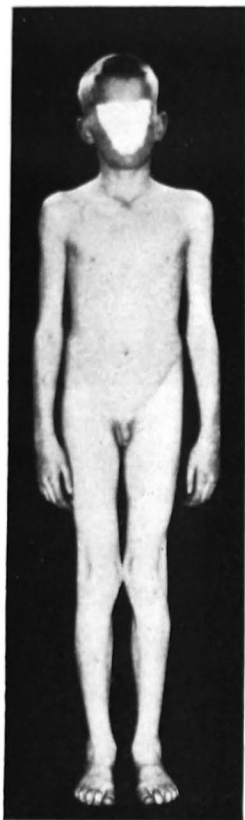
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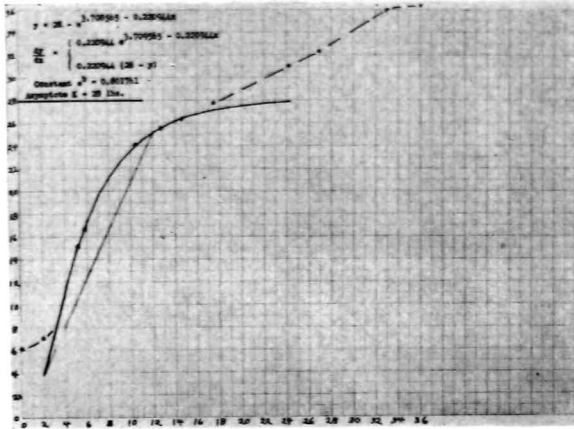
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Slide 12



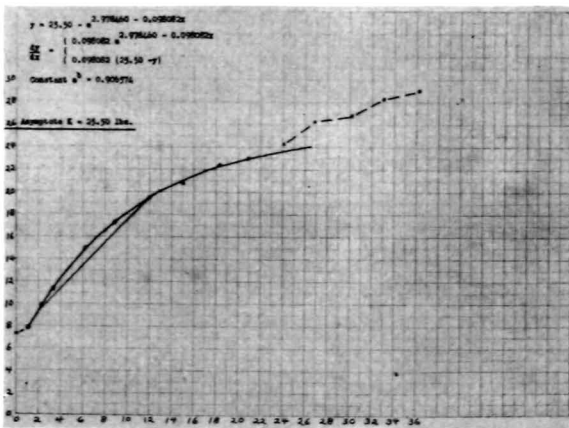
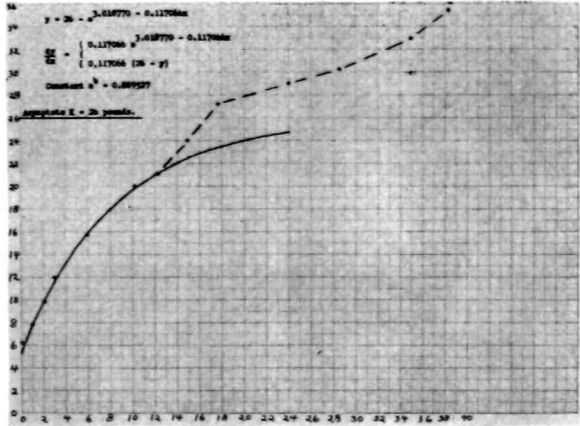
Slide 13



Slide 14

Typical male pattern of infant growth in weight, though very slow to get started on typical pattern.

Slide 15
 Typical female pattern of infant growth in weight. Breaks away sharply from infant pattern when curve begins to level off.



Slide 16

Pattern of infant growth in weight extremely feminine —very unusual for a boy.

ing the middle and Kenny the youngest. If you will look at their weight curves, John's is the solid line and Kenny's is the dotted line plotted against the background of the percentile averages of all our healthy children. You will note that there is not so much difference in the weights of the two boys as there is in their heights, and you would have very little difficulty, I think, in accepting the fact that each of these boys was following a pretty regular pattern. You would have very little doubt as to what the difference was going to be in their body build should you see them or their photographs.

There is a remarkable difference in the timing of the adolescent growth spurt, Kenny not having started yet whereas John was already well ahead of him.

Slide 3. Here we have photographs of the three boys, this being John and this Kenny, whose curves you just saw, and this being Fred. Each photograph was taken on the fourteenth birthday. It is perfectly obvious that the difference in body build which you saw was a general pattern that each boy followed and that there is a marked difference in the degree with which maturity has taken place at the age of fourteen years.

Slide 4. Then a slightly different type of illustration in regard to pattern. Here I have used percentiles 10, 25, 50, 75, and 90 and have charted the height and weight of one child against these percentile backgrounds. This type of pattern, in such marked contrast to the general progress of most of our children, is an interesting item on which I am not going to dwell at length. There was pretty good evidence of some endocrine disturbance distorting the pattern. As you look at the period from five years on, in which this youngster came down with an acute rheumatoid arthritis followed by a mild degree of heart involvement and six months later by chorea, you will notice that these conditions had a very definite effect in distorting the pattern of his weight curve. Now, some two years after the last evidence of activity of the rheumatic infection, the weight curve is getting to where it was along the 75 percentile. But all during that period of time the height curve progressed smoothly along the 25 percentile. The boy is a relatively short, stocky individual, as are his sister, his mother, and his father.

Slide 5. The next three slides show the pattern, as charted on the Wetzel Grid, followed by three girls. Each of these three photographs was taken on the thirteenth birthday. You will notice that in one girl, who might perhaps boast of being that mythical norm, the height-weight relationship progresses quite smoothly up approximately the central channel of the grid.

Slide 6. Here is a pattern that certainly deviates well away from the average, the height-weight relationship having dropped so far down as to be in that zone which Wetzel considers abnormal or beyond the pale of health. The child is slender. One might possibly suspect her of being—or of being worried about her being—malnourished, yet you might be interested in knowing (she is now, by the way, seventeen years old) that she shows the next to the best health record we have in the whole group. Incidentally, you will notice that her characteristic pattern on the developmental side of the grid also makes her appear to be way behind schedule in everything. Well, she was behind schedule in the start of adolescence, she was about a year and a half behind the average in the start of the menses, but those were about the only two items in which she was well behind schedule. In many aspects she has been ahead of our averages for maturity.

Slide 7. This is the opposite extreme, a very large girl who grew very rapidly, following pretty much her own pattern. I put this in because she is large and follows a different pattern, and also because I thought that the amusing bump on her grid curve was perhaps as nice an example of the sudden interference of environment as you could ask for in a child. At this point all of her schoolmates were teasing her because she was bigger than anybody within two or three grades of her and her father accused her of getting fat (her father is 6'4" and weighs 230 lbs.), so she put herself on an extremely rigid diet. We all got worried and tried to bring pressure on the situation, until finally she relaxed her diet, started eating reasonably well again, and as you see is working up toward her original pattern.

3. *The Integration of Parts and Functions*

Some years ago Julian Huxley showed the remarkably uniform relationship existing between the growth rate of one part of the body and any other part in some of his experimental animals. The Wetzel Grid curves, which you have just seen, demonstrate the relatively constant relationship between height and weight during healthy growth. My next four slides show how very uniform is the relationship between the growth of different bones.

Slide 8. Here we have charted out the growth of the six long bones of the body on one small girl against the percentile ranges for our group as a whole. You will see a very great degree of uniformity in the pattern which her long bones follow. You will see on the whole a fairly close relationship in the different bones. The only bones that are very far off are the tibia and fibula, which are somewhat longer than are

the other bones. If I had time to run through fifty such slides you would see that each child follows a pattern that is apparently his own and follows it from a fairly early age. This particular stretch of measurements started between five and six, and there is a tendency for a child to follow his own pattern pretty closely from somewhere around one and one and one-half on.

Slide 9. And this is the same type of charting of the length increases in the long bones of another girl, who is one of our larger girls. Perhaps the only thing that needs to be pointed out in contrast to the last girl is the fact that the femur growth is giving evidence of an early adolescent growth spurt, which of course was characteristic of the curves of various other findings on this girl.

Slide 10. This is a slide that Dr. Maresh, our roentgenologist, is very fond of because she likes to have things she can measure. I put it on merely because it shows again the same point I am trying to get at. This is taking the measurements of tibiae and fibulae on our whole group of youngsters, and at each age level at which we have taken x-rays, simply pointing out the growth of the fibula against the growth of the tibia. It gives a beautiful relationship; as a matter of fact, there is a coefficient of correlation of 99.9 per cent, which is one of those almost unheard of things.

Slide 11. This last slide of this particular group I put on in an attempt to show on one chart in a very simple way, just as actual measurements, the curves of one healthy boy. At the top, his height increases during the years from birth to nineteen, and then next his weight increases, next the increase in his basal metabolic rate charted as total calories, next what we call the mental growth curve (which is simply charting the growth in the mental age in months against the chronological age in months), then the curve of vital capacity changes, and finally the curve of his physical fitness as demonstrated on a bicycle. I put these on to show again that growth in various different aspects is not a completely haphazard affair, but tends to follow very definite patterns.

4. *A Prediction from Infancy Growth Patterns*

There is, I believe, an increasing number of people engaged in growth studies who are convinced that certain morphological and behavioral aspects of the infant observed during the early months following birth have good predictive value for later age periods. Some of Gesell's predictions made in infancy and substantiated fifteen to twenty years later are classical. Dr. Aldrich, also, has been

able to confirm some of his early predictions based on the dynamic quality of the infant's reactions to his new environment. With some of our records on individuals now spanning the whole growth period, we have become increasingly interested in the earliest observable assertion of meaningful patterns in the individual's growth. My last eight slides illustrate briefly one such observable and measurable pattern.

Slide 12. There are two groups of curves here. The top group shows the curves of four girls and the other the curves of four boys. The age in months for both groups is in the center. The first two curves in each case represent the infancy cycle of growth; there is a mathematical equation applied to the actual weight increases, and you can see in each case that it makes a reasonably smooth fit. It is an extraordinarily smooth period of growth for the average healthy child. You will notice the curves of the upper three girls are all following more or less the same type of pattern, namely, a curve which decelerates rather slowly, a rather slowly bending curve, in contrast to that of the curve of the girl at the bottom which is bending very much more sharply.

Then in the lower group you will see the three more sharply bending curves of three boys, and below these three a more gradually bending curve of a fourth boy. If one takes the mathematical figure which expresses the rate of deceleration of those curves and one takes the figures on 100 children, one finds a significant difference between the girls' average and the boys' average; but the interesting thing, and a finding which I think one might well expect, is that the figure for some of the boys scatters up into the girls' end of the range and for some of the girls it scatters down into the boys' end of the range. So we have depicted the curves of three girls for whom that figure representing the rate of deceleration is about at the girls' average, and down below three boys whose figure is the boys' average, and one girl whose figure puts her down in the boys' range and one boy whose figure puts him up in the girls' range.

Slide 13. I have here the photographs of a typical boy and a typical girl at nine years on your left, and on your right the same boy at ten years compared with a less typical boy. I am particularly anxious for the moment not to get into the possible controversy as to how you determine andric versus gynec bodily characteristics. It is perfectly obvious, without getting into that controversy, that there are differences in bodily contours. If you start at the shoulders, there is the bony prominence showing, making the boy's shoulder square while the girl's is smoothly rounded, and you come down to the arms and see the hang

of the arm is different. By the way, if any of you have not noticed how the sexes hang their arms you will get a lot of entertainment from watching them. There is a difference in the showing of muscles, which is not too evident in the photographs but which is a real thing, the rather smooth contours of the girl against the bulgy contours of the boy which show muscle groups. Then there is the space between the thighs, the knees, and the groin in the boy and the lack of any such space in the girl. There is the difference in the shape of the calf and various other parts of the body. However, I am concerned simply with the fact that their bodily contours are different.

Slide 14. Here we have the infancy growth curve of the boy whose photograph you were just observing, and you can see the relatively sharply bending curve that is so characteristic of boys; as a matter of fact, this boy's curve bends slightly more sharply than that of the average boy. The straight line on some of these charts was drawn by somebody who was showing the slides earlier simply to show the sharpness of the curve.

Slide 15. And this is the curve of the girl whose photograph you just observed. Even without that straight line being drawn across, you can see without any question that the curve is much more slowly bending than the growth curve of the boy.

Slide 16. This is a curve of the boy whose photograph you just saw at the extreme right of the last photograph (slide 13). We have entertained ourselves by taking some of these curves and showing them to statisticians, telling them what they represented and then asking them on unknown curves to try and figure out whether they are dealing with a boy or girl. Of course everybody picks this out as a girl. I don't think one needs to go into any tremendously detailed discussion of bodily contours to see very quickly that this boy's bodily contours are very much more like those of the girls than they are like those of the other boy.

I was asked to talk to the specific question: "What have we learned about emotional growth and development in a growth and development study?" If at the moment you are thinking that we have learned very little, I shall not be offended. In a somewhat roundabout manner I have tried to suggest some partial answers. These are all based on the notion that the emotional responses of the individual are part and parcel of his unique physical and physiological characteristics interacting with the various factors in his own particular environment.

We have learned a good bit about the nature of the general human pattern of growth in its physical, physiological, psychological, and social aspects. We have increased our understanding of the varying individual patterns within the general human framework. We have acquired a great deal of insight into the consistency with which a given individual adheres to his own pattern, beginning often at an early age. We have at least glimpsed the possibility of making valid and useful evaluations at an early age which have meaning and significance in the later life of the individual. I cannot say that we have made any significant contribution to an understanding of any specific emotion such as fear or anger.

Evidence from the Rorschach tests is still in too preliminary a stage to warrant any formal presentation. Here I might simply say that those psychological characteristics which we might include in the word temperament appear to show definite consistency within the progressive changes of growth of a given individual. This, then, would appear to be accordant with the concept of characteristic individual patterns in the physical and physiological aspects of growth. Without implying any one-to-one relationship between emotions and temperament one might, nevertheless, be justified in suggesting that the emotional reactions of an individual may depend as much or more upon his characteristic temperament as upon the provocations or frustrations which we may find in our study of his environment. And so, finally, we feel that we are learning to try to understand the individual first before trying to say whether his particular environment is "good" or "bad." Its quality can be assessed only in relation to the kind of person he is.

SOME BASIC THEORETICAL CONCEPTS OF EMOTIONAL GROWTH AND DEVELOPMENT—*Dr. John M. Murray*

My topic is emotional growth and development particularly during infancy and childhood, up to and including something of adolescence. As Dr. Senn has indicated, there is a great deal of controversy in this matter. Some theoretical concepts are rather universally accepted; others are pretty debatable. I am going to try to confine myself to that body of theoretical considerations which is more or less universally accepted. These data are acquired from observations of adults who have decompensated or who have

broken down into neurotic illness and who have later been studied—studied by a historic method with childhood reproduced—and also from child psychiatrists who have observed children troubled in their efforts to adjust to the eternal struggle of life.

When I was in the Air Forces and was faced with the problem of organizing schools in psychiatry, I felt it wise to incorporate into the teaching program a rather heterodox point of view, and so the Macy Foundation sponsored a couple of meetings for about twenty-five leading psychiatrists throughout the country, about half in the service and half in civilian life, where the problem of treatment techniques and the problem of the theoretical knowledge which we should give our students were discussed. What I shall speak of today, although it seems highly tinged with the psychoanalytical point of view (that, of course, is to be understood because I am a psychoanalyst), has passed through the screen of this rather heterodox group of people, and I think is rather representative of what the progressive and dynamic psychiatrists regard as good working tools.

In order to understand the child at birth from the emotional point of view, one must begin with the consideration of dependency. Certainly understanding dependency and how the child expresses his dependency needs is vitally important. I cannot help but think of a remark my son Jimmie made when he was about eight years old. Witnessing for the first time Felix and Helena Deutsch's newborn calf, Ferdinand, Jimmie got quizzical. He asked, "Daddy, how old was I when I began to walk?"

"Jimmie, you were about sixteen months old."

"Gee, that's funny, isn't it? Ferdinand is only two days old, but he was hopping up there and he nearly knocked Felix over."

Jimmie was quite puzzled by that, and he had an important point there of which we are all aware: the tremendous dependency which he, as a child, had by contrast with Ferdinand's relatively greater maturity. I think there are tremendously important psychological and emotional considerations involved in this difference, and a moment's observation of how these needs are expressed during early infancy will help us in understanding our over-all problem.

At birth the infant needs to relate himself to his mother, the

breast of his mother, which is all-important to him for survival. In this way, of course, he expresses his dependency on his mother. In later life if he becomes dependent on a woman for the glories of the love relationship, there will be a large psychological component of the relationship that will have developed in the interval between birth and adulthood. In infancy, however, he has no such fantasy life, no intellectual orientation; his relationship is completely and totally somatic, and in the first moments of life, so to speak, somatic essentially in terms of the mouth and in terms of the sucking reflex, the joys of sucking, and the security which he soon learns to experience from the warm, soft, and kindly body of his mother.

Although the intensity of oral satisfactions diminishes as the child grows older and finds other ways of relating himself to those he depends upon and loves, this dominance continues for quite a period of time. I think I am safe in saying that if I take this watch and give it to a child of eighteen months and let him listen to it and learn to love it—he likes it because it is bright and shiny, it has a hand that moves around, and it is generally intriguing—if he wants to show his love for such an interesting object, he will put it in his mouth. That is his way of expressing this positive relationship. Such a relationship and the affective way of expressing the relationship continue to some degree throughout our whole life. Our capacity to express ourselves orally is something that we always carry with us. Even as adults, those of us who are deeply religious, and who, feeling sorrowful at the loss of our leader, that great love-object, Christ, go to the communion service, symbolically relate ourselves with Christ in the communion service.

As the child grows older, the next part of the body that assumes an increasing importance is the other end of the gastrointestinal tract, the anus. We can see many important character traits originating during this period in which the child expresses the relative emotional importance which these parts of the body have for him. Take the child who in early life has been an irritable problem child and an intense thumb-sucker. If he is deeply frustrated in his thumb-sucking during this phase, he is apt to turn to the other end of the gastrointestinal tract, with the body of the stool in the rectum, and establish there also a capacity for defiance. I know you pediatricians are all aware of the child whose mother is tense

and nervous because the bowel movement does not come automatically each day, the child who learns to utilize this situation to command a high degree of intense interest from his mother and who later utilizes this function as an important expression of the emotional relationship with his mother. In many problems of this kind it is first necessary to straighten out the mother and establish more normal relationships between her and the child.

It is highly important that the child pass through these phases adequately without too much suffering, yet with a willingness through normal growth and progress to express his acceptance of responsibility. We realize how important it is that a child progress and that he be willing to pay his adequate taxes to growth, giving up his individual narcissistic and asocial tendencies in order to develop an ego within himself that serves to adjust and relate him to the world around him.

I believe that you have to allow a child an adequate amount of gratification during these periods of growth or the child becomes frightened and panicky at any stimulus arising from the successive dominant areas and goes into acute anxiety. I recall a case with which I once worked very unsuccessfully, a woman who was an epileptic and an alcoholic. The case history was that the mother, a fine young woman, was a maid, an immigrant, who married the son of the house in which she worked. It was highly important to her to prove that although she was a maid and came from a lowly economic status, she herself was indeed a lady. Practically at birth she began training her first child, a girl, in habits of cleanliness. She succeeded in training the child to go to the potty at an amazingly early age. But the girl carried within her an unrelenting emotional intensity combined with hostility for those she loved and tremendous anxiety at any tension that existed between herself and those she loved. She had serious epileptic seizures and was sent abroad. With no treatment, she went for two years and a half without having a single seizure, but on the way back home, half an hour outside of New York harbor, she dove from one of the top decks of the boat with all her clothes on and swam around until they came out in a boat and got her, as an act of defiance and hostility against her family to whom she was now returning. She worked with me for two years, and all during that period, after the first month, she had no convulsions.

However, upon one occasion when she was traveling with an older man and had come to the point where she could talk about bladder and rectal functions, she said, "I am afraid if you don't find a good spot to park alongside of the road, a filling station, or something like that, I am going to have an accident."

"All right, I will find a side road."

He found a side road and turned in, and as the girl put her hand on the knob of the car door to open it and get out, she had a convulsion. We later found out that the idea of talking about this matter to her companion created sufficient emotional intensity to act as a trigger situation for a convulsion.

I mention this in detail because I think it aptly illustrates the fact that we must allow the child enough of the gratifications he finds somatically in himself. On the other hand, we know we can find equally serious disturbances if we go to the other extreme and allow the child excessive gratification. These are vitally important matters to consider.

The child passes on in its phases of development from the oral and anal stages to a genital phase, a phase in which the genital zones become the most intensely pleasurable. I believe it is normal for a child to pass through a rather desultory phase of handling the genitals and that an adequate phase of this kind is necessary in order to leave the older oral and anal primacies behind. If a child is frightened too much at this time, there may be trouble. Again we must stress the importance of the two factors which will keep a child from progressing normally through the phases of his development: excessive gratification and overly intense repression. Both tend to keep the child fixed in one or another emotional era so that he fails to develop according to the normal processes of growth and development.

When the personality fails to develop toward maturity we know that acute regressions may occur and become the starting points of serious and acute psychological illnesses or that chronic and crippling neurotic manifestations may result. Even in the absence of these two more serious disturbances, there may be serious malformations in character development.

We know, for instance, that the person who has had too much oral gratification in childhood may become an orally dependent person. If you want to see a beautiful example of this, go and see

"The Iceman Cometh" and watch Dudley Digges express his oral regressive dependency in his alcoholic state. It is simply magnificent, the way he keeps acting out a character trait involving the somatic expression of the dependency which has led him into a permanently crippling life situation. In such individuals we find an overly dependent character, which expresses itself, in a sense, in the need to find life always a cornucopia. The attitude of the orally dependent child now becomes the basic characterological pattern of the individual's relationship with the world around him.

We know what goes on in the so-called anal character not only from the psychiatrist but from the literature as well. I have forgotten the Frenchman's name who gives us such a beautiful description of the anal character, that intensely rigid, obstinate, penurious person, sometimes with scrupulous cleanliness and sometimes with extreme dirtiness in his character pattern make-up. The obstinacy of the character is modeled, as it were, on the attitude of the anal sphincter during the time of life when this function was so overly important that the oral phase was never adequately left behind. Some of these character deviations, although they may not result in frank illnesses, are in many instances crippling attitudes which deny the individual the fulfillment of his best destiny.

It is important that these attitudes be left behind if we are to live happily. If we are rigid, if we have, like the patient I have discussed, too readily stimulated an anxiety regarding these primitive tendencies, the result is an unhappy person, a person who is not flexible enough to adjust happily to living.

As we would expect, we find these regressions expressed essentially in three areas. The first is the somatic area particularly centered around the gastrointestinal tract, the skin, the autonomic nervous system, the respiratory apparatus, the circulatory apparatus, and the like. Any of those areas which during childhood become important in the expression of emotions may become in later life the seat of symptomatic expressions of chronic tensions. The second is the psychological area. Here we may begin with the minor phobias and go on to the more severe phobias, the compulsive states, the paranoid states, and the delusional states of the psychoses. Here again we find that symptoms are dependent on certain failures and inadequate emotional growth and development

in childhood. With adequate study we can learn to understand the language which these symptoms speak and see how they relate back to the earlier archaic patterns of infancy. We see, for instance, how the schizophrenic regresses to an infant pattern. Many times one of his symptoms is the smearing of the feces. We know what this means from observing little children. My own son on one occasion when his aunt had given him a dime, took his aunt by the hand and said to her (he was very young at the time) "I give you a present too." He led her upstairs to the bathroom and from the toilet bowl said, "Take this from me too." We see this same expression in the schizophrenic who has gone back to this emotional pattern, who has given up the higher psychological relationships to human beings, and who now lives his life according to this pattern. We see it many times in the delusional symptoms focused around the gastrointestinal tract in such illnesses as involuntional melancholia, where the body is used to express ideas and relationships which the normal adult should be handling in terms of the activities of the frontal lobes.

The pediatrician needs to know many practical aspects of these situations in order to play his role in aiding adequate emotional development in children. I believe emotional development begins at birth. I believe that if we are going to be a better race, there is nothing more important than for us to understand the highly emotionally charged aspects of birth itself—in terms not only of the mother's relating herself to the child but also of what birth in itself means to the child.

I sometimes wonder why we have neglected for so long the effort to understand the emotional dynamics of this most important experience. As a practicing psychoanalyst let me tell you that this is a most important emotional experience. I want to come back to this later, but for the moment let me speak of an interesting episode.

A young psychiatrist in training told a very interesting story of his return in a B-17 after a raid on the submarine pen at Laurent. They were flying at a tremendous altitude and had just given the pen what the Air Forces would call a "hell of a pasting." They had gotten through and had dropped their bombs and in the process had lost more than 50 per cent of the planes that were flying with them. The doctor's own ship was riddled, and a sergeant who was

a career man in the Air Forces was there with his arm practically shot away, with just enough substance left for the doctor to put on a tourniquet. After they had gotten down out of the higher air and were back over the Channel, coming home, the doctor sat down and started talking with the sergeant, who said, "Isn't it funny? I have been in the Army sixteen years, and all I have ever done up to now, now that I look over those sixteen years, is to get ready for that five minutes that have just gone by. All I did before was to get ready so I would not make any mistakes as I went through it. That is what my whole life has been, just getting me ready to go through this experience, and doing everything I should so wrong things wouldn't happen to my buddies and me and the mission we were trying to accomplish. Sixteen years for that five minutes of activity!"

I cannot help but be struck by the contrast of how little we have done in preparing a woman for the highly loaded emotional experience of bearing a child, particularly the first child, when a third party comes to alter the earlier relationship with the husband alone. How important it is to prepare the woman for the way she is going to feel toward the new arrival, how she is going to feel about dividing her emotional self between the child and her husband, considering her own intimate emotional need for both of them and how these needs relate to her earlier emotional experiences of childhood and her growth and development. I feel that one day pediatricians will pay a great deal of attention to this emotional problem, because I believe it is their job to prepare the mother not only in terms of how to handle the child but in terms of what the emotional experience means to the mother herself. From my experience with patients I find that the obstetrician cannot do it, and certainly it is not a job for the psychiatrist, because after all this is a normal event. There are so many normal emotional events which approach the pathological that these must be treated by persons other than the psychiatrist. Perhaps later we can speak in greater detail about the importance of the emotional meaning of birth to the mother. At this time I only want to introduce it as a special subject in which I believe medicine needs to take a greater interest and which doctors need to understand more fully in order to be of greater help to those who need help.

SESSION II

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

THE moderator, Dr. Benjamin Spock, proposed starting the discussion with the newborn child and called on several conference members for examples from their practice. Their descriptions included certain assumptions about the psychology of very young babies and led to some questioning as to whether the alleged emotional reactions really do occur, the suggestion being made that the observed behavior might be explainable physiologically. Several responses to these objections were made, the chief being that what is aimed at is not so much the prevention of psychological damage to the child as the early establishment of a good mother-child relationship. The following is an abbreviated transcription of what was said.

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Moderator Spock. The topic, what can the pediatrician in practice do in the field of mental health, has always interested me. I started pediatric practice right after having a year's internship in psychiatry and while starting psychoanalytic training. I had spent a year taking histories and carrying on supposed psychotherapy with dementia praecox and manic depressive patients and I kept thinking there must be some connection between this and pediatrics; but what was it? A psychiatrist would say, "It's important that babies should not be weaned too early." That sounded like something that applied to pediatrics, so I would ask, "What is too early?" The psychiatrist would shrug his shoulders, and answer, "I don't know but it shouldn't be too early." Too vigorous and too early toilet-training seemed to contribute to the character disturbances and the neuroses of many of the cases that we were dis-

cussing, so I kept asking, "What is too early and too severe toilet-training?" Again there was the shrug of the shoulders.

I became gradually aware of the fact that the application of psychiatry to pediatrics is not really the fancy jobs, like treating a neurosis; it is such things as getting along with mothers and making them feel comfortable. Perhaps the chief thing in pediatrics is to avoid giving parents the kind of advice that inevitably creates difficulties between them and the child. We should set that as one of our aims in teaching medical students and pediatric interns.

We pediatricians who are interested in psychiatry are also coming to agree that our job is to try to give babies back to their mothers. We see the insecurity, the squeamishness, with which the modern mother approaches the care of her child, especially her first. I was pleased that Dr. Langford emphasized this point. Perhaps we should start with some comments on how we can reach our goal.

Dr. Little. I think preventive mental hygiene is the primary task of pediatrics. The pediatrician has to deal chiefly with the parents of his patients, primarily with the mothers, individuals who have perhaps a good many unresolved emotional problems of their own and who have a great many emotions stirred up by the birth and the care of their children, particularly the first child. If they have an opportunity to share those feelings and the thoughts behind them with their pediatrician, they can be relieved of a great deal of emotion that is piling up inside them and can be assisted in going forward and using their own intelligence.

When I was practicing pediatrics I tried to get to see each mother as soon as possible after the baby was born. I don't mean to say that as soon as I heard a baby was born I started for the hospital on a dead run, but I got in there as reasonably quickly as I could. I went over the baby first, without seeing the mother. After a while, after mothers drew my attention to details that I had not at first noted very carefully, I got to be quite adept in this first examination. After that I went in to see the mother. If I could in all good conscience tell the mother that she had a perfectly normal baby, I did so. I got so that I could anticipate certain things that might be troubling her and so gave her a special opportunity to bring out some of these problems. For instance, the fact that a newborn baby has very little chin is often a source of considerable

worry to a good many mothers. They don't know that the chances are that he will develop a reasonably good jaw after a while, and they visualize him as chinless. Also, angiomas on the eyelids cause considerable concern, so it is very comforting to a mother if you take a little time to reassure her about this.

You can discuss in such an interview what the mother will need for her baby when she leaves the hospital. Even if she says, "Oh, I have been down to so-and-so department store, and I have a complete outfit," the matter of practical needs serves as a good starting place. Then you go ahead from there to the question of feeding and try to get that started on a reasonably satisfactory basis.

Most mothers do not know the vaguest thing about how the child behaved in the hospital. They don't know whether it vomited immediately when it got back to the hospital nursery or not. They don't know whether it had one bowel movement a day or six, or even what is normal for a baby. They don't know that a baby sneezes a great deal of the time and hiccups all the time. Twenty-four or thirty-six hours after mothers have reached home, they will have made some observations of their own and probably encountered some difficulties. If you can go over such things point by point with them at this time, you can prevent a tremendous amount of anxiety from piling up.

It seems to me that if you can prevent such anxiety in a mother and share her feelings with her at an early point, she will then be free to use her intelligence on the things she has read and the advice you give her in a reasonably constructive manner. From my standpoint, this is what a pediatrician can do in practice in the mental hygiene area. A pediatrician is not going to be consulted on deeply emotional problems nor should he attempt psychotherapy, though there are some modifications of it he might attempt. But if he does the kind of thing that I have described and develops a good relationship with the parents, particularly the mother (of course the relationship with the patient is also important but certainly in the early years it is not nearly as important as the one with the mother), he is going to head off trouble before it arises, for the mother is going to feel free to come to him with all manner of questions.

To achieve this kind of relationship one must never give a

mother the impression that any of the questions she asks are ridiculous, that it is stupid for an intelligent woman to take up your time with questions of that kind. Any question that a mother brings up, whatever the factual basis for it, is an important question to her. It is an indication of the way she feels, and that feeling ought to be met. Such a relationship is fundamental to sound mental hygiene practice by the pediatrician. A great deal can thus be accomplished in the way of remedial mental hygiene, the most important way for a pediatrician to function according to my way of thinking.

Dr. Montgomery. I think there is nothing more striking to all of us who practice pediatrics than this terrible feeling of incompetence with which a mother goes home from the hospital, her feeling that the whole situation is just too much for her. We felt that there must be some way in which this could be avoided, and so in our hospital we have been trying a "rooming-in" plan. We have used only the equipment which was at hand. This included cribs with transparent plastic sides that happened to be just the same height as the mothers' beds. The baby's crib is placed beside the mother's bed. It is put on her left side if she is right-handed and on her right side if she is left-handed, for then she can reach over and grasp the four corners of the blanket and lift the baby onto her bed and thus take the entire care of it. The arrangement has been used only with mothers who said they wanted it, a fact that must be kept in mind in judging results.

The baby is kept entirely in the mother's room throughout its whole neonatal period except for the first few hours, usually about twelve hours, when the private room is not available. We put the baby in the nursery during that time, an arrangement that works well, for if there are going to be any acute disturbances in a newborn child, they are most likely to arise during that period.

Throughout the entire hospital procedure the mother is given expert instruction in the care of her own baby. We have proceeded rather cautiously here. Since this is a very important feature of the plan, we feel that a nurse who has had postgraduate training in child development should be the one to give the mother instruction. The mother carries out simple procedures in the presence of this instructress, who discusses with the mother the expected developments of the first few weeks. We always warn the nurses not

to go too far, not to try to discuss adolescence or some other ridiculously distant period. As a result of this experience the mother takes home with her, not an infant who is a stranger to her and of whom she is terribly afraid, but a baby whose needs she feels she recognizes, and she feels confidence in her ability to take care of it.

Another feature of our plan which we think is very important is that the father is brought into the picture. Fathers usually get the worst treatment of anyone in the whole family during this newborn period. Instead of treating him like an outcast, we insist that there be no visitors in these rooms except him. Sometimes, I admit, the maternal grandmother manages to break in, but we have tried to limit visitors to the father because we feel that this is a family party. We would like to keep it a family party to see if we can't do something to facilitate a normal adjustment of mother, father, and baby during this period. As one means of accomplishing this we give the father one of Dr. Sesall's behavior day charts and some colored pencils, and the mother gives him her notes on when the baby nursed, how long he cried (these children are all on demand feedings), and the like, and the father has a gay time filling in the colors and making the chart look pretty. This has seemed to us to be very useful, as the father then attains a sense of participation.

Incidentally, the amount of nursing care which this plan requires has turned out to be much less than we had anticipated. Replenishing the supplies, instruction time to the mother, and nursing care of the baby have averaged between fifty-five and sixty minutes a day, which is quite economical as far as time is concerned. The reason is, of course, that the mother really does most of the work of caring for the baby.

We are keeping careful records of as many of these children as we possibly can. So far we have been successful in getting all of them routed through the Merrill Palmer Nursery Service, which conducts long-time longitudinal studies. Experiments much like ours are being carried on in other parts of the country. We have a committee working on the problem. Through this committee we are trying to coordinate our research in order to avoid duplication and yet to be sure that we get the type of information which we think will be valuable.

Dr. Allen. This rooming-in plan interests me very much, as it

has some real recognition of what goes into the birth experience, not only for the mother but for the infant. It provides an opportunity to reunite two people who have been physiologically disunited in the birth experience, in that it enables them to begin their living together as separate people with the very close relationships that are needed. For the infant, as well as for the mother, I am sure it is very important to have this early close association with the individual with whom he is going to have his most important living experiences. The infant very quickly reacts to the beginning experiences of his own living.

In teaching medical students and young pediatricians it is important to use illustrations that help them to realize that a baby is a person and is not just a kind of automaton that responds to anything that is done to it. A mother gave me one such illustration not long ago and I find it carries a great deal of meaning to students in showing that a young infant does a kind of talking in his own responses and in his own actions. Following the birth, as is customary in most hospitals, the baby was removed to the carefully sterilized nursery and brought to the mother by a nurse for feeding. On the second day the baby was brought in and held to the breast by the nurse. The baby was doing some pretty interesting talking at that point by clamping its mouth down tightly and refusing to take the breast. The nurse, evidently carefully trained in the belief that a baby should be fed, held the child tightly to the mother's breast, but the youngster continued to say no in a very vigorous and effective way, so he was taken back to the nursery. A short time later he was brought back again and the same performance was repeated. At this point the mother said to the nurse, "Let me hold the baby." She held the baby quietly in her arms for a few moments and felt him relax. Following this the baby took the breast of his own accord.

That is just a simple illustration but it seems to me to get over to the beginning student, who probably regards the baby as a pretty helpless, inarticulate, unresponding individual who takes what is offered to it, three points: one, that a baby does respond very early to the circumstances that are provided in his living; two, that a baby is able, even in the first few days of life, to respond negatively, to assert itself against that which is being provided;

three, that even an infant, if given an opportunity to live through that first negative reaction, relaxes and yields not only to his own biological needs but also to what another person is wanting and requiring of him. In those very early infant experiences we can see much of the important pattern that is going to develop between the child and the mother as the youngster begins to take on forms of behavior that are required of him, when he takes these on out of his own participation in them and not merely because someone requires them of him. It is the kind of understanding that I feel is so important to get over to the medical student in the teaching of pediatrics—the normal and natural behavioral responses which we see and can guide and direct in the young infant.

If we recognize the parent's feelings, as Dr. Little has indicated, we have an appreciation of the parent as a person who is going through quite an experience and we have a chance to help him or her with early normal and natural anxieties. I think that too many times we have regarded the parents, particularly the parents of a young infant, as merely the satisfiers of the child's needs. We must remember also that the child has an impulse to grow as well as to have its needs satisfied. One of the most important needs that even an infant has (maybe as that young infant in the illustration I gave had) is the need to be aware of having a need.

On this point I think we have two schools of thought. One postulates that frustrations are needed in order that the infant shall grow. The other school—and I think we find some of that possibly in Dr. Ribble's experiments and work—puts, I think, too much emphasis on the mother as merely a satisfier of the child's needs. This point of view might, in its overemphasis, take away the normal frustrations that I think are inherent in growing up. I think we have to appreciate the mother not only as a satisfier of the child's needs but also as the one who creates a medium in which the child can begin to make those earliest outreaches to satisfy his own needs which give him his first sense of himself as an individual.

These are points that are important to emphasize in the training of the medical student and in early pediatrics, so that practitioners will not regard a mother merely as somebody who satisfies all of the needs of the child, but will have an appreciation of the inter-

play of forces that begin to take place between mother and child and realize that growth is a process, not just something that has a stage here and another stage there.

Dr. Jackson. Several speakers have stressed paying attention to the mother's needs as well as to those of the child. More and more it seems that the people who are working in this field are recognizing that a mother can give to her child the attention it needs only if she feels that in some way she is getting the required attention to her own needs. In this connection I would like to mention that at the New Haven Hospital we, too, have a rooming-in arrangement, something like Dr. Montgomery's, which has grown up out of the combination of pediatric and psychiatric interests and out of the cooperative effort of the departments of obstetrics, pediatrics, the nursing administration, and the hospital administration.

In contradistinction to Dr. Montgomery's work we, adapting to our possibilities, use ward rooming-in rather than single room rooming-in. We have four mothers and four babies together in a solarium. This plan has been in operation since last October. The work is carried on by a pediatrician in training (an assistant resident in rank) and a nurse. They carry out the actual work of the selection and care of mothers in the hospital and the follow-up of the mothers after hospitalization. I share in the selection of the mothers and in the supervision of the unit.

The assistant pediatric resident and I also work in the prenatal clinic. We introduce ourselves to the pregnant women as pediatricians interested in the baby when it arrives and therefore interested in it now. The mothers like that very much. I want to give you just one example of what may happen in such a situation.

One of our pediatricians in the prenatal clinic interviewed a Negress who was carrying through a pregnancy for the first time. She had had six miscarriages. I don't know the reason for them. I did not see her until she came into the hospital but she told me then how tremendously she appreciated her conversation with the pediatrician. She said she had resisted coming to the clinic (because of her former miscarriage experiences, I think) and when she finally did come she did not feel content until she had an unexpected conversation with him. She was then in her eighth month. In telling me about the conversation she said, "My hus-

band and I had not even spoken of our baby in terms of a baby. We did not mention the fact that a child was to be born, but after I talked with the pediatrician I began to feel for the first time as though I was really having a baby and I went home and talked to my husband about it, and from that time on we spoke of our child."

Dr. Weech. I'd like to introduce a note of—I don't think it is skepticism but, if it is, it is intended to be provocative skepticism as to an expression I have heard used several times. The trauma of the birth experience has been mentioned, and then most of the conversation has dealt with the mother's trauma. I have wondered whether there wasn't also an intention to imply that the trauma of being born had an effect on the subsequent development of the baby. I listened to the story of the baby who would not nurse until held to the breast by the mother. I am thinking about Roy Connell's anatomical studies, which give reason to believe that the cortex, particularly the frontal lobes, is not functioning at the time the baby is born but that the midbrain is thoroughly developed. It may be that midbrain reflexes acting in an emotional manner at this age can affect the reaction of the baby. The point at issue in my mind, however, is whether this experience is going to have anything at all to do with the subsequent development of the baby, except as habits formed at this time are perpetuated beyond the age where the cortical impulses do begin to flow. It is exceedingly difficult for a pediatrician who sees a newborn baby having a major laparotomy without anesthesia, happily sucking on a sugar ball through the whole procedure, to believe that at this age traumatic experiences are going to reflect on his behavior at all. A little later I will agree that they might, but can the psychiatrists here produce any evidence to justify the belief that traumatic experiences under the age of one month are going to have anything to do with subsequent behavior patterns?

Dr. Allen. Personally, I don't like the phrase "trauma of birth," though I think birth can be traumatic. I like to think of birth as a creative experience where two people begin to travel a journey of their own related and separate existences. Whether the events of the first two or three weeks leave any kind of a residual that has a traumatic effect depends upon the continuation of that early rela-

tionship rather than upon any specific occurrence, but patterns that carry through certainly can get laid down at the beginning. Just take the little baby who says, "No, I won't eat." You can immediately picture what happens when the anxiety of the mother or the nurse or somebody is aroused and she says, "You *must* eat, otherwise you won't live." Right there the elements of a very severe eating problem are beginning to develop if the conflict continues as a pattern—not if it happens once or twice but only if the two individuals get locked in a struggle, the anxiety-conditioned struggle on the part of the mother and the natural first negative reaction on the part of the child.

Dr. Murray. Perhaps at this time we cannot say that a child has anxiety the first two or three days following birth when he becomes involved in an adaptation that taxes him beyond his capacity and there is a conflict, but we know that anxiety can occur when the child is a few months old. From that point on, when the adaptive demands are too great, emotional conflict ensues and anxiety does occur. Perhaps we should not reason by analogy and say that the same thing can happen at birth, but should observe and find out whether this is really so. I will admit it is pretty hard to observe acute anxiety when a baby is only a day or so old. Nevertheless, I like to think in terms of anxiety when the child is threatened and I think it is wise to take an attitude that will minimize the likelihood of such situations following birth.

Dr. Butler. I would like to stress one particular point. I agree that the prepartum contact between the mother and the doctor who is going to take care of the baby is a good idea. I believe that the postpartum emphasis on the relationship of the mother and the child is a good idea, but I hope we will not forget the importance of a few seconds in the postpartum life of the newborn baby. We have pediatricians now, apparently, who are thinking of going to visit the mother before the baby is born, and we have pediatricians who are going to stress the importance of synchronizing education with the rate and the rhythm of growth; but we have almost no pediatricians who take the trouble to be present at the birth of a child to see what the difficulties of labor and birth are, what the condition of the baby immediately after birth is, how long it takes the baby to breathe, what the degree of cyanosis happens to be, and so forth. I would like to enter a plea that what happens to the

baby in those few minutes is important for the later behavior of the child.

Dr. Crothers. I would just like to say that while I think Dr. Weech is dead right, I don't see that it modifies the situation very much. I cannot imagine intellectual processes going on during the process of birth, where the oxygen need of the forebrain in the precompression level necessarily must be very slight. Physiologically, it seems to me simply inconceivable that a newborn baby functions at the cortical level. However, even granting that and granting all of what Dr. Butler said as true and of great importance, still the question of the management of the baby and the mother may be just exactly as described. On the question of the mother's management of the baby Dr. Allen described, I don't know enough about decerebrated animals to know whether you can comfort them by soothing them but very probably you can. You can certainly make great changes in them. However, it has always seemed to me that the occasional references to birth trauma as psychological phenomena were fantastically unsound from the physiological standpoint.

Dr. Washburn. It seems to me that we are missing an important point. With apologies to Dr. Allen, he has used an example which I have observed a good many times in a good many hospitals throughout the country and have torn my hair out over. I think I am right in saying that the correct interpretation of what happens when the nurse brings a baby in to be fed is that she almost always puts her hand against the cheek of the baby that is away from the breast and tries to push the face over to the breast. As Aldrich has shown, the baby has a beautiful rooting reflex. He tends to start searching for the nipple on the side that touches his cheek, the idea being, I presume, that it is instinctive when the cheek touches the breast. That gives the reflex to start to root and find the nipple. By coddling the baby the mother put him to her breast, and the baby answered its natural reflex and reached around and found the nipple. It seems to me the moral of that little tale is not that the baby was already showing his negativism; the moral is that the pediatrician should take the pains to understand the natural reflexes a baby has. The mother got along beautifully by using the rooting reflex properly.

Dr. Montgomery. There is one other physiological point in-

volved there. Dr. Aldrich has recently shown, although I don't think he has published it, that a newborn if awakened won't root. In other words, babies get hungry at very irregular intervals, wake up, and will then spontaneously root and nurse. Our current orthodox practice does not permit them that natural experience.

Another fact which may be important is that we have found that there is a peak in the number of times of nursing a day. That peak usually occurs on the sixth day in the primipara, and on the fourth or fifth day in the multipara. Usually lactation is very abundant after that peak, and we are probably sawing off the peak by our present orthodox management. Maybe that peak is important in the establishment of the period of lactation.

Dr. Stevenson. Upon analysis there seems to be no difference in what Dr. Weech and Dr. Allen have said. We don't have to think of these early processes as being intellectualized or anything of that sort. There can be a series of habitual developments, and we don't have to be concerned at this point as to whether they are cortical or subcortical. The establishment of a series of reactions peculiar to a given child is the essential thing. It seems to me that there is a difference in words much more than a difference of fundamental concepts in our arguments.

Dr. Wilson. I am the last one to want to separate psyche from soma in a baby. I know we cannot do it, and everybody knows that we cannot practice pediatrics without being psychiatrists at the same time, even though we don't think of ourselves as such. But this afternoon it has interested me very much that so much of this discussion has been on ordinary, old-fashioned pediatrics. In any teaching department these questions of educating the mother in the minutiae of taking care of her newborn baby are pretty basic. True, this education is not well done in many places, because even though the pediatrician may realize how important it is, it is one of the various things that get lost in the pressure due to defects in the curriculum, lack of personnel, and so forth. Such things as the presence of the pediatrician at the delivery is a matter of economics. Someone has to pay for it, either the university or the parent. Even though it is valuable, is it as valuable as the pediatrician spending his time with his present equipment, his personnel, and the like in doing something else?

On the question of the nursery versus having the baby stay with his mother, I think we all realize that for somatic reasons it is immensely profitable to have the baby with the mother instead of in the nursery. For instance, epidemics of diarrhea of the newborn are going to continue unless we dispense with the nursery or learn much more about prevention than we know now.

What I am getting at, however, is that when I present these ideas to medical students, there are plenty of good arguments to use in telling them why to teach mothers about the cheek reflex in the baby and why it is dangerous to have a bunch of babies together in one room poorly run. What I would like to learn actually is why it is psychiatrically dangerous to put a baby in a hospital nursery and why the baby is going to be psychologically traumatized in the first week or first months of life because certain things have happened to him. I am appealing for data to present to medical students to show them why from a psychiatric point of view, not from a somatic point of view, we do these things which I think we are all generally agreed ought to be done.

Moderator Spock. My own feeling is that a baby's psyche at this point is of relatively small importance compared to the mother's psyche. If at the start the mother can get the feeling of being comfortable and secure as a mother, that feeling has tremendous benefit for the baby in subsequent months.

Dr. Allen. Don't you think that the emphasis should be not on what is psychically traumatic and what is harmful but rather on what is natural and helpful? To have a child in a mother's room to prevent some future maladjustment seems to me to be ridiculous. To do so because it provides a normal beginning relationship which helps to accomplish the very thing that Dr. Spock has just mentioned is the real reason. You don't have to justify that by trying to go back and get out of case material instances where it has been harmful to have the baby in the nursery; you can find any number of instances where having the baby in the mother's room has enabled the mother to get a natural, positive, healthy connection with her child.

Dr. Weech. I have aroused a good bit of discussion deliberately, and now I think I ought to say a word again. Everyone seems to be in agreement. The conclusion permits us to put full attention on

the mother at this time without thinking too much about how the baby feels about its mother. Rather, we want to think about how the mother is going to feel about her baby.

I think that if we say to ourselves that the rearing of a child in a home is a process which is attended probably by the greatest happiness and is simultaneously associated with the greatest worry that any human individual is capable of experiencing, and then say that the purpose of pediatric practice is to do what it can to raise to maximum heights the sum total of happiness and to reduce to a minimum the amount of worry, we come to the conclusion that that process of work should begin with the mother at a time when we don't have to be thinking too much about the experiences of the baby. I think that is the purpose behind these recommended procedures.

Dr. Wilson. We are not greatly concerned, then, about psychological damage to the small baby; we are concerned about preventing the mother of that baby from having unnecessary burdens in caring for it.

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With agreement apparently reached on this point, the discussion turned to whether giving attention to the emotional aspects of children's health is feasible for a practicing pediatrician, particularly from the standpoint of time. Dr. Langford reported that preparatory to the present meeting he had sent letters to ex-members of the Babies Hospital staff (New York) asking their opinion on this question. Replies were received from fifty-six out of eighty of these pediatricians, now practicing in small and large cities throughout the country. Dr. Langford said that among his correspondents those who seemed to know what they were doing and had some confidence in their ability were not the ones who "squawked" about the time involved. The very few who mentioned time were those who were groping and who, as one of them put it, were "hoping to take a few months or a year off to learn something about this." Other comments relative to the time required to practice pediatrics with an eye to emotional problems follow.

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Moderator Spock. The matter of time-saving always has to come up, certainly when you are talking to practitioners. You can make

the point that an hour's prophylactic talk with the mother at the start really saves a great deal of time later on.

Dr. Baty. I will admit that a doctor who has a very large case load does not have very much time for each individual patient but I think he can still do a great deal in this field that we call mental health. It actually takes only two or three minutes to do a fairly complete physical examination, so even if the pediatrician is on a busy schedule and allows fifteen minutes to a half-hour for each patient, particularly if he has some nursing assistance in preparing patients, he still has a reasonable amount of time left to talk. He can take that time to be a sort of family advisor along with being a medical supervisor.

We don't see a patient just once. In my practice, for example, I usually see a mother three or four times while she is in the newborn nursery; so we have a chance to become acquainted. I spend more time with mothers at this stage than at any other. The point is that we see our regular patients month after month, year after year, and we are familiar with the family set-up; consequently our contribution is not in exact proportion to the time we spend on a patient per day.

Dr. Rubin. Often asking a simple question will take much less time than an examination. Just yesterday the pediatric intern on the surgical service came to me and said that a nine-year-old girl had suddenly stopped walking. She had pains in her legs. He had done a very thorough neurological examination and could not discover why she did not walk. I asked a simple question: "Was the sudden failure to walk in any way related to her home or school situation?" He said he didn't know. An hour later he came back in great glee and said that the failure to walk had suddenly occurred when the child changed classes in school. The pediatrician who says he is too rushed is simply not interested in these problems. I have practiced for about fifteen years and have found that sometimes a problem can be solved with just a word or two and a visit or two with a mother. It is just as important to have those talks as to make a complete physical examination of the child; often the physical examination is not needed after the mother is straightened out.

It was suggested that literature for parents might have some value as time-savers and that members of other professions—social workers, psychologists, public health nurses—might be used to carry some of the burden. Regarding these points, Dr. Senn made the following comment.

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Dr. Senn. We must emphasize to the pediatrician who uses literature because he believes it will save him time that there is more to getting something out of literature than just reading it in an intellectual fashion. What is important, either in reading or hearing advice, is the attitude of the person receiving the advice. The pediatrician must go beyond the common-sense approach and must realize that there is a relationship between him and his patient and the mother that can help or hinder the mother in accepting what he has to teach. Social workers have much to tell us about interviewing techniques that establish the right feeling tone. We may have to consider using auxiliaries, such as social workers, to assist us in the mental health aspects of pediatric practice, for even though I believe that many practitioners could find time for such work if they really wanted to do it, still I suspect that there are some who literally do not have time for it.

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At Dr. Senn's request, Miss Esther Heath, a psychiatric social worker, described the collaborative work she carried on some years ago with a pediatrician, Dr. Stork, in his private practice in Los Angeles. Operating as his "mental hygiene consultant," Miss Heath had interviews with mothers selected from Dr. Stork's private patients, the cases chosen being those—at the outset at least—which the doctor's method of advice and reassurance had failed to benefit. Miss Heath described her method of working with these women—slowly and patiently discovering what it was that specially bothered them about the children's behavior, giving them plenty of time to tell their stories, encouraging them in their efforts to deal with the problems, giving assistance with various environmental matters, and so on.

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Miss Heath. As a by-product, the pediatrician began to regard mothers as individuals and to become more patient with those who were not able to accept the good advice he was so willing to give. One of the social worker's contributions was to help the parent at his own pace. One problem might be cleared up in just one or two interviews, whereas in other cases the problems had to be worked on for weeks in regular weekly interviews. As a result of this procedure, parents were led to work out their own problems (the problems they brought up themselves and were ready to work on) and the pediatrician, thanks to the information obtained in specific cases, gained a good deal of necessary identification with the patients as persons.

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This description of how a social case worker operates led Dr. Janeway to ask two provocative questions. First, is it not possibly an unnecessary "luxury" to turn the medical profession, which requires a minimum of eleven years of training, to doing a job which non-medically-trained persons, such as social workers and teachers, can often do better? Second, since emotional problems involve the whole family, have we perhaps gone too far in specialization?

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Dr. Janeway. Should doctors be prepared to deal with the emotional problems of childhood or should they merely be made aware of the facilities that use far less expensively trained personnel to accomplish the same end? All psychological problems involve the family as a whole group. The pediatrician in his office practice rarely sees anyone but the child and the mother. In getting away from the concept of the general practitioner who does absolutely everything, surgical and medical, have we gone too far in dividing people into categories? Perhaps the great mass of the population ought to be taken care of by doctors who deal not only with the baby but with the family as a whole. It is possible that specialization in pediatrics could be a bad thing if it extended beyond the development of those few individuals whose special competence fits them for teaching the general practitioner.

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Dr. Janeway's word "luxury" was a red flag that stirred up a good deal of vigorous discussion. The conference then attacked the problems from three angles: whether it can be expected that pediatricians will ultimately serve a large proportion of the child population; whether pediatrics can rely on auxiliary professions for carrying on part of the mental hygiene aspects of its work; and what is meant by the mental hygiene aspects of pediatrics?

With regard to the present coverage of pediatrics, Dr. Felix stated that the majority of children are cared for by non-specialized physicians. Dr. Hubbard cited the American Academy of Pediatrics survey figures for North Carolina to show that the proportion of children cared for by general practitioners is about 80 per cent and that the pediatricians' share is only about 10 per cent. "It is certainly true," he added, "that the general practitioner is taking care of most of the children. He is the one who guides the mother through her pregnancy; he is very likely to be present at the time of delivery, if indeed he is not delivering the mother himself; he is there to guide the mother, grandmother, and baby through the uncertain siege directly following the delivery." "Even though there is an increasing number of pediatricians," said Dr. Baty, "I think few of us believe that pediatricians will ever take care of the bulk of sick children."

This situation should not deter the development of pediatrics as a specialty, however, or the incorporation into it of pertinent data from dynamic psychology, several persons said, and they gave their reasons for that point of view.

In the first place, as Dr. Wilson pointed out, pediatricians are increasing in number.

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Dr. Wilson. This "luxury," pediatrics, has grown enormously. A comparatively short time ago there were only fifteen or twenty pediatricians, earning most of their income from consultation. Now enormous numbers of young men have been demanding this training. Already in North Carolina some 10 per cent of the children receive service from pediatricians. We should regard that figure not as negligible but as an indication of what is likely to happen. When you consider the number of applications for this train-

ing that now have to be refused by medical schools, you wonder if the figure is not going to be 40 or 50 per cent or even higher in twenty years. Whether or not pediatrics is going to develop into a specialty to take care of all children will be determined not by us but by the public, and it has already spoken. Pediatricians are burdened because they have done a good job and because the public has become educated to the point where it wants baby doctors. There is only one answer and that is to have more pediatricians. When there are more pediatricians, perhaps they will have time to deal with the psychological problems that constantly arise.

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In the second place, said Dr. Stevenson, the value of introducing psychological concepts into pediatrics is not limited to pediatricians and their patients.

Thirdly, pediatrics cannot be properly practiced without attention to the emotional aspects of the patient's problems. Dr. Washburn made that point briefly in saying, "I don't see how it is possible to practice pediatrics in any sensible or adequate way without getting directly into psychological or, if you will, psychiatric problems. I cannot see how you can call that a luxury; it is a complete necessity if you are going to care for a child." The moderator, Dr. Spock, spoke to the point in more detail.

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Moderator Spock. If the pediatrician is merely going to give injections, then it may be unnecessary for him to know about anything else. But if he is even going to go so far as to prescribe formulae, the pediatrician has to know something about the way babies accept formulae. We have a fantastic number of feeding problems in this country (these not only produce malnutrition but are often the starting point for all kinds of subsequent problems) because pediatricians have been aware of the caloric and the chemical aspects of nutrition but have usually paid no attention to the emotional aspects of feeding.

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There is, then, the question of how a pediatrician can find time to meet the new demands imposed upon him by a psychological

orientation. Can he relieve the situation by utilizing persons trained in other professions as auxiliaries? That may depend in part on the definition of a pediatric problem under this new conception of pediatrics.

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Dr. Grothers. The question of deputies or subordinates seems to me extraordinarily difficult. We could train selected people to do a great deal of the routine of technical medical work by telling them exactly what to do or we could attempt to make a diluted doctor out of almost anybody. However, anyone in the medical field has to use as a powerful, legitimate tool whatever authority he has, based on knowledge, competence, and reputation. You can use these people as colleagues but not as subordinates. You can use a social worker as a consultant, as Dr. Stork does. You can use the knowledge of psychologists, nurses, anybody you choose, but to hand over the medical prestige to any group of non-doctors is absurd.

Miss Cockerill. It is my firm conviction that while a social worker has something very specific and skillful to offer, she is not a substitute for the help that parents must get from a pediatrician or a psychiatrist. A social worker is particularly fitted to free the parent to use the help of a doctor. Frequently parents are afraid to share their problems, afraid to reveal to a pediatrician or a psychiatrist just how inadequate they feel. A social worker can do a good deal to save a doctor time, not as a substitute doctor but as one who can help the parent to use the doctor's help. Also, it is often the social worker who can engage the parent into actually assuming responsibility for bringing about some changes in the environment.

Miss Towle. This is a job we must all do together. Social workers in pediatric settings have failed rather miserably in doing adequate social case work. I think one of the sources of their failure has been that they have worked with pediatricians who did not really understand mothers and children; consequently, a nice integration of the two professions was not achieved and preventive work was not done. In the early part of the discussion today we seemed to be envisaging a kind of pediatric work that had an understanding of people, not

just of illness. I would be thrilled to be a social worker in a pediatric setting in which some of the things you were describing today were being done. Why? Because you would make it possible for me to achieve the aims of social case work. I see this field as one in which we all have certain areas of responsibility. I think it is important to define our areas more precisely, especially as we draw lay people in. I think we will find that we have certain knowledge and understanding in common—the psychiatrist, the pediatrician, the public health nurse, the social worker, and the psychologist—but that we depart from one another in our uses of it. It seems to me that one of the really challenging tasks is to envisage where we work on the same basis and where we differ.

Dr. Allen. I want to say how important I think Miss Towle's comments are. We don't develop professional skills in other groups by seeing them only as substitutes or by using them because we don't have time to do what they are there to do. One of the important things we have to learn as a profession is that our effectiveness is greatly enhanced when we give up some of our prerogatives and utilize other professions, not as substitutes but as furnishers of the collaborative services that are so essential to our own jobs.

The pediatrician and the psychiatrist need to learn more about how much each of us needs the other—not to become like one another but to be effective in our differences. I hope that we can define some of the differences between pediatricians and psychiatrists, between psychiatrists and social workers and psychologists—differences that have a real value when we learn to use them together for a common purpose.

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Following these remarks, a conception of the areas of mental hygiene in which a practicing pediatrician might work was outlined by Dr. Langford. Dr. Spock then stated his point of view, which is that as a pediatrician he has been most concerned with discovering the crucial points at which most emotional problems begin.

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Dr. Langford. Pondering on what the practicing pediatrician can do in the field of mental health, I have concluded that the

work falls into three general areas: prevention, the care of minor emotional disturbances, and the care of well developed disorders.

The psychiatrist dealing with adults thinks of prevention largely in terms of dealing with the emotional disorders of childhood. A person dealing with children's disorders feels that prevention consists of dealing with them before they get started or in their incipient stage. Here the pediatrician can logically function through his work with the parent and the child in the course of well-baby care. The pediatrician's relationship with the mother is one of professional authority. He can in these early years foster self-sufficiency and confidence in the mother so that she can go ahead on her own and use what knowledge she has successfully.

With regard to the minor problems, the normal emotional disturbances which accompany the "jiggles" that Dr. Washburn showed in his growth curves this morning, the pediatrician can prepare the way and keep the parent and child from being too much upset by something that is inevitable. He can accomplish a good deal through this approach.

When we get to the well developed problems, most pediatricians feel that they do not fall within their territory. Nevertheless, the economic situation often prevents the pediatrician from referring these problems to psychiatrists or psychiatric clinics for appropriate care; or the community may not offer any facilities for this type of care for children. In such cases the pediatrician is forced to assume a certain amount of responsibility in an area where he does not feel competent and in which there is no reason why he should feel competent.

Moderator Spock. The thing that has preoccupied me in pediatric practice is finding the crucial areas where problems begin. In a majority of cases you can find the crucial spots. Sometimes it is too much formula when the baby is brought home from the hospital—occasionally a severe feeding problem begins right there. Sometimes it is the introduction of solid foods—an appreciable number of feeding problems begin with a bang then and are never solved afterwards. More frequently difficulties begin between three and six months when there are temporary decreases in appetite. I don't know whether this decrease is related to the decreased

rate of weight-gaining that takes place between three and six months or whether it is the beginning of teething. But most problems begin around the age of a year. At this age there are not only further natural variations in appetite (due perhaps to teething or to further decreases in weight-gaining), but also and probably more important a rather sudden emergence of the ego of the baby, who seems to realize that he is a separate person entitled to express himself.

During the first year of life it takes a pretty disturbed mother to make a disturbed child. The baby enhances the mother's ego rather than challenges it. But it is easy for things to go wrong during the second year. Unfortunately, at this time the pediatric visits become less frequent. Also, the pediatrician finds himself poorly trained to handle the psychological problems that so frequently occur. Toilet-training conflicts develop during the second year because the baby now has an ego and begins to have feelings about bowel function.

Even more troublesome is the whole matter of discipline during the second year. It suddenly hits the less-than-secure mother square in the solar plexus. This baby who formerly was just cute, whom she could put down anywhere (toss him a couple of toys and he was perfectly happy), all of a sudden is full of determination, must be everywhere, must handle everything, and feels specifically the itch to defy her. It is a period of intense ego development. The insecure mother is challenged, is panicky, and resorts to all kinds of inappropriate methods in trying to re-establish her authority. My feeling is—and I would never say this publicly—that if mothers dared to spank a little, there would be fewer problems from the second year on. Mothers, inhibited in general from using natural methods, uncertain of what to do because in this civilization they feel that only experts can tell them what to do, go in for too many warnings, moralizing, and other gentle but subtly vicious measures during this age period. By the time the child reaches two or three, it is too late to undo the harm completely, even when we have the help of the nursery school.

One of the things we must consider seriously in prevention is how to give better guidance during the second and the third years. My feeling is that we should not advocate wholesale nursery

school experience at the age of two but should wait until three. That leaves two years where we really have no adequate techniques at all for parental guidance.

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Dr. Butler rounded out the session's discussion by calling attention to a proposed new journal, *Pediatrics*, which could serve as a medium for bringing clinical data about the emotional problems of children and their treatment by pediatricians to the attention of practitioners. In so doing he was speaking to a point made several times during the session but so far not stressed in the present report: the request for more research, for more facts, and for a more detailed elaboration of the theory of the emotional aspects of pediatrics.

SESSION III

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

IN opening the third session of the conference, the moderator, Dr. F. H. Wright, called attention to the reports that had been obtained and distributed, as a background for discussion, from ten departments of pediatrics in medical schools that had been carrying on work in mental health for some years.* These reports indicated that there has been a consistent pattern in establishing within the pediatric departments special facilities for service and teaching along mental health lines, but that there has been considerable divergence in emphasis, in personnel, and in organization pattern. Some pediatric departments utilize special child guidance clinics, others have child psychiatrists attached to the department, while a few entrust mental hygiene teaching and demonstration to pediatricians who have been psychiatrically oriented.

The first part of the session was devoted to descriptions of how some of these pediatric departments carry on their task of mental hygiene instruction. From there the discussion naturally proceeded to consideration of what the psychiatric facilities of a pediatric department should be and what the essentials in teaching are. The following are the chief remarks that were made on these topics.

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Moderator Wright. Yesterday's meetings had two objectives: first, to establish some fundamental principles and, second, to start a discussion of the pediatrician's relation to mental health in an attempt

* See Appendix, pages 155-180.

to find out in what ways the practice of pediatrics is deficient and what can be done about the deficiencies. Dr. Langford's paper demonstrated clearly that many practicing pediatricians feel that their medical school training and pediatric house officership have not adequately prepared them for the mental health aspects of their practice. The task today is to examine what medical schools are doing in the field of child psychiatry or mental health, what the organizations they use are like, and what the advantages and disadvantages, difficulties and needs of specific organizations are.

In order to get the ball rolling, I would like briefly to mention some impressions from the reports of the ten medical schools regarding their present facilities for the teaching of mental health. First, one is struck by the fact that some effort at establishing child guidance clinics has been going on for a period of about twenty years. Second, one is impressed by the diverse sources from which this effort has arisen. In some schools the development of child guidance clinics sprang from the psychiatric department, in some from the department of psychology, and in others from the pediatric department. In our own school in Chicago the initial impulse came from the School of Social Service Administration. Obviously the plans differ from one another, the difference depending on a variety of local situations, geography, personnel, and medical school organization.

In addition to the statements regarding the present staff and personnel, these reports give an indication of the aims of the individual departments, what their current needs are thought to be, what teaching is going on, and the important matter of the level at which teaching is being conducted. Some departments are teaching preclinical medical students, some are teaching clinical medical students, some are teaching pediatric residents, while others instruct graduate social workers and nurses.

Dr. Kanner. Our experiment started back in 1930 at the Harriet Lane Home when Dr. Meyer asked me to teach psychiatry to the pediatricians. The general trend in the early 1930's was very different from the trend now. The question then was what could psychiatrists do for pediatricians if they were allowed to go into a

pediatric clinic. My main emphasis then was and had to be: What can we psychiatrists learn from pediatricians about children? The watchword was service.

Teaching the pediatricians consisted of helping them to select the children who seemed to need care that went beyond attention to physical needs. These children were referred to us and then we took over. There was very little direct contact with the pediatricians; we thought we had accomplished a great deal when a pediatrician, in referring a child, was helped to write an intelligent referral slip. We reciprocated by sending to the pediatrician a transcript of our notes, which went into the pediatric history.

The question no longer is what you psychiatrists can give us but what we pediatricians can do with your help. In the course of time, a program has evolved which includes young pediatricians, young psychiatrists, and medical students. In such a collaborative, integrated setting the question of who should do what no longer arises, as it would in the private practice of pediatrics, for we all do something together. When we get together and do the work, these problems of competence, delimitations, and duties do not arise.

Dr. McQuarrie. I tried to emphasize the importance of this mental health aspect of pediatrics long before we had the child psychiatry division by having some of the part-time child psychiatrists give our students a series of ten lectures, which were mostly a series of reports on cases. But attendance soon dropped off; the lectures were so artificial, so detached that they had no interest in them. Nor can you rotate the senior students and resident staff members through a detached, special child guidance clinic—very few of them will like it as they do not feel a part of it. Now we have a man trained both in pediatrics and in child psychiatry who works in the department of pediatrics. In our arrangement this full-time child psychiatrist has an assistant child psychiatrist, a psychiatric social worker, a clinical psychologist, a speech pathologist, and a secretary. These people have the right to go through our wards, and they participate in our seminars. Our students have turned to liking this subject.

The child psychiatrist should go into the wards and the students should see every case through his eyes. When we have this approach to every patient, we will have fewer difficulties. We can im-

bue the whole student body and the faculty with the importance of a good mental hygiene approach in the care and upbringing of children. Many problems can be checked early, so that later on the patients need not consult a psychiatric specialist. Of course we need a few doctors in the community who are highly specialized, who can take care of the really difficult problems; but pediatricians with the proper kind of training can do a vast amount of therapy themselves, referring to the specialist the problems that are too tough for them.

This is not a luxury. It is a necessity. Any good medical school ought to be able to afford this kind of set-up. About one-third of our budget goes into this, but we do not consider that expensive for so essential a part of our work.

Dr. Jensen. There are three principles we follow in teaching the resident staff under the arrangement Dr. McQuarrie has described. We begin our teaching at the level of understanding of the resident staff. We try to relate their experience to the problems at hand. We try to speak their language. One of our first aims is to demonstrate by actual work with patients that there is no division between the functional and the organic. We do this by participating in ward rounds, in grand rounds, and in the regular pediatric lecture series which the resident staff gives to medical students. We also meet weekly with the resident staff as a group for discussion of patients in the hospital and with members of the resident staff on an individual basis to help them to do as much as they can for their patients without referral to our clinic. Lately we have begun having fellows in psychiatry and fellows in pediatrics spend three full months in our clinic for more intensive work. We introduce them to child psychiatry literature. We try to give them an increased appreciation of the kind of psychiatric problems encountered in children in both clinic and ward services of the pediatric and psychiatric departments. We attempt to give them a better appreciation of the normal growing child by having them spend a day a week for these three months in the University Nursery School. We give them a few carefully selected emotionally disturbed patients with whom to work. We give them information about community resources for child care and how to use them in connection with specific patients. Our aim throughout is

to arrive at the place where the pediatrician does not ask whether a problem is emotional or physical, but considers it an integral part of the whole field of children's disorders.

Dr. Stevenson. During the period in which a well known psychiatrist gave lectures to the Minnesota pediatric students and in which the child guidance clinic held weekly case conferences (twenty years or more ago), the chief of pediatrics was not interested in the kind of thing we are talking about. It was of no special importance to him that a pediatrician should know how to talk with parents, to talk with patients, to interview, and to recognize problems of anxiety. To refer a case was merely a matter of making out a slip, not something that dealt with a person. In other words, the chief of pediatrics had no interest in matters that demonstrated to the students that emotional factors were something vital to a comprehensive pediatrics. Such an interest is now present in the Minnesota situation, and it is this interest that makes it effective to have a psychiatrist participate. In order to have any progress in this field of education, the chief and the instructors must regard mental health as an essential part of pediatrics.

Dr. Shirley. From the experience of our unit I feel that educating medical students and pediatricians in mental health is a primary function and that the minimum staff needed is a child psychiatrist, a psychiatric social worker, and a psychologist. With such a staff, you can confer with the pediatricians, you can make ward rounds, you can be a part of the pediatric activities both on the ward and in the outpatient clinic, you can carry enough of the cases which the pediatricians feel that they are not well enough trained to treat, and you can use those cases for teaching. Yet even this staff is not sufficient to satisfy our own pediatric department and our own pediatricians. They want more service, and I have come to the conclusion that we need a staff of about twice that size to satisfy their needs and demands.

It is my feeling that the pediatric department is a logical and a strategic place for the development of child guidance facilities, not as a separate project but as an integral part of pediatric activities. The child guidance staff should be on the pediatric staff. They should take an active part in the wards and the outpatient clinic in consultation and in teaching.

Then the question also comes up, how much community service can you give? With our staff we are barely able to meet the demands of our own pediatric service. We find it practically impossible to give any service to community agencies, courts, and schools.

Dr. Powers. I have extremely strong feelings that every pediatric department should have within it somebody who is competent in the field of child psychiatry. The psychiatric should be just as strongly represented and emphasized as the other techniques—bacteriological, chemical, and physiological—through which we approach the problems of the child. I would say that our psychiatrists have done more for the students and staff of the pediatric department at Yale by their example in handling children than could possibly have been done by lectures, reading, and so forth. That is the very essence of the matter, and I, for one, do not want to have anything to do with a pediatric department that does not have the psychiatric aspect emphasized right along with every other aspect of the study of the child. We never have had anything like adequate resources to meet all the demands, but I would rather have one person emphasizing the mental health aspects of the work with one or two patients than not have it emphasized at all.

Dr. Butler. I think it is a mistake to work toward an optimum program in a pediatric department. For instance, Dr. Washburn told us yesterday how he has been examining and studying a great many people in order to give a description of the growth pattern. At Massachusetts General we have been approaching growth studies in a different fashion; we are asking what factors determine the growth pattern. I refer to these two approaches to the study of growth in order to call attention to the probable benefit of having many ways of studying a problem, to suggest that we should set up various types of units for teaching and practicing child psychiatry based on a variety of interests and not aim at one optimum type.

It seems to me that there are two patterns for such units. One is to add to the staff of the pediatric department a psychiatrist, interested in pediatrics; the other is to train a pediatrician along psychiatric lines. At the Massachusetts General Hospital, merely because we have a large department of psychiatry, we do our child

psychiatry through that department. The child psychiatry in our children's medical service will be dominated by the professional psychiatrist of that department and thus our entire service will become interested in child psychiatry. We are thus in a position to have child psychiatrists educated by a psychiatrist who has an appropriate contact with pediatricians, and to train pediatricians in the concepts of child psychiatry. We will also be in a good position to train psychiatric social workers, other social workers, public health nurses, and ordinary nurses. We won't try to develop an optimal technique in setting up these teaching units in child psychiatry; we will develop a variety of units, using the particular interests of the individuals concerned and the particular facilities available at the various institutions.

Dr. Anderson. Four years ago I went to Utah; there our problems are decidedly different. In that state there are about 500 doctors and only 9 pediatricians—a proportion of about 1 per 20,000 school children. The sparsity of population and difficult geographic situation may necessitate a doctor's crossing three mountain ranges to see a patient sixty miles away. We can never hope to populate this area with pediatricians or child psychiatrists, and so in introducing a mental health slant into children's work we have had to go at it very differently from the ways that have been described.

The only thing we can do is to train good general practitioners who will have an awareness of emotional disturbances in children. We have tried to broaden the scope of teaching pediatrics, incorporating into it the school health programs and the well-baby clinics, both city and county. This gives us an opportunity to place residents, interns, and students in such settings so that they can see the emotional difficulties that arise in children and can follow along with well-baby care.

Dr. Spock. It is not so important whether the psychiatric unit is part of the pediatric department or in the same building, but whether the psychiatrist is able to help pediatricians to understand their job better. I have seen psychiatrists working in a department of pediatrics who not only did not teach the pediatricians, but actually relieved them of the responsibility of considering these things. If a psychiatric appointment can be made without

the slightest trouble, the pediatrician can easily and glibly refer everything and learn nothing.

What we should be teaching to medical students and interns who plan to care for children is the maintenance of emotional normality, not how you treat fully developed behavior problems. Certainly the pediatrician should know what a real behavior problem is and something about how it can be treated, but for every one of these cases there are at least a hundred where he needs to know how to keep the child on the right track.

Specifically, the pediatrician or general practitioner needs to be taught how to avoid arousing anxiety in parents. A great number of difficulties are created right in the pediatric situation because the physician, being unaware of the danger, slightly insecure himself, fearing perhaps that he may not know the right answer or that the parent is not going to follow his advice unless he makes it potent, tends, without any realization of it, to terrify parents about their children. He needs to know how to avoid being too authoritative or arbitrary, how to take into account the parent to whom he is giving advice—to know when to play down the importance of the advice or the exactness of the formula in one case and when to talk turkey in the case of a mother who is irresponsible and happy-go-lucky.

The pediatrician certainly has to know how to take a history. Unfortunately, medical education, for perfectly good reasons, emphasizes a history taken in categories. Even when, in the early days of the pediatric department at the new New York Hospital, some psychiatric questions were included in the pediatric history outline there were just three items listed; enuresis, epilepsy, and nail-biting. If the medical student could get negative answers on those, then he had taken the psychological part of the history! We need the help of psychiatrists in teaching history-taking.

We also need to teach the pediatrician the pattern of normal emotional development which he can expect to see unfolding in the child, so that he can use it in prophylactic advice to parents. The trouble with teaching emotional development is that we don't know much about it. Pediatricians see emotional development all the time but they don't pay any attention to it because nobody has indicated that it is of importance. My opinion is that psychiatrists

don't know much about emotional development either. They have a body of knowledge about later childhood and about adulthood, about the structure of the neuroses and other disturbances. But nobody really knows much about the period of infancy and early childhood where, everybody agrees, lies the real origin of these disturbances. In this area we need a joint study by pediatricians and psychiatrists.

We need to take the psychiatrist who is going to be of help to the pediatric department right into the well-baby clinic and into the newborn nursery—by the ears if necessary—and make him look at babies. Have him sit in the well-baby clinic and answer or try to answer the questions that mothers ask about such things as what you do when the baby won't sleep, and when you wean a baby, and how you go about toilet-training. We have got to have teams of pediatricians and psychiatrists working in newborn nurseries and in well-baby clinics before we can collect a respectable body of material to teach pediatricians. It cannot be done by either group alone.

We should also include the teacher in the team—the nursery school teacher and the elementary school teacher. At the present time pediatricians give advice to parents that takes no account of what the school is trying to do for the child; and the school is trying to do things for the child without any awareness of the child's difficulties or problems. School teachers could teach a lot to child psychiatrists and vice versa. The essence of training in a children's center should be a seminar type of case discussion among pediatrician, psychiatrist, and teacher, each contributing his own special knowledge about the child and each learning from the other during the process. I would include also the physical therapist, occupational therapist, orthopedist, and nurse.

Dr. Crothers. I am one of the people who has struggled into a method of practicing pediatrics through going into a specialty which I did not understand at all—the general development and difficulties of the nervous system. My feeling is that diagnosis, prognosis, and medical treatment are all related to growth and development. Development from conception to birth has all sorts of hazards for the child; the birth process itself has hazards, and many diseases, not only nervous diseases but many others, have an influ-

ence on the quality of a child's development. Granting this, you have to develop a formula or a diagram that makes some sense out of this relationship [indicating Dr. Washburn's diagram of normal growth*], for your prognoses always have to be concerned with a child going up, coming down, coming back (with a good deal of confusion at that point), and then going on at a predicted rate. What you have are various motor tracts and sensory tracts producing motor behavior. If you say that this is a pattern manifested by reflex activity, by deviations of actual motor capacity, then you have to add intelligence and also the setting in which the child lives.

In order to validate this method of plotting errors of development, you must have psychological help and, more important, you must have a history. Pediatricians have never faced the fact that their histories are badly taken, so badly taken that they probably are inadequate from the point of view of growth and development and emotional management. It is not a question of taking a good history or a bad one; it is a question of regarding the history as a continuing matter, although at times it may quite properly be confined to the immediate physical situation. Nine times out of ten there is no great mistake in taking brisk, competent histories of the immediate disease and letting it go at that for the moment. But when you want information concerning the different people impinging on the child, then the history becomes the most important part of the whole procedure.

The question then comes up as to how to teach history-taking. It seems to me that that first interview with people who come in with troubles about their children is so crucial that it can be very useful for teaching purposes. There is a widespread prejudice against having people talk to you in the presence of a third person; but if a child is coming into the hospital, you can explain to the parent that the house officer or the resident is the person who is going to take direct care of the child and hence he should be included in the discussions.

As long as histories consist of questions and answers, with prejudice as to what information is necessary, you will get a form filled out perfectly, but your history will be static. To secure interest in

* See page 19.

growth and development, the history ought to be a narrative that is useful to someone else. It is well worth the effort to deal with diseases of the nervous system from the growth and development point of view with full recognition of what the parents are worried about, how they are going to deal with their problem, and what sacrifices and readjustments they will have to make. Parents can make it impossible for a child to develop normally in a difficult situation. For instance, infantile paralysis may be the cause of emotional difficulties because the parents may be pressing on the child, organizing things for him, and trying to make up for his defects. We must make parents, schools, and the like integral parts of our planning for the care of disease. We must know there are parents and actually see them; the senior men must see them and know what they are talking about when they predict parental behavior. The top men of each service must realize that the most important information we can have concerning the child is the parent. In most children's hospitals parents are accessible only once a week and at a time when the senior staff is not there!

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In the course of this discussion concerning the arrangements needed for teaching the mental health aspects of pediatrics, the question of whether it is better to entrust this teaching to a psychiatrist or to a psychiatrically oriented pediatrician came up. There was not much direct discussion of this question, however, perhaps because several basic issues had not been clarified. The discussion soon moved to a consideration of how a psychiatrically oriented teacher-pediatrician should be trained and what the objective of the training should be.

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Dr. Schade. The question we are considering—special mental health programs within departments of pediatrics—requires a definition of the function of such a unit. This involves what we, as pediatricians, can and cannot do in relation to teaching mental hygiene to students. It involves clarifying the concept that teaching is the primary purpose of such a special unit, with the teaching emphasis on the interrelationship between emotional growth and development and physical growth and development. It involves

the recognition that the pediatrician so oriented in the field of mental hygiene can make mental hygiene an integral part of his pediatric practice and also recognize those severe problems which are outside his scope and should be delegated to another discipline. It is difficult for pediatricians to achieve some definition of themselves, perhaps because they are afraid they may lose something in accepting the limitations of the field in which they work.

Dr. Senn. One thing that disturbs me about the development of mental hygiene in pediatrics, as it disturbed me in the development of psychiatry in other areas, is the sudden rush toward psychiatry, with the expectation that it will do so much. Departments of pediatrics are now genuinely interested in incorporating mental hygiene into pediatrics. It is no longer a bandwagon sort of thing. However, what happens is that the demand for mental hygiene grows very rapidly and in most communities becomes a demand for psychiatric service, which is one of the things we must define here.

Do we, in pediatrics, aim to train pediatricians, nurses, general practitioners, medical students in a new way of thinking, not only teaching them some of the psychotherapeutic techniques but also making it clear that they are not psychotherapists able to deal with profoundly disturbed individuals? I know that many communities do not have psychiatrists to treat the seriously ill, that the demand for such service is real, and that one should try to meet the demand. But as doctors come to me seeking training in "pediatric psychiatry," one of my first jobs is to help them define what they mean by "pediatric psychiatry."

Many of the doctors coming to us for fellowship training in the mental health aspects of pediatrics really want to become child psychiatrists. Others, who go back into their communities after being trained, soon feel community pressure to become child psychiatrists. Even the psychiatrists in the communities say to them, "We can't wait for you to get back into practice. We have such a case load of disturbed children." We have not trained these doctors for this job. It is, therefore, very important that we know just what we are training doctors for. We must not lose sight of the important differences between the training of the undergraduate, the medical practitioner, the pediatrician, and the child psychiatrist.

Dr. Felix. I would like to ask Dr. Senn to define "child psychiatrist" and "pediatric psychiatrist" and to describe the training objectives for these two groups. This seems to me a very critical question.

Dr. Senn. I don't use the term "pediatric psychiatrist." I use the term "pediatrician with training in psychiatry." The child psychiatrist has had more extensive training in the fundamentals of psychological growth and development and in psychopathology. He has had more experience in mental institutions, where he can study psychopathology, and he has been carefully trained in the therapy of children and parents in a good child psychiatry center. We have tried to give a different kind of training to the pediatricians. I cannot say what the ideal should be, but I can tell you what we have been trying to do.

We start with doctors who have had a good basic training in pediatrics (of at least two or three years' duration), and we first give them six to nine months in a mental hospital, where they deal with mentally disturbed patients under the guidance of psychiatrists. At this point our students are on a par with child and adult psychiatrists who are in training, and they attend lectures and seminars with them. At the end of that time they work under guidance in the pediatric outpatient and psychiatric outpatient departments. In the beginning they work as so-called consultants under the direction of a child psychiatrist and they also carry a limited case load, trying out the new attitudes and techniques they have learned in psychiatry. In the psychiatric outpatient department they work with children and their parents under the supervision of a child psychiatrist. They also work in the well-baby clinic, in order to learn about the relations of normal, healthy infants to their parents. In this clinic they start with the parents in the prenatal period and work with the same parents and children for a year and a quarter. In addition, for one day a week they observe normal preschool children in the Sarah Lawrence College nursery school and attend lectures there on child psychology. They also do some work in the Bethany Day Nursery, where there are children from two to six years old and where there is a good staff of teachers and a psychiatric social worker.

In the second half of the two-year training period, the program

is adapted to the individual student's future professional plans. Each fellow comes to us with the promise of a teaching position in a department of public health or a medical school. We try to adapt their training to their particular job. One of our questions is whether we should continue with this two-year program or whether it can be wisely reduced to one year.

Dr. Vander Veer. I would like to ask whether the nine months in a mental hospital is necessary to fit the pediatrician-teacher for this job. Doesn't it make it easy for him to slip over into psychiatry afterwards? Also, couldn't he get the necessary experience by ward visits or by perhaps one month rather than nine months in a mental hospital?

Dr. Senn. The question is one that we have been struggling with for a long time in planning our program. That is why we wonder whether we should cut down our training program from two years to a year and a half or one year, leaving out the experience in a mental hospital. On the other hand, as Dr. Murray pointed out in his paper yesterday, when a pediatrician sees a schizophrenic patient regress to the point of being a baby, it has a lot of value for him. I could talk until the cows come home about regression, but unless the student has been oriented psychoanalytically, it would probably mean nothing to him. We know, however, that there is a danger connected with experience with mental patients; it may give the student false confidence and encourage him to go into an area of therapy where I don't think he belongs. On the other hand, although a short time on a psychiatric service may be sufficient, I think that this should be a pretty intensive kind of experience. A student cannot come in an hour a day and walk through the disturbed ward and get as much out of it as when he sees these patients day after day for a period, talks to them, and observes them.

Dr. Spock. It is important to make a distinction between the training of practicing pediatricians and the training of the "pediatric psychiatrist" who plans to stay in pediatrics and go back to a pediatric department to teach other pediatricians. I feel, as Dr. Senn does, that if a man is going to go back and teach others in this field, it is of considerable importance for him to have been in a mental hospital and seen sick patients. But at the present stage of our medical education there would be no point in trying to put all

students of pediatrics through even two months of mental hospital work.

Moderator Wright. Perhaps Dr. Zimmerman, who has had this training, will give us his opinion.

Dr. Zimmerman. I have been a sort of guinea pig in the particular set-up that Dr. Senn has described. I am still not at the end of the period of transition into one field or another, but I can tell you some of the things that I have begun to think about in relation to this experience.

One of the first things that comes up is the decision that the individual who is presented with this opportunity for training has to make in regard to leaving pediatrics. If you take an individual who is at the peak end of a training period, and you ask him to forsake clinical pediatrics for a period of two years, he finds himself in a difficult situation. It is not a complete forsaking, of course, but since he has to spend a good deal of his time in the psychiatric situation, there is a price to pay in terms of his growth in pediatrics. In the long run, however, there are compensations in the new knowledge and experience.

The experience with mental patients was extremely important to me. I felt insecure in going from pediatrics into psychiatry, but at Payne Whitney my introduction to mental patients was done very well. I was made to feel a part of the psychiatric division. I was oriented carefully and slowly with the men training to be psychiatrists. I lived with them. We had bull sessions about the patients, and I learned a good deal of psychiatry there that I did not learn on the wards. The residents showed no favoritism in the assignment of cases and that made me feel more secure.

From my own experience, I believe it is a necessity to take care of mentally ill patients as part of this training. The experience with mental patients tremendously confused me and then upset me, to the extent that I went through what psychiatrists call identification with various patients. Then I learned that I did not do very well with the type of patient with whom I identified myself. I found out later that that was often the reason why I could not handle some pediatric patients—the difficult mother, for instance, or the parent of a mentally deficient child who came in with raw emotions and released them on me. I used to get uncomfortable

because I did not know what the mechanism was. I had to learn that. I spent six months as a psychiatric resident, so to speak, and in that time I saw almost every kind of psychopathological entity and read a great deal of psychiatric literature.

The experience with psychiatric inpatients was also useful preparation for the handling of psychiatric outpatients. Here is another world in psychiatry, a world that is closer to the type of thing that one is going to deal with in the handling of parents in pediatric practice. Once you come out of your psychiatric training and go back into pediatrics, you begin to realize that you are a different person. The experience has changed you.

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This description of the training of the pediatrician who is to serve as a teacher led to a discussion of the extent to which he is thereby equipped to treat the emotional disorders of children. Several reasons for undertaking such treatment were given: The demand for such service is great, and psychiatrists are often not available. Pediatricians with mental health training need to "keep their hand in" so that their teaching about emotional disorders does not grow sterile. Teaching and research should not be divorced, clinical work in child psychiatry being regarded by some speakers as the equivalent of research in this field. There is the economic consideration that part-time practice of psychiatry provides a supplement to inadequate university salaries. Dr. Little first made these points and the discussion continued as follows.

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Dr. Little. The program Dr. Senn has outlined is excellent, but it is necessary to go a step farther and ask: What is the person who has had this training going to do with it in a department of pediatrics? What is going to be expected of him; what are the situations he is going to encounter?

A psychiatrically oriented pediatrician should have adequate training to carry on fairly intensive psychiatric treatment because, first of all, with such a background he is considered an expert when he goes back to his job. He is regarded as a person to whom patients can be referred, and he can't stop short with a diagnosis and say, "I can't do anything more than this because I can't do

treatment." For one thing, there is usually no one else to whom the patient can be referred at that point.

Furthermore, for the pediatrician to further his own knowledge about emotional growth and development, he must carry on some psychiatric treatment. He cannot go on indefinitely teaching medical students about emotional growth and development and the emotional problems of children on the basis of secondhand material. He has to get some of his material through fairly intensive therapy of actual patients.

In addition there is the reality that very few departments of pediatrics are financially capable and emotionally ready to pay this psychiatrically oriented pediatrician a salary adequate for the support of himself and his family. He has to do something to add to his income, and the obvious something in private practice is therapy.

Dr. Allen. What Dr. Little has said poses one of the important problems in this field. What he speaks of as a reality is also a dilemma, which brings us right back to the point that Dr. Senn raised: Are we going to give this kind of training to pediatricians to enrich them as teachers in the field of pediatrics, or are we going to stress service and utilize the person as a child psychiatrist? That is a big dilemma. I don't know exactly what the answer is, but an important part of it lies in the kind of planning that first brings men into this new professional field.

The point that was stressed by Miss Scoville in her original planning was that the fellowship training was to be an opportunity for individuals who would retain their essential professional base in the field of pediatrics. One way of insuring that was to have the arrangements made not only with the individual but with a good teaching institution to which the fellow would go as a teacher after having this special training.

The dilemma in this is that when the person so trained does go to a pediatric center, he is confronted with a great many difficult problems that need a child psychiatrist's skill in therapy. He soon finds himself almost swamped with service cases and is diverted from the long-range goal, that of being a teacher who will enable house officers and young pediatricians to gain the kind of under-

standing of human beings that will make them more effective pediatricians.

This can be less of a dilemma if we keep that long-range view in mind. The economic situation, I know, does pose a problem. If the specially trained pediatrician is expected to earn a living through private practice and to do his teaching more or less as a side line, then he is really forced into the practice of psychiatry, thereby defeating the basic purpose for which the whole program has been set up. So it comes down to the question of whether pediatric departments consider this field of teaching sufficiently important to warrant financing it on a proper scale.

This is expensive training. We cannot train people in the way Dr. Senn has outlined if they plan to go out and be private practitioners. It is a highly specialized training that lays the foundation for the broader training of the practicing pediatrician. So I am troubled to learn that Dr. Little finds himself engaged in carrying a heavy load of therapeutic work or sees himself as organizing a clinical service within a children's department; for he is thus being diverted from his essential and long-range purpose of enriching the training of the general pediatrician. This may continue to be the case until the structure is laid whereby the trained individual is given the opportunity, both economically and professionally, to go on developing in the field for which the training was originally designed.

Dr. Senn. I would like to correct one notion, that this two-year training program is set up *in vacuo* and does not consider reality. I tried to point out that we are training for a specific purpose. We are training these people for work in the departments into which they are going. So I must take issue with Dr. Little for thinking that we just train men and then let them go out and muddle along, with the result that one day they find they have to go into private practice to earn money to supplement their salaries.

About finances, I raise the question as to whether we should train pediatricians in psychiatry and then send them out into communities where there are no psychiatric treatment facilities. Such facilities may not be adequate; they are not adequate any place.

But I wonder if we shouldn't restrict our trainees to work in pediatric departments where they can sensitize the pediatricians, psychiatrists, and other disciplines in medicine to the need for treatment.

Dr. Langford. The thing that has impressed us for these past twelve years has been the demand for psychiatric service for children. We have every reason to believe—our basis being a spot check of consecutive admissions to the outpatient department of Babies Hospital—that almost 30 per cent of the children (averaging about 4,500 admitted to the Medical Center through the pediatric clinic per year) need some sort of psychiatric attention. Either the children are brought to our clinic primarily because of some emotional disturbance, or the pediatric resident who is doing the admitting feels that the pediatrician needs help from someone who knows a good deal more about the emotional aspects of children than he does. That makes the potential case load for us 1,300 or 1,400 children a year. We have never attempted to handle that load. In the early years, psychiatric clinics for children were available at the Medical Center under the operation of the Department of Psychiatry. Changes have taken place, but at no time in recent years have we been able to make more than a dent in the therapeutic needs of these children.

Teaching becomes a very sterile procedure unless one has his finger in the clinical pie. For example, one cannot discuss with students or staff the opportunities in the well-baby clinic for working with mothers and tending to their emotional problems, their frustrations, and what not, unless he knows what cooks in there, unless he knows mothers and deals with them and their babies. It is exceedingly valuable to take care of the emotional aspects of a few children well so that the house staff sees in operation what can be accomplished. For these reasons, the clinical experience of the man who is working in the pediatric teaching center should not stop with his training period.

Dr. Rubin. I rise to defend the Buffalo Children's Hospital where Dr. Little does his work. Dr. Kanner tells me it has taken fifteen years for his clinic to get where it is. Considering this factor of time, I wonder if we have the right to say that we will not send

young men with training in psychiatry into places where there are no established psychiatrists—in other words, that we will do nothing until we have the optimum.

Most of us who are attempting to establish psychiatric divisions in departments of pediatrics have had no psychiatric training at all. We have simply become aware of emotional problems in children. In our own situation, an important aim in maintaining a clinic is to have the people in the community, in the hospital, and in the medical school become aware of the need for a more complete set-up for child psychiatric study. There are all degrees of training, as there are all degrees of treatment. If a doctor becomes aware that there is an emotional problem and talks to the parent about it, is that treatment, or does one have to have a series of hourly sessions in a special setting? I think treatment must be offered at all levels, and the purpose in training house officers is to teach them when to act and when not to act.

One must make house officers aware that they should not provoke emotional strains. Second, they should be made aware that they are capable of treating patients. If a man is adequately trained, he will know when the pediatric situation requires consultation with a psychiatrist, just as he is aware now that certain situations on the physical side require consultation with other specialists. As for the criticism of the pediatrician with training in psychiatry doing therapy, I wonder how many of us would be perfectly willing to spend all day in teaching and no time at all in our laboratories attempting to work out techniques for ourselves and establishing reliable data. It would be a very poor child psychiatry teacher who did no therapy of his own, but spent his entire day teaching.

Dr. Janeway. I seem to have the unfortunate habit of calling attention to economic problems. Today I would like to go from luxuries to necessities. Having the psychiatric or the psychological point of view is a necessity in pediatrics as it is in any phase of medicine today. Our concern as university people is, first, teaching and, second, research. University experience has always shown that teaching divorced from research, from practice in the field, is sterile. Teaching and research together constitute enough to keep any man busy. The person who is going to do both obviously has to be

selective. He can't try to meet the demands of all the patients of the community. In university hospitals we select the patients for whom we can do the most and from whom we can learn the most to advance the field of knowledge.

The type of pediatric-psychiatric unit we ought to be thinking of is one that is not going to contribute merely by training people to teach and practice pediatrics, but is going to blaze new trails in pediatrics, using the techniques of a field which has been extremely fruitful in explaining the symptoms of patients, in treating their ills, and which, like bacteriology and chemistry, should affect practically every problem with which a doctor deals. If a department of pediatrics is going to be set up in this way, it certainly requires people working on a full-time basis in the exploration of the new and fruitful approach to disease. In time this research may be so important that pediatric departments will tend to drop many of the activities in which they are busily engaged today, but I don't think we are ready to do that now. Departments of psychiatry or departments of pediatrics, depending on how you organize this work, must have enough money to endow the facility so that it can operate on a full-time basis and not be forced into becoming a service department in order to support itself.

There is another corollary. If we are going to emphasize research as well as teaching, then in addition to money, we must have people with adequate training. I agree with Dr. Senn on this and only question whether anything less than two years of training is really adequate. I would hate to see a man, for example, go into chemical work in the field of pediatrics with just one year's training in a chemical laboratory. If a man is going to infiltrate a department with a dynamic psychiatric point of view, he has to be well grounded in the whole field, since the techniques and the area are fairly foreign to the average person with medical training. I don't think he can possibly get a proper foundation in less than two years.

The words which appear all along the line on the program are "mental health." The word we have been using in our discussions a good deal is "psychiatry." We know what we mean by these terms. Mental health is the emphasis on prevention, and psychiatry is to mental health what major surgery is to general practice, let us say.

Psychiatry (major psychiatry, that is) is a technique for dealing with people so disturbed that they require treatment which is both expensive and time-consuming.

At least 50 per cent of the practice of pediatrics is devoted to preventive medicine rather than curative medicine. But the institutions in which we teach pediatrics are hospitals intended more and more to be centers to which all of the special, difficult therapeutic problems of pediatrics are referred. The result is that the clinical material in the facilities available for the teaching of medical students emphasizes problems with which the students will not be particularly concerned when they are practicing medicine. We have an enormous divorce in pediatrics between practice and its necessities, on the one hand, and between our clinical facilities and the actual interest of the people who are teaching, on the other. If we are going to accomplish anything in this field, a lot of reorganization of the medical curriculum is required. We will have to orient students differently right from the start. Most of us who run pediatric departments will have to think very hard as to how to bring into our departments the facilities and the types of experience whereby students, residents, and even graduate physicians can learn this new preventive approach.

Dr. Wilson. We are, of course, concerned about this problem of trying to teach doctors of all kinds to pay more effective attention to emotional disturbances and to mental hygiene, but I think our group ought constantly to be aware of the sad facts of life. Dr. Powers won't have anything to do with a pediatric department if there is not a trained psychiatrist-pediatrician in it. I would prefer not to be connected with a lot of pediatric departments that have other deficiencies; but there they are. I don't think I am far off when I say that the average budget of the departments in medical schools which are given the responsibility of teaching all there is to be taught about child health is somewhere around \$15,000 a year. We not only have to think about what we can do in our relatively rich schools, where we can develop these beautiful systems, but also what we can do in the majority of schools right now, as they are.

You can do a great deal at a very low level of mental hygiene by simply adding a few more instructors to a department's staff, even

if these instructors are not specifically trained in the field of mental hygiene. Departments are so crowded, with so little time in the curriculum or so few resources to teach even the simplest basis of organic disease, that it is not surprising that such unfortunate situations arise as one which I saw recently. A little nine-year-old girl, with the intelligence and presumably the sensitivity of a Solon, was presented to a group of students because she had fecal incontinence, and the time was spent (as it needed to be, a lot of it) on the neurogenic background of that fecal incontinence. No attention was paid to what this child's emotional life had been and was going to be because of this condition. We see such things happening all the time.

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This emphasis on the need for psychiatrically trained pediatricians to carry on a certain amount of psychotherapy, for either research or service purposes, led several participants to question whether there is something wrong with the prevailing conception of a psychiatrically oriented pediatrician. To them it seemed that the difficulties encountered and envisaged—tremendous pressure, tremendous expense, more and more training required—stemmed from the unresolved question of the previous session: Just how does a knowledge of psychiatric principles affect the daily work of a practicing pediatrician? Only when this relationship is determined in specific terms, can it be expected that the principal question of the present session—how to modify the present training of pediatricians so as to take this into account—can be answered. Suggestions were made along the lines of both questions, as the following abbreviation of the discussion indicates, and the session ended with a description of how schools of social work have dealt with a similar problem.

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Miss Scoville. We are facing a dilemma, but I think that we have reached bedrock, and if we can work some of these problems through, this conference will have meant something quite real.

It would have been possible to get further in our discussion today, if we had been able to get a little further ahead in our thinking yesterday. Our dilemma is that, with regard to mental health,

we have not clarified the function of the pediatrician in practice. Until this point is clearer, we cannot define the function of the special set-up within the teaching pediatric department. That is one of our problems right now.

There is probably also a problem in semantics. Dr. Janeway referred to the fact that we are using the terms "mental health" and "psychiatry," also "child psychiatrist" and "pediatric psychiatrist" interchangeably and loosely in the discussion. This is confusing. We need to clarify our terminology. The difficulty is, I believe, that what we commonly refer to as psychiatry is something larger than the specialty of psychiatry. It extends itself over a wide range of concepts that are basic to and belong in general medicine and in pediatrics. How these concepts can be incorporated into pediatrics is to me the crux of this conference.

Personally, I don't regard child psychiatry as the responsibility of pediatrics. I see something else just as important, just as real, as the responsibility of pediatrics. That "something else" lies in the area of the maintenance of mental health—the preventive, the prophylactic phases pertaining to emotional growth and development. Thinking in terms of the medical disciplines, I see child psychiatry related to the specialty of psychiatry, as pediatrics is related to medicine. We get confused when we think of pediatrics attempting to encompass all of child psychiatry. We are confused with regard to training. We are confused with regard to therapy. Certainly, on Dr. Rubin's point, I don't think anybody would say that the pediatrician in his work with parents and children does not carry therapeutic responsibilities regarding the emotional aspects of his cases. He cannot help but be either therapeutic or destructive in everything he does and in all that he touches.

The major point of how we can transfer a body of knowledge from psychiatry to pediatrics relates directly to this morning's discussion about the specific type of setting and the special personnel required within a department of pediatrics. I am wondering whether the so-called pediatric psychiatrist whom we, the foundation, have been helping to train with fellowships, and the special, so-called psychiatric clinic within a pediatric department are not both stopgaps, necessary right now but needed only until pediatrics can develop its own education to include those basic concepts

from psychiatry that are in reality sound pediatrics, and until every pediatrician in a teaching hospital combines consideration of the emotional and the physical as part of his job. Perhaps we need not think of these special teaching facilities as permanent additions to departments of pediatrics.

Maybe we are on the wrong track. This development may have been necessary, but perhaps we have to look at it in a different way right now. Maybe we don't want special clinics in departments of pediatrics. Maybe we don't want a special pediatric psychiatrist. Maybe we want to approach the problem in a new way, get a new entering wedge. Something Dr. Spock said and something Dr. Janeway said helped to crystallize this question in my mind. Maybe we have to reconsider the whole area of need and responsibility of pediatrics. We may find that our opening wedge is not through a special child psychiatry clinic, but through a division of growth and development which will include the physical, emotional, and social, and which will keep pediatric thinking focused on child development and preventive work and will not raise all these red flags between child psychiatry and pediatrics as to who is going to do the major psychotherapeutic job.

Dr. Schade. I had my training, along with Dr. Senn and Dr. Little, for a period of two years at Dr. Allen's clinic. When I returned to my own setting, I returned as a pediatrician in a department of pediatrics. I was not put off in a small room called a habit clinic; I was related to a pediatric outpatient department where what knowledge I had obtained might be useful. I did not feel I was a psychiatrist in any manner, shape, form, or deed, but rather one who might be able to help all individuals get good care in the outpatient department. Some people might term that therapy, and I really believe that even the fourth-year medical student institutes a great deal of such therapy under proper supervision.

I agree with Dr. Senn when he says that "pediatric psychiatry" is a tough term as a label to live under. When I returned to the Bay area, all my colleagues in the practice of pediatrics said, "Thank God, you are here. We have a lot of problems that we will now be able to get rid of. Boy, here they are." A psychiatrically trained pediatrician has to stand up and give a definition of his own feeling about himself and the function that he will fulfill. Of course

he can be smothered with a lot of work from the outside. He can be smothered in his own department with the demands made upon him. The service factor can absolutely overwhelm any teaching prospects he may have in his department. He has to stand up and say no and find for himself a particular area of effective functioning. I like to call this area just plain old mental hygiene, common sense with an orientation. I feel comfortable under this label because I can hang my hat on it and sleep nights with my conscience not bothering me. If one is willing to set his own definition and go his way within his department of pediatrics, things will go well. If you are undecided yourself as to who you are and what you can do, it is a hell of a life.

Dr. Senn. I must emphasize with Miss Scoville that the problem is one of definition. I do not mean that because the ideal cannot be set up, a new venture should not be started in a community. I believe in experimentation, but when an experiment is set up, I think we must know the limits and purpose of the experiment very clearly.

I think, too, that in terms of psychotherapy we kid ourselves that the person who is doing this teaching can get therapeutic experience only when he treats very disturbed patients. The pediatrician with psychiatric experience can continue his education without dealing with the deeply sick, the deeply involved. He can be a therapist in his everyday work with children in the well-baby clinic.

When the pediatrician with psychiatric experience becomes drawn into psychiatric therapy and further psychiatric experience because he enjoys it, then he becomes a psychiatrist doing child psychiatry. I can only hope that he will get good training and not try to become a psychiatrist on his own without supervision. If, with this additional training, he retains his pediatric viewpoint, he can become a good teacher and be of great service to pediatrics. However, the person must have it pretty clear in his own mind what his primary function is—that of a teacher or that of a therapist.

Miss Towle. All morning I have felt that I was reliving my own past and still struggling with some of the unsolved problems of my profession, social case work. Some of my colleagues have registered the same impression. I think it may be helpful if I tell you what we

in schools of social work are thinking concerning this same problem, for we have been struggling with it for a long time.

The social case worker from the present-day school of social work (I think I can honestly say this) is a psychiatrically oriented case worker. Her work deals with the whole gamut of human beings, from the individual who is relatively healthy but who is emotionally upset because of some stress or strain, to the very sick individual who is on his way in or out of a mental hospital and shows up in a social agency with some social problem.

How do we psychologically orient the social worker to deal with these people? There are several means of orientation; I shall mention only two of the most important ones. Every social case worker takes courses in psychiatry taught by psychiatrists: a course in the development of the normal personality, a course in behavior disorders of children, and a course in psychopathology. The psychiatrists, who are skilled teachers, are doing an excellent job for us. If, however, our students were to have psychiatry as taught by psychiatrists as their only orientation, they would go out into the field more psychologically disoriented than oriented. So we teachers of social case work begin in the very first course to draw into our discussions the content that the students are getting in their psychiatric courses. We teach (and this same principle is followed all the way through to the advanced psychiatric social work course) that the case worker's first responsibility is to understand the person who has the problem, to try to get at some of the meaning of that problem to him, and to render social service—financial assistance, obtaining medical care, helping to find recreation resources for a child, or whatever it may be—in the light of his understanding of that person.

These social case workers have their field work experience in social agencies, and in their second year they may choose specialization in the family field, the children's field, or psychiatric social work. If the last field is chosen, field work is carried on in a mental hospital or psychiatric clinic. Let us then define a psychiatric social worker. I said that a social case worker today is a psychologically or psychiatrically (if you prefer that term) oriented case worker. A psychiatric social worker is that same case worker who has been trained more thoroughly in psychopathology and has had

more experience in understanding and in assisting in the treatment of psychopathological conditions.

We have one problem that is not completely solved, and when Dr. Zimmerman spoke this morning I thought of it. We find that all our students want psychiatric field work, and all social agencies seem to want workers who have had that experience. However, that was more true in the past than it is right now. As our students go into field work in psychiatric agencies, they become more useful in dealing with the clients of general social agencies. For the past few years we have been dealing with that problem by putting into children's and family agencies more and more supervisors and instructors who are trained psychiatric social workers and who help the students to integrate their psychiatric knowledge with child welfare work, medical social work, and family case work. In the last two or three years students have been coming out of such agencies feeling as satisfied to have had their advanced field work there as in a psychiatric clinic.

I would like to tell you also what we think we are training case workers to do. Let us take one of these general social case workers, not a psychiatric social worker but one who is a psychologically oriented case worker in a public assistance agency. One day a man comes in; he presents only the problems of being out of money and of not having a job. We expect that case worker to be immediately oriented and to call to mind all that she has learned about what people commonly feel in our society, men especially, when they don't have a job, all that she has learned about the meaning of money to people. With that as a background, we hope that she would then immediately focus on this particular man and try to understand what it means to him in the light of his prior experience, in the light of present circumstances, and in the light of his future aspirations to be without money and a job. Her treatment would be to give financial assistance, perhaps to give help in finding a job but, because of her broader understanding of the man, to assist him in such a way that she would give him an opportunity to express his fears, his feelings of self-doubt and anxiety about the future, so that he could take financial help without a feeling of humiliation. She would conduct the whole interview in such a way that she would build up his self-confidence, help him keep his ego

intact so that he might emerge from this experience capable of dealing with his own life situation more competently.

We have a lot of conviction about this. People will say, "Why does it take a trained worker to do that? You give the person money, you help him find a job, and that is all there is to it." We feel that the richer orientation which this worker brings to her interviews enables her to help people undergo such experiences without becoming pauperized, as people used to become pauperized when they had to accept public relief.

This same worker on the next day might deal with a man presenting the same problem in the same way; but as she went on rendering financial assistance and helping the man to find a job, she might discern that this experience had activated certain old conflicts for him. I recall one such instance of a man whose whole work life, quite successful up to that point, had been a kind of reaction against a strong wish for dependency, so that loss of a job and loss of money reactivated the old, lifelong, deep-seated conflict. This man did not use the social worker and the assistance she could offer to move ahead. Very soon, because of her orientation to psychopathology, the social worker was able to see that he was a person who needed more assistance than social work could give; so she helped him get to a psychiatrist in a clinic. There a psychiatrist and a psychiatric social worker helped him with the more fundamental conflict problems that had been aroused by the social situation.

It seems to me that pediatricians have the same problem of integration that we social case workers have. It is my conviction that a large part of the teaching will have to be done by pediatricians who are able to combine psychiatric orientation with the specific practices and policies and routines of physical care that are the pediatrician's job.

SESSION IV

What are the next steps in pediatric teaching and training toward better understanding of the emotional life of the child?

Lists of topics to be covered were presented by the moderator, Dr. Milton J. E. Senn. The suggestion was made that dynamic psychology is an additional basic science to be added to the required medical curriculum. Some of the participants objected to such a formal, categorical approach to the problem and held that psychological considerations should be brought to the student's attention throughout all or most of his courses and clinical practice. Tutorial instruction was held preferable to lecture methods, and a good deal of emphasis was put on the attitude of the instructors. As Dr. Smyth, opening the discussion, put it, "Schools are trying to get away from set courses. Just as in the laboratories we teach students by doing, so at the bedside and in the clinic . . . we must not depend too much on formal courses but rather on the attitude of the staff."

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Dr. Murray. In my opinion there is a basic body of psychiatric knowledge which should be presented to medical students today. Most of the psychiatrists in the Group for the Advancement of Psychiatry are agreed that this basic teaching should begin in the first two years of medical education, with lectures being given once or twice a week. During the third and fourth years perhaps 250 to 300 hours could well be devoted to the clinical manifestations of psychiatric illness, as seen in outpatient departments and hospitals.

The scope of this teaching in the first two years might be defined in four areas: (1) emotional stresses and tensions, chiefly anxiety, as possible disease-producing factors; (2) the regressive, dependent attitude of the sick person, the emotions involved in illness; (3) illnesses as "trigger situations" which may activate deeply buried anxieties; and (4) the emotional reaction of the patient to the doctor, the dynamics of the patient-physician relationship, and how this may be handled to the patient's benefit.

To acquaint students with these four areas, the following topics should be covered. First, the students must become acquainted with normal personality development and the growth of the emotions. Next, we must teach the students what the normal variants are as children go through various emotional vicissitudes and what the significance of temporary decompensations is when the balance is broken down. The student should understand what happens when the homeostatic balance is lost, how serious certain failures in this balance are, what the chances are of a return to a normal balance, and what can be done by way of assistance. Students need to know, also, the sources and meaning of anxiety. They need to be acquainted with the normal devices for handling anxiety and with the flexibility which the personality must maintain. They should be aware that there are certain periods in an individual's life when he is traveling under a greater load of emotions and that external events can be more damaging at these times than at others.

Students need to know, also—and now we go into psychopathology—the defense mechanisms which the personality uses when it experiences acute anxiety and acute decompensation. We must acquaint them with regression, identification, introjection, projection, displacement, devaluation, overcompensation, rationalization, and about half a dozen other defense mechanisms which the individual uses as a flight from intolerable conflict and which make him much less efficient in adapting to the realities of the world around him.

Finally, we should show students some of the standard types of illness which occur as end results of these overwhelming emotional experiences: hysteria, obsessive-compulsive states, the various types of character neurosis, the reactive depressions, abnormal grief, and the psychoses.

It is possible to convey to the student in the first two years of medicine such basic psychiatric knowledge as will prove valuable to him as a practicing physician. This basic training is inadequate for the individual who has a special interest in psychiatry, but it will equip the average physician for competent practice in all the areas in which he is going to deal with human beings.

Dr. Felix. About a year and a half ago the mental hygiene consultants to the United States Public Health Service met with us in Washington and outlined some criteria for the psychiatric training of medical students. Since I believe that these criteria apply to pediatrics as well as to general medicine, I would like to read a little of the outline. It puts what Dr. Murray said in slightly different words, with slightly more of an eclectic viewpoint:

The following should be the objectives of psychiatric instruction to the undergraduate medical student:

1. To teach fundamental concepts of human behavior, i.e., motivation, gratification, and conflict
2. To teach the emotional experiences of sick people and their relatives. The student should also be made aware of his own emotional relationship to his patient.
3. To teach that emotional disturbances as well as toxic, metabolic, or physical factors produce illness
4. To teach an understanding of illness associated with or caused by disturbed cerebral metabolism
5. To teach some classificatory knowledge of psychiatric diagnostic syndromes
6. To teach useful diagnostic and interviewing techniques
7. To assist the student in gaining insight into his own personality make-up—particularly his emotional biases, prejudices, and blind spots—preferably through intimate contact with the psychiatric teacher
8. To give a reasonable concept of methods of psychotherapy and an appreciation of his own potentialities and limitations in this regard

The consultants made further recommendations with regard to teaching and clinical facilities. I shall pick out just a sentence or two:

To give acceptable training, a medical school should offer inter-departmental training in psychiatry, under the direction of a full-time professor of psychiatry and such additional staff members, including residents, as are indicated by the size of the student body. The non-

psychiatric staff should have a good understanding of psychiatry, and the psychiatric staff, in turn, must have a good understanding of general medicine.

Liaison with outpatient and inpatient services of other departments is essential. Psychiatric examinations, abbreviated to fit the case, should be a routine part of the medical study of every case the students see.

There should be outpatient facilities connected with the medical school in which the case load is large enough to provide sufficient patients with psychiatric diagnostic and treatment problems—not necessarily straight psychiatric diseases but psychiatric problems—so that all junior and senior students can work with at least two such cases in the course of their respective years.

The undergraduate training curriculum should offer courses essential to psychiatric understanding in all years of the medical school.

It is essential that there be clinical experience in outpatient and inpatient psychosomatic medicine in which psychiatric consultation is utilized.

Dr. Wegman. We are supposed to be on the question of how, when, and what medical students should be taught about a better understanding of the emotional life of the child. If this material is to be taught by the pediatrician by practical demonstration, as Dr. Smyth put so definitely before us earlier, how can I, as a pediatrician who has a little better than average orientation about problems of emotional development, even begin to cover the things which Dr. Murray and Dr. Felix have talked about? I am lost; I cannot do it. I can talk to students to some extent about the emotional development and the emotional problems which come up in children in the ordinary feeding situation or the weaning situation as I have learned them, but it seems to me that these other fields are rightly the problems of teaching psychiatry.

Dr. Little. The problem we are up against is the problem of how to teach and how people learn. In order to teach medical students you have to meet them where they are. Also, you have to meet them on the basis of their conscious experience. Perhaps a good way to start is in, let's say, physiology, where the students are learning about the effect of the emotions on the gastro-intestinal tract. From there you can go on to the effect of the emotions on thinking, on behavior, and the like, and then to emotional development—how a person learns to live with his feelings, to react to

them, to accept them, and to control them. This can be discussed superficially, if you will, but it is the kind of discussion that means something to medical students because it touches their conscious experience.

On this point I disagree fairly sharply with Dr. Murray. A good many things he talks about are not closely related to the conscious experience of medical students. Yes, you can reel the material off to them and you will get back parrotlike just what you have told them. The material can become meaningful after a time, but I think you have to start in another way.

Students should be taught in connection with their cases. Very little teaching should be done in the lecture room. In the medical outpatient department you can go over the medical problems of the patients and, by a word here or a word there, bring to the student's attention the emotional factors which he has missed. Because it is his case and is interesting to him, the student will want to go on from there. In this way the idea sinks in and really takes hold.

Dr. Smyth. If I understand the psychiatrists rightly, they are proposing to introduce a basic science, shall we say in the first two years, comparable to anatomy, physiology, and biochemistry. I would like to have some of the members of the Association of American Medical Colleges hear this discussion, as the curriculum is under fire in a great many quarters. We are far from contented. An administrator sometimes looks on departments as convenient administrative units, with no conviction that they have any proprietary sphere in the teaching program. For closer integration some schools are having the clinicians meet classes in anatomy to relate the study of anatomy to clinical experience. Biochemistry is taught in the same manner. The problem of introducing another basic science, however, is a very serious one with regard to costs.

Dr. Little has a clue as to how the problem can be handled without creating another basic science. For instance, an introduction to psychology in the physiology course may have a value in providing a general basis for clinical use greater than that which could be provided by any one of the various schools of psychiatry. The approach should be physiological at first; later the students can come to the clinic and learn the interview system just as they learn

their history-taking. I think we ought to try to differentiate the request of the psychiatrists for a basic science from the application of psychotherapy to the immediate clinical problem.

Dr. Allen. I wonder if it is so much a question of a new basic science, which may only create a dichotomy, as a way of making the basic sciences alive and vital and meaningful in terms of function. It is a question of giving a new understanding of the growing, developing human being, an understanding of what it is that makes him alive, vital, not only a biological organism but a social organism as well. Early in the life of the medical student we should help him to see and to understand (possibly through seminars, possibly even in lectures, where we always run into the danger of giving him toxic doses before he is really immunized) the interplay between the biological forces which are so well characterized by the curve of biological growth, and the social forces which, as Dr. Washburn has pointed out, exist in every setting. Always the individual is trying to find a way of being an individual while at the same time he is learning how to be a member of the group. This principle is as basic to all psychiatry, to all symptom formation, as it is to all normal growth and development.

To give the medical student a simple understanding of what this means in the setting of the family is an accomplishment. We talk about the family as a sociological institution, often without really bringing to light its essential dynamics. I have found it very helpful with medical students as well as with social workers to give this simple definition: The family is a social unit made up of three units, father, mother, and child, each with a different role to live in relation to the others. But within the social unit you have the important mother-child relationship—set off by itself in a sense—which has the greatest significance in the early life of the infant. Out of that relationship comes growth, change, and differentiation for the child, a process always related to the social force that the mother represents. The emerging self of the child thus acquires meaning and direction and begins to form a relationship with his father—another grouping of units.

As the student becomes aware of these simple elements as they relate to a developing organism, he also becomes aware of the complications that arise—complications that sometimes build a fence around these relationships. He begins to see the constant interplay

between the forces that determine the healthy or unhealthy nature of growing up. You can build a whole course in such a way that the medical student really grasps these psychological concepts, taking them out of mid-air and bringing them down to what people are and what they are doing in day-to-day living.

The student can become acquainted with the important dynamics of the interview. An interview is another social situation in which an individual, a biological organism, enters into a relationship with another social force in the person of the doctor, who introduces into the situation an opportunity for reflection, for interchange, for thought, and for feeling out of which change begins to develop. As the student begins to understand the dynamics of such situations, he is getting down to things that really have meaning to him because they are close to his own interests and experience.

As we get down to essentials we realize that this important biological curve is always forming in a setting in which there is an interplay between the individual and the social forces around him. Every problem the pediatrician meets in the behavior of the child and every problem the psychiatrist meets in his patients is always related to these two forces and never anything else. As we understand that, I think we have a chance to make psychiatry a science that can give more vital meaning to physiology, to pathology, and to anatomy.

Dr. Wilson. One of the things that we worry about in the groups I have been working with is the compartmentalization in medical schools. All these little subjects are artificially separated and taught independently, so that the student gets through biochemistry, gets a B, closes his book, and is likely to forget the material shortly afterwards. I dread the thought of another basic science course. A trend which I approve of is breaking down the basic sciences we have now and mixing them up. If we must start something new, we might start a course in the first year and put the word "anatomy" on it. That would help a lot—the anatomy of symptomatology. We could have psychiatrists and everybody else come in but we would talk about things like bellyaches and headaches. I would be hesitant to use some of the words that Dr. Murray used. They utterly confuse me. They sound so much like some of the dermatological terms in the book.

Certainly I feel—and I think we all agree—that more of our

teaching ought to be around individual problems, which some of us have to call cases even though it involves a child, and should include all aspects at the same time. There is now a trend, of which I approve, to get away from lectures and give more time to small-group teaching about individual problems. Let the students go home and read the lecture in the book instead of giving it to them personally. Yet in some schools the psychiatrists (and now I am complaining a bit) are demanding a retreat from that attitude. They want another bunch of lectures. Just as we are getting rid of some of the anatomical lectures, we have a group of people coming in who want to give lectures, on the theory that they will provide a nice background of solid knowledge on which to build up an experience. I don't think that is the way to do it. I think we should cut out rather than add lectures, even in psychiatry or pediatrics.

Dr. Washburn. It seems to me that a discussion of what part the psychiatrist must play as against what part the pediatrician must play in initiating an understanding of human behavior and the growth of emotions in the students, dodges one possible solution altogether. Sometimes we forget that the teachers of anatomy, physiology, biochemistry, and the like have been children, frequently are fathers—sometimes even mothers—and that they have had fairly valid experiences. Not infrequently, with a little help, they can be considerably instrumental during the first two years in starting the students to think about something more than structure.

At the medical school of the University of Colorado I have been serving on a committee which is trying to revamp the entire curriculum. Some rather interesting items have turned up as we have talked with various people in the basic science departments. One particular episode appeals to me as being apropos. An associate professor of anatomy started looking around the medical school for someone who was interested in speech and could discuss it in conjunction with a sectioning of the larynx. He found that there was not a physician in the community who knew much about speech. That struck a thoughtful anatomist as rather extraordinary, so he looked about the community a bit and found an excellent speech clinic with two or three excellent staff members in it. While the staff did know something about speech, they knew nothing

about the larynx. So the professor got three people out of the speech clinic to dissect the larynx along with the medical students. While they were dissecting it, he had the speech clinic people talk about speech and, in turn, the medical students instructed the speech clinic people in the anatomy of the larynx.

It is the feeling in my committee that a great deal can be accomplished by informal conferences of faculty members—including, if you will, people from pediatrics, internal medicine, psychiatry, and the rest of the departments—meeting simply as a group of medical teachers without labels and discussing how, as the students move through these first two years, we can keep constantly exposing them to new experiences that will be related to things they have experienced. These people will start the students thinking about the functional relationships of human behavior and the growing human organism during the very time that they are studying different aspects of anatomy, of physiology, and of biochemistry.

Dr. Weech. I have gathered from what Dr. Washburn and others have said that if we are going to put across this idea of the need for guiding the emotional aspects of early life, we have to have it hit the medical student from as many different angles as possible. It is not going to serve our purpose to bring in a pediatric psychiatrist or any one individual to try to put this information across; we have to have contributions coming from all sides. So many of our faculty, however, are insecure in their understanding of these things that they prefer not to mention them. For that reason I purred a little at Dr. Allen's description of growth in terms of a simple, basic concept. We should get that sort of concept impressed upon, not only the medical students, but everyone in our departments who engages in teaching. It is simple enough that they can comprehend it. If they are more interested and can go further with it, fine! Let them carry the analysis along as far as they feel they are competent to do so. But when a person who, let us say, has devoted the majority of his years to specializing in the narrower field of cardiology within the field of pediatrics is presenting a patient who has a peculiar heart murmur, he may feel completely incompetent to discuss the attitudes of the family toward the heart murmur and the attitude of the child toward his

family because of their attitude toward the murmur. One way to handle the problem would be to have a pediatric psychiatrist on hand; that is better than not touching the problem at all. But how much better it would be if the pediatric cardiologist himself became aware of the emotional aspects and included them in his teaching.

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Intermingled with this discussion of how and what medical students should be taught, were several descriptions of the work actually being done in various centers.

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Dr. Vander Veer. At the University of Chicago we start in the second year with six lectures on personality development, which is one of the first subjects that a medical student ought to be introduced to in the field. I am not sure that is early enough. The first two years in medical education have an unfortunate effect on the student's thinking about people, in that they tend to deflect his previous interest in people and their emotional states and emotional reactions into a sort of anatomized conception of the individual as a composite of a cadaver, physiological reactions, pathological lesions, and various infections. Many students have told me that they considered themselves in pretty good rapport with people in general until they got into the scientific laboratory discipline of the first two years of medicine. Therefore, we ought to reach students at the first-year level, not through any complicated series of lectures or case demonstrations, but through spending enough time with them so that they don't forget that the patient is a total person.

We at Chicago are trying to accomplish this by having the incoming medical students distributed among the members of the psychiatric staff for interviews, each staff member having about five students. Our main purpose is research; we are trying to discover some criteria for selecting students who will be the best practitioners of medicine. But this contact with the student in his first year may have effects on him too. Having talked with a psychiatrist so early in his career, the student may be less likely to lose his conception of the patient as a whole. We have also invited the stu-

dents to come back to us with any problems that may develop in the course of their medical education. It is still too soon to know whether many of them are going to avail themselves of this opportunity, but I think it is one way of reaching them. We should also use other ways.

Dr. Kanner. This is the way we conduct our undergraduate training at the Harriet Lane. I admit that I practice child psychiatry, but I definitely do not teach child psychiatry. The students come to me in the third year of the medical course, having had for the first two years, under the leadership of Dr. Whitehorn and his staff, the sort of lectures that Dr. Murray advocates.

Earlier I made a grave mistake: I continued with lectures. I had the classroom and the students before me; they sat there and I sat on the platform, and they lent me their ears. I soon felt that I did not return the loan with appreciable interest. I then decided to break up the group into small sections of two or three. The students now come over to the clinic and informally present something, and we have a chat. We don't talk about schizophrenia, we don't talk about severe behavior problems; we talk about children and their needs at various ages. The students sit through several of these sessions of two hours each. They are not in the form of a lecture. They are conversations in which the students have a chance to speak up at any time. The students bring with them puzzlements left over from the lectures. They want clarifications. They bring in reminiscences of their own childhood and place themselves in the picture, which is always helpful. We talk about such things and then later we talk about treatment, not in the sense of what you do when a child wets the bed or has tics, but treatment in the sense of what you do when you and a child are together.

Up to this time the students have never had an opportunity to be confronted with a child or an adult professionally. This is their first opportunity to come into contact with patients. They don't have to learn to take histories at this time. What they learn is how a child comes to the office, how a child behaves in the waiting room with the parents, and how the parent and child behave when the child is called away. They learn to pay attention to the non-verbal contributions of the child, which seems to me to be a very important thing to know before coming into actual working con-

tact with children. They learn that the child can say a lot of things without expressing himself verbally. They come to see how a child makes his first relation with the physician and how he begins to test the physician. The things that the child does and does not do assume meaning for them.

In addition to this, the students sit in at our noon conferences, when children are presented who have been examined in the morning. The students are invited to express themselves. Questions, puzzlements, comments, suggestions—no matter how naïve they are—are accepted and dealt with seriously.

The students come back in the fourth year by way of pediatrics. They work in the pediatric outpatient department, and there they see children. Whenever they have any question about emotional involvements, they bring the child to us. They come upstairs and say, "Well, here is the problem. This is the thing that puzzles me." In addition, we always have a person on call to the outpatient department, so that students can reach us in a variety of ways.

I don't believe that this is teaching child psychiatry; this is teaching students how to know and understand children and how to deal with them. What they get is an orientation before they come into actual contact with children as patients. In this orientation I make use of a set of principles which I think can be taught not only by a child psychiatrist but by a pediatrician as part of his pediatric teaching:

First, coercion which is intended as prophylaxis does not prevent. In a not-too-distant past I think we all fostered, or at least sanctioned, coercion. We have laid down rules and regulations to mothers and told them that they were good mothers only if they rigidly followed those rules. We have come to learn from clinical experience that attempts to prevent feeding difficulties by forced feedings do not prevent feeding difficulties but foster them; that coercive bowel training does not prevent constipation; and that coercive enforcement of obedience brings about anything but conformity—it may bring about rebellion, unwholesome submissiveness, substitutive reactions, but it does not bring about the type of conformity which is desirable.

Second, the nuisance value of a child's problematic behavior depends upon the thresholds of annoyance and anxiety of the

people around the child—the parents, the pediatrician, the school teacher, and sometimes even the psychiatrist.

Third, this threshold of annoyance and anxiety depends upon the attitudes of the people who are annoyed or anxious and not on an absolute value assigned to the symptom.

Fourth, the attitudes of the adults should not be dismissed with adjectives; they are the resultants of emotional problems which exist in the adult and therefore must be approached and understood as such.

Fifth, there is a semantic confusion, which we should eliminate, with regard to the terms "spoiling" and "discipline."

Sixth, attitudes rather than the individual acts of a parent are the things that count in the relationship between parent and child. I know adults who come and say smilingly that their parents spanked them quite often. They have no resentment because they sensed underneath the spanking an attitude of fondness. I have known other adults who say with a great deal of resentment that their parents never laid a hand on them. The resentment was caused by the fact that their parents were so detached from them that they never expressed an attitude in a personal way.

These are just a few points. If we can arrive at a mutual understanding, if we can accept these points—or some of these points or some additional points—as basic principles by which to guide our attitude in practice and teaching, I think we would have a crystallization of a great deal of work done in a variety of fields.

Dr. Washburn. I have been asked to tell about my present teaching. I feel rather embarrassed about this, however, for next year I shall be doing something different from what I have been doing for the past twelve years. In the past I have tried to give second-year medical students a brief course in growth, with the idea that I could use it as an introduction or orientation to pediatrics. I have done my best to relate it to experiences to which the student is close enough to understand. Using small sections of students, I have brought in newborn babies, and I have taken the students to the ward and to the outpatient department so that they could at least have an opportunity to see the reactions of parents and children. Generally, I have tried to expose them rather thoroughly to the kind of data that I presented in my paper yesterday.

I have been by no means satisfied with the experiment. Next year I am moving back to the first quarter of the freshman year. With Dr. Edith Boyd handling the anatomical aspects of growth, Dr. Jules Coleman handling the psychological aspects, and me attempting to handle the physiological aspects, we shall give a joint course that will be under the jurisdiction of anatomy.

Dr. Putnam. There are several things I should like to say about our methods of teaching medical students and interns. First I would emphasize that the psychiatrist who is going to work in conjunction with a pediatric department or in a medical school should have direct experience with infants and preschool children. It is in this period that the fundamentals of personality are laid down (though I don't mean to disregard the importance of later age periods), and a psychiatrist can then bring to pediatricians from his own experience vivid pictures of the emotional development of the young child, the needs of mother and child, and the tremendous significance of the mother-child relationship.

Second, I want to stress two points that others have already described: the importance of a certain degree of gratification of the instinctual urges in the first year or first few years, and the fact that within each child there is a very powerful urge to live up to the limits of his capacity in every way. The latter point can be brought vividly to the attention of the medical school student in terms of the child's neuromuscular development, his learning to stand, and to walk, and to talk. We don't think of teaching the child these things or even trying to modify them very much. But it is very rarely brought to the medical student's attention that the child has just as strong an urge to take on the morals, the manners, and the social ways of the people around him.

We can make this process meaningful by having clinical material to illustrate points at which it does not occur successfully. For example, long ago in the New Haven Hospital we had a one-year-old baby who was there for the third time for vomiting. He refused all food, with the result that he had secondary anemia and just lay in his crib. He was unable even to support his head when he was picked up. There had been absolutely no neuromuscular development, gross motor development, since birth. We had rather assumed that this was a feeble-minded child. He just lay there, a

little responsive but not doing much of anything. After the psychological examination of the baby indicated that he had normal potential development; an interview with the mother showed an unusual degree of rejection of the child (I don't like the word "rejection"; I should say a high degree of ambivalence). As she herself told me, when the baby was six months old, if she walked into the room he would turn his face away with an expression of disgust and often vomit. As soon as we had these facts, we encouraged the mother to come in every day and also encouraged the interns and nurses to pick up the baby. As soon as the baby was treated like a human being, the rate at which he started to develop and to catch up with himself was the most astonishing thing I have ever seen.

Such things can be demonstrated very much more vividly and tellingly in the early years of life. Psychiatrists often cannot bring that kind of experience to the students' attention because their experience with children usually begins in the school years. One reason we established the Children's Center in Boston was to give psychiatrists an opportunity to observe directly the behavior of very young children when, for instance, new siblings are born into the family, when they have to go to a hospital for an operation, when they are separated from the family, and in all such situations which we believe to be so terribly important.

The third point is that we should teach all this to medical students not only because we want to reach the student before he has firmly jelled in his ways, but also because it is just as important for the surgeon and every other doctor to have a human approach toward mothers and children and to avoid some of the disastrous things which they can do to children by not understanding what is significant to them. We must teach these things to medical students so that they do not make these errors. The teaching should continue all through the four years, so that the more human, understanding approach to mothers and children and patients in general will be constantly brought to the students' attention.

If we have to do this by the lecture method, I agree with Dr. Kanner that it is very much better to do our teaching in small groups so that we can begin where the student is. I am doing my teaching in both ways. The Children's Center (for preschool chil-

dren) has some connection with the three medical schools in Boston. Boston University students are now coming over in their fourth year to spend two mornings each week. They watch the children in our nursery school for a little while. Then we sit down, ask them what they are interested in, what their feeling is about psychiatry, and let them go ahead with anything they want to discuss. If the class is large (in the first year, for instance) one would want to begin to describe the normal emotional development of children, how it looks clinically, and where children easily "go off the trolley." At that stage the lecture method is probably preferable.

It is of the utmost importance to have two-hour sessions for lectures. At the Tufts Medical School I started with four fifty-minute lectures for the third-year students. I just could not stop in time to allow a question and discussion period, and this was absolutely disastrous. The material is so close to the students' own emotional experience that it arouses—no matter how tactfully and simply you put it—emotional reactions which must have some opportunity for expression if the students are going to understand what you are talking about. So now we have three two-hour sessions. I talk for perhaps three-quarters of an hour and then the students begin raising their hands. There are never less than ten hands at once. They are bursting with questions, usually very pertinent questions about the things I have said, and sometimes about things I have not even mentioned.

We can begin to give a half-dozen lectures to the first-year students and then try to round that out not only by allowing them plenty of time for discussion and questioning, but also by encouraging them to obtain some direct experience with mothers and children, perhaps with the children of their friends. Students might be encouraged to talk with their married friends and find out what kind of difficulties they are having with their babies. Perhaps students should go, in company with somebody who understands emotional development, to the well-baby conferences to get the feel of what the complaints of the mothers are.

If we could begin our teaching in this way, we could get across to the medical students that they should be sympathetic and tolerant of difficult mothers and difficult children and not deal with

them moralistically. Once students have a real desire to understand why mother and child are so irritable and so unhappy, they will carry that point of view into all their medical interviewing, and that in itself will have therapeutic value for patients.

I would like to stress, as others have, that there is not much use in lecturing about these things and drawing the student's attention to them if they are going to be knocked down or even totally disregarded by other medical teachers.

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From here the conference moved on to a consideration of various means of educating pediatric interns and residents. The use of the outpatient department as a teaching medium was the chief subject of discussion, but mention was made of the good opportunities for teaching that the ward, the well-baby clinic, the school health program, and other situations afford.

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Dr. Butler. Most of the pediatricians here are teaching pediatrics in hospitals. One of the first things we can do is to teach an understanding of the emotional life of the child in the hospital: first, the immediate hospital environment and what it is doing to the child's immediate emotional reaction; and, second, the effect of the child's total emotional experience on his illness—what it is doing today to the illness for which the child is hospitalized and what the major components of his emotional life are. If you begin to talk with medical students and house officers about these two very pertinent and immediate problems of the child's emotional life, you will find that you get a good deal of teaching done about the child's total emotional experience.

On ward rounds, if you think of the patient as I have indicated, you begin considering the treatment of any patient in terms of his mental hygiene, his psychiatric reactions. Then in your consultations you can go further than just bringing an individual psychiatrist down to a ward to see a patient. For instance, at the Massachusetts General Hospital we send a patient with an emotional problem up to the general ward round of the department of psychiatry. Then we have our house officers, graduate students, and the like go along with the patient and see what the psychiatric department, as

a group, is going to say about this patient and his emotional problem.

We also have social service rounds, in which we try to include a psychiatric social worker. These rounds bring before the house officers and students the problems that social workers know about but which we, perhaps, do not. We also have a home service in the Massachusetts General Hospital which teaches us a lot about the total environment of the patient whom we are treating either in the outpatient or on the ward services. The home service is run by social workers, and they take medical students along with them on their visits.

You can also teach by presenting cases to the Pediatric Society or the evening graduate seminars or the intensive graduate courses in the summer. There again you can bring in a pediatrician to present the medical end of the case and a psychiatrist to give a professional opinion on the psychiatric end of the case. The ways in which we can integrate mental health and child hygiene in our pediatric teaching institutions are numerous.

Dr. Spock. I was challenged this morning by the questions about what you could do with a strictly limited budget with no chance of adding a psychiatrist to the pediatric staff. We all agree that it is advantageous to have a psychiatrist or a pediatrician with some training in psychiatry in a department of pediatrics, but it is not true that if you cannot have that, you cannot have anything.

Dr. Weech mentioned this afternoon that we cannot really get our point of view over to medical students and the house staff until an appreciable proportion of the permanent staff in pediatrics has some tolerance and sympathy for it. It seems to me that a great deal could be accomplished if the professor and the associate professors of pediatrics sometimes came to the outpatient department and saw cases there. Too often the medical students and house officers, seeing the professors apparently interested only in severe illness on the wards, conclude that the everyday physical and emotional problems of the outpatient department are not "real" pediatrics at all but unimportant drudgery. If the top members of the staff would see patients in the outpatient department and—perhaps most important—at regular intervals hold staff conferences there, the student and the intern would get the feeling that outpatient care is a vital part of pediatrics.

In these staff conferences the thing to do is to avoid the rare case with the spleen and concentrate on relatively simple problems. In the health department teaching that I have been doing (perhaps because the staff of physicians and nurses were consciously or unconsciously trying to put me in my place) there has been a tendency for the cases to get more and more complicated. I would be faced with a discussion of a case where the father was a drunkard and the mother was psychotic and the children were lost souls. The staff would look at me and say, "What do you do now in the well-baby clinic?" I think you should take a case of a baby that is refusing to be weaned or a child that is mildly malnourished as the kind of problem on which to concentrate in these conferences.

If you can then add other professional people, even on a part-time basis, it will add to the conference's value. The first one I would add would be a social worker, so that the intern or medical student can know about the background of the child. Then, without any expense, you might be able to borrow occasionally a teacher from a nursery school or, if the patient is a child in grade school, you might be able to get the teacher to come to a conference. Then if you have a department of psychiatry in the medical school or a child guidance clinic in the city, perhaps you can ask a psychiatrist to come over once a month to discuss a problem that has come up in the pediatric outpatient department, which no one has been able to fathom.

Dr. Wilson. I, too, work in the outpatient department and on the wards and take care of children. The first step in any attempt to improve psychiatric teaching within the department of pediatrics is to bring the psychological aspects of a case into the discussion with students right then and there, just as we do with questions about blood sugar, and so forth. The outpatient department is ideal for that teaching, but so are ward rounds. It doesn't make any difference where the teaching is done as long as we bring up the psychological implications of the child's illness, the mother's stupidity, the home's poverty, and the like. If you don't have that as a basis, there is no good in having anything.

Dr. Butler. I, too, am a professor who teaches pediatrics in the outpatient department, and I agree with Dr. Spock that this is a very good way to teach pediatrics. We put on a teaching ward round in our outpatient department every other week. But the main rea-

son that I go to the outpatient department is not what it does for somebody else; it is what it does for me. If you are a teacher you lose a very valuable contact in terms of the patients you are discussing if you yourself don't continue to see patients in the outpatient department.

Dr. Allen. The outpatient department of the pediatric hospital offers the greatest opportunities for doing effective teaching in this area. It is in the outpatient department that the student really comes into contact with parents, and it is in work with parents that the pediatrician has his most effective opportunity.

At the present time we are trying to set up in the Children's Hospital in Philadelphia, with the help of Dr. Stokes and Dr. McNair Scott, a limited service in which the house officer in the outpatient department offers the parents an opportunity to talk over some of the concerns, questions, doubts, and puzzlements which they have about their children. The parents may elect to come back for a limited number of interviews, sometimes one, as a rule not more than two or three, to discuss their problems further. One of two things can develop from this: The parent may work through with one of the house officers some of the simple anxieties that he or she may be having—anxieties which may not seem simple to him and which may be accumulating; or, if the anxiety and concern are of a greater nature, he has an opportunity to decide whether or not he wants to seek the help of a child guidance clinic.

The house officer has the opportunity of exploring his own possibilities in working with parents up to that point, and he has the equally important opportunity of knowing what goes into a referral process. The latter is one place where general physicians and pediatricians fail badly. Often they don't seem to realize the important distinction between referring a parent to a child guidance clinic and referring a patient to a nose and throat clinic or some other medical dispensary. They don't seem to realize the importance of helping parents to take an active participation in arriving at the decision to go to a child guidance clinic, to think through what they really would like to get in the way of help. So this work with the parent offers a very rich opportunity, right within the structure of a pediatric dispensary, to give a meaningful kind of training in the mental hygiene of the parent as well as the mental hygiene of the child.

It is amazing how many simple things are overlooked in dealing with parents in an outpatient dispensary. For instance, a student should call a mother by her own name and not just let her become the generic "mother," and he should call her, not Suzie or Clara, but by her dignified name of Mrs. Jones. That may seem a simple thing, but it can be really meaningful for the student to have that kind of respect for the individual whose thinking and feeling he is trying to understand. If our training can be brought down to such simple, elemental things, we can teach some of the most fundamental things in psychiatry in a pediatric setting. True, we don't call it psychiatry; we call it good mental hygiene and respect for people. Maybe they are the most important things to teach.

Another thing that clutters up a great deal of pediatrics is the tendency for the pediatrician to become identified with the child, so that the parent is seen only incidentally. We get so wrapped up in our need to help the child that we see the parent only as the person who is going to carry out our instructions. It is the capacity to have identification both with the parent and with the child that makes for good pediatric practice. It makes for good medical practice. It makes for good psychiatric practice in the child guidance clinic.

Dr. Jackson. Following up on Dr. Allen's remarks, I'd like to say that I think all parts of the hospital are equally fitted for the teaching of the pediatric staff, specifically in providing an opportunity to come into contact with parents and children. Many of the children who are in the wards of the hospital have been under great stresses in their homes. Since they are relieved in being temporarily away from their parents, the doctor can achieve a much better relationship with them than is possible in the clinic. By the same token, physicians have a much less impeded relationship with the parents.

Visiting hours provide a much neglected therapeutic opportunity for the resident staff. The situation probably is changing, but in my experience the pediatric staff has not seen the advantage of getting acquainted with parents, getting a lot more data on family situations, and observing the relationships of parents and children at that time.

The development of the relationship between the psychiatrist

and the nursery worker has been perhaps one of the most fruitful means of teaching the resident staff. We are using the rooming-in project as part of a larger teaching project for at least one or more assigned members of the pediatric staff. They handle the problems of presumably normal parents—the parents who come into the hospital and into the newborn clinic—and follow those problems into the home through the year they are working on the project. They also have charge of a well-baby clinic, which is part of the hospital work in conjunction with the Visiting Nurse Association.

Dr. Anderson. One means of education that has not been mentioned is the school health program. My past experience with school health programs had been a systematic blessing of 30 to 50 children in an afternoon—a blessing with the stethoscope; but when I took part in the establishment of a new medical school, another plan developed. We were asked to take over a school health program, a task that was an impossibility from the standpoint of service for it involved some 10,500 children. However, thinking of the educational opportunities for the training of the pediatric residents and medical students, we decided to provide the clinics for four types of children: those who had abnormalities of growth, those who were frequently absent for reasons other than illness, those who were absent because of frequent illness, and those who had behavior problems.

This plan has been in process for only two months. The time required for the work is not great. The number of children seen does not exceed more than 12 or 15 in one afternoon, and we can offer no therapeutics. The residents have come back quite thrilled at the interesting material present in these apparently normal children. We think that this plan will provide students and residents in training with the emotional problems that are most likely to crop out in these four categories. Also, school clinics offer an older age group than well-baby clinics and in them one can survey the enormous number of emotional disorders that occur. For all these reasons, I think that school clinics might be tied in, in some way, with pediatric training in institutions.

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The final question, briefly considered, was what can be done in

the mental health area for the pediatrician in practice. Dr. Weech brought up as a possibility the offering of consultation service by the psychiatric unit of the pediatric department, but he recognized that this might require too much time of the already over-worked staff. Dr. Wegman suggested public health well-baby clinics as an excellent medium for demonstrations of the behavior and needs of infants and their parents. The Commonwealth Fund's experiment in giving a two-week course on the psychotherapeutic aspects of medicine to general practitioners was briefly described.

That practicing pediatricians, even those who have received training in a pediatric hospital in which mental health is stressed, are in need of further instruction was testified to by the replies Dr. Langford received to his letter previously mentioned. The writers, ex-members of the (New York) Babies Hospital staff, were almost unanimous in saying that attention to the emotional aspects of children's health was part of their everyday practice. Most of them added that they had not received sufficient training either in medical school or during pediatric training to do a good job in this area, and many suggested that the medical curriculum be revised in such a way as to incorporate psychological principles into various phases of the instruction.

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Dr. Langford. Men in practice find that they must pay attention to the emotional aspects of the child, that the parents are demanding it. They find that they need to know more and more about normal growth and development, especially with regard to the emotional and social aspects. They need to know more about the management of the child with minor personality difficulties and the parent-child relationship, and they are asking us to give them the proper information. Most of them feel that during their period of postgraduate pediatric training they should have had, as a part of their service, rotation through a service dealing with the psychiatric aspects of pediatric problems. They feel that this rotation should be full time, that only in these ways can they be enabled to practice the type of pediatrics that they consider worth while and that the community wants of them.

I would like to read from one letter, which was written by a man who began pediatric practice about 1935. He is one of Dr. Powers'

old students, as well as having been at the Babies Hospital. This letter expresses the opinions of many other pediatricians.

I feel that in a general pediatric practice, emotional problems, emotional aspects of disorders, and the development of personality are extremely important. And I feel that the training we have received along these lines has not been sufficient, either in our general medical training or in our pediatric training. I think that very extensive and fundamental changes in medical education will be necessary before good results can be obtained.

As to the areas of pediatric practice in which attention to emotional aspects is feasible, I find it hard to think of any situation or case in which such attention is not warranted and important. Breast-feeding, the feeding problems of infancy and childhood, behavior problems, injuries, operations, hospitalization—all have important emotional aspects. In general, I should say that a pediatrician's role as regards psychiatry is more preventive than therapeutic, though he should be equipped to deal with the minor behavior and anxiety problems.

I think there are major deficiencies in the teaching of psychiatry to pediatricians, but I think it goes back to the inadequate teaching of psychiatry in the medical schools (and, as a matter of fact, further back than that). In his preclinical years the medical student should get a sufficient knowledge of personality development and of the emotions so that when he begins on the wards, he is as familiar with the signs and symptoms of anxiety as he is with those of cardiac decompensation, for instance. During the preclinical years most psychiatric training should be given by psychiatrists, and each student should have several hours of individual sessions with a psychiatrist in which he can study and understand his own personality development and problems. In the clinical years most of his psychiatric teaching should come from his general medical teachers, the internists, surgeons, pediatricians, and so forth. There should be clinical work in psychiatry itself as a specialty, but the present complete segregation of psychiatry should be abolished, and I think it can be accomplished only in the way I have outlined above. Every doctor should be enough of a psychiatrist at least to help prevent the development of emotional problems and to recognize them when they do occur, and I don't think we can reach this goal as long as adequate teaching of the fundamentals of psychiatry is confined to those few who specialize.

In the specialized training of pediatricians, the major part of the psychiatric teaching should be done by pediatricians on the wards, in the clinics, and so forth. Pediatric teaching should include an adequate course in the development of a child's behavior and personality through the various months and years. During his period of pediatric training, the student should have the opportunity of treating and following

through several cases of behavior or emotional disorders with the guidance of a child psychiatrist.

This is a rather sketchy presentation of my ideas on the subject, but I feel keenly that our training in this respect has been neglected. The medical profession has claimed as its own the treatment of emotional and medical disorders, and the responsibility is also ours. The pediatrician should take a heavy share of this responsibility because he, better than any other type of specialist, can detect and influence these disorders during their early phases.

SESSION V

What are the next steps in furthering comprehensive pediatric service?

THE bulk of the discussion, directed by the moderator, Dr. A. A. Weech, centered around how present facilities and practices may be improved, chief attention being paid to hospital practices affecting the emotional comfort of the young child.

With regard to what hospital and other community facilities are needed to give effect to pediatric and psychiatric functioning in the field of mental health, it was held that the need is not so much for new facilities as for better use of those already present. Although mention of several needed additions was made, in the main, improvement in the attitudes and practices of the persons already serving children was deemed more important, though several speakers from small cities and rural states questioned whether this would be sufficient.

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Moderator Weech. We have already heard quite a bit of discussion on the question of facilities. We spoke on the first day of the opportunities offered in the newborn nursery in preparing the mother for some of the emotional problems which she will face. We have talked about the public ward and making free use of visiting hours and also about the importance of the outpatient department for contact with mother and child. We have heard, on the other hand, some brief mention of the possible dangers of setting up too large a mental health division, dangers arising from the fact that referring pediatricians are apt to say, "Refer to Mental Health," and then forget about the patient. It would almost seem that no extra facilities are needed, that there are dangers in having extra facilities, and that one should make use of what is present.

Dr. Jensen. There is one other thing that I think we ought to mention with respect to making better use of the facilities we have. So many times the pediatrician recognizes that maybe a mother would do a whole lot better if she had a chance to sit down and discuss her problems with someone. I don't know how it is in other cities, but in Minneapolis there is a society prepared to give just such service. When we, as physicians, become better acquainted with the already available services and agencies in our community, know what they do, and know how to use the services they have to offer, our work will be much easier. Instead of having people work for us, as it is traditionally expected that people will do for doctors, we will learn how to work with other people and how to encourage them to work with us. When we can establish that kind of relationship, our work will be a lot more pleasant and satisfying.

As regards the need for other facilities, probably only one is indicated as far as hospital care is concerned. Some provision should be made, probably in conjunction with the department of psychiatry, for an inpatient facility for children who have severe psychiatric difficulties. Scarcely a week goes by without our having at least four children on the adult psychiatric service—severe behavior problems, some with psychoses. If we could have an inpatient service in which the pediatrician and the psychiatrist could interest themselves in the dynamics and psychopathology of early childhood and adolescence, both would be enriched. For the more severely disturbed children this would have to be a separate ward. In our hospital we admit as many children with psychiatric problems as we can on the open pediatric ward—children with conversion hysteria and anxiety hysteria, children with somatic complaints without physical basis, children who are anxious and fearful—but the more severe disorders need a separate ward.

For instance, not long ago we had a twelve-year-old boy who since the age of four had set \$25,000 worth of fires. He had had innumerable homosexual experiences and an occasional heterosexual experience. He had killed four cats by choking them with his own hands just to see their eyes pop. He had run away from home and was unpopular in school and in the community. That kind of youngster cannot possibly be admitted to an open pediatric ward. Then, too, because we do some diagnostic work for the courts, we

need a place where we can be sure that youngsters who have a tendency to drift will not drift out of the hospital.

Miss Cockerill. I am especially interested in Dr. Jensen's comment that what we need to think about is not so much new facilities as the better use of existing ones. Being identified with social work, I cannot help but think of further and more intelligent use of the social service department. The social case worker in the hospital has a real contribution to make in helping mothers to accept hospitalization for their children and to participate in the hospitalization through maintaining a constructive relationship with the child.

Dr. Schade. The medical social worker can certainly come into play beautifully when one is confronted with a problem in an outpatient clinic. Many times a mother comes into the outpatient department not intending that her child shall be hospitalized or hoping that it will not be necessary. Sometimes in the physical work-up and preparation of the case the decision is reached that the child would be better studied by coming into the hospital. The mother receives the information with considerable shock—she is to be separated from her child. It is here that the medical social worker can take over, for if the doctor spent all his time dealing with such situations, he would see only one or two cases a day in an outpatient department.

Dr. Anderson. In regard to community facilities that might be used to improve pediatric and psychiatric functioning, I would like to emphasize the importance of an educational program within the hospital, both for the child who is in the subacute phase of his illness as well as for those in the chronic or long convalescent phase. From a psychological standpoint it was extremely impressive this spring to see a group of high school students on the convalescent ward with poliomyelitis achieve their grade along with the others. These children went back to school not with two defects—retardation in their grade and a physical incapacity—but with only the physical incapacity to adjust to. So I want to emphasize that a properly conducted and continuous expansion of educational programs within the hospital is a very healthy thing for the child who is in the subacute phases of illness and for the child who is going to be chronically ill.

Dr. Spock. By bringing teachers into your hospital you can also use them in staff conferences to educate the doctors and the nurses of the pediatric service about the educational aspect of children's lives. I think that instead of the usual type of ward rounds there should be substituted twice a week a staff conference, such as is held in good mental hospitals. There the psychiatrist, physiotherapist, occupational therapist, and the like could gather in the morning and, running quickly over the cases where nothing important has changed, concentrate on one or two cases—their background, what is happening at the present time, what the whole staff of the hospital should be aware of in their development, and plans for the future. A great deal more use could be made of such a technique in the pediatric hospital. This would be one way of dispensing with the solemn, threatening discussion that goes on at the foot of the patient's bed and putting it in a setting where the discussion can be better organized and more thorough.

Dr. Wegman. Speaking of schools, it has been suggested that there should be a nursery school in the outpatient department. We tried to use nursery schools for several years in New York, but we could not get nursery school teachers. We did find, however, a training school for nursery teachers which was delighted to send over girls in training at no cost to us for the mutual business of working with and learning more about children.

As for other facilities, with help from the pediatricians who are in medical schools, well-baby clinics within health departments can become meaningful in improving parent-child relationships. The Board of Health well-baby clinics spend more actual time with more children than we do in hospitals. The opportunities there for working with parents and with children are tremendous. When you realize that the public health nurse who sees the child in the well-baby clinic is the same one who gets into the home and can report back the reactions between mother and child in the clinic and the home, you become aware of the great potentiality in community facilities for achieving mental health ends.

Dr. Smyth. No matter what facilities are available, we cannot find in them—not even in the child guidance clinic—the entire answer. We have to get over the idea that the clinic is a dumping ground or solution and realize that it is overburdened already. We

have to stand upright and not lean so much on some convenient adjunctive development; we have to cultivate better attitudes ourselves and correct some of our teaching.

Dr. Jackson. I want to speak to the point that Dr. Smyth has raised. I feel very strongly that it is not *either/or* but *and*. At present in New Haven the clinic pediatricians are having to deal with practically all the problems that come to the pediatric outpatient clinic. We have psychiatric guidance; that is, the physician who is in charge of the community child guidance clinic comes over twice a week for conference and discussion of the cases that have been screened out by the pediatricians in the clinic as definitely needing more help than they can give. But now the situation is such that the pediatricians in the clinic are completely overwhelmed with the work that has to be done and feel unable to cope with the number and types of problems that come in. Attitude alone is not enough. We feel very strongly that we need a strengthening of a community facility to which these children who need long-time care and treatment can be referred.

Dr. Smyth. The local situation in a large metropolitan unit is one thing and the situation in, say, Utah is another. Are we going to emphasize that we cannot get along with the existing facilities? Shouldn't the emphasis be on attitudes as well as on facilities? I, too, fortunately have a child guidance clinic relationship, but I think that our discussion has pointed again to the fact that if we create or organize something and use it as a dumping ground and forget the importance of attitudes, we miss the boat.

Dr. Miller. In Kansas the items that you are discussing are rare, and that is, I think, the proper definition of a luxury. Kansas is not without a great deal of proper spirit and attitude toward all these problems, but it is without the substance. The University of Kansas lacks child psychiatry facilities, and this is true of most of the state. We have every possible link with the Menninger Clinic in Topeka. But the thing that concerns me is where Kansas is going to get these facilities and this substance.

This situation is not peculiar to Kansas. It must be true of a great segment of the population of this country. Dr. Senn tells me that he is training two pediatricians a year in child psychiatry. Dr. Kanner tells me that he is training six people a year, but four of

them come from foreign countries and will return there. Dr. Felix tells me that his program for the men that he is hoping to train is going to take a minimum of five years. So I see no hope for Kansas for a considerable period of time. I wonder whether this conference is cognizant of the fact that we in Kansas are starving and that probably a great many other segments of the country are likewise starving.

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Many illustrations were given of how attitudes and practices can be improved and how present facilities can be put to better use. Most of these illustrations had to do with handling children and their parents in a hospital (admission procedures, regulations about visiting, preparing children for operations, helping them to endure painful experiences, the conduct of ward rounds, and so forth), for most of the conference members spoke from such experience. These were meant as examples only, however, and they referred to the psychological principles described in more general terms in earlier sessions.

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Dr. Putnam. I would like to say something about hospital practices, especially as they affect the very young child. It seems to me that we have become so used to our routines that we have neglected to think about hospitalization in terms of the mother and the child. There is not time to go into a full discussion of what separation may mean, but I would like to emphasize what we can do about it.

In the Floating Hospital in Boston they have instituted a plan which is very simple but seems to me to have fundamental importance. The head nurse from the ward in which the child is to stay comes down to the admitting office and talks with the mother and child before there is any separation at all. She finds out from the mother what the child is accustomed to, what words he uses when he wants to eliminate, what he likes to eat. She directs the conversation in such a way that the child feels her interest and her kindness and her desire to understand him and to make him happy. Then she goes a step further and tries to establish certain links between the mother and the child, allows the child to bring in a toy,

suggests to the mother that perhaps Johnnie would like to have her leave her scarf or some article that belongs to her, suggests that Johnnie would like to have postal cards every day, and a few very simple things of that sort.

One of the most important aspects of this particular procedure is not simply that the child becomes acquainted with the nurse in the presence of the mother but that the child perceives a friendly relationship between the nurse and the mother. We have noticed at the Children's Center, where we have emotionally disturbed children, that (particularly in our two-year-old group) if a teacher feels antagonistic to a mother, the child cannot make a good relationship with that teacher.

Also, the practicing pediatrician or the hospital pediatrician should advise the mother on how to prepare her child for hospitalization. It is amazing how little pediatricians hear about the aftermath of hospitalization. But we psychiatrists get it. It has just not occurred to mothers to tell pediatricians that their children began to wet and soil after they came home, although they may not have done so in the hospital; that they began talking badly or wanting to be fed or were sometimes not able to sleep for months unless the mother was right beside the bed all the time. I know these are the exceptions but, as in all medicine, we have to direct our practice toward the child who may get diphtheria and the child who may have emotional disturbances, not toward those who do not have them. I believe that a great deal can be done that will contribute toward the mother-child relationship in general if we can help mothers to anticipate with their young children—two years old or perhaps even younger—what is going to happen in the hospital, to describe it in detail so that events don't come as overwhelming shocks to the child.

One reason pediatricians in hospitals have usually neglected this problem of the emotional trauma of separation, and of operations as well, is that the young child has an extraordinary capacity for repressing his emotions. We can see that on visiting days. If there is only one visiting day a week, the whole ward is screaming and crying on that day. So the tendency is to say: "Once in two weeks is enough. This is terrible. This is bad for the children. Why do the mothers upset their children this way? They are bad

mothers." Actually, this is the first time the child has dared to allow himself to know how bitterly disappointed he is in his mother, how angry and how terribly anxious he has been made by this experience. Since I have begun discussing this with nurses, they have brought me many stories in corroboration.

One such story was about a three-year-old girl whose mother was allowed to come every day because the child was on the danger list. This little girl was in a room by herself and she cried so hard when the mother left that the mother felt it was bad for the child to have her return. The nurse noticed that the little girl quietly cried and looked very depressed when she was left alone, but the minute anybody walked into the room, she spruced up and tried to blink away the tears and to deny the fact that she had been crying. The nurse realized that the child was trying to repress her feelings, so she got the mother to come in. The child's first reaction when the mother appeared was: "You get out of here. You go home!" Her fury just burst out. The mother was starting to go home but fortunately met the doctor in the corridor and he brought her back. Of course when the mother went at it a little slowly, the child was thankful to have her there.

When a mother cannot get to the hospital on visiting day, it is not uncommon for the child to make up stories to excuse her. When somebody walks into the room the child says, "You know my mother and my father could not come today because the automobile broke down," or "The bus didn't run today," making up a whole line of excuses because he cannot tolerate the idea that the hospital personnel should think that his mother and father would do such things to him.

In Boston most hospitals permit visiting only once or at the most twice a week, and visiting is regarded as something to be endured rather than as a possibly constructive experience. In contrast, the Boston City Hospital allows very free visits. But there they defeat their purpose because all the neighbors are allowed to come too, so the situation really becomes difficult. The Boston City Hospital nurses are quite convinced, however, that with very sick children and certain other groups of children it hastens the recovery to have the mother visit every day. I don't see how we can get around it. It seems inhuman that we don't stop to feel what it must mean to a

two-year-old child to be snatched away from his mother for the first time and put through the hospital procedure. We should maintain as close a link as possible between the child and the mother.

If it seems necessary not to have daily visiting—incidentally, I think there would be much less crying with daily visiting, though I have not tried it—I wonder whether we could not consider the possibility of using the mothers' assistance in the ward. If the nurse makes a friendly relationship with the mother, she will avoid all the carping, irrational criticisms that mothers make about the care of their children. If nurses feel it is their responsibility to understand the mothers, to make them comfortable, and to elicit their assistance instead of provoking their antagonism, we really might be able to achieve something.

Dr. Janeway. Dr. Putnam has put her finger on something that all of us charged with pediatric services are feeling very keenly. There are two problems involved. Is the construction of hospitals for children adequate, since most of them were built in an era which did not expect to bring mother and child together in the wards? The other one is that we have given a great deal of time and thought here to the education of the doctor in the field of psychiatry, when those who perhaps most need education and with whom education is going to be most effective are the nurses and people of that sort who deal with children on the hospital ward far more than the doctors do. Obviously, the doctors have to set the tone but I think that both the nursing profession and the school teaching profession have a certain emotional barrier that has to be overcome by education.

Another point I would like to bring up with regard to the use of facilities concerns the waiting room. Like most outpatient departments, our waiting room has always been a bedlam, with hundreds of children running around, screaming, and getting in each other's way. This year Dr. May, who is in charge, had the intelligent idea of bringing in a trained nursery school teacher and running a continuing nursery school in the waiting room. The contrast is remarkable. Why you can practically hear yourself talk without lifting your voice at all! The whole place is quiet and orderly. The nursery school teacher gives quite a little time to the instruction

of mothers, particularly with regard to the types of toys children of various ages should use and the way they can play. This is a very simple arrangement, but we have found it extremely effective.

Dr. Jensen. There are several things that we have learned to do which make matters move along a little more easily. When a child who has been coming to the outpatient department has to be admitted to the hospital, we have found that just such a simple thing as extending him an invitation to come to live with us a little while so we can get better acquainted with him helps a great deal and makes him feel a part of the whole process. Sometimes we get refusals. When we do and it is not an emergency, we say, "All right. You think it over for a little while." This was the case with one 250-pound fourteen-year-old girl. Six weeks later when the girl came in and we talked with her again—for things had not been going so well for her at home and among her companions—she said, "Yes, I would like to come." We had no difficulty whatsoever with her in the hospital after that.

After the child is on the ward there are a good many things we can do. We can recognize, as Dr. Putnam has suggested, that it is a rather traumatic experience for a child to be separated from all that is familiar and suddenly projected into a totally strange place. Recognizing that, we can encourage the nurses to try to pay a little extra attention to him. If we can encourage nurses to think of themselves as substitute mothers and if we regard ourselves as substitute fathers, both of us being warm and friendly, it also helps.

We try to pay attention to where the youngster should be placed in the ward, what group he should be with. We had a very interesting experience some years ago with a ten-year-old child who was with a group of five-year-old children and was acting like a five-year-old. She had some vague gastrointestinal disorder that might have been iliac disease and she was doing poorly. One day we decided to put her in with the ten-year-olds. The transformation was remarkable, and her stay in the hospital was quite markedly shortened as a result.

There is one thing that we should examine rather critically: the time-honored custom of ward rounds, when, as Dr. Kanner so nicely put it in one of his papers, a group of people clad in white suddenly descend on a helpless youngster lying in bed, and the

child hears a long recitation of his past history and his family history in terms way beyond his comprehension. There is a discussion of what the laboratory and physical findings are and what they mean, and then some unthinking person speaks up and asks about the prognosis. After a hasty discussion of that, they move on to the next bed, leaving a bewildered youngster wondering what is going to happen to him next. We had some rather bitter experiences until we began paying more attention to this. The old tradition of bedside teaching, no matter how we try to avoid it, still creeps back into the routine, and we have to remind ourselves constantly on our ward rounds, as well as on our grand rounds, that we can dispense with the patient's presence during the entire discussion.

I think there is something else we can do with respect to parents. Although it is not possible in every hospital to have parents visit every day, we can encourage them to call us and let us answer their questions from time to time. We have found that very helpful. In fact, recently we learned a great deal when the mother of one disturbing youngster, as a result of calling us day after day, said, "I have never been able to trust anybody in my life but now I can trust you."

Dr. Wegman. The iniquities of ward rounds and the harm they can do to a patient were thoroughly indoctrinated into me, but it is still difficult when you are actually out on the ward, even knowing all about the danger, to avoid it. However, the alternative also bothers me. You gather your whole group of white-coated people, bring your patient in, examine him with a few terse remarks perhaps about history, and then move away in dead silence and discuss his fate in the corner. I wonder if that is not presenting just as difficult a problem as talking right at the bedside, provided you can be sufficiently friendly to the child and make the situation as pleasant as possible.

Dr. Butler. We are all aware of the evils of ward rounds, but we ought not to stress the evils without also stressing the opportunities they afford for establishing nice relationships among house officers, medical students, and patients. I recall vividly one instance in connection with a patient with ulcerative colitis. The contact I established with that little fellow during formal ward rounds was such that I can remember everything about him. Out of that con-

tact we undertook an intensive psychological study of the emotional factors in the etiology and therapy of ulcerative colitis that has entirely revamped our treatment of ulcerative colitis at the Massachusetts General Hospital.

Dr. Vander Veer. Some of the most simple but telling examples of the extent to which a small child can repress traumatic experiences are to be found in two little books by Anna Freud and Dorothy Tiffany Burlingham, *War and Children* and *Infants without Families*.^{*} They show very clearly how a child can keep experiences of terrific import under cover and away from his own awareness for as long as one or two years.

We constantly see instances in which a mother has known that her child is going to be hospitalized or will probably be hospitalized, and yet has either concealed this fact from the child in advance—this is particularly so with young children—or else has told him that he was just coming to the clinic to be examined and would not remain in the hospital. The motives which lead mothers to behave in this deceitful way are various. There may be a residue of guilt about the child; the mother may be fearful of arousing the child's hostility toward her; or the action may spring from the delusion that the child should be spared anxiety for as long as possible. The mother also spares herself difficulty for as long as she possibly can, for she is afraid that the child will kick up a fuss at home or that he will be troublesome in coming to the hospital. Very often when a child comes to the clinic under these false assumptions we refuse to admit him, on the basis that the mother should keep her word to the child. We send him home with the statement that he must come back later and be hospitalized because hospitalization is necessary. This not only acts as a disciplinary measure for the mother but also relieves the child's anxiety and often makes it very easy for him to come into the hospital later.

One principle that we should all recognize is the fact that for all children—for adults, too, but particularly for small children—it is the unknown that is the most dangerous. It gives the child

^{*} Anna Freud and Dorothy Tiffany Burlingham: *War and Children*, Medical War Books, New York, 1943; and *Infants without Families*, International Universities Press, New York, 1944.

scope for the play and development of all sorts of anxieties and fantasies which are infinitely more dangerous than the reality.

The same principle applies in preparing a child for an operation. In the hospital we often find that a child who is going to be operated on does not know about it until the morning of operation or at most the night before. It is my feeling that children ought to be prepared several days in advance, that they ought to be told in detail what is going to be done and why, and that they ought to be allowed also to have time with the pediatrician or the surgeon or the nurse (whoever prepares them) to express their ideas about what they think is going to happen. If the child brings an unrealistic anxiety right out into the open and you confront him with the truth, your reassurance will carry much more weight than if you just tell him that nothing bad is going to happen or that he is going to have his tonsils taken out and they are located in the back of his throat, and so forth.

We see an error springing from the same motives in some of the medical students when they prepare to carry out painful procedures on a child. These are medical students who have learned a fair amount about how to handle children but have not learned quite enough. They know that three or four people should not sit on a child and one of them jab a big needle in his arm, because then the child will feel that he is being attacked. Therefore, they try to prepare the child for the vena puncture and to get him to submit to it voluntarily. The thing that they often don't understand is that even though a child recognizes the necessity for a vena puncture and consciously is willing to go through with it, he does not have the capacity to control his emotional reactions. Therefore, you may actually be doing the child a service if you hold him, if you supply the controlling strength that he cannot supply himself—provided you hold him in the right way, that is, with the feeling that you are supplying for him what he cannot supply for himself, not in the spirit of anger or irritation at him.

I remember very well I once went on the floor and found two medical students trying to draw blood from a six-year-old girl. They were being very kind and they felt very kindly toward her while they were trying to persuade her to go through with the procedure. Well, the child was getting more and more anxious. She

had a blood dyscrasia, so she had had lots of vena punctures before, and she knew very well that the vena puncture was important, that it was necessary, for the study of her disease. Nevertheless she kept complaining, "Why do you take the blood out of a little girl when you can get all of the blood you need from the big ones?" and so on and so forth. Finally, I could not restrain myself any longer, so I went over and said to her, "Now, look, you know as well as I do that you have to have the blood taken. Let me help you do it." I held her tightly, while the medical student stuck the needle in the vein and took out the blood. Then as he went out of the room I spoke to the child and said, "I should think that this would make you very mad at me or at the other doctors. That is perfectly all right, so why don't you tell me about it?" She said, "I am not mad at you. Thank you very much!" The child was grateful because I had supplied the restriction in the right way.

Then there is the question of how to handle a child whom you have to hurt—for instance, in dressing burns. I know how painful that can be. One ought to try to ease the physical pain as much as possible by sedatives in advance and then make the procedure as quick as possible and go through with it as seldom as possible. After each dressing one should give the child a few minutes to react (preferably to the person who has done the dressing, but if the child does not have the courage to do that, then to someone else on the floor with whom he feels in good emotional rapport) and express his feelings about what has been done to him. The ventilation of hostility about some procedure that the child has undergone often reduces anxiety and makes it possible for him to go through the same thing again with less difficulty.

Dr. Jensen. May I say just one word about operations? We frequently encounter this situation: A child is scheduled for operation, the parents are called in, and everything is all set. Then, because the operating room is very crowded or an operation takes longer than anticipated or the surgeons get rushed, there is a delay; sometimes not only a delay but a cancellation. We have had one youngster in our hospital who was prepared for an operation six times before it actually took place. It should be possible to get together with the surgical staff to see that when an operation is scheduled for a child it is followed through on time. Certainly it is one thing that we might encourage the surgeons to keep in mind.

With respect to the burn cases, we happen to have in our hospital at the present time a boy who has been there for three years. This boy had about three-quarters of his body burned and he has been a very difficult problem in management. After three months, the first three months, the surgical resident came to me one day and said that this boy was a behavior problem. I sat down with him and asked, "What do you mean?" "I can't do anything with him. He won't cooperate." I asked, "How old is the lad?" "Well, I don't know." "Where does he come from?" "I don't know." "What grade in school is he?" "I don't know." "How many are there in his family?" "I don't know." "What are his interests?" "I don't know." After three months all the boy represented to that physician was a burn. No wonder the kid was having difficulty. If we had had an opportunity to get acquainted with the lad, as he was getting acquainted with us, his course over the past three years would have been different.

Dr. Baty. Since Dr. Putnam has mentioned the Floating Hospital, I think I ought to outline some of the things that we have attempted to do to minimize the hospitalization experience for children. We realize that we cannot entirely prevent the emotional disturbance attendant upon hospitalization. Dr. Putnam has mentioned the interviews that our head nurses have in the admitting room. We attempt throughout the organization to have that same type of personal relationship, beginning with the information desk. The person who is at the front door of the hospital seems to us to be a very important person. We have had a great deal of trouble with families when that person happened to be one who was a little indiscrete or unsympathetic with people.

Our outpatient department set-up is like the one that Dr. Jane-way mentioned. For some twenty years we have been fortunate in having a similar type of arrangement in which the children participate in activities while they are waiting to be seen by the doctor. Sometimes it is difficult to get the children away and into the examining rooms.

Another very important experiment which we tried last year was setting up a modified play group or nursery school group in the hospital for the convalescent children who are in for study and who otherwise would be confined to their beds or cribs. We found

it made a great deal of difference to these children to be kept busy painting or doing various other types of nursery school work under the supervision of a trained worker. All these things are simply methods of using our existing facilities in order to minimize emotional trauma.

Dr. Kanner. I should like to introduce still another person into the consideration of the hospitalized child, and that is the outside physician who has treated the child and who will treat the child after he is discharged. Here we have a good opportunity, and perhaps the only opportunity, to transmit our interest in the child and our better understanding of the child to the outside practitioner.

Now I am going to speak about iatrogenic conditions, physician-determined problems, of which there are many. I remember one particular child who was full of iatrogenic problems. This was an only child of three, who had very fond, well-adjusted, normal parents. The family lived in the residential section of a small town, the child played happily on the grounds, and everything was all right. Then the father was asked to apply for a military commission, which he did. Before leaving he decided that it would be hard for his wife to keep up a large house, so with her consent but without consulting the child he rented a small apartment in another section of the town and shortly afterward he left.

Then something happened. The child had a cold, a grippe, whatever you want to call it. The doctor called it a touch of bronchopneumonia, and the child was in bed for about ten days. She got up and was well again. Two or three days later the mother met the doctor on Main Street, and he said, "Well, how is Janie?" The mother said, "Thank you, Doctor, Janie is all right."

"Well, what is her temperature?"

The mother said, "Well, Doctor, she is all right. I don't know."

Right then and there on Main Street in this small town, where everybody knows everybody else, and without lowering his voice, as a matter of fact raising it, the doctor asked, "What kind of mother are you if you are not interested enough to take your child's temperature so shortly after the child has recovered from a touch of bronchopneumonia?" He ordered her right then and

there to take the child's temperature rectally twice a day and to report to him if it was elevated. Furthermore, he also decided that Janie was an undernourished child. The mother said that she had always been a thin, wiry sort of child. Well, apparently the mother did not feed her enough, and he prescribed a very fattening diet right then and there, without charging for it.

The mother went home. All along she had thought she was a good mother and now she had received an authoritative statement that she was not. She went home and started taking the child's rectal temperature. While the child was sick she had submitted but now she began to resist and run away, with the mother running after her in an effort to carry out the doctor's orders. The temperature was not elevated, so the mother did not have to call the doctor. The process was continued, and the child had temper tantrums for the first time. The mother put the child on the rich, fattening diet. The child, who had never had any major feeding problems, at first refused the excess food, then began to refuse food altogether, and a battle developed. Finally, after about a year of this the child became such a feeding problem and also developed such constipation that she was sent to the Harriet Lane for a check-up.

The child came, was very pleasant, and ate well. Then I was called in and the mother told me the story. I talked with the child and after we got acquainted asked her to draw something for me. She drew a picture of two tents, her conception of a military camp, and then a man in uniform, saying, "He is a captain in the Army. He has a uniform just like my daddy." Then, looking at me, she added, "But he is not Daddy." (Emphasis through negation.) There was still space left, and she drew a little girl. "Where is the child's mother?" I asked. With the greatest contempt she replied, "Oh, she is at home."

Then things came out as to what had gone on within that child for a whole year, from the time her father had left. Before her father had left, everything had gone along very nicely. Then her mother, after her father's departure, began to do things to her which she had never done before—ran after her with thermometers posteriorly and forced her to eat. She had heard stories about Cinderella and Snow White and she developed the idea that her

mother was one of those witch mothers whom she had to resist in every way possible.

We got in touch with the doctor, and he responded beautifully. This was the first time he had heard of the ideas we are considering; he had been reared differently.

I could mention innumerable examples of the same sort. There are doctors who diagnose restlessness or a blinking tic in a child as St. Vitus' dance or a touch of St. Vitus' dance. These are iatrogenic conditions. Through hospitalized children we have a good opportunity to bring a better general orientation to such practitioners.

Dr. Rubin. Oftentimes in the writing of a child's ward diet we get into routine habits. I remember a child we had on Dr. Brennemann's clinic who had chronic colitis. She refused to eat anything at all. Her weight kept going down. One day on his rounds Dr. Brennemann asked her what she would like to eat. She said she liked ketchup. For the first meal she ate a bottle of ketchup. She did not eat ketchup every day; but from that time on she began to eat other things. We have children coming from homes where dietary habits are different from ours, and we put them all on a hospital diet which many of us don't like ourselves. Some discretion should be used in this matter.

Another thing I learned from Dr. Brennemann was the importance of having a mothering nurse in the hospital. Of course it is hard to get even a non-mothering nurse right now, but I think it is very valuable to have someone with that attitude in a children's hospital, where it is often necessary that one child be picked up or played with more than another. For example, we have a child at the hospital now who has a lye burn. We could not get at the nose and throat to try prophylactic measures, so we dilated the child's esophagus. The child was not in an acute condition at this point; it was simply a matter of starvation. The child refused to eat, even though there was an opening established in the esophagus. Actually it seemed as if the child did not want to live. We got the occupational therapist to mother the child and to play with him, and now we have a blooming child who is fighting to live. Sometimes the additional dose of one person makes a great difference in the outcome of a disease.

Moderator Weech. In Cincinnati we have an arrangement whereby a mother can stay overnight in her child's room at a charge of only a dollar a day extra. Many things of interest have come out of the plan, but I shall not say more than that we are better able to manage the problems of the patients and that the whole cause of medicine has been raised in the eyes of those who partake of this arrangement.

I might tell one story. A nine-year-old girl came to our hospital with a septic fever that had been running up to 106° or 107° every night for eleven weeks. She had a tremendous hepatosplenomegaly, and we had no idea what was wrong. Both parents came to stay with her and refused to leave her room at all, even for meals, although we did not serve meals to relatives in patients' rooms. When the nurse came to give insulin, which in our ignorance was all we could offer for the fever, they refused to let her give the injection.

At this point the executive of the hospital was called in to see what could be done. We started by asking the parents if they would leave the room for a few minutes while we talked with the child because the will to live might have something to do with her recovery. We did not get much from the child. Then we took the mother out alone and talked to her and found that she was convinced that the child was going to die. She felt that if the child died while she was out of the room, it would be unfair to ask her husband to break the news to her. Then we took the father out and found he had the same feeling in regard to his wife. Neither of them had mentioned this to the other one, however.

With this little bit of information, we went down and told the sad story to the diet kitchen. From then on the loveliest trays that one could imagine were served to the parents three times a day in the room. About thirty-six hours went by. Then the father came out and said that this was foolish, that they did not have to carry on in this fashion. We started working a little more with him. We got him interested in the wards of the hospital and the work that was being done for other children. He came in one day and said that he had decided to transfer the child to the public ward because he was just an obstructionist. I told him that we did not want that. He said, "You don't?" in complete surprise. I said, "No, we

want you here, because we want to be able to talk to you, and I think you would, perhaps, change your mind twenty-four hours from now." He said he had not thought of it that way but he supposed that he might change his mind. So the parents stayed on through trying circumstances, for purpura had begun to appear and finally the child died. (For those who are clinically interested, I will say that this girl had Letterer-Siwe's disease, and I don't know how we could have diagnosed it, for as far as I know there is no other case of that age in the literature.) The surprising thing to me was that a few weeks later the father wrote to both the head nurse on the ward and to me, saying in simple words, "You have revived our faith in your profession."

I have come to have a totally different view of the nuisance value of parents. It is grand to have them around. When they are neurotic and obstructive, it offers a real challenge to the physician and an opportunity to see what can be done. Also, a good bit of teaching can be done with the young men who are there to carry out a great many of the procedures.

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Discussion about research did not prove to be as fruitful as discussion of the previous topics, probably because so little has been done in this area. Nevertheless, some interesting suggestions in regard to topics to be studied were made, and some methods that might be followed were noted. For the most part, subject matter and method were discussed together, but some speakers emphasized one rather than the other. In the following condensation of what was said, the suggested topics for research and the methods considered appropriate to them will be presented first. The comments made with respect to general principles appear later.

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Dr. Spock. I was exaggerating when I insisted yesterday that very little is known about emotional development, but this is an area that needs serious research. So far, we have theories of emotional development which are true enough as far as they go. They do explain a lot of the pathology that the child psychiatrist sees. But from the vantage point of a pediatrician, I have the feeling that emotional development is a more highly patterned thing and much

more meaningful than any of the concepts that have been evolved up to this time.

For instance, in child psychiatry there is a tendency to think of anxiety as being much the same at different age periods. However, in pediatrics one can see that a child is the friend of all the world at the age of three months but leery of strangers at five months. He loses that sensitivity at eight, nine, or ten months of age and accepts a stranger fairly casually. At twelve or thirteen months he is acutely conscious of the potential danger of strangers and screams when the pediatrician approaches. (This has little to do with the previous immunizing shots he has had.) He yells bloody murder and tries as strenuously as he can to get to his mother.

Then as children near the age of two, there is an increasing frequency of "separation anxiety." Something is happening in the child's normal emotional development at the age of two that makes him peculiarly liable to alarm if his mother leaves him. He was not nearly as susceptible to that at the age of a year and a quarter, and he will not be as susceptible at the age of two and a half. Then at the three-year-old period come the more elaborate and morbid anxieties that seem so unrelated to the experiences that the child has had.

I have been amazed to find that nine out of ten cases of stuttering begin between two and three years of age, with a peak right in the middle of the third year. I don't think this is explained by any of the vague concepts about stuttering that we now have.

I feel that we must look at these common phenomena much more sharply, possibly using some of the microscopic observations that have been so effective in Gesell's studies of neuromuscular development, to find the meaning of normal emotional development at different age periods. We need this knowledge not only in order to handle problem children better but also to advise parents and pediatricians what to avoid at different age periods. From such research we will get better explanations of all emotional disturbances.

Dr. Washburn. There is one research problem in the growth and development field that is obvious: Is it true that the disturbances the psychiatrist sees in the young adult are dependent upon

early infancy? This problem is ideal for definite cooperative work between pediatrics and psychiatry.

The pediatricians are, after all, in a perfect position for observations in the early years, from the newborn period on. I see no reason why they should not get together with the psychiatrists and find out what kind of observations can be made and recorded through the early years that will eventually lead to some definite answer as to whether emotional difficulties and trauma really are causing emotional disturbances, neuroses, and what will you at later age periods. I am assuming that the important item here is for all of us to stress the need for careful follow-ups.

You don't have to have anything fancy in the way of a growth and development institute to carry out adequate follow-ups. In talking with a number of the conference members in off-hours, I have learned that there are plenty of people here who can talk in terms of ten- and fifteen-year follow-ups on individual children who have been their patients. If that is the case, then it seems to me that what is needed is for all of us to get together in our own centers and work out some definite schedules of the kind of observations we should make and keep track of.

The same thing is probably true in this field as in many others. When you start making careful observations and keeping a record of them, you may find that there are just as many children unharmed as harmed by early disturbing experiences, and you will have to look elsewhere for the difficulty. That certainly has been our experience with such things as the common cold. We used to think that a child who during infancy and early childhood had, say, as many as twelve upper respiratory tract infections in the course of a year with involvement of the sinuses and with the sinuses remaining involved pretty much through the winter months, was going to have chronic sinusitis as a young adult. I think we have succeeded in completely exploding that theory. By keeping careful observations it has been very simple to show that there is no connection between the incidence of chronic sinusitis of the young adult and upper respiratory infections in early childhood.

I see no reason why the very same type of procedure cannot be carried out with a lot of problems in the emotional realm. It is a matter of the psychiatrist and the pediatrician getting together in

different centers (I hope the procedure won't be standardized because I am sure we won't get very far that way) and each little group trying to figure out what kind of observations of infants and young children they want to make and then following up those infants and children as they grow. I think this also implies cooperation with the departments of internal medicine, for lots of the answers are not going to be obtained until we follow these individuals into young adult life—possibly some of you want to say follow them even beyond young adulthood.

Dr. Vander Veer. Dr. Spock mentioned one age period that should be studied. Another period that is very fruitful for study is adolescence. By joint observations of pediatrician and psychiatrist more may be learned about the relation between a disturbed endocrine system and a disturbed emotional life. Perhaps we can discover how the adolescent achieves eventual equilibrium, psychologically as well as physiologically.

This research can in many ways be carried out best in institutions. In this connection I would like to emphasize the lack of therapeutic institutional facilities for caring for disturbed adolescents who cannot be successfully cared for in foster homes and who often cannot be cared for in their own homes. I think that therapeutic institutions should be established throughout the country or that steps should be taken to revamp the present children's institutions in order to make their programs really therapeutic instead of custodial.

Dr. Jensen. There are two problems that pediatricians and psychiatrists might investigate together. One has to do with the child who is repeatedly admitted to a hospital. We suspect a relationship with emotional problems in such cases. If we could discover what factors may be important there, it would be a good step forward.

The second problem is that of the relative importance of psychological factors in certain disease conditions now regarded as organic whose etiology is as yet little understood. I think of such conditions as asthma, idiopathic epilepsy, and mild rheumatic fever. We have had several cases in the past few years of children who were frequently admitted to the hospital with the presumptive diagnosis of rheumatic fever and who, when studied from the

psychiatric point of view, were found to be living under very difficult circumstances. When attention was given to these circumstances, the children no longer had to come into the hospital but got along very well.

Dr. Zimmerman. I would like to suggest research into the nature of the relationship between ourselves as teachers and the pediatricians who are studying under us. What are the ways by which we as teachers can give interns more confidence in themselves in handling the emotions of others? The ritualistic practice of medicine, as I have been taught it and as I have seen it in offices, involves safeguarding, camouflaging, or putting up barriers against the emotions that people want to bring along with their illnesses into the doctor's office. There are ways to go about overcoming this approach. The social workers know some of them. (I fall back on the social worker because in my experience she is the only person who is given some training in handling emotions in the family.) In their literature there is an abundance of good, understandable language which shows the growth of individuals in handling emotional problems. If we can incorporate a similar approach into our medical teaching, we, as teachers, will begin to learn. I would like to see a body of data collected of the emotions of pediatric teachers in relation to the students who come under them. It would be a very revealing thing and a very educational thing, for both the teachers and the students.

Dr. Butler. Dr. Kanner said yesterday that we ought to try to transfer our direct objective clinical observation into scientific information. Shouldn't we, therefore, develop good, objective case histories, first in terms of etiology and then, as we proceed with our technique, maybe in terms of therapy?

Can we make objective clinical observations on the problem of parent-child relations in the hospital? Dr. Putnam mentioned one aspect of that relationship, that is, how nice it was to have the parents in the hospital when they were disturbed and when the child was disturbed by the hospitalization. But are we sure we are on the right track?

I would like to say one word about the type of research that we have been interested in. We have been doing a lot of work with adolescence, and we have found that you need a team to do re-

search when you are dealing with emotions. We have had to call in pediatricians, endocrinologists, psychiatrists, nutritionists, and now we are making a venture of collaborating very closely with gynecologists.

Dr. Wilson. I want to say something along the line of what Dr. Washburn talked about. I can think of nothing that we are discussing in this meeting that is as important as this question of research. What we do depends, of course, upon how thoroughly we believe in what we do. If little Mary's future emotional life is going to be seriously damaged by being bronchoscoped four or five times, we ought to go to great limits to see that she is anesthetized whenever that procedure is necessary. If a little baby is really going to have its future life influenced by being allowed to yell until the exact hour comes around to be fed, we should go to extreme limits to prevent that. If we can avoid emotional upsets by preventive measures, we have a way of changing our whole civilization. We are not thoroughly enough convinced of these things, however, to go the limit to avoid them (or to investigate them for our conviction). This research is so important that we must take steps to raise all the money and use all the facilities necessary to do it properly. I doubt, however, if some of these studies can ever be done properly in one section alone or in one university alone. Several resources are probably necessary to tackle some of these problems that involve so many variants—the family's emotional reaction, the genetic background, the economic background, and so forth.

Perhaps I can think a bit more clearly about this if I cite a question which has concerned most of us: the influence of maternal nutrition on infant health and on congenital abnormalities. How tremendously important that problem is. Many studies have been made about it and they have been expensive studies, but it seems to me that every one of them has failed. The nutritionists who were involved are confirmed in the opinion that they had before the studies were undertaken. Those who were a little skeptical are still skeptical. The studies were not intensive enough, they did not involve good controls, and neither heredity nor environment was considered in most of them.

If we here have any influence, it seems to me that we ought to urge and to help organize some extensive and expensive long-time

follow-up studies. In our present state of knowledge, this means nothing but exact recorded observations, such as those which Dr. Washburn by his excellent example has taught everybody to do.

Dr. Murray. Consider the nature of the psychiatric problem from the standpoint of research. We psychiatrists deal with material that is essentially subjective experience. In this connection I would refer you to an article by Phillippe LeCorbeilleure that was published in the December 1946 issue of *The Atlantic Monthly*, entitled "Stars, Atoms, and Proteins." The thesis is Auguste Comte's idea of the hierarchy of the sciences, which maintains that verification in each science depends upon the increasing perfection of the science in the next higher echelon.

First, says LeCorbeilleure (who, by the way, is a highly rarefied mathematician and physicist), the mother of all science on the top echelon is mathematics. That is the exact science, the predictable science. Under this in the next echelon are physics and chemistry, the natural sciences. The development of chemistry and physics depends largely upon the perfection of mathematics, the next higher echelon. Underneath physics and chemistry in the next lower echelon come the biological sciences, which in turn in their exactness depend upon the perfection of physics and chemistry. Below the biological sciences, we come upon the social sciences, psychology, psychiatry, criminology—all those sciences which deal with human behavior and human motivation.

LeCorbeilleure makes a very nice plea for tolerance for the psychiatrists who, he says, are sincere, serious, hard-working individuals, and generally trustworthy. (I think so too.) As psychiatrists, we must make a plea to you to recognize the inherent difficulties of our problem.

The psychiatrist deals essentially with distortion, a distortion which inner instinctual stimuli undergo before we see the end product of what the frontal lobe is doing in its function of adjustment. The distortions which we observe are much harder to see correctly than those in the natural sciences. It is much harder to apply, as LeCorbeilleure says, the strict scientific requirements of careful precision to them. I am very much interested in the work that is being done by the Dartmouth Institute in an exact evaluation of the distortion which ocular stimuli undergo as they are

translated from the pure stimulus of vision into the apperception of exactly what is being seen. I have high hopes that out of this work will come a good meeting ground, for what we psychiatrists have to demonstrate to you are the distortions which the instinctual tension stimulus undergoes before it is finally expressed in terms of action with an aim and an object in the outside world.

Dr. Janeway. Dr. Murray makes a plea for tolerance for the psychiatrist because his material is subjective. That degree of difference is quantitative, not qualitative. Every piece of medical research involves subjective factors. For instance, there are few diseases that are 100 per cent fatal. The introduction of a therapeutic agent which reduces mortality to 20 per cent presents us with a clear-cut answer; but the majority of the problems we try to solve in medicine require the subjective evaluation of subjective impressions of a great many people, so I don't think that subjectivity is an excuse for getting away from the scientific method.

The method that has been successful in science begins with a definition of the problem. You cannot set out to solve every problem at once. Frequently social research workers try to do just that. Such an approach does not justify a huge expenditure.

The second point is that some problems have to be attacked in one way, while others have to be attacked in another. Certain problems are short range; you can define your objective quite clearly and try to set up a mechanism for attaining it. The method is as applicable to the problems of mental hygiene as it is to the problems of chemistry and immunology. On the other hand, you may have an entirely different type of objective, which Dr. Washburn has hinted at and which he has carried forth in his own work: that of setting out to describe long-range processes about which we do not have adequate information. In setting up such a project Dr. Washburn has tried to think of as many things ahead of time as possible, things that ought to be done to yield important information later on. He has alluded to the fact that one method is to consider the end result, find out the problems there, and then go back into your study and get the information which can be applied to those problems. That is an effort to define a problem.

. One problem is that a lot of people go off the trolley in adoles-

cence and young adulthood and fall into the hands of psychiatrists. On the basis of sheer clinical description, the psychiatrists have acquired certain ideas about the mechanism behind the formation of these symptoms. As Dr. Wilson has pointed out, their only proof is that the mechanism seems to provide a rational explanation. It is time to go back into Dr. Washburn's study and other similar studies to try to get information based upon the data of a whole series of normal people. This is going to require a large, expensive set-up, but it will be directed toward a clear-cut objective. You can acquire information as you go along which may later yield very valuable points, as Dr. Washburn has pointed out. In other words, you are employing what amounts to a combination of statistics and description to get at different types of problems.

The essence of the scientific method lies in controls. Controls do not seem impossible in this type of research. The degree to which you can get controls is going to determine the degree to which you are going to get valid information. Dr. Butler has made a plea for the better recording of objective data about individual cases. There your control is your past experience with cases of a similar type. If enough of that past experience is available along with enough of this new experience in dealing with disease through a study of emotional and therapeutic factors, I think we can come to certain conclusions about disease.

Those of us who are concerned with hospital pediatrics are, as Dr. Butler has pointed out again and again, essentially concerned with better patient care. That is the main objective of clinical research and its main motivation. We mentioned this morning all types of hospital practice, and the point was made again and again that in our hospitals we used to do that but now we do this and everything is better than it was. Well, that is like saying that we used to treat pneumonia with serum and now we treat it with sulfadiazine; the mortality was 15 per cent, now it is 9 per cent. In the meantime, however, the pneumococcus may have gotten less virulent or become less frequent in the community or a great many changes may have resulted from this over-all adoption of a new method of therapy.

Dr. Montgomery is the first person who has started to use controls in clinical work. He is setting up on one side of his nursery a

group of people who are being handled in one way, and he is going to contrast them with a group of people being handled another way. There is, however, a slight fallacy in this, as he himself pointed out: the group he is putting into one type of regimen consists of people who want to go into that type of regimen.

We ought to try—certainly those of us who are interested in changes in hospital practice—to do some of these things on a really controlled basis. The minute we do so, however, we change a great many other factors. Let us say that I give up the “no visitors” rule in our isolation ward, and next week we begin to allow visitors to come in freely. In order to do that, I have to re-educate doctors, nurses, the man scrubbing the floor, the person at the front desk, and so forth. Every bit of hospital procedure has to be changed. I have made the hospital a much more human institution than it was.

The only way we can get data that are really worth while regarding this matter of simple hospital care is to take two wards with the same personnel, instruct the whole group in this procedure, and then continue one practice in one ward and another practice in the other ward. Of course you have to have money and people for follow-up to see what happens, but it is an eminently worth-while expenditure. We are not going to change the practice in pediatric hospitals to a more rational way of handling children unless we make an attempt to do this sort of thing wherever it is possible. When this is done, we shall have data which people like Dr. Wilson will accept with a great deal more pleasure than they do now.

Moderator Weech. Studies such as are going on in Denver and in a few other places are among the most valuable contributions to this field. These experiments, however, are expensive, and very few of the small organizations undertaking research over the country as a whole can hope to set up as forward-looking, as long-reaching, and as elaborate studies as these. Nevertheless, even for smaller studies I should like to express the opinion that what I shall call, not research, but the scientific method, applies, as in all other fundamental sciences. I define that as follows.

1. Research begins with curiosity. Without curiosity there is no problem.
2. It begins with the formulation of a hypothesis.

3. It consists—and this step is often forgotten—in contemplation of the significance of the hypothesis and its logical corollaries if the hypothesis should be true. The hypothesis is often discarded at this stage, and the research so far costs no money.
4. One examines such corollaries as can be examined by scientific experiment and observation. If one finds that the direction of reasoning was wrong, a new hypothesis is formulated as a result of the experimentation, provided curiosity is still active, and the process is continued.

I believe that in our field, as in all others, the dollar cost of the item of new information will be less if the scientific method is followed than if one just goes ahead saying, "Let's see what children do."

SESSION VI

Summary of the discussion

THE sixth session of the conference was largely devoted to a résumé of the previous sessions. Committees had been appointed by the moderator, Dr. Charles A. Janeway, to sum up what had been discussed, and their chairman made brief reports to that effect. The conference came to a close with the following comments from representatives of the two professions in addition to pediatrics—psychiatry and social case work.

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Miss Towle. I am speaking for my colleagues on the place of social case work in pediatrics. We are here in pediatrics to contribute to effective pediatric service. We are termed one of your facilities. We are termed an adjunctive service. As social case workers, we don't care what you call us; social case workers would have a very hard life if they cared about that. But I do want you to know that it is as we have become an integral part of your services that we have made the contribution which we have to offer. We fail to fulfill our function adequately when we are adjunctive in the sense of being an appendage.

What is effective pediatric service? You have made very vivid to us in these meetings the fact that it is the practice of pediatrics permeated with an understanding of human behavior, the practice of pediatrics interfused with social insight.

I have been very much interested in your term "pediatric psychiatry." I, personally, prefer to think of it as good, sound, modern pediatrics, because according to my lights the modern pediatrician, like the modern case worker, is a psychologically oriented pediatrician. We have been thrilled throughout this conference at the headway made in integrating psychiatry into pediatrics in such

matters as ward rounds, putting the baby at the mother's bedside, making visiting hours flexible, preparing the child for hospitalization, helping the parent accept hospitalization, considering the feelings of the child through operative procedures, and in innumerable other ways which have been mentioned throughout this conference. I cannot help but feel that you, as pediatricians, are doing something that we often have to call to the attention of social case workers: that while they may not be practicing psychotherapy *per se*, they are using psychotherapeutic methods.

Why are we so thrilled about this? Perhaps we think of it in terms of the gains to us. To us it means that sound social case work can at last be practiced in a pediatric setting. In the past you did not have this nice understanding of human behavior and social insight and much of the social case worker's time was spent in easing the anxiety of a mother who could not visit her child or in easing the resentment of a mother who felt herself misunderstood, even attacked by the physician. Or we were assigned a child who was emotionally disturbed and visited him on a ward where the nurses were witches, at least as far as the feelings of the child were concerned, and sometimes the feelings of the social worker also. In these instances it was impossible to work effectively with the child because the nurse had a negative relationship with the social worker, just as she did with the mother. Hence the child, who had to spend all his hours with the nurse, could not get much security out of contact with the social worker when the nurse got upset every time the social worker appeared on the ward.

Your present concepts of pediatric practice clear the decks for social case workers to contribute to and to carry forward the sound work of pediatricians rather than to make amends for deficiencies in the service.

What has the social case worker to offer today now that pediatrics is incorporating an understanding of behavior and social insight, now that it is incorporating psychiatric concepts and good social case work into its practice? It might almost seem that you have taken over our job, but you have not. There is still a large area of activity in the pediatric hospital or outpatient clinic and in the education of interns, physicians, and pediatricians. We are assuming that social case work in a teaching center has a responsi-

bility in the total teaching program, and whatever contribution we make to service goes hand in hand with our educational contribution.

You, yourselves, have emphasized that you are treating the total individual in the context of his environment rather than merely treating a disease within a hospital. You recognize that you cannot cut the patient off from his environment. The social worker is the liaison person between the hospital and the family and the community. She can bring, first of all, firsthand knowledge of the facts of family life and, second, an understanding of the interplay of family relationships.

A good bit of mention has been made of the importance of keeping the family in the picture. There has been a good bit of comment too upon the pediatrician's tendency to become identified with the child and to exclude the parents, an identification which you are recognizing and which you are handling to a large extent. It seems to us, however, that almost inevitably, perhaps inescapably, the pediatrician is primarily identified with the child. Therefore, the social worker's contacts with the family can help the pediatrician to keep the family in the foreground and to work with the child with an understanding of the child's relationship to others.

Social workers are used to getting facts about family life. The adequately trained social case worker of today has a capacity for a dynamic kind of history-taking in which we do not merely extract a lot of facts from people for the doctor's use; we are beginning to establish a good working relationship between the family and the hospital, a good working relationship between community resources and the hospital. Suppose your patient has been referred by a social agency: The social worker within the hospital will get considerable information from that agency, and she will also begin to establish a good working relationship between the agency and the hospital, as against the day when the child returns to the community.

The social worker can help to solve practical problems which are interfering with the use of the medical service. Very often it is the social worker who has the skill and the time—or it certainly is her responsibility to take the time—to sit down with the mother

who is thrown into a panic when she learns that her child must be hospitalized. I think we can well understand that the pediatrician would only get two cases handled a day if he sat down and saw the mother through that panic. The social worker can well spend the time. This is the role she often plays in a hospital, that of helping the mother to accept the medical regimen. Certainly it is the social worker who often can help the parent who resists medical recommendations of one sort or another. Social workers traditionally have dealt with people overburdened by adverse circumstance; hence they bring understanding and skill to the task of helping people to face threatening realities.

The social worker presumably brings a knowledge of community resources, and she should offer help in the use of them. It is often the social worker in the hospital who must interpret a patient's special needs to the school and the like. It is the social worker who can help the physician by making known to him not only a community resource but what it has to offer and what it does not have to offer. One of the big areas of responsibility of the social worker is that of making the community useful to the outpatient clinic or the hospital and helping to maintain that relationship.

All this might be summarized with the comment that the social case worker enters the case at the point of a social problem; the physician enters it at the point of a medical problem; and the two, as you here so well recognize, are frequently related. As the social case worker sets out to solve the social problem, she brings in all that she learns in order to enlighten the medical problem, and she may also bring in resources for the solution of either or both, or at least for a partial solution of the medical problem. So I think we might say that the social case worker makes it possible for the pediatrician to recapture the sense of being the understanding family physician of the horse-and-buggy days, for which you are all obviously a bit nostalgic. We, as social case workers, like to think that we add something more. I hope that I have indicated some of the resources available to you through social service which were not available to the horse-and-buggy doctor.

As to the social case worker's part in medical education, I shall

speaking very briefly. I know it has been a practice in some settings for the social workers to have some formal teaching sessions with the medical group and in these teaching sessions to deal with the social components of illness or to acquaint the physician with what social work within the hospital and the community has to offer. Another part of the content may be how to use the social service department productively. There is a place for those formal teaching sessions, but we feel that our biggest contribution in education has not come through those formal sessions, but through the natural teaching opportunities which arise hour by hour in the course of a day's work when the intern turns to a social worker for help.

It is as the medical people bring to us practical social problems for which they want help that we can expect the adequately trained social worker to apply her teaching experience. In the field of social case work we have had a long experience in tutorial supervision—teaching the individual around specific situations as they arise. Social case workers were supervised that way. First of all, we begin where the learner is and we explore his ideas regarding the solution of a problem; we explore with him what he has actually done to solve the problem and try to enable him to discover for himself what he might have done in relation to what he did. We affirm whatever he brings that is useful, we supplement it as we can out of our experience, we differ in so far as is necessary for sound handling of the social situation.

Another aspect of the learning problems with which we are well acquainted in regard to social case workers is that point at which students are first becoming aware, and sometimes only dimly aware, that they are meeting their own needs rather than the needs of the other individual; when they are first becoming uncomfortable about their own discomfort in situations. It is our practice to try to help the social case worker to identify that learning problem, become conscious of it, to see it as his or her emotion entering into this situation. We appreciate that sometimes we must move very slowly in helping students to see this, but we try to help them see it as soon as possible so that they may begin the practice of dealing with their own feelings in the situation.

Dr. Allen. This conference has been a momentous one in many ways. A number of years ago it is very doubtful if we could have had the kind of professional collaboration that has characterized the discussion of these three days. We might almost say that we have here today the evidence of our own maturity, since we have been able to come together on the common ground of our interest in the growth and development of the child, the common denominator of our own professional concern. While we probably could go farther in getting a clearer understanding of the important differences in the way in which our professional techniques function, we have at least laid an important groundwork for the achievement of that understanding.

I think that we psychiatrists at this meeting feel that we have arrived at an important place of sharing. Too many times a psychiatrist comes into a meeting of this type with the feeling that he has to sell a bill of goods and he sometimes gets himself locked up in terminological confusions which make it necessary for him to resell the bill at the next meeting. Such has not been the case at this meeting. We have met on a high plane of respect for one another's professional accomplishments. Psychiatry is no longer looked upon with suspicion, with a feeling that it represents something mysterious. It has been found to be a professional discipline that does not have to be obscured by weighty, non-understandable words.

We have accomplished in this meeting a kind of collaboration that gives each of the professional disciplines represented here a better appreciation of the contributions which the others have to make. For the past three days we have been talking about how persons from different professions—pediatricians, psychiatrists, social workers, nurses, and psychologists—can integrate their skills into a service that is helpful to parents and children. Such integration does not just happen. Too frequently, however, expediency determines the way in which these various professional groups work together on a collaborative basis. This is really a matter for research—research into clinical method, into the collaborative method; research that grows out of the working together of people who have responsible jobs in this highly important field of helping parents and children.

It might be a fascinating research problem for some of our pediatric centers to undertake the job of seeing how they can work out effective ways of pooling and integrating the various professional endeavors—not for the pediatrician or psychiatrist to determine what the job of the social worker shall be, but to develop a process that is determined together out of clinical day-to-day experience. In child guidance clinics this has been an area of research that goes to the very heart of the clinical method. If this research could be consciously planned and carried out, other areas of research would be effectively advanced. In this area of behavior we are dealing with human material, material that carries within itself the capacity for change. It is only as we are engaged in the helping process that we begin to understand the universal phenomena of change, of growth, of where anxiety begins to develop in a child, of where the parents fit into the picture.

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In brief, the experience of those present at the conference seemed to indicate that pediatricians became reasonably comfortable in dealing with the physical phases of growth and development quite a long time ago. They are much less comfortable in dealing with the emotional phases of growth and development, but they have perhaps gone far enough in that direction so that they will never be comfortable again until they can deal with total growth and development.

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 ¹⁹¹⁴1911 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.