sulting room with the social worker, the mother and father, and perhaps the child, and one got a delightful " slanging match " in which one got on to a great deal which helped in subsequent procedures.

In conclusion, although he might have used the word " deprecate " in referring to the case conference, he wished to emphasize the meaning he attached to the case conference. It was not the actual situation ; it was a description of it removed from actuality, but it was valuable and helped the team to work together. The team must work together and explain to one another what they had discovered, but the true cross-section was lower down, not in this somewhat exalted conception of the case conference.

The PRESIDENT proposed a vote of thanks to Major Miller for his paper, which was accorded by applause.

PAPER.—" Technique," by KATHLEEN M. TODD, M.B., D.P.M.

PAPER.—" The Future of Child Psychiatry," by MARGARET M. METHVEN, M.A., M.B., D.P.M.

I feel I ought to start by apologizing for my temerity in reading this paper after the two experts whom we have heard to-day, but as I have been rather closely connected with starting two clinics under two different local authorities, I have had the administrative problems and the difficulties in starting clinics brought very closely to my mind, and I feel strongly that the time has come when psychiatrists should clear their own minds, and be prepared to give an expression of their opinions on this controversial subject.

Local authorities, on the whole, are aware of the need for child guidance clinics, but they are only vaguely aware of the functions of such clinics ; they are not at all aware of the fundamental nature of the problems involved, and therefore they are not aware of the qualifications which those undertaking the work should hold. The one consideration ever present in their minds is finance, and in our proposals to them it is essential that we bear this in mind, and at least give the impression of being economical. If we ask them to employ the more highly-paid psychiatrist and not only the less highly-paid psychologist, we must be able and willing to prove that the community will not in the long run be the loser. It is time we made our views on this subject clear to local authorities in general, and I think this Association should take the lead. I am not going to attempt to give a detailed account of my own views on the subject, but I would like to stimulate some discussion. I do not propose to say very much on the question of the relative position and spheres of action of psychologists and psychiatrists because this was discussed very fully in the Child Psychiatry Sub-Committee yesterday. As a result of that meeting, we hope eventually to put a draft circular to the Council for its approval, prior to wide circulation—a circular which will emphasize that we believe that the problem is fundamentally a medical one, i.e. one of health and not of education, but it would take too long to enter upon this topic to-day. I think, of course, that a very great deal of the difficulties and trouble have come from the lack of adequate training and selection of personnel. Training must always be regarded as the corner-stone upon which all proposals should be built. Of the original team of psychiatric social worker, psychologist and psychiatrist, the social workers alone have a recognized training and are selected on a personality basis. The psychologists have now formed a professional association, and are striving to obtain some uniformity and a basic standard of training. But we are still tending to leave our training rather in the air, and I think it is time that we did express more definite views on that subject. I am sure this lack of adequate training and the number of psychiatrists practising without any real training at all are the chief factors contributing to the attitude of so many Educational Psychologists—that attitude which relegates the psychiatrist to the small back room, there to deal with the cases of poor prognosis which would otherwise waste the time and/or lessen the prestige of the lay psychologist.

How many of us have an inadequate knowledge of the normal in the behaviour of children ? How many Superintendents of mental hospitals who have never dealt with an adult out-patient are willing to diagnose and treat an emotionally disturbed child ? How many physicians with no psycho-pathological background will diagnose a potential schizophrenic ? (And, to leave our profession for a minute,

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how many psychologists attribute mental disorder to endocrine imbalance and ask us to prescribe for it ?) Obviously, as a profession, we must clear our minds on the question of training, and demand that those who profess to practise in this speciality should first have had this training. As to the details, I hope those better qualified to speak than I will do so in the discussion, or that eventually it may even be possible to devote a whole session to this one topic.

When we come to the question of the auspices under which the Child Guidance Clinics should be run, there are many possibilities to consider. At present they are attached to children's hospitals, mental hospitals, education authorities, and voluntary bodies. Everyone here will probably accept the view that we should be part of the mental health service, attached to the adult mental health services. I would like to point out that this does not mean that our clinics in the future will have no connection with children's hospitals. On the contrary, they will probably have a very close connection, even as the adult clinics will be working in conjunction with the general hospitals. Even although we feel we should belong to the general mental health service, we are not trying to form a schism between ourselves and the children's hospitals. Nor does it mean that the clinics will not retain a close connection with the Education Authority, but they will have a wider scope than if they were run by that body. As for the future of the voluntary clinics, it will presumably be the same as that of the voluntary general and children's hospitals.

Before going on to the scope of our work, I would briefly touch on the question of in-patient accommodation. I do not need to stress this point as I am sure that everyone in this audience is clamouring for residential accommodation. We are all aware of the need for some place, which I would sooner call a hospital than a hostel, for short-term cases requiring intensive therapy, and I think we all want accommodation for the longer term case in a specialized type of school. I think we all feel, too, the need for hostels for our adolescent delinquents from which they will be able to go out to their first jobs when there is something wrong with their homes, so that they have some security and background.

To return now to the scope of the work, I said that if we were under the Education Authority we were restricted in our scope, and that is particularly so in regard to age limits. There are numerous administrative difficulties (chiefly financial), over the treatment of the pre-school and the post-school child—both age-groups which can be very greatly helped, and whose problems have even more urgency than in the child of school age. So urgent are their problems and, in the bulk of cases, so amenable to treatment, that I believe the emphasis in our work should be placed on just such age-groups. In the case of the post-school-age adolescent, adjusting to the change from school to holding down a job as well as to the multiple metabolic changes and general endocrine imbalance associated with puberty, there can be no doubt about the urgency of any problems presented—especially when we remember that this young person may, in a comparatively few years' time, have married and become a parent and be promoting difficulties in the emotional lives of the next generation. But a more immediate danger is that, unhelped, the problem adolescent may altogether miss the way which leads to good citizenship, and although (in the Golden Age we all envisage) a life of delinquencies will eventually bring him psychiatric help, we all know how often we have to say those most tragic words, " Too late, too late." And when we consider the problems of the under-fives and remember the dictum, " Every neurosis has its origin in a feeling of loss of love in the first five years of life," surely we must be ready to devote a large portion of our time and energy to trying to remedy the state of affairs which has led to the appearance of any behaviour problem. And it is in this sphere particularly that the Psychiatric Social Worker comes into her own. I would be the last to minimize the extent of her help with any age-group, but with the under-fives—or should I say the parents of the under-fives—she is of paramount importance.

To digress again, I am still frequently amazed to meet psychiatrists who know nothing of the excellent work which these women carry out—who know nothing of their intensive and careful training, on top of experience in various branches of general social work—who, in short, know nothing of the help they can obtain in all branches of psychiatry if they are fortunate enough to have a psychiatric social worker on their staff. Unfortunately, the number of psychiatric social workers is very limited and vacancies are very numerous, but I am sure that in children's clinics in the future we shall aim at a ratio of psychiatric social workers to psychia-

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trists of something like 3 to 1. To return to the problems of the under-fives, surely we ought to be available in the Maternity and Child Welfare Centres, so that the mother who has struggled up there with her problem child can be seen on the spot, and need not be asked to take a possibly needless journey to a possibly distant Child Guidance Clinic. Of course the physicians in the Maternity and Child Welfare Clinics must be educated—(I wonder if in the future we shall have any Child Psychiatry included in the examination for the Diploma in Child Health ?)—as must also the Health Visitors, but even when this has been done there will be need for a psychiatrist actually present in the clinic. It is heartening to find so much interest among Health Visitors in the development of character and emotions in childhood, and if we can stimulate and satisfy this interest, we may go a long way in our prophylactic measures. It seems to me tragic that the well-meaning, intelligent mother of the problem child of 7 or 10 or 12 should so often say, " If only I had known when he was a baby . . ." For it is the best-meaning mothers who unwittingly do the greatest damage, and their very anxiety to undo it sets up still more problems during treatment. Surely then we must make our knowledge of the mental development of the child available to parents from the earliest age. I therefore welcome the inclusion of a lecture by a Child Psychatrist in every course of Mothercraft given to the A.T.S. or other organizations of young women. I would like, too, to see a psychiatrist attending ante-natal clinics, helping prospective mothers to deal with their own emotional problems before the child has been born. How often in taking a case-history have we all come across the unhappy mother who has viewed the arrival of her baby with misgivings, if not repulsion, and has had no help in dealing with this state of mind until the child has become a problem ?

Another sphere in which we should do more is in relation to the children left in War-time Nurseries, babies from six months to five years old. They are left there from 7 in the morning until 7 at night, and in some cases over-night when the mother is on night duty. The children do not know where they are, in any sense. I do not know how we can expect these babies, who are sharing the attentions of one probationer nurse with a number of other children, who are learning to know only a work-weary and anxious mother, and who have no one absolute authority to which to turn for guidance, to attain emotional stability as they grow up. As we must have these nurseries under existing circumstances, surely we must do all we can to show the matrons and staffs the difficulties and the important nature of the task they are undertaking. We hear so much of the physical good which accrues to the children attending nurseries, and of the desire of the general population that these nurseries should be perpetuated, that it is high time the psychiatrist expressed his views on the subject. The number of children coming to clinics for treatment is already so great that it is impossible with existing supplies of trained personnel to do more than attain a most superficial adjustment in the bulk of cases, and on that ground alone we ought to be shifting the emphasis from treatment to prophylaxis, and how is that to be done if we neglect the psychiatric aspect of the health of the under-fives ?

Prophylaxis.—Prophylactic measures must necessarily first mean education—education of all those dealing with the young : doctors, health visitors, nursery matrons and staff, youth leaders and other social workers—not forgetting magistrates—and not being presumptuous enough to include teachers. And as part of our prophylactic efforts, should we not be taking an active part in discussions on the housing schemes of the future ? What is the use of a space for a pram if there is no space in which the occupant of the pram can play ? What is the good of a well-equipped playroom in a clinic if there is no room at all in the home ?

In the future we must, along with all other branches of medicine, concentrate on prophylaxis, and to do this we may have to take time off individual clinical treatment to give advice wherever and whenever it is needed—in the ante-natal clinics, maternity and child welfare centres, nurseries and youth clubs. I do not believe that much real damage is ever done during school days and school hours—already existing problems may be (and often are) lit up and exaggerated, but none are directly attributable to the educational régime. I believe, therefore, that advancement of educational methods and adaptation of school routine to particular children is much more the province of the educational psychologist than of the psychiatrist. But the problem of the adaptation of the developing individual to

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society in general and the family in particular is essentially our province (aided by the psychiatric social workers), and we cannot too widely make our influence felt in this direction.

The public (lay and medical) still regard many psychiatrists with suspicion, e.g. it is amazing how many doctors still prefer to remove apparently healthy tonsils rather than refer the child to a psychiatrist for help with nightmares. Until we come out of the seclusion of our hospitals and clinics and talk in simple language and show that our chief stock-in-trade is common sense, this feeling is bound to continue.

I hope we shall see the children's clinics of the future linked with the adult clinics, the children's hospitals and the public health services generally—staffed by adequately trained and sanely-orientated men and women—and dealing as much with the preventive as the curative side of mental health.

Discussion.

Dr. Caplan asked Dr. Methven where she expected to find all the psychiatrists who would be needed to supply all the clinics in all the places where she hoped to have them.

Dr. E. S. Stern said that he had never listened to two papers with more enjoyment or instruction. There were one or two minor points which he wished to raise. He noticed that Dr. Todd did a good deal of interpretation to the child. He always felt that it was very dangerous to do this because the interpretation was always bound to have a subjective element in it, and he was not convinced that either child or adult did any better if one did interpret. The other point was a small one. The situation in the wartime nurseries was sometimes unfavourable. He knew of one run by two nurses who had rather an unhealthy attachment to each other, and one of whom had a very long and bad psychiatric history, and was at present in a mental hospital with severe schizophrenia with a poor prognosis. He hoped there were not many nurseries like that, but a great many of these children would need a great deal of psychiatric help.

Dr. Isaacs asked if Dr. Todd could speak about the treatment by the psychiatric social worker and the parents. She did not touch on that. He thought this was rather an important point, and those who had necessarily to leave a good deal of handling of parents to the psychiatric social worker were very concerned sometimes to decide how much should be left to the psychiatric social worker and how far she should go.

Broadly speaking, in one's clinic work one did find that with the average psychiatric social worker one could come to some sort of mechanism of approach, and decide whether a case should be handed on for adult treatment to a clinic when deeper mechanisms were coming out in the parents, but it was very often a practical issue which had to be faced. When this question of the help of psychiatric social workers came up one had to consider the personality of the psychiatric social worker. Because she had been vetted by a committee and passed examinations it did not necessarily mean that various conflicts of personality might not arise. Very difficult situations could sometimes arise in which there were all sorts of projections of an undesirable character originating.

Dr. F. Bodman congratulated Dr. Todd on her valuable paper with regard to technique. With regard to the psychiatric social worker he had had the advantage of working at two different clinics run by two different authorities. In one case he had the opportunity of working hand-in-hand with the psychiatric social worker who was able to interview parents while the child was receiving treatment. In the other clinic he had not the same advantage because for reasons of distance the psychiatric social worker was not able to get into contact with the parents of an affected child, and progress was much slower in that case. Where the psychiatric social worker was dealing with parents progress proceeded at a much more rapid rate.

It had to be borne in mind that the psychiatric social worker was hand-picked; she was not even selected by a committee. She was interviewed by a series of selected interviewers, and having gone through that sieve, she was approved before she was selected for training—which was quite rigorous. There were many psychiatric social workers who were better equipped to deal with emotional problems than many so-called psychiatrists working in child guidance clinics.

Dr. Todd brought out a good point in her case-histories, and that was the importance of the psychiatrist grasping the opportunities presented to it by the child. One had to seize these opportunities as they came; it was not always possible to work to a preconceived plan; and the psychiatrist must be prepared to be an opportunist, and grasp the material which was held out and then withdrawn almost in a matter of seconds by the child during the treatment interview.

One speaker was discussing the danger of interpretation to the child. It was not always necessary, perhaps, to make a direct interpretation to the child. One might have a child who was playing out a situation, and one noticed that he discarded or rejected any objects he might regard as bad, and one felt that the situation was getting static when he produced the same kind of play two or three sessions running. It was possible to make a change in the situation by the psychiatrist introducing a variation, a new factor to which the child had to make an adaptation.

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This was a disguised interpretation to the child when he was getting stuck ; he had to deal with the bad object as well as the good ones with which he had been playing.

Play could be interpreted at various different levels, and the objects which the child selected for his play were continuations of his fantasy life and the materials of his fantasy, and it was possible to interpret them at a great many levels.

Dr. Todd stressed the value of talk, and how talk was a valuable method of communication between the child and the psychiatrist in the treatment situation ; and he would agree that it was very valuable, particularly with children of high intelligence, but it was rare with a child under the mental age of eight to get very far by talk alone. With the older child a very useful way of opening np the treatment situation was to start off with a word association test; with that test and dealing with the words that had long reaction times, one could open up the situation and proceed to discuss matters which were of importance to the child. It was a very valuable short cut.

Dr. MARGARET LOWENFELD asked if Dr. Todd felt that the word " interpretation " was sometimes used to cover two classes of operation. It might help to clarify their views with regard to it if these two classes were separated. One of the things which the psychiatrist did, as Dr. Todd had illustrated and as the last speaker had explained, was to draw the child's attention to what it had been doing, or to alter the situation in such a way that the child was faced with new possibilities or new challenges, thus making it aware rather than interpreting to it. They all knew from adult work, or even from relations with friends, how valuable it was if somebody pointed out a certain habit and of which they immediately became conscious, and with consciousness came self-criticism. All child workers had the experience that with a child it was more profoundly true than with the most obstinate neurotic. The child was never aware of what it was doing; it moved spontaneously, and the older child had the parents' awareness of what he was because of the parents' reaction. It said, " This is naughty, is it not ? " and so on, and it was found that that was the word the parents had used.

There was, therefore, in all work with children a very large element of bringing to the child awareness of what he did. Side by side with that was the entirely different aspect of interpreting to the child out of the adult's greater knowledge what the underlying meaning was of what the child could do, and it seemed very important that these two aspects should be differentiated, because one could train quite unversed people to do the first without any danger of damage, whereas as soon as one came to the second, one came up against the whole problem of the acceptance of fixed symbolism, the acceptance of a particular type of psychopathology, the acceptance of whatever symbolism one was interested in, and, as had been pointed out, the interpretation was in the hands of the psychiatrist.

Dr. Lowenfeld wished to bring forward one point which had a good deal of bearing on the value of getting to know what objects meant to the child. On the point of a lion she heard of a child who said that a lion was a friendly creature and purred like a cat. This was a little difficult if one had accepted it that the lion was raging and roaring. She would like to ask Dr. Todd whether they should make clear to themselves what they were aiming at when talking to the child about its play. Were they aiming at making the child aware of what it was doing, or were they aiming at explaining to the child the unconscious or deeper significance of what it was after ? If it was the second did they use all forms of psychotherapy, or did they find that they tended to move within the scheme of one or the other ?

A MEMBER said that in these days there was a good deal of separation of parents and children, and he asked Dr. Methven how she would treat the children whose parents were away, the mothers working and the fathers at the war.

Dr. KIMBER said that for hundreds of years voluntary hospitals had been supported so that they could treat the physically sick, and at last they were looking round to see how illness could be prevented by providing adequate school meals and treatment in the school medical service, and so on; and he did not think they should be frightened of what Dr. Methven had suggested, that psychiatrists should leave their clinics and the hospitals and go out and attempt to put forward something of what they had learnt to other people in the ante-natal clinics, to health visitors, and so on. It was not a matter of having armies of psychiatrists, but of preaching the gospel and instructing people about the possibilities of prevention. It was important that they should try to look at the problem in that light and not be afraid of their responsibilities. It might be found that they would require fewer people to staff Borstal institutions, remand homes, and mental hospitals and schools under Section 80 for unmanageable children ; and, in fact, there might be less to do. That was what had to be envisaged.

The question of interpretation was a thorny one, and he would like to ask Dr. Todd whether in fact the child did not very frequently almost give the interpretation to the psychiatrist, and perhaps the psychiatrist actually contributed very little to a gradual awareness and understanding. Many lay people particularly were very afraid of these interpretations which they learned were to be given to their children. In fact, he believed, and Dr. Todd had given some indication, that often the interpretation was in fact found by the child patient.

Dr. SESSIONS HODGE thanked Dr. Todd for her paper. He had recollections of happy asso-

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ciations with her in pre-war days and he was delighted to hear her speak. On the point of interpretation he wondered whether some of the mechanism which occurred was largely a question of acceptance by the psychotherapist of the child's own playing out of its problem. It was not so much a matter of concrete or verbal interpretation to the child as there was an adult who, apparently, from the child's point of view realized the situation, accepted it, and acted as a shock-absorber to the child's own difficulty.

Another small point in technique. The Rorschach test was mentioned in the earlier discussion, and he used it not only as a total personal estimation or psychogram, but also as a departure point for attacking the particular disability. Each Rorschach test interpretation was not only an all-in test but was also specific for that individual, and something could be learned from a careful noting of the exact type of interpretation which the patient made on a particular card and following that interpretation later as a departure point.

Much had been said regarding the training of future psychiatrists; there was an important point in that in time it would be a good thing if it could be contrived that psychiatrists should be trained in the art of living. They should not come from a first-class medical school or college and begin to practise the art of psychiatry; they would be better psychiatrists if they had lived a little first. In dealing with children he had found it of great value to have had three of his own. It was possible to observe such a group of so-called normal children, and to know how many of the reactions shown by the child who appeared in the clinic were exhibited by one's own children, not with the same amount of stress and strain, but perhaps a great deal more freely. For instance, such a question as the drama of birth could be and was expressed by a so-called normal child, and if it was fortunate in having a mother such as his own children had it was dealt with promptly. The child was terrified of the idea of birth, and the idea of what went before was still more terrifying.

Lt.-Col. PEARCE said that every now and then a psychiatrist made a plea that psychiatry should set its house in order and he was more than grateful to Dr. Methven for her clarion call. No doubt she had been informed, as he had from various sources, that there a was a growing body of distrust in the medical profession as a whole with regard to psychiatry. He had been given this information on sound authority and they must do something to straighten things out. Dr. Todd, in her extremely valuable and illuminating talk, said that technique was still in its infancy. But there was no need to be discouraged.

The question to Dr. Methven as to where and how she hoped to find an adequate number of psychiatrists for the work was quite beside the point; she would not find them at present; but that was not a reason for discouragement. They had to aim high, and he personally deplored the rapid mushroom growth of child guidance clinics throughout the country which had been going on during the past few years. Dr. Methven had already said that at least some of the personnel employed in such work had not been adequately trained and this had to be put right. It would be better for the country if psychiatry, instead of trying to treat too many cases, let them go while it put its house in order and while a proper policy was defined for implementation. They were told at the meeting yesterday that certain policies were laid down and would be put forward, and he thought such policies should be stressed very strongly. They were far too much a house divided against itself.

With regard to the emphasis being placed on prophylaxis, there again he was in full agreement with Dr. Methven. He was very glad to see that she aimed high and far. If they could concentrate on the first five years of life, and by education and every other preventive method see that things were right during those years, their contribution to society would be far greater than by cleaning up the mess afterwards. There was nothing new in the suggestion that psychiatrists should work in ante-natal clinics. He was sorry that the consultant-psychiatrist to the American Army was not present, because he had told him that a large part of his time at Yale was spent in the ante-natal clinic dealing with the problems of the mothers before the children came into the world. Surely they would not aim at anything lower than that?

Dr. MABERLEY said that it had been taken for granted that there would be a shortage of child psychiatrists. Were there really too many or too few? Lately he had been talking with an Army psychiatrist who appeared to think that the modest efforts of the Child Guidance Council to train, or give some training, to child guidance psychiatrists was a threat to their post-war livelihood. They seemed to consider the training of less than ten psychiatrists a year a menace to their future. He could not see the justice of that view, but he mentioned it because there were some people who thought there would be too many, not too few.

Dr. W. C. SCOTT asked what were the priorities in psychiatric training. If all the people going into psychiatry in the clinics, in the hospitals and institutions carried on the next generation would be a great deal better, particularly if the new psychiatrists went into child psychiatry first. This went back to the problem of training, and a child psychiatrist should be well trained. He should have his training on adult work before he specialized in childhood, but the training which he would need would take two or three years.

With regard to the more specific points which had been brought out, for instance the difference of opinion as to whether to interpret or not to interpret, in other words, whether to help the patient to become more quickly conscious of what he had been unconscious of or not, Dr. Kimber mentioned that the child would become conscious himself, given time and opportunity. It was

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just fifty years ago that Freud and Breuer penned their first paper, and it was interesting when an argument like this came up to realize that they said that given time, opportunity and urging, the child might become conscious. In other words, they might forget all they had learnt and type the patient just as Freud did fifty years ago. Every student had had the experience of being very annoyed at himself for reporting a week or fortnight of treatment and then having a senior colleague ask, " Did you interpret this, did you see this, or that material ? " They must become more expert in being able to see the significance of correct interpretations. That brought up the problem of incorrect interpretations, which was a matter of discussion. They still hoped that there were some interpretations which were correct so that treatment could progress more rapidly.

He had said something about the priority of training of the future psychiatrists. What was important in Dr. Methven's paper was her discussion of the problems of the adolescents and of the pre-school children. The problem of the first five years was extremely important, and unfortunately, it had not been taken up very much in the discussion. This work should not be left to the psychiatric social worker, although she was the best person to train as a lay psychotherapist, but just as many neuroses and psychoses began in infancy, so they were most easily influenced in infancy. They were not only influenced by helping the parents to deal with the situation themselves in those years, but often the material was displayed to the psychiatrist in such a way that he could do something in addition.

Dr. Bodman mentioned non-verbal interpretation by which something was done which the child would interpret for himself. He interpreted something which the psychiatrist put into his mind, and that was an interpretation just as much as a verbal interpretation. When they were on the fringe of understanding feelings and emotions it might be important not only to move objects in the room, but also to do certain things with children because, as Major Miller mentioned that morning, it was for the psychiatrist to know what he was doing, and become conscious of the meaning of what he was doing when treating an infant of three years of age when so much of the time was spent in bodily contact with it. This was where more research had to be done.

Dr. T. P. Rees said that one of the difficulties of the psychiatrist in the Army had been the fact that some of them had had no experience outside mental hospital work, while others had never been inside a mental hospital and could not tell a psychotic when they saw one. He hoped that after the war there would not be any such thing as a specialist child psychiatrist. He believed that every psychiatrist should be an all-round person. A psychiatrist who concentrated all his time on children was not competent to deal with the neuroses of the parents, and a good deal of the trouble did arise from unsuitable handling by neurotic parents. He was very interested in what Dr. Methven said about prophylaxis. In his own area he was in close touch with the medical officers in charge of the ante-natal clinic, the maternity department, and the child welfare clinics, and he would like to go a step further after the war. If they were going to do really prophylactic work they should run classes for engaged couples.

Col. Petrie said that reference had been made to the necessity for putting their house in order and a good deal depended on that. One had heard of child guidance clinics which were supposed to be adjusting the children, but which were failing to adjust themselves to their environment; they were not co-operating properly with the school medical officers, with other people concerned, and therefore did not get the material which they should. This brought in the very knotty question which Dr. Methven had skated over, the relation to the educational psychologist. One had been rather depressed at times by hearing that child guidance clinics were not doing as well as they should. It was not only in one area of the country where they were not fulfilling the function which the neighbourhood felt they should. One had heard it said by these clinics that a child was so bad that it would have to be moved away to possibly the residential schools which Dr. Methven had mentioned.

All mental maladjustments and illnesses were due possibly to some heredity and some environmental factors; at any rate it was vitally important if child guidance was to spread and become the prophylactic of the future, which one hoped it might become, that a careful decision should be made as to the people with whom one should work.

Dr. Methven spoke of the children in the earlier stages and also of the adolescents as they left school. He had hoped she would say something about the knotty question of their vocational guidance, because that was one of the things in which one could adjust a person at the school-leaving age, and it had the elements of a still wider thing, which again demanded great co-operation with the educational authorities. Probably the psychiatrist's influence would be best used by meeting those who dealt with it as well as dealing with it themselves.

Dr. Kathleen Todd, in reply to the discussion, said that the outstanding question from her point of view seemed to be concerned with the psychiatric social worker, and she seemed to be asked to give a lecture on the question of interpretation.

The psychiatric social worker had two functions. One speaker had described her as being hand picked. She did not just go before the committee; she was interviewed by trained psychiatric social workers and one or two psychiatrists. She went to be trained, but did not always

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go through the course. She dealt particularly with two situations: first of all the environment of the child, and they were sorted out and helped to understand on the basis of their personality; some of them were most suited to do environmental work and some were better qualified to do deep treatment. She did not mean that the psychiatric social worker did deep treatment; she co-operated with the doctor, and one of the talks given to them every year emphasized that they were not treating patients or mothers or dealing with unconscious mechanisms—they were dealing with the child's problems, and enlightening and explaining mechanisms to the mother so that she might understand her child better. The psychiatric social worker could engage in a to-and-fro piece of work with the doctor, which hastened treatment and was of much value in the weekly visits of the child. She had these two functions therefore: first of all dealing with the environment, and secondly, in the deeper treatment of the child. It would take a whole lecture to explain the kind of work done in the training clinic.

Someone had said that the psychiatric social worker was better qualified to do the deeper work than the psychiatrist; she was, of course, trained, and the psychiatrist might not be. Some of them took it so lightly that they went to the child guidance clinic as though they were going to golf, and she agreed with the many speakers who suggested that one of the main points for the future was the better training of child psychiatrists.

Interpretation was, of course, subjective. It was a subjective element, but then, every human relation had its subjective element. The child psychiatrist must be aware of that and must work with every child at a different tempo, on a different basis, at different levels. It was very intricate and very specialized, and it should be compared with psychotic work in the adult, and should not be attempted without training. It was not as dangerous as all that provided the individual had had a training, and not only training, but training under supervision.

Dr. Lowenfeld made some interesting remarks, and she agreed with her as to the different types and levels of interpretation. There were three different approaches to the child, only one of which could be called interpretation. First of all, there was what might be called teaching or explanation. Many doctors when they enlightened a child about the biological facts of sex called that interpretation; it was not interpretation at all; it was telling the child something The second level was the enlightening of the emotional repercussion of that fact, and in the same instance when the doctor explained the child's feelings in connection with masturbation that was enlightenment, but it was something which the child had known all the time and was not interpretation at all. It was interpretation when the child's problems had been so deeply seated that they had been hidden from himself, and when the doctor explained something of which he had no knowledge, that was interpretation. In teaching students one had to make them realize that because there was a great deal of loose talk about interpretation, almost anything the doctor said in some clinics was dignified by the name of interpretation. It could be verbal, indirect, by movement or by gesture, but in the intelligent child it always had to come to the level of words. Dr. Kimber suggested that the child could interpret the deeper problems himself if given time, and she thought she would agree. In the days when she worked with Dr. Kimber and they had time to go on with cases for two years twice a week one could allow—especially intelligent and intuitive children—them to work out their problems themselves. But this could not be done now, and through the pressure of time a quicker therapy of interpretation had been learned which had forced them to see things more quickly. This would have to be used in the future, and quicker work would have to be done privately than in the clinics before the war. Dr. Rogerson brought this out in his book. She told her students that they would make mistakes, but that they should be courageous and allow themselves to do so; they learned more from mistakes than from success.

Dr. Pearce's point about the quality of psychiatrists of the future was very pertinent. Greater psychiatrists rather than more psychiatrists were needed; better trained psychiatrists and people who had had both adult and child training were needed who could co-ordinate the two.

She was not so happy about extending their work into every field of social activity as of educating psychiatrists thoroughly, so that they would be good advertisements for their work, especially in child psychiatry, where there was much more charlatanism than in adult cases. She was glad to hear Dr. Maberley suggest that there would be too many psychiatrists in the future rather than too few, although she was filled with trepidation with regard to their training.

Dr. Rees had said that there should not be a child psychiatrist specialist, and she would strongly agree that in the future psychiatrists should be trained in all branches of the work, not in water-tight compartments as they were at present, each one divorced from everyone else.

Dr. Methven, also in reply, regretted that there had not been more expression of views on training, but perhaps it was too big a subject to take at the end of the day. She was glad to be in agreement as to the necessity for an all-round training. The number of years it took did not matter. She would not leave the work with pre-school children to the psychiatric social worker, but she did more work in that field. She did not know where all the psychiatrists who were needed would come from; that was why she suggested they should concentrate on prophylaxis. She was glad that Col. Pearce felt that there was a growing distrust in the medical profession regarding child psychiatry. Nothing could be done about the mushroom growth of child guidance clinics; she was afraid they would spring up because local authorities had suddenly wakened to the need for clinics without being aware of what they meant. They were putting into them anyone who was willing to go in.

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She agreed that she had said very little about vocational guidance, and that she skated over the subject of educational psychology. She was aware of all the problems but was not aware of the answers, and she hoped the older psychologists who did know the answers would become vocal about them in the immediate future.

The PRESIDENT said that the large attendance at the meeting in spite of the difficulties of transport, and the attention which had been given to the discussion, showed the interest taken in the subject of child psychiatry. It would provide a stimulus to those who were going forward to deal with it in a Sub-Committee, perhaps to become a Division of the Association.

He proposed a very hearty vote of thanks to the readers of the papers and to those who had taken part in the discussion, which was accorded by applause, and the meeting terminated.

NORTHERN AND MIDLAND DIVISION.

Minutes of Special Meeting of the Northern and Midland Division, held at the Royal Victoria Station Hotel, Sheffield, on Friday, March 3, 1944, at 2 p.m.

Present: Dr. T. C. Graves, President, in the Chair; Drs. J. S. Allen, M. A. Archdale, C. B. Bamford, J. Bonnell, W. E. W. Bridger, H. Burt, H. Dove Cormac, Patricia S. Clarke, P. M. Crowe, T. M. Cuthbert, T. W. Davidson, T. M. Davie, K. K. Drury, C. J. Earl, T. R. Forsythe, F. W. Furniss, D. Gilmour, J. F. R. Goodlad, E. Harrison, E. A. Haslam-Fox, J. Erskine Howie, E. Randal Hull, M. Jeffrey, Major T. S. Johnstone, Drs. A. Kelly, F. Kingston, Major E. H. Larkin, Major S. L. Last, Drs. I. Magee, G. E. Mould, J. R. Murray, N. F. MacKenzie, G. W. MacKay, Duncan Macmillan, I. R. Macphail, J. J. O'Reilly, J. J. O'Riordan, Major J. C. Penton, Dr. E. Power, Drs. E. V. H. Pentreath, Arthur Pool, Major E. Rosenberg, Lt.-Col. J. I. Russell, Drs. E. F. Skinner, H. F. Stephens, G. Talbot, F. T. Thorpe, R. C. Walker, G. Williamson, A. H. Wilson and C. E. H. Turner.

Visitors: Dr. K. B. Cobb, Lieut. J. A. Herd, Capt. Leviten, and Lieut. T. A. Muckle.

The SECRETARY read a letter from the Secretary of the Medical Planning Committee, suggesting the appointment of a Divisional Planning Committee and a Divisional representative to attend the main Planning Committee.

After discussion, it was resolved that a Divisional Planning Committee be appointed, to consist of six members and the Divisional Secretary *ex officio* as convener. The following were elected:

Drs. T. M. Cuthbert, E. R. Hull, J. J. O'Reilly, Lt.-Col. J. D. W. Pearce, Drs. A. Pool, H. Freize Stephens and J. I. Russell.

The PERSIDENT stated that the Terms of Reference would be as defined for the main Planning Committee, and to report to this Division and to the main Planning Committee as and at such times as circumstances dictated.

Dr. O'REILLY suggested that the Sub-Committee should establish liaison with the northern branches of the Medical Superintendents' Association with the view of meeting and discussing with medical superintendents of the general hospitals.

The PRESIDENT replied that non-members of the Association might be invited to attend meetings of the Sub-Committee, but could not be co-opted as members of the Committee, and should not have any responsibility for any opinion forwarded in the name of the Sub-Committee.

Resolved that—

> "In the opinion of this meeting, the Divisional Representative should be given full membership of the Main Planning Committee, and that the Secretary be instructed to make formal application to this effect."

Resolved that—

> "The Divisional Representative be one of the seven members of the Planning Sub-Committee."

DISCUSSION.

Dr. GRAVES explained the origin and purpose of the Interim Report. The Government White Paper left us still in doubt, but it appeared that the principle was accepted that special safeguards were indispensable in a mental health service in which persons might have to be treated against their will. This necessitated a committee with direct and complete responsibility. To that committee a medical superintendent should have direct access, and he should not have to submit any recommendation or report through an intermediate channel of communication. He opposed also the tendency to introduce a dual control in hospital administration. It had been suggested that with a staff of visiting psychiatrists, medical superintendents might be abolished. He hoped he was not going to see that occur.

Dr. DRURY said that for some years there would be a dearth of medical men to staff the hospitals. The Planning Committee should consider means of encouraging men into the specialty. The same applied to nurses. He suggested the institution of a Nursing Diploma to qualify nurses for responsible posts in the extra-mural and ancillary services that were envisaged.

Major LARKIN said the army psychiatrists were particularly interested in the discussion.

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