A History of Child and Adolescent Psychiatry in the United States

September 01, 2003 | Child Adolescent Psychiatry [1], Addiction [2]
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The American Academy of Child & Adolescent Psychiatry will hold its 50th anniversary meeting in October, but the field can trace its U.S. origins to Chicago in 1899. Learn how the specialty has developed over the years in this historical essay.

Next month in Miami, the American Academy of Child and Adolescent Psychiatry will hold its 50th anniversary meeting. In recognition of this event, the following is a brief history of the organization and of this subspecialty (Schowalter, 2000, 1994).

Most historians of child psychiatry date its beginning in this country to 1899, when Illinois established the nation's first juvenile court in Chicago. This occurrence set forth the following sequence of events. A group of influential, socially concerned women on the board of directors of Jane Addam's Hull House was shocked by juvenile delinquency. They wanted to understand its origin, prevention and treatment. These women were approximately 90 years ahead of the Centers for Disease Control and Prevention's decision to accept violence as a public health problem. In 1909, these foresighted women created the Juvenile Psychopathic Institute and hired a neurologist, William Healy, M.D., to be its first director. Although a neurologist interested in studying the delinquents' brain functioning and IQ, the perspective of the settlement house's board of directors made sure that attention also was paid to the delinquents' social factors, attitudes and motivations. To accomplish these broad evaluations and treatment strategies, Healy formed teams composed of a neuropsychiatrist, a psychologist and a social worker. This approach became the template used by most child guidance clinics for most of the 20th century. Child psychiatry's roots became implanted in the community, rather than in medical schools, and colleagues were more likely to be teachers, judges, social workers and social scientists, rather than physicians.

Child guidance clinics blossomed in essentially all U.S. cities during the next two generations. The influence of European child psychoanalysts such as Hermine Hug-Hellmuth, Anna Freud and Melanie Klein became pervasive in this country. In the 1920s, Americans went abroad to study, and during the 1930s and 1940s, many psychoanalytically minded clinicians immigrated to the United States to escape religious persecution. Many, if not most, of these clinicians were women.

At the edges of the dominant psychodynamic and psychosocial viewpoints were organic psychiatry and behaviorism. Organic, or biologic, psychiatry was widely considered a failed pathway espoused by forgotten old men near retirement age. Behaviorism became popular in academic psychology, with John Watson and B.F. Skinner being articulate advocates. However, translations of strict academic behavioral paradigms to clinical use mainly failed. The majority of clinicians believed the behaviorists were so narrow and dogmatic that the "whole child" was lost. Anna Freud's The Ego and the Mechanisms of Defense, first published in German in 1936 and in English in 1946, and the first edition of Child Psychiatry by Leo Kanner, M.D., in 1935 were very influential. Kanner took the name from the German term Kinderpsychiatrie.

While it might seem curious, World War II helped child psychiatry in a number of ways. Because of the huge military draft, background histories were available for hundreds of thousands of late adolescents and young adults with varied backgrounds and socioeconomic levels--rich, poor, white, African-American, educated, uneducated, urbanite and farmer. By the end of the war, it was obvious that soldiers who had behavior problems as children were much more likely to be prematurely discharged, disciplined, wounded or killed. It was a statistic that could not be ignored.

On July 3, 1946, President Harry Truman declared war on mental illness when he signed the National Mental Health Act. Three years later, the National Institute of Mental Health was born. Prevention was an important goal and the quality of mothering was considered key. Women's magazines cropped up like mushrooms. If mothers failed, professionals were needed to be available to intervene. A cadre of experts was building. Increasing numbers of trained psychiatrists spilled over
into a greater number of child psychiatrists. At the same time, many pediatricians found that the new antibiotics made their specialty consist largely of well child care. Some found this boring. Federal training funding became available to convert pediatricians into pediatric psychiatrists. The American Academy of Child Psychiatry was founded in 1953. It was preceded by two organizations interested in children's mental health. One such organization, the American Orthopsychiatric Association (AOA), was formed in 1924. It was multidisciplinary, and its main focus was prevention. Politically, members often leaned to the left and tended to view diagnoses as hurtful labels. In 1948, 54 child guidance clinics created an organization of clinics. The foci of this group, the American Association of Psychiatric Clinics for Children (AAPCC), were to develop standards for clinical care and for training. Before child psychiatry residencies, the gold standard credential for child psychiatry was an AAPCC certificate of training.

The movement toward subspecialization picked up speed in 1943 when the American Psychiatric Association converted its section on Mental Deficiency to the Section on Child Psychiatry. Six years later, the Section was elevated in status to the Standing Committee on Child Psychiatry. In 1947, the Group for the Advancement of Psychiatry appointed a Committee on Child Psychiatry. In 1951, the presidents of AAPCC and AOA—George Gardner, M.D., and James Cunningham, M.D.—called together 17 psychiatrists who worked with children to discuss the formation of a separate organization for child psychiatrists. The following year, 96 psychiatrists met in Atlantic City, N.J. They agreed to form the American Academy of Child Psychiatry (AACP) and have membership by invitation only. There were 107 charter members. Subsequent members were required to have three member sponsors and American Board of Psychiatry and Neurology (ABPN) certification. Members applying were also required to have made an "outstanding contribution to the field of child psychiatry," as reflected by unanimous approval by the AACP Council and a two-thirds majority of the members. (The requirements have changed; for more information, please visit <www.aacap.org/membership/joinaacap.htm>.)

In 1948, Frederick Allen, M.D., proposed that child psychiatry be recognized by the ABPN; however, nothing came of his proposal. Although some child psychiatrists favored an autonomous specialty, similar to pediatrics' break from internal medicine, this did not seem feasible. There was some debate as to whether the new specialty would be pediatric psychiatry or child psychiatry, but a vote by AAPCC clinic directors overwhelming favored a link to psychiatry rather than to pediatrics. In 1958, six child psychiatrists met with the ABPN's president and secretary to discuss the possible particulars for a new psychiatric discipline. There was agreement on a two-year child psychiatry residency, with the option to replace the third year of general psychiatry residency with the first year of child psychiatry training. The subspecialty was approved in February 1959. As a result, a six-person ABPN Committee on Certification in Child Psychiatry was formed. The American Board of Pediatrics (ABP), through the American Board of Medical Specialties, demanded that there always be an ABP non-voting observer on the committee to ensure that the ABPN treated child psychiatry right, and an ABP observer remains today. About 160 clinicians were grandfathered into the subspecialty. The first certifying exam was in the form of essay questions. The committee found them impossible to grade, so it announced there would be a follow-up oral examination. There are those today who are still hot with anger about first missing the cut to be grandfathered, then taking the essay exam, and then being forced to take a not previously announced oral exam. Nonetheless, in April 1960, 101 candidates passed the first child psychiatry boards. Also in 1960, the Accreditation Council for Graduate Medical Education's Residency Review Committee (RRC) in Psychiatry approved 11 child psychiatry residency programs. The stipulation that child psychiatry residencies must be linked to psychiatry residencies and that these must be linked to medical centers was an occurrence of extreme importance. It forced child psychiatry, sometimes kicking and screaming, from community child guidance centers to hospitals and medical schools. In my opinion, this saved child psychiatry from being marginalized. If it had not been pulled into medicine, it would have been replaced by a new iteration born in medicine.

During the 1960s, the AACP struggled with its identity. The Journal of the American Academy of Child Psychiatry was launched in 1962, granting the field its own publication. However, as more and more clinicians were trained and certified, they wanted to have an organization of their own. Regional organizations formed, and there was the beginning of a push for an open, not invitation-only, national association. The AACP, after much debate and a 176-11 vote, opened its organization in 1969 to include members on the basis of their practice and training in child psychiatry (Bemman, 1970). That year, its membership tripled from 218 to 688. Although leadership of the American Psychiatric Association was ambivalent about this somewhat unexpected "child," in 1969, then Medical Director Walter Barton, M.D., offered rental space in the
APA building, and eight file drawers of records were moved in. In 1973, Virginia Anthony was hired and she remains the academy’s executive director. In 1983, the academy published *Child Psychiatry: A Plan for the Coming Decades*. It was the summary of five years' work by 100 consultants to, and members of, six task forces. These were not only child psychiatrists, but also included nationally known general psychiatrists; pediatricians; deans; professors of epidemiology, nursing, psychology and law; leaders of the NIMH; and various child advocates. Recommendations were made for manpower, clinical service delivery and training; the most important recommendation, however, was the challenge to develop research strategies that would allow data-based understanding and treatment of the mental illnesses of children. While child psychiatry had long gathered anecdotal data, particularly about social and psychodynamic influences, it was 10 years behind general psychiatry in biological and epidemiological research. Indeed, this document changed the field.

In the past 20 years, there has been a steady increase in residents who choose child psychiatry, and academy membership now numbers almost 7,000. In 1986, the academy voted to expand its name to the American Academy of Child and Adolescent Psychiatry and within a few years, this expansion was approved by the ABPN and the Psychiatry RRC.

Besides its journal, the AACAP has published books, both for professionals and the laity, approximately 50 policy statements and over 200 "Facts for Families." The latter are available to families and are printed in English, French, Spanish, German, Polish and Icelandic. The AACAP collaborates closely with the APA, the American Academy of Pediatrics and other organizations in regard to clinical, policy and research issues. During the past decade, the academy was awarded funding from both the NIMH and the National Institute on Drug Abuse to oversee five-year K-12 training grants for young investigators in child and adolescent psychiatry.

During the past 50 years, evolving interest in and understanding of developmental psychopathology have shown how intertwined developmental stages are for patients' diagnosis and treatment. In the decades to come, genetics, neuroimaging and other new techniques will not only affect our work with children, but also determine the type and number of professional organizations that will be needed to treat children and adolescents with mental illnesses.

**References: References**


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