THE
BRITISH JOURNAL OF PSYCHIATRY
(THE JOURNAL OF MENTAL SCIENCE)
[*Published by Authority of the Royal Medico-Psychological Association*]

SUPPLEMENT, NOVEMBER 1965

THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION

ONE HUNDRED AND TWENTY-FIFTH ANNUAL MEETING

THE ONE HUNDRED AND TWENTY-FIFTH ANNUAL MEETING was held in Glasgow on 13-16 July, 1965. Dr. Ian Skottowe presided over the earlier proceedings and Professor T. Ferguson Rodger after his induction on 14 July.

TUESDAY, 13 July, 1965

Committees met at the New Arts Building of the University of Glasgow, and Council in the Senate Room of the University.

Seminars were held in the New Arts Building as follows:

"INTENSIVE TREATMENT OF LONG-STAY PATIENTS." Dr. George S. Stirling.

"THE PLACE OF PSYCHOANALYSIS IN A MENTAL HOSPITAL." Dr. Thomas Freeman.

"BEREAVEMENT AND DEPRESSION." Dr. Alistair Munro.

"VITAMINS IN ALCOHOLISM AND CONFUSIONAL STATES." Dr. P. W. Kershaw.

"THE PSYCHIATRIC ASPECTS OF THE DISEASES OF PORPHYRIN METABOLISM." Dr. A. Goldberg.

"THE MOLECULAR BASIS OF MEMORY." Professor J. N. Davidson, F.R.S.

"A PSYCHOSOMATIC STUDY OF DUODENAL ULCER: AN EXPERIMENT IN COMPUTING." Dr. A. I. M. Glen.

The President-Elect, Professor T. Ferguson Rodger, entertained members of Council at Dinner at the Royal College of Physicians and Surgeons of Glasgow. Mrs. Rodger took the wives of members of Council on a bus tour, with lunch at Loch Lomond. Members of the Association and their wives attended a Reception at Gartnavel Royal Hospital at the invitation of the Western Regional Hospital Board.

WEDNESDAY, 14 JULY, 1965

Morning Session

Dr. Ian Skottowe in the Chair

The minutes of the One Hundred and Twenty-Fourth Annual Meeting held at Basingstoke in 1964, having been published in the Supplement to the *British Journal of Psychiatry*, were confirmed and signed by the President.

Obituary

The President announced with regret the death of the following members:

DILLON, FREDERICK, formerly Medical Superintendent, Northumberland House, London. An Ordinary Member since 1915.

VAN DAM, LUCIE, formerly Psychiatrist at the Provincial Hospital, Port Elizabeth, South Africa. An Ordinary Member since 1939.

Officers and Council, 1965-6

The President said that the Special Committee appointed to prepare and present the College Petition to the Privy Council had sought Counsel's advice. When this advice was forthcoming it would be possible to see whether the President to follow Professor Rodger could be elected under the proposed new bye-laws, which would be presented to the membership in due course, or whether the present bye-laws should still apply. It was proposed to put a motion for the adjournment of the Annual Meeting,

and the Ad Hoc Committee would hold itself in readiness to be recalled if necessary. Thus, the President could be elected under the new bye-laws or under the existing ones according to how the situation developed during the coming months.

The President moved that the Officers of the Association for 1965-6 be:

Treasurer: Wilfrid Warren.
General Secretary: A. B. Monro.
Registrar: William Sargant.
Librarian: Alexander Walk.
Editor-in-Chief: Eliot Slater.

The motion was carried unanimously.

The President moved that the Nominated Members of Council for 1965-6 be:

P. H. Connell, R. K. Freudenberg, J. G. Howells, J. T. Hutchinson, E. B. McDowall, W. H. Trethowan.

The motion was carried unanimously.

The President reported that in accordance with the bye-laws the following had also been elected as Officers of the Association:

Immediate Past President: Dr. Ian Skottowe.

Vice-Presidents and Divisional Chairmen:
S. W. Hardwick (South-Eastern)
A. J. Galbraith (South-Western)
E. Stengel (Northern and Midland)
M. M. Whittet (Scottish)
J. N. P. Moore (Irish)

and that the following had been elected *Divisional Secretaries:*
A. J. Oldham (South-Eastern)
R. W. Simpson (South-Western)
B. Ward (Northern and Midland)
A. K. M. Macrae (Scottish)
Mary Sullivan (Irish)

The President reported that the Representative Members of Council for 1965-6 would be:

Divisions: B. Pitt (South-Eastern), C. P. Hellon (South-Western), D. C. Bland (Northern and Midland), G. C. Timbury (Scottish), J. J. Fennelly (Irish).

Sections: Portia Holman, G. S. Clouston (Child Psychiatry); G. McCoull, W. A. Heaton Ward (Mental Deficiency); H. V. Dicks, G. S. Prince (Psychotherapy and Social Psychiatry); P. Sainsbury, A. J. Coppen (Research and Clinical).

Election of Committees

The President moved that the Standing Committees be re-appointed, with the additions and deletions printed in the Agenda, and the additional resignation of Dr. W. McCartan from the Library Committee. Prof. M. Hamilton, Dr. Linford Rees and Prof. W. H. Trethowan were re-elected to the Journal Committee.

Annual Reports of Council, Officers and Standing Committees

Annual Report of Council

During 1964 the increase in our membership very nearly equalled the previous year's record (244 as against 255). On 1 January 1965 the total membership stood at 2,727. A further 160 members have joined between that date and 1 April 1965. The figures for the past five years are:

	1961	*1962*	*1963*	*1964*	*1965*
Ordinary Members	1,839	1,948	2,135	2,382	2,615
Honorary Members	28	27	27	27	29
Corresponding Members	39	43	45	47	50
Associate Members	16	20	21	27	33
	1,922	2,038	2,228	2,483	2,727

There is reason to believe, however, that there are still a number of psychiatrists in senior posts who are outside the Association, and members are asked to do all they can to encourage their colleagues to join. This applies also to non-medical professional staff who are eligible for Associate Membership; the former restriction on the number of Associate Members has now been removed.

At the time of drafting the last report, negotiations were still in progress for the re-housing of the Association in the new building of the Royal College of Physicians. These, however, were abandoned, as a more satisfactory opportunity presented itself at Chandos House, which had recently been acquired by the Royal Society of Medicine. A lease has been taken of the whole of the second floor which besides adequate office accommodation includes a spacious Library which can also be used for Council meetings. The move to Chandos House began in February and was completed by the end of April. It should be realized that the lease is for five years in the first instance, and although it may be extended the R.S.M. will eventually require the whole house for

its own use. An Endowment and Building Committee has been set up with a view to planning future permanent headquarters.

This matter is, of course, closely connected with the aspiration of the Association to become the Royal College of Psychiatrists. The result of the ballot held in May 1964 showed a large majority among those voting, and an absolute majority of the members resident in Britain, for immediate action, and accordingly Council recommended to the Annual Meeting in July that the Privy Council should be petitioned for the Association's name to be changed to that of "Royal College of Psychiatrists", and this was approved by the Meeting.

Two Committees were set up, one to prepare and present the Petition, the other to prepare a scheme for a higher qualification in psychiatry to be granted by the proposed College, and to revise the Bye-Laws so as to provide a structure suitable for a College.

Informal meetings have since been held, on behalf of the Petition Committee, with officers of the Privy Council and the Ministry of Health. These discussions, and the advice of a solicitor experienced in Privy Council affairs, resulted in a reversal of the original policy to press first for a change of name, and then to amend the bye-laws and revise the constitution. This involved much hard work by the relevant committee so that the Association could present its Collegiate structure at the same time as the petition for a change of title. This further entailed postponement of the petition for a Supplemental Chapter until the Collegiate structure had been worked out and approved. Since obtaining the services of an experienced solicitor, the steps taken have been those advised by, or agreed with him.

Meanwhile the Committee on the Revision of the Bye-Laws and the institution of a Higher Qualification has been very active, and provisional proposals were reported to the February and May Quarterly Meetings.

That opposition still exists to the recognition of psychiatry as a major branch of the profession is shown by the fact that the Joint Consultants' Committee rejected the Association's request for representation on the grounds that "no sectional interests should be represented". On the other hand Dr. Linford Rees has been appointed to the Clinical Trials Sub-Committee of the Committee on the Safety of Drugs, and he has stated that through this Sub-Committee it is quite possible for him to safeguard the interests of psychiatrists. Council has also been concerned to note that there is still inadequate representation of psychiatry on Hospital Boards in England and Wales and accordingly this was brought to the attention of the Minister of Health, who promised to bear the Association's views in mind.

Shortly before the May Meeting, 1964, the Association sustained a grievous loss in the death of its President-Elect, Dr. Walter Maclay. In consequence it was necessary for the Ad Hoc Committee and the Council to make an immediate nomination of a new President-Elect, and Dr. Ian Skottowe was chosen. He was inducted at the Annual Meeting in July; there was no change in the venue of the Meeting, which was held at Park Prewett Hospital, Basingstoke, on the kind invitation of the Hospital Management Committee and Dr. I. Atkin. Dr. Skottowe's Address was entitled "Somatometry—A Second Look". The Annual Dinner was held at the hospital, and the guests included the Rt. Hon. Anthony Barber, Minister of Health, and Mrs. Barber.

At the November Meeting, the Maudsley Lecture was delivered by Professor Erwin Stengel on the subject of "Pain and the Psychiatrist".

In last year's Annual Report it was mentioned that the American Psychiatric Association had proposed a Joint Meeting with our Association, to be held in Great Britain during 1965. Edinburgh was chosen as the most suitable place, and much of the organization was done by Dr. Macrae and the members of the Scottish Division, to whom the Association is much indebted. H.R.H. the Duke of Edinburgh accepted the position of Patron of the Meeting, and Sir David Henderson was nominated as Honorary President of the Joint Meeting; unfortunately Sir David fell ill and died before the date of the meeting. At the plenary sessions the Chair was taken by Dr. Ian Skottowe and Professor Curran for the R.M.P.A., and by Drs. Howard Rome and Daniel Blain for the A.P.A. A full programme of concurrent Seminars was arranged, as well as social functions and tours in which both hospitals and places of interest and natural beauty were visited. The Association were the guests of the City and the University of Edinburgh and of the Royal Edinburgh Hospital.

Another notable gathering during the year was the Sixth International Congress of Psychotherapy, of which the Association was the chief sponsoring body. There were over 1,500 participants from more than 40 countries. The event attracted considerable attention and was the subject of well-informed reports in the national press. A gracious message was received from H.M. the Queen, Patron of the Congress, and a number of appreciative letters came from participants. Unfortunately it was not possible for the Congress to cover its expenses fully, and the guarantors had to be called upon to meet the deficit.

Special thanks are due to Dr. S. T. Hayward, who has been tireless in the work of organizing the Congress.

During the year the Government has appointed a Royal Commission on the Penal System, under the Chairmanship of Lord Amory, In anticipation of the Association's being invited to submit evidence, the Council set up a Special Committee consisting of representatives of the Parliamentary Committee and the Forensic Psychiatry Sub-Committee, with co-opted representatives of other interests, to prepare a Memorandum of Evidence. This will be supplemented by oral evidence in due course. Oral evidence has also been given during the year to the Salmon Committee on Senior Nursing Staff Structure.

The Joint Committee of the Association and the Society of Medical Officers of Health has completed its labours and issued its final Report on Co-operation in Mental Health, a comprehensive and authoritative document which should prove a most valuable guide to future action by members of both bodies. Council wishes to express its warm thanks to Dr. Isabel Wilson who took an important part in this work.

Two other Special Committees were appointed during the year on the recommendation of the Parliamentary Committee. One was for the purpose of considering what should be the practice in regard to the giving of anaesthetics for electro-convulsive treatments, and its report has been received. The second will be concerned with consultation with the Ministry of Health on the drafting and revision of Hospital Building Notes, having regard both to practical details and to the wider policy implications of these Notes.

On the recommendation of the Education Committee the Council has decided to use a part of the legacy left to the Association by the late Dr. R. G. Blake Marsh to found an Annual Lecture, of a standing equal to the Maudsley Lecture, on a subject connected with Mental Deficiency, to be known by his name. The conditions attaching to the Gaskell and Bronze Medals and the Divisional Prizes have been revised.

A further stage in the progress of the *Journal* was reached on 1 January, 1965 when it appeared for the first time as a monthly issue. It may be worth recalling that the *Journal* was originally issued every six weeks (1853 to 1855); from then until 1935 it was published quarterly; from 1936 there were six issues a year, but quarterly publication had to be reverted to on the outbreak of the War; the six issues a year were resumed in 1961.

Sectional and Divisional activities have continued on the same lines as in previous years. The Forensic Psychiatry Sub-Committee, to which over 200 members have adhered, applied for recognition as a Section, and the Films Sub-Committee of the Education Committee asked to be raised to the status of a Standing Committee; consideration of these applications was deferred until the recommendations of the Special Committee on the Revision of the Bye-Laws are available.

The greatly increased activities of the Association, together with the higher rental which will have to be paid for our new offices, and the need to make provision for the future, have necessitated an increase in the subscription rates. The opportunity has been taken to correct anomalies.

Other matters which have come before the Council but which are more particularly connected with the work of individual Officers and Committees are referred to in their separate Reports.

Council would again like to record its appreciation of the amount and high quality of the work done for the Association by many members, and in particular to thank the Chairman and Secretaries of Sections and Divisions, and the Officers and members of all Committees and Sub-Committees.

Report of the Treasurer

The audited accounts for 1964 show that at the end of the financial year (31 December) the credit balance was £88,232. The income of the Association during 1964 amounted to £14,586 and the expenditure was £12,097 leaving a surplus of £2,489 compared with £3,142 for 1963. Investments stood in the accounts at £62,505; market value £56,715 on 31.12.64.

Subscription rates for all Members were raised as from 1 January 1965 as follows: Ordinary Members (which include Overseas Members), from £4 4s. od. to £6 6s. od. (those members qualified less than eight years paying £3 3s. od.), Joint Members from £5 5s. od. to £7 7s. od.

With the move to Chandos House, with greatly increased rent and rates, and the advent of a monthly *Journal* it is anticipated that the year 1965 will show a considerable deficit and that further monies will need to be raised to meet this deficit. Council has set up an Endowment and Building Committee and an Appeals Committee to go into the whole question of the future habitat of the Association and finance.

Report of the Registrar

During the year further very successful series of Maudsley Bequest Lecture Courses have been held. In January 150 people attended the course in Psychology organized by Dr. Denis Leigh for candidates

taking Part I of the D.P.M. Over 340 members and 34 non-members who promised to join the Association attended the course held in February. In May eminent American speakers lectured to 150 members in London and Edinburgh following the Joint Meeting with the American Psychiatric Association.

In September over 100 General Practitioners attended the Refresher Course in Psychiatry.

Professor E. Stengel has been appointed Gaskell Examiner in place of Dr. Eliot Slater who retires.

Report of Editor-in-Chief and Journal Committee

For the first time, in January 1965, the *British Journal of Psychiatry* went into monthly publication. Efforts are being made to stimulate the Correspondence Section, and it is hoped that gradually the backlog of papers accepted, but not yet published, will diminish.

During the year Dr. Michael Pritchard was welcomed to the editorial staff of the *Journal* as Assistant Editor.

The Journal Committee and the Board of Assessors supported a proposal to publish a series of monographs for sale. This was approved by Council and enquiries are now being made about putting the scheme into operation.

The Editor announced that contributors to the Association's meetings could assume that his consent was automatic if they wished to publish papers read at meetings elsewhere than in the *Journal*. This decision would apply until such time as Bye-Law 75, which stated that these papers were the property of the Association, was amended.

It was anticipated that rapidly rising costs and monthly publication would result in greatly increased expenditure and the Association's accountants were therefore asked to carry out a realistic costing of the *Journal* for the current year, taking into account all overheads and expenses, and to report. This report shows that in 1965 there is likely to be a deficit of £7,430 on the *Journal* account; but no allowance is made for the fact that all members of the Association, in accordance with the bye-laws, receive a free copy of the *Journal*. As 20 per cent. of the general expenses of the Association are now charged to the *Journal* account it might seem fair to allocate 20 per cent. of members' subscriptions to the Journal, thus reducing the deficit to approximately £4,000. The accountants have suggested various measures which should curtail expenditure and increase revenue, and these and other proposals will be considered by the Journal Committee and a Report will be submitted to Council in July.

One way in which it is hoped to increase revenue is by the sales promotion drive now being directed at institutions, hospitals and libraries in Europe, U.S.A., and Canada. The Association is very grateful to Dr. W. G. Burrows for his enthusiasm, hard work and expert knowledge in directing this project.

Report of the Librarian and the Library Committee

At the time of writing this Report the Library is in process of rehousing in the Association's new home at Chandos House. New shelving has been erected in the very fine room allocated to the Library, and part of the old shelving is being put to use in other rooms. It is hoped that the furnishing will be completed and the books and journals placed in position by the date of the Annual Meeting.

One-hundred-and-thirty new books were acquired during the year, and issues to borrowers numbered 676. The Library receives 83 periodicals, either by exchange or by subscription. It is proposed to publish lists of acquisitions in the *Journal* Supplement.

A well-attended meeting on the History of Psychiatry was held in November 1964 when Dr. M. Annear and Dr. B. Barnett read papers on psychiatric aspects of the history of witchcraft. Another meeting has been planned to be held during the Annual Meeting in Glasgow.

Report of the Education Committee

The Education Committee has met four times during the year. Concern was expressed at the size of the Committee, and it was considered that with the introduction of the five year retiral rule there should be a gradual reduction in the total membership. It was decided that in addition to the Officers of the Association, the Medical Examiners, the Representatives of the Sections and the Secretaries of Divisions, there should be no more than twenty-five elected members of the Committee.

An annual Blake Marsh Lectureship on the subject of Mental Deficiency has been instituted and Professor Dent will be the first Lecturer.

The value of the Bronze Medal and Prize has been increased to twenty-five guineas. The value of the two Divisional Prizes has also been increased to twenty guineas and ten guineas respectively and they have been made open to papers read at all meetings of the Association.

Representations have been made to the Association of Undergraduate Teachers in Psychiatry concerning

THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION

BALANCE SHEET 31ST DECEMBER, 1964

1963 £	£		£	£
		General Fund:		
	46,553	Balance at 1st January, 1964	49,351	
		Add: Legacy received from the Estate of the late Dr. R. G. Blake-Marsh	23,501	
		Surplus for the year ended 31st December, 1964, per annexed accounts	1,801	
	2,798			
49,351				74,653
		Current Liabilities:		
	215	Subscriptions received in advance ..	276	
	2,436	Creditors and Accrued Expenses ..	2,976	
2,651				3,252
52,002				77,905
		Congress Account:		
		Bank Overdraft ..	4,827	
		Creditor	525	
				5,352
		Special Funds:		
		Maudsley Bequest:		
	2,086	Capital Account	2,086	
		Income Account, balance at		
(105)		1st January, 1964 ..	5	
		Add: Surplus for year ended 31st December, 1964, per		
110		annexed account ..	10	
	5			15
	2,091			2,101
	76	Creditor		65
2,167				2,166
		Gaskell Memorial Fund:		
	2,128	Capital Account	2,128	
		Income Account, balance at		
687		1st January, 1964 ..	658	
		Deduct: Deficit for year ended 31st December, 1964, per annexed		
29		account	22	
	658			636
	2,786			2,764
	—	Creditor ..		45
2,786				2,809
£56,955				£88,232

1963 £	£		£	£
		Fixed Assets:		
811		Furniture, Fixtures and Fittings at cost, less depreciation		780
146		Library at valuation		146
957				926
		Current Assets:		
	41,065	Investments at cost or value at date of acquisition	62,505	
		Market Value £56,715 (1963: £40,262)		
	—	Short term Deposit with a local Authority	3,000	
	5,274	Debtors and Prepayments	6,116	
	4,706	Balances at Banks and Cash in Hand ..	5,358	
51,045				76,979
52,002				77,905
		Congress Account:		
		Amount due from Guarantors in respect of the Sixth International Congress of Psychotherapy		5,352
		Special Funds:		
		Maudsley Bequest:		
	2,086	Investment at cost	2,086	
		Market Value £1,151 (1963—£1,228)		
	81	Balance at Bank	80	
2,167				2,166
		Gaskell Memorial Fund:		
	2,450	Investments at cost	2,450	
		Market Value £2,265 (1963—£2,437)		
	61	Debtors	70	
	275	Balance at Bank	289	
2,786				2,809
£56,955				£88,232

IAN SKOTTOWE, *President.*
WILFRID WARREN, *Honorary Treasurer.*

REPORT OF THE AUDITORS TO THE MEMBERS OF THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION

We have examined the accounts made up to 31st December, 1964, comprising a balance sheet and income and expenditure account, which are in agreement with the books of account. The Association has kept proper books and we obtained all the information and explanations which we considered necessary. In our opinion the accounts give a true and fair view of the state of affairs of the Association at 31st December, 1964, and of its surplus for the year then ended.

Alderman's House, Bishopsgate, London, E.C.2. *8th February, 1965.* BARTON, MAYHEW & Co., *Chartered Accountants, Auditors.*

MAUDSLEY BEQUEST

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 DECEMBER, 1964

1963			1963		
£		£	£		£
	Lecture Course:		74	Interest on Investments ..	74
93	Fee and Expenses	53	2	Bank Interest	2
53	Use of Rooms	54	275	Grant from General Fund ..	150
—	Advertising	46			
23	Printing and Stationery	15			
68	Postage	48			
4	Sundry Expenses	—			
110	Surplus Carried to Balance Sheet ..	10			
£351		£226	£351		£226

GASKELL MEMORIAL FUND

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 DECEMBER, 1964

1963			1963		
£		£	£		£
75	Prize	75	99	Interest on Investments	113
21	Medal and Engraving ..	22	8	Bank Interest	7
40	Examination Fees and Expenses	45	29	Deficit Carried to Balance Sheet ..	22
£136		£142	£136		£142

INCOME AND EXPENDITURE ACCOUNT FOR THE YEAR ENDED 31 DECEMBER, 1964

1963				1963				
£		£	£	£	£		£	£
2,613	Salaries, National Insurance and Pension Contributions	4,104		9,256		Members' Subscriptions		10,722
946	Rent, Rates and Insurance	891		14		Net Income from Lecture Course		13
67	Lighting and Heating	77				*British Journal of Psychiatry* and Year Book—		
22	Repairs and Provision for Dilapidations	553						
90	Depreciation of Furniture and Fittings	87			7,432	Sales	7,085	
1,285	Printing, Postage and Stationery	1,371			1,759	Advertisements	2,012	
48	Telephone	57						
752	General (including Ballot) Expenses	920			9,191		9,097	
558	Library Expenses	505				*Less:* Cost of Printing, Publishing		
366	*Journal* Supplements	572			8,069	and Despatching	9,035	
396	Year Book	—		1,122				62
	Publications					Publications		
1,231	"Report on Hallucinogenic Drugs Symposium"	—				Sales:		
—	"Handbook for Psychiatric Nurses"	958			23	"Recent Progress in Psychiatry"	26	
26	Expenses of New Premises	304				"Report on Hallucinogenic Drugs		
315	Professional Charges (including Audit)	423			533	Symposium"	236	
	The Sixth International Congress of Psychotherapy—			556				262
—	Cocktail Party	125				Royalties:		
944	Expenses of Meetings	1,118		177		"Handbook for Psychiatric Nurses"		427
—	Committee Members' Expenses	32		1,608		Interest and Dividends on Investments		2,907
3,142	Balance Carried Down	2,489		68		Bank Interest		193
£12,801		£14,586		£12,801				£14,586
69	Loss on Sale of Investments	538		3,142		Balance Brought Down		2,489
275	Grant to Maudsley Bequest	150						
2,798	Surplus Carried to Balance Sheet	1,801						
£3,142		£2,489		£3,142				£2,489

JOURNAL ACCOUNT FOR THE YEAR ENDED 31 DECEMBER, 1964

1963				1963			
£	£		£	£	£		£
6,963		Printing Expenses	7,535	7,237		Sales	6,964
452		Reprints	442	1,759		Advertisements	2,012
605		Postages, Wrapping and Despatching	1,011	195		Sale of Old *Journals* and Year Books	121
		Sundry Expenses Including Commis-					
33		sioned Articles	47				
16		Publicity	—				
8,069					9,035		
1,122		Surplus Carried to Income and Expenditure Account			62		
£9,191			£9,097	£9,191			£9,097

THE SIXTH INTERNATIONAL CONGRESS OF PSYCHOTHERAPY

INCOME AND EXPENDITURE ACCOUNT FOR THE PERIOD 1ST MAY, 1962 TO 31ST DECEMBER, 1964

	£	£
Administration and Organization:		
Organizing Agent's Fee	3,000	
Secretarial, Registration and Information Services	7,556	
Printing and Stationery	5,411	
Postages	1,257	
Telephone	272	
Translating Services	283	
Sundry Expenses	235	
Public Relations Fees	970	
Organization Committee Expenses	381	
Insurance	464	
Professional Fees (including Audit)	727	
Bank Charges	114	
		20,670
Conference:		
Accommodation and Hire of Furniture	4,877	
Interpretation (including Hire of Equipment)	3,111	
Folders and Badges	525	
Speakers' Expenses	186	
Receptions:		
Guildhall	2,268	
Hurlingham	2,804	
Catering	962	
Ladies' Programme	586	
Transport	237	
		15,556
		£36,226

	£
Registration Fees and Associate Membership	25,754
Day Tickets	305
Exhibition	324
Hurlingham Reception	2,692
Donations (including £500 in lieu of payment due under guarantee)	1,679
Bank Deposit Interest	120
Amount Receivable from Guarantors	5,352
	£36,226

the inadequacy of teaching in mental subnormality to undergraduate medical students.

A sub-committee has been appointed to prepare and submit evidence to the Special Committee of the General Medical Council which is reviewing Medical Education.

Professor Stengel has been appointed as Gaskell Gold Medal and Bronze Medal Examiner in succession to Dr. Slater.

The Mental Nurses Sub-Committee has met once during the year and made recommendations to the General Nursing Council concerning the minimum age of entry to student nurse and pupil nurse training. It also gave preliminary consideration to the Platt Report on a Reform of Nursing Education.

(The Report referring to the activities of the Films Sub-Committee had not been received in time for printing and had not therefore been circulated to members, and was now read by the General Secretary to the meeting.)

"The Films Sub-Committee met four times during the year. Film Shows have been produced at Basingstoke and in London. A Northern Première of the R.M.P.A. teaching films was held at Manchester University in October and was attended by over 100 psychiatrists.

The tripartite appraisal panel between the Scientific Film Association, Mental Health Film Council and the R.M.P.A. continues its work.

The most important activity was the request of the Films Sub-Committee to the Education Committee that it may develop into a full committee of the R.M.P.A. concerned with Audio-Visual Means of Communication. This is now with the Special Committee dealing with the bye-laws."

Report of the Parliamentary Committee

The Parliamentary Committee has met five times during the year.

The attention of the Ministry of Health was drawn to the obsolete phraseology in note 6 of the application form for driving licences, and they have replied that, after consultation with the Ministry of Transport, the obsolete part has been omitted from later prints of the application form. In addition, the Ministry were asked to ascertain if Licensing Authorities were exercising discretion in the case of persons suffering from mental disorder. In their reply, they indicated they did not feel that they were able to influence the Licensing Authorities in any way in the performance of their statutory duties. Correspondence with the Society of Medical Officers of Health revealed that none of their members could recall any reference from a Licensing Authority in regard to mental illness, but they felt that if the question did arise the help of a Consultant Psychiatrist would be sought.

Following discussion about the production of Building Notes by the Ministry, Council was recommended to set up a Special Committee to consult with the Ministry on the drafting of future Building Notes and revising those that have already been issued.

As the result of a communication from the secretary of the Royal Commission on the Penal System in England and Wales inviting the Association to submit written evidence, Council was recommended to set up a special Committee, consisting of members of the Parliamentary Committee, Forensic Psychiatry Sub-Committee and Child Psychiatry Section to prepare the evidence.

A circular letter was sent to all members asking for information about any problems or difficulties they had experienced in connection with the procedure of Mental Health Review Tribunals. Only a few replies were received, and of the points that were raised none was felt to warrant any action at the present time.

Further correspondence has taken place with the Ministry concerning the provisions of Section 30 (2) of the Mental Health Act, and the Ministry have replied that they are continuing to give the matter active consideration and hope to be able to give their conclusions in the near future.

Following representations made by the Association on behalf of psychiatric social workers a reply was received from the Ministry that the points raised had been taken into consideration by the Industrial Court when arriving at their last award, but that a further claim for increase of salaries was under discussion.

As a result of representations on the privilege relating to confidential information entrusted to psychiatrists, a letter was sent to the British Medical Association to ascertain the exact position which had been reached by the Joint Committee of that Association with the General Council of the Bar and the Law Society. Research into the medical privilege in the United States of America is at present being carried out, and the British Medical Association has indicated they will provide us with a summary of the position when the matter is completed.

A complaint was received that fees were not paid when psychiatrists furnished reports to Magistrates' Courts although these involved considerable time. It was known that this matter had been considered by the British Medical Association, and the Psycho-

logical Medicine Group Committee of that Association were asked if they would re-open the question when they felt it was appropriate.

Note was taken of the unfavourable differentiation of salary scales of child psychotherapists employed in the Hospital service compared with those in the Local Authority service, and Council was asked to make representations to the Ministry. A reply was received that there were few such posts in the National Health Service and that in consequence there was no nationally negotiated rate. The Ministry were not prepared to create an anomalous situation by approving higher rates than those applicable to clinical psychologists of comparable professional standing, but pointed out that a claim for higher salaries for clinical psychologists was at present being discussed by the Professional and Technical Whitley Council, "A", and that any agreement reached would be reflected in the salaries considered appropriate for child psychotherapists.

Consideration was given to the Industrial and Provident Societies' Bill, which is a consolidating measure incorporating corrections and improvements in existing law necessary to bring it into line with the Mental Health Act. The Committee had no observations to offer.

Considerable discussion took place of the narrow view taken by the Home Office as regards the meaning of "leave of absence" in the case of patients restricted under Section 65. Though there was considerable sympathy with members who had difficulty with the Home Office in this matter, it was felt that no amendment of the relevant section of the Act was indicated. The delay, however, in obtaining replies from the Home Office was criticized and it was agreed to recommend Council to take the matter up with the Home Office.

Following representations to the Ministry against the policy of counting beds occupied by patients on leave as "empty beds" for statistical purposes, the Ministry have replied that they appreciate that this method gives a low "occupancy" in hospitals which aim to prepare patients for life in the community by giving a good deal of leave, and that "occupancy" needs to be re-interpreted. They have in consequence revised the notes on the statistical form in question, and hospitals have been invited to give on the forms any facts relevant to the interpretation of the figures.

Report of the Papers and Discussions Committee

The Committee met four times during the Quarterly Meetings of the Association, and a special meeting was convened in September 1964 to deal with the papers and seminars for the joint A.P.A.-R.M.P.A. Meeting in Edinburgh, May 1965.

At the Annual Meeting at Basingstoke, July 1964, a Symposium on Drug Addiction took place. Seminars were held at Graylingwell Hospital, Chichester.

The topic for the November meeting was the treatment of Homosexuality by psychotherapy, aversion therapy and other means. Seminars took place at King's College Hospital.

A whole day symposium on the drug treatment of Schizophrenia took place in London in February and was well attended and successful. A successful series of seminars dealing with various aspects of Epilepsy was arranged by the International League against Epilepsy.

The complex arrangements for the joint A.P.A.-R.M.P.A. Meeting in May proceeded smoothly. This was the first joint meeting with the A.P.A. and proved highly successful.

Report of the Public Relations Committee

The Committee held four meetings during the year.

The question of a part time or whole time Public Relations Officer had to be shelved, at least temporarily, partly on financial grounds, on the advice of the Treasurer, and partly to await crystallization of the plans for converting the Association into a Royal College. For the same reasons the pilot experiment referred to in last year's Annual Report, whereby a small working party was to be set up jointly between the R.M.P.A. and the N.A.M.H. was also shelved. In this instance, however, the reason for postponement was the reluctance of the N.A.M.H. to proceed with this project unless the R.M.P.A. could make a financial contribution to their anticipated joint expenses in providing a public relations service.

Special public interest was created in the London Meeting of the Association, at which a symposium on Schizophrenia was presented, and at the Joint Meeting of the R.M.P.A. and the A.P.A. in Edinburgh a successful Press Conference was held.

Report of the Research and Clinical Section

Three meetings of the Section's Executive Committee were held during the year, in July and November 1964, and February 1965.

On 1 January 1965 there were 1,460 members of the Section.

The following members were elected to fill vacancies on the Executive Committee: Dr. W. McC. Anderson, Dr. S. Cohen, Dr. J. A. N. Corsellis,

Dr. R. E. Hemphill, Dr. J. Hoenig, Dr. D. W. Kay, Dr. R. Maggs, Dr. D. Richter.

Dr. J. Hoenig was appointed Secretary of the Clinical Psychiatry Sub-Committee to succeed Dr. A. J. Coppen, who was elected Secretary of the Section. Dr. P. Sainsbury was elected Chairman of the Section. Dr. J. A. N. Corsellis was re-appointed Secretary of the Pathology, Biochemistry and Neurophysiology Sub-Committee, and Dr. R. Brittain Secretary of the Forensic Psychiatry Sub-Committee.

The Secretary of the Clinical Psychiatry Sub-Committee arranged a course of ten weekly lectures in the Autumn of 1964 on "The Application of Statistical Methods to Psychiatric Practice" which were given be Dr. Lilli Stein, followed by a further course of ten lectures in the Spring of 1965. These proved remarkably successful and were very well attended. The following open meetings were also held: "A Technique for Cross-Cultural Intensive Analysis of Psychiatric Disorders", Dr. Nathan Kline (July, 1964); "General Mechanisms underlying Treatments" by Dr. W. G. Dewhurst, "Structure Activity Relationship Studies on Mescaline" by Dr. J. R. Smythies, and "Effect of Lithium Therapy on Electrolyte Metabolism" by Dr. P. M. Shaw (November 1964).

The Secretaries of the Clinical Psychiatry and Pathology, Biochemistry and Neurophysiology Sub-Committees arranged a joint open meeting on dementias in old age. Dr. Myre Sim spoke on the "Clinical Aspects" and Dr. Walter Smith on the "Pathological Aspects" of "Cerebral Biopsy in the Investigation of Pre-Senile Dementia". After supper Dr. Valerie Cowie spoke on "The Genetical Aspects of the Organic Dementias", Dr. Malcolm Piercy on "Is Dementia a Unitary Defect or a Collection of Specific Disabilities?" and Drs. J. Margerison and D. Scott on "EEG in Pre-Senile Dementia, with particular reference to Huntington's Chorea".

The Secretary of the Forensic Psychiatry Sub-Committee arranged the following open meetings during the year: Dr. Tollington addressed the meeting at Grendon Underwood Prison in July 1964; four papers were delivered at the November 1964 meeting—"Aetiological Patterns in Delinquent Adolescents", Dr. F. H. Edwards; "Preliminary Survey of Twins seen at the Portman Clinic", Dr. A. Limentani; "Sexual Motivations in 'Ordinary' Offences", Dr. L. H. Rubinstein; "Gerontophilia in Identical Twins", Dr. H. M. Horden.

A Research Advisory Panel of 20 members with research experience has been formed to assist members with research problems, and a Sub-Committee set up (Secretary, Dr. Sainsbury) to organize its activities. The same sub-committee is also examining the kinds of centralized research which might be profitably promoted by the Section.

Report of the Child Psychiatry Section

The Child Psychiatry Section has met on four occasions during the year.

On 10 July, 1964, Section members visited the Adolescent In-Patient Unit at Chandlers Ford, where Dr. Allchin showed us round the Unit and gave a paper on his work and this was followed by a discussion. In the afternoon the Section met at the Central Health Clinic, Southampton. Lady (Hilda) Lewis and Dr. Christopher Haffner read a paper on Adoption. After a lively discussion the Section toured the new clinic under the guidance of Dr. Mary Capes. Forty members attended.

On 19 November Dr. D. A. Pond gave the Chairman's Address on "Compulsory Child Guidance?" Forty members joined in the subsequent full discussion.

On 11 February, 1965, the Section met at University College Hospital when Dr. Mavis Gunter showed a film and gave a talk on "First Responses in Feeding". Dr. L. Frankl contributed a paper on "The Significance of Early Feeding Disturbances in Neurotic Symptom Formation and Character Development in Children and Adolescents". The meeting was followed by a Buffet Supper at University College Hospital.

The Annual Study Week-End was held at Hamilton Hall, St. Andrews. The theme of the conference was Research and Child Psychiatry. Drs. W. J. B. Rogers, P. H. Connell and G. O'Gorman led a panel discussion on "Objects and Priorities in Child Psychiatric Research". Dr. John Bowlby spoke on "Problems of Aetiology and Methods of tackling them". Dr. Sulammith Wolff described a plan for comparative study of clinic and ordinary schoolchildren regarding behaviour disorders and their background. Dr. Ian Berg read a paper on Psychological Aspects of Functional Faecal Incontinence in Children. A visit was made to the Child Psychiatry Units in Dundee. Professor Herbert Birch of New York also addressed the meeting. Drs. F. Stone, L. Hersov, W. Warren, M. Rutter and Professor Millar led a panel discussion on "Research Methods in Child Psychiatry".

The three Working Parties continue consideration of (1) Psychiatry and Juvenile Delinquency, (2) Psychiatric Needs of the Blind, and (3) Special Schools and Hostels for Disturbed Children. Evidence was given to the Ministry of Health Working Party on the Safety of Children in Hospital.

The Executive Committee met on three occasions.

On 1 January 1965 there were 750 members of the Section.

Report of the Psychotherapy and Social Psychiatry Section

Seven meetings of the Section were held during the period under consideration. The programme was planned to continue the attempt at defining social psychiatry and its relation to psychotherapy, and the Chairman, to further this, invited a series of speakers from outside psychiatry asking them in particular to describe their methodologies. Thus there were papers from an educationalist, sociologists, a social anthropologist, an ethologist and a Professor of social administration.

The attendance at meetings was extremely disappointing and the Executive Committee, which has met regularly, has been considering methods of improving attendance. It has also been faced with the lack of funds to enable speakers from outside psychiatry to be offered expenses.

On 1 January 1965 there were 1,277 members of the Section.

Report of the Mental Deficiency Section

July Meeting, 1964. The Section met to discuss reports of Sub-Committees on the problems of clinical classification, and decided to devote a Section meeting to a discussion of this at a later date. It was agreed that steps should be taken to ensure that both classification and documentation were comparable throughout the hospitals, and the Committee were asked to look into this matter.

November Meeting, 1964. The Section met at the time of the Quarterly Meeting to hear a paper on Genetic Counselling.

February Meeting, 1965. The meeting was devoted to documentation and the discussion was opened by Dr. J. M. Berg. The problems of selection of information to be recorded, availability of data, use of Local Authority records and standized methods of records were discussed, and the Committee were asked to look into the matter, and design records which would be acceptable to all hospitals.

Annual General Meeting, 29 April, 1965 Rampton Hospital. During the course of the meeting Lt.-Col. Freer read a paper on Review Tribunals with special reference to Rampton Hospital.

The Section Executive Committee had prepared a memorandum on the training of specialists in mental deficiency, which was presented at the July 1964 meeting when it was referred back to the Sub-Committee. This Memorandum was redrafted and approved at the Annual General Meeting of the Section and is being discussed by the Education Committee prior to its submission to Council when it is hoped it will be published.

The Scheme for a multicentre drug trial is at present in abeyance pending detailed arrangements being made by the special Sub-Committee. The Section has also set up a Sub-Committee to consider a new Green Handbook for Nurses.

The most important event in Mental Deficiency during the course of the past year has been the International Congress on the Scientific Study of Mental Deficiency which was held in August 1964 in Copenhagen and the setting up of the International Association for the Scientific Study of Mental Deficiency. The Mental Deficiency Section of the R.M.P.A. has played a leading part in the setting up of the International Association and participated fully in the organization of the Congress.

Report of the Proceedings of the Council Meeting held on 13 July, 1965

The General Secretary read the following report.

"Council met yesterday afternoon at the University, and accepted the report of the Petition Committee to the effect that this Committee had sought the advice of learned counsel and would take the negotiations a stage further when his advice was available.

Counsel approved the minutes of the Special Meeting of Council held on 26 June which accepted in principle the Special Committee's proposals for the nature of the higher qualification, for the inception procedure of the College and the consequent revision of the bye-laws, supplemented by draft Council Resolutions and proposed Regulations. It was reported to Council that at the present time work was proceeding on drafting these proposals in precise form.

Council were glad to learn that the Memorandum on Medical Education prepared by the Education Committee had been submitted to the General Medical Council.

The Co-Editor reported that the Journal proposed to follow a more positive policy regarding the publication of papers read at Quarterly Meetings.

The Parliamentary Committee Report contained an account of the difficulties which had been encountered in the operation of Section 30 (Sub-Section 2) of the Mental Health Act. The Council approved the circulation of information on this subject to members of the Association and to the Committee of the Psychological Medicine Group of the British Medical Association.

The Papers and Discussions Committee reported that at the November Meeting the morning session would be devoted to a symposium on "The Effect of Early Bereavement on Mental Disorders in Later

Life". The February Meeting would be devoted to a discussion on "Impotence and Frigidity", and the May Meeting to forensic psychiatry.

The Report on Schools and Hostels for Maladjusted Children, prepared by the Child Psychiatry Section, was approved with amendments.

The Reports of the Council, the Officers and the Standing Committees were adopted.

A motion proposed by Professor M. Hamilton was also passed, that the methods of selection of papers and speakers by the Papers and Discussions Committee be considered.

Dr. J. Bierer questioned the method of selection by Council for membership of Special Committees, with particular reference to the Organising Committee for the Sixth International Congress of Psychiatry.

The usual grant to the President during his year of office was approved.

Dates of Meetings, 1965-66

The following dates were approved:

Thursday and Friday, 18 and 19 November, 1965 (London); Wednesday and Thursday, 9 and 10 February, 1966 (London); Tuesday and Wednesday, 3 and 4 May, 1966 (Nottingham); 5-8 July, 1966 (*Place and date to be confirmed*).

Election of Members

The following were unanimously elected:

Honorary Members

ROME, Howard P., President, American Psychiatric Association.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. A. B. Monio, Dr. William Sargant.

BLAIN, Daniel, Past-President, American Psychiatric Association.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. A. B. Monro, Dr. William Sargant.

FARRAR, Clarence B., Editor, American Journal of Psychiatry.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. A. B. Monro, Dr. Eliot Slater.

Corresponding Members

ALSTRÖM, C. H., St. Gorans Sjukhus, Stockholm.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. A. B. Monro.

AUERBACK, Alfred, Associate Clinical Professor of Psychiatry, University of California.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. A. B. Monro.

POLONIO, P., Professor, Department of Psychiatry, University of Lisbon.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. Eliot Slater.

STÜRUP, G. K., Medical Superintendent, Herstedvester, Denmark.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. A. B. Monro.

TOMPKINS, Harvey J., President-Elect, American Psychiatric Association.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. A. B. Monro.

VOLMAT, Robert, Professor of Psychiatry, University of Besançon, Paris.
Proposed by Dr. Ian Skottowe, Professor Desmond Curran, Professor T. Ferguson Rodger, Dr. A. B. Monro.

Ordinary Members

AHMED, Syed Haroon, M.B., B.S., D.P.M., Resident Medical Officer, Jinnah Post Graduate Medical Centre, Karachi, Pakistan.
Proposed by Drs. G. F. M. Russell, D. L. Davies, P. D. Scott.

AITKEN, John Alexander, M.R.C.S., L.R.C.P., Junior Medical Officer, Coldeast Hospital, Sarisbury Green, near Southampton.
Proposed by Drs. J. F. D. Murphy, A. E. P. Swinson, J. S. Harcombe.

ALI, A. K. M. Amjad, M.B., B.S., Clinical Assistant, Long Grove Hospital, Epsom, Surrey.
Proposed by Drs. J. J. Cockburn, I. Husain, A. G. Khan.

ANGUS, Ian Alexander, M.B., Ch.B., Senior Medical Officer, H.M. Prison, Birmingham.
Proposed by Drs. H.St.J. Mansbridge, M. W. Fowles, C. Tetlow.

BACAL, Howard Athol, B.A., M.D., C.M., L.M.C.C., Senior Registrar, The Tavistock Clinic, 2 Beaumont Street, London, W.1.
Proposed by Drs. J. D. Sutherland, R. Gosling, J. L. Wilson.

BEAUBRUN, Michael, M.B., Ch.B., D.P.M., Professor of Psychiatry, University of the West Indies, Kingston, Jamaica.
Proposed by Drs. William Sargant, A. B. Monro, W. Warren.

BIRD, Donald William Kemp, M.A., M.B., B.Chir., Registrar, Claybury Hospital, Woodford Bridge, Essex.
Proposed by Drs. Elisabeth Shoenberg, May Monro, D. V. Martin.

BLAYA, Marcelo, M.D., Associate Professor of Psychiatry and Director, Fac. de Medicina de Porto Alegre; Avenida Joao Pessoa, 925, Porto Alegre, Brazil.
Proposed by Drs. J. Satten, W. G. Burrows, C. G. MacRae.

BOWEN, Elizabeth Joan, M.B., B.Ch., D.Obst.R.C.O.G. Registrar, Brookwood Hospital, Woking, Surrey.
Proposed by Drs. J. M. Frew, S. M. A. Malik, Joan Garai.

BRISCOE, Oliver Villiers, M.B., M.R.C.P., D.P.M., Senior Registrar, Maudsley Hospital, Denmark Hill, London, S.E.5.
Proposed by Drs. P. D. Scott, J. T. L. Birley, M. D. A. Heller.

BURVILL, Peter Walter, M.B., B.S., M.R.C.P.E., Fellow in Psychotherapy, Ross Clinic, Aberdeen.
Proposed by Professor W. M. Millar, Drs. H. G. Tough, F. J. Jarrett.

CASSON, Frederick Ronald Christopher, M.B., B.S., D.P.M., 66 Montagu Mansions, London, W.1.
Proposed by Drs. M. I. Pines, A. C. R. Skynner, P. B. de Mare.

CHARY, Parastu Srinivas, B.Sc., M.B., B.S., Director. Neurological Institute of India, Madras 10, India.
Proposed by Drs. D. P. Patel, O. Somasundaram, A. Walk.

COPUS, Paul Edward, M.A., M.B., B.Chir., M.R.C.S., L.R.C.P., Medical Officer, *R.A.M.C.* Royal Victoria Hospital, Netley: 2 West Road, Barton Stacey, Hants.
Proposed by Drs. G. G. Wallis, F. P. D. Easby, J. F. D. Murphy.

CRAUSE, Jack, M.B., B.S., D.P.M., Senior Assistant Psychiatrist, Rauceby Hospital, Sleaford, Lincs.
Proposed by Drs. H. A. Cole, D. Glendinning, A. H. Lorimer.

DAVIES, Bridget Ann, B.A., B.M., B.Ch., D.P.M., Registrar, Department of Psychological Medicine, Guy's Hospital, London, S.E.1.
Proposed by Drs. D. Stafford-Clark, J. J. Fleminger, G. F. Vaughan.

DOVE, Peter Raymond, M.B., B.S., Junior Medical Officer, Long Grove Hospital, Epsom, Surrey.
Proposed by Drs. A. B. Monro, C. M. B. Pare, A. A. Black.

EGAN, John, M.B., B.Ch., B.A.O., Registrar, Clifton Street Day Hospital, Belfast and Holywell Hospital, Antrim: 18 Easton Crescent, Belfast 14, N. Ireland.
Proposed by Drs. R. W. Whiteley, N. Lukianowicz, Eileen Kane.

EL-DEIRY, Nabil Kamel, M.B., B.Ch., L.M.S.S.A., Registrar, Royal Edinburgh Hospital, Morningside, Edinburgh 10.
Proposed by Drs. A. D. Forrest, J. W. Affleck, D. W. Hall.

EZZAT, Dorry Hassam, M.B., B.Ch., Diploma Psychiatry & Neurology, Senior Psychiatrist, Kuwait State Hospital for Nervous and Psychological Disorders: P.O. Box 2305, Kuwait, Arabian Gulf.
Proposed by Drs. H. A. Darwich, A. Bentovim, R. P. N. Singh.

FARID, Amadeldin Ahmed, M.B., B.Ch., Post-Graduate Student and Clinical Assistant, Maudsley Hospital, Denmark Hill, London, S.E.5.
Proposed by Drs. E. Moran, H. G. S. Sergeant, H. A. Darwich.

FILER, John Leslie, M.B., Ch.B., House Physician, Royal Infirmary, Sheffield.
Proposed by Drs. N. L. Gittleson, I. G. Bronks, Professor E. Stengel.

GALLOWAY, Elizabeth, M.B., Ch.B., Registrar, Gartnavel Royal Hospital, Glasgow, W.2.
Proposed by Drs. H. C. Fowlie, J. Moffat, Sheila Black.

GATH, Ann Mary Gethin, M.A., B.M., B.Ch., D.C.H., Clinical Assistant, Department of Child Guidance, St. Thomas's Hospital, London, S.E.1.
Proposed by Drs. F. J. Letemendia, K. L. Granville-Crossman, E. S. Paykel.

GOMEZ-BENEYTO, Manuel, L.M.S., D.P.M., Registrar, Little Plumstead Hospital, near Norwich.
Proposed by Drs. G. L. Ashford, I. Heald, R. Payne.

HAIDER, Ijaz, B.Sc., M.B., B.S., Senior House Officer, Severalls Hospital, Colchester, Essex.
Proposed by Drs. Russell Barton, D. Sarbadhikary, L. Hurst.

HAJIOFF, Jack, M.B., Ch.B., M.R.C.S., L.R.C.P., D.P.M., Senior Registrar, St. Clement's Hospital, London, E.3.
Proposed by Drs. P. H. Tooley, J. Denham, S. J. M. Fernando.

HARRIS, Jean Mary, M.B., Ch.B., D.P.M., Part-time Psychiatrist, County Council of Essex: 252 Fronks Road, Dovercourt, Essex.
Proposed by Drs. M. Sim, R. W. Tibbetts, H. C. White.

HEARD, Dorothy Helen, Ph.D., M.B., B.S., M.R.C.P., Senior Registrar, Tavistock Clinic, 2 Beaumont Street, London, W.1.
Proposed by Drs. J. Bowlby, H. V. Dicks, J. D. Sutherland.

HIGGINSON, John Christopher, M.R.C.S., L.R.C.P., Senior House Officer, Long Grove Hospital, Epsom, Surrey.
Proposed by Drs. J. S. Bearcroft, J. J. Cockburn, L. J. Clein.

JUKES, Majorie Vida, M.B., Ch.B., D.P.H., Junior Medical Officer, Deva and Moston Hospitals, Chester.
Proposed by Drs. J. Browne, T. G. Parker, B. G. Jackson.

KHAN, Mohamed Abdul Majeed, M.B., B.S., Registrar, Powick Hospital, Worcester.
Proposed by Drs. M. Harper, I. E. I. Williams, K. S. R. Bedi.

KING, David John, M.B., B.Ch., B.A.O., Medical Officer, Belfast City Hospital: 1 Princes Gardens, Larne, Co. Antrim.
Proposed by Professor J. G. Gibson, Drs. J. C. Meenan, S. J. Knox.

KIRMAN, Brian Herbert, M.D., D.P.M., Consultant Psychiatrist, Fountain and Carshalton Hospital Group; Queen Mary's Hospital for Children, Carshalton, Surrey.
Proposed by Drs. Valerie Cowie, E. C. Donoghue, E. A. Harvey-Smith.

KOHIYAR, Jehangir Ardeshir, M.B., B.S., Senior House Officer, Psychiatric Department, St. Pancras Hospital, London, N.W.1.
Proposed by Drs. E. W. Dunkley, Elizabeth M. Rich, S. Carlish.

LEAHY, Thomas Charles, M.A., M.B., B.Ch., Senior Medical Officer, Hortham-Brentry Hospital Group: 14 Owen Grove, Henleaze, Bristol.
Proposed by Drs. W. Lumsden Walker, W. A. Heaton-Ward, J. Jancar.

LISHMAN, William Alwyn, B.Sc., M.B., Ch.B., M.R.C.P., D.P.M., Senior Registrar, Maudsley Hospital, Denmark Hill, London, S.E.5.
Proposed by Drs. R. Levy, M. G. Gelder, D. F. Scott.

LORIGAN, Philomena, M.B., B.Ch., Assistant Medical Officer, Our Lady's Hospital, Lee Road, Cork, Eire.
Proposed by Drs. Margaret Kelly, C. Carey, M. J. Kennefick.

MCEWEN, Jean Mackinlay, M.B., Ch.B., D.P.H., Registrar, Gartloch Hospital, Glasgow.
Proposed by Drs. J. Buchanan, I. A. Gibson, C. B. Whittaker.

MCKIBBEN, William Robert, B.Sc., M.B., B.Ch., D.T.M.&H., D.P.H., Senior Registrar, Royal Eastern Counties Hospital, Colchester, Essex.
Proposed by Drs. D. M. Lynch, G. D. Fraser Steele, J. N. Badham.

MACKINNON, Ranald Scott, M.B., Ch.B., Trainee in Psychiatry, Royal Victoria Hospital, Netley, Hants.
Proposed by Drs. E. G. Lucus, J. F. D. Murphy, A. W. Scott-Brown.

MACKINTOSH, Bertine Janet Cameron, M.B., Ch.B., Medical Officer, Child Guidance Clinic, 339 Wakefield Street, Adelaide, South Australia.
Proposed by Drs. F. M. M. Mai, J. E. Cawte, Professor L. G. Kiloh.

MCLEAN, Iole L'Estrange Kilburn, M.B., Ch.B., D.R.C.O.G., Junior Medical Officer, Herdmanflat Hospital, Haddington, East Lothian.
Proposed by Drs. W. D. Boyd, A. B. Hegarty, W. M. Mason.

MADEN, James Gordon, M.R.C.S., L.R.C.P., Registrar, Oldham and District Hospital Group: 11 Hargreaves Drive, Rawtenstall, Rossendale, Lancashire.
Proposed by Drs. A. Pool, G. Milner, J. Johnson.

MALAN, David Huntingford, M.A., D.M., D.P.M., Senior Medical Officer, Tavistock Clinic, 2 Beaumont Street, London, W.1.
Proposed by Drs. H. V. Dicks, S. Bourne, D. C. Wallbridge.

MORRIS, David, M.R.C.P., D.C.H., Consultant Paediatrician, Woolwich and Thanet Hospital Groups: 7 Wimpole Street, London, W.1.
Proposed by Drs. Portia Holman, J. H. Kahn, A. Walk.

MURPHY, Kathleen Pamela, M.B., B.Ch., B.A.O., Senior House Officer, All Saints' Hospital, Birmingham, 18.
Proposed by Drs. N. W. Imlah, R. Antebi, C. Mellor.

NAKHLA, Fayek Latif, M.Sc., M.B., B.Ch., Registrar, Cassel Hospital, Ham Common, Richmond, Surrey.
Proposed by Drs. A. R. Wilson, A. Brook, J. D. Templeton.

NEHAMA, Victor Salim, M.B., Ch.B., D.P.M., L.M.S.S.A., Senior Registrar, Rubery Hill Hospital, Birmingham.
Proposed by Drs. J. R. Mathers, J. G. Wardell-Yerburgh, V. J. Richards.

NOBLE, Peter John, M.B., M.R.C.P., Senior House Officer, Maudsley Hospital, Denmark Hill, London, S.E.5.
Proposed by Drs. J. P. Watson, J. Sakinofsky, D. P. B. Goldberg.

PANAHLOO, Hassan Ali, M.D., Clinical Assistant, Maudsley Hospital, Denmark Hill, London, S.E.5.
Proposed by Drs. A. D. Isaacs, H. D. Beckett, D. Smedberg.

PELL, Bryan Anthony, M.B., Ch.B., Registrar, Department of Psychiatry, Leeds University, Leeds.
Proposed by Drs. E. A. M. Wood. A. T. Lloyd, R. P. Snaith.

PHILLIPS, John Ernest, M.B., B.Ch., D.P.M., Registrar, Fulbourn and Addenbrooke's Hospitals; Tudor House, 1 High Street, Hauxton, Cambridgeshire.
Proposed by Drs. D. H. Clark, R. L. Buttle, B. Davy.

PILLUTLA, Venkata Subbayya, M.B., B.S., D.P.M., Medical Officer, Government of Western Nigeria, Aro Hospital, Abeokuta, Western Nigeria.
Proposed by Drs. M. W. Annear, H. Rosenberg, K. S. Jones.

PLAYER, David Arnott, M.B., Ch.B., D.P.H., D.P.M., Medical Officer of Health, Royal Burgh of Dumfries, Dumfries.
Proposed by Drs. A. C. Tait, R. A. Robinson, P. J. Browne.

PONCE-CORNEJO, Carlos Manuel, M.D., Clinical Assistant, Maudsley Hospital, Denmark Hill, London, S.E.5.
Proposed by Dr. D. L. Davies, Professor Aubrey Lewis, Dr. F. Kraupl Taylor.

PORTER, Robert Alexander, M.A., M.B., B.Ch., B.A.O., Deputy Medical Superintendent, Moss Side Hospital, Maghull, Liverpool.
Proposed by Drs. J. McDougall, B. Finkleman, R. B. Taylor.

PRYCE, Gwenllian Joy, M.B., Ch.B., D.C.H., D.R.C.O.G., Registrar in Child Guidance, North Wales Clinics: 2 Beach Avenue, Old Colwyn, Denbighshire.
Proposed by Drs. E. Simmons, T. G. Williams, J. H. O. Roberts.

PRYSE-PHILLIPS, William Edward Maiben, M.B., B.S., Senior Research Fellow, University of Birmingham: The Manor House, Bristol Road, Birmingham, 31.
Proposed by Professor W. H. Trethowan, Drs. R. H. Cawley, J. E. Varley.

RATNAVEL, Chellappah, F.R.C.P., L.R.C.P., L.R.C.S., D.C.H., Assistant Medical Superintendent, Central Mental Hospital, Tanjong Rambuton, Perak, Malaysia.
Proposed by Drs. J. D. W. Pearce, L. T. Hilliard, E. M. Creak.

REDA, Mohamed Talaat, M.B., B.Ch., D.P.M., Director, Kuwait State Hospital for Nervous and Psychological Disorders, P.O.B. 1077, Kuwait, Arabian Gulf.
Proposed by Drs. H. A. Darwich, R. P. N. Singh, H. Islam.

RICHARDS, David John, B.Sc., M.B., Ch.B., M.R.C.S., L.R.C.P., Medical Adviser, John Wyeth and Company, Taplow, Bucks.
Proposed by Drs. A. D. Forrest, J. W. Affleck, Sallie Gray.

RICHARDSON, Thomas David Ellis, M.B., Ch.B., Registrar, Storthes Hall Hospital, Kirkburton, Huddersfield, Yorkshire.
Proposed by Drs. A. L. G. Smith, D. H. Ropschitz, N. V. Wilkinson.

RONDEL, Richard Kavanagh, M.B., B.S., Medical Adviser, John Wyeth, Taplow, Bucks.
Proposed by Drs. A. D. Forrest, J. W. Affleck, Sallie Gray.

SEIDEL, Ulric Paul, M.B., B.S., D.P.H., Principal Medical Officer in Mental Health, Borough of Harringay: 68D Holden Road, Woodside Park, London, N.12.
Proposed by Drs. K. A. Graf, R. C. Greenberg, Rachel D. Fidler.

SHAW, Horace Arthur, M.B., Ch.B., M.R.C.S., L.R.C.P., D.Obst.R.C.O.G., General Medical Practitioner: 12 Unity Place, Oldbury, Birmingham.
Proposed by Drs. H. Thakurdas, D. L. Aspinall, H. C. Fisher.

SHIELDS-WATTS, Thomas Patrick, M.B., B.S., Clinical Director of Psychiatry, Salkirk Hospital and Associate in Research, Rockland State Hospital, New York, U.S.A.
Proposed by Drs. R. Macdonald, J. A. Irwin, C. R. Harris.

SIMPSON, Gavin John Stuart, M.B., Ch.B., Registrar, Birch Hill Hospital, Rochdale, Lancashire.
Proposed by Drs. S. Falk, J. T. Elliott, J. Devlin.

SMITH-MOORHOUSE, Peter Milner, M.B., Ch.B., Medical Officer, H.M. Prison, Wakefield, Yorkshire.
Proposed by Drs. W. A. Weston, I. G. W. Pickering, R. E. D. Markillie.

SODDY, Andrew Geoffrey, M.A., M.B., B.Chir., Senior House Officer, Hellingly Hospital, Hailsham, Sussex.
Proposed by Drs. M. H. Symes, K. Soddy, H. B. N. Jennings.

SPELMAN, Michael Stanway, M.B., Ch.B., D.P.M., Lecturer in Psychological Medicine, University of Liverpool: 25 Bushbys Park, Formby, Lancashire.
Proposed by Drs. R. Kellner, D. Jones, D. V. Coakley.

THOMPSON, Arthur Geoffrey, M.Sc., M.D., F.R.C.P.I., Consultant Psychiatrist, Tavistock Clinic, 2 Beaumont Street, London, W.1.
Proposed by Drs. H. V. Dicks, J. D. Sutherland, J. H. Padel.

TODES, Cecil Jacob, M.R.C.S., L.R.C.P., Registrar, Tavistock Clinic, 2 Beaumont Street, London, W.1.
Proposed by Drs. H. M. Holden, W. P. K. Calwell, K. C. Martin.

TOLLINGTON, Hugh John, M.A., B.M., B.Ch., D.P.M., Senior Registrar, Warley Hospital, Brentwood, Essex.
Proposed by Drs. G. C. Heller, D. P. Cronin, C. P. B. Brook.

VICKERY, Heather Felicity Ann, M.B., B.S., Senior House Officer, St. Luke's-Woodside Hospital, Muswell Hill, London, N.10.
Proposed by Drs. A. Duddington, H. W. D. Davies, D. H. Morgan.

WALDENBERG, Samuel Stuart Anthony, M.B., B.S., Senior House Officer, Department of Psychological Medicine, University College Hospital, London, W.C.1.
Proposed by Drs. E. W. Dunkley, S. Carlish, E. M. Rich.

WATT, John Alexander, M.B., Ch.B., Registrar, Ross Clinic, Aberdeen.
Proposed by Professor W. M. Millar, Drs. J. M. Todd, J. G. Henderson.

WILKINS, Gavin Donaldson, M.B., B.S., D.P.M., Psychiatrist, Larundel Psychiatric Hospital, Bundoora, Victoria, Australia.
Proposed by Drs. J. B. Gordon-Russell, J. W. Newton, P. D. Rohde.

WILLEMS, Pierre Jacques Anthony Vincent, L.M.S.S.A., Registrar, Littlemore Hospital, Oxford.
Proposed by Drs. F. J. Letemendia, D. H. C. Surridge, I. H. Jones.

WRIGHT, Henry Beric, M.B., F.R.C.S., Medical Director, Institute of Directors' Medical Centre: 10 Belgrave Square, London, W.1.
Proposed by Drs. R. F. Tredgold, D. V. Martin, J. Pippard.

ZILLIACUS, Oswald Joseph, M.R.C.S., L.R.C.P., D.A., Registrar, Warley Hospital, Brentwood, Essex.
Proposed by Drs. T. H. Kaplan, C. P. B. Brook, D. Cronin.

ASSOCIATE MEMBER

The following, whose candidature was approved by Council on 10 May, 1965, was unanimously elected:

METCALF, Maryse, Dip. Psych. App. (Geneva), Scientific Officer, Neuropsychiatric Research Unit, Medical Research Council, Carshalton, Surrey.
Proposed by Drs. D. Richter, A. J. Coppen, D. M. Shaw.

Adjournment of Annual Meeting

It was proposed, seconded, and carried unanimously that the Annual General Meeting should be adjourned at the end of the present sessions with a view to re-assembling in London at a date to be arranged in the Autumn.

Paper

The rest of the morning was devoted to a paper by Dr. Joseph Wortis entitled:

"SIGMUND FREUD—SOME RECOLLECTIONS AND ANTICIPATIONS"

Lunch

Members and their wives were the guests of the Board of Management of Gartnavel Royal Hospital to Lunch.

Afternoon Session

Vote of Thanks to Officers and Council

In proposing this vote Dr. E. J. C. Hewitt thanked Council for the enormous amount of work done during the past year, and the members of Special Committees, particularly those concerned with the new bye-laws and the presentation of a Petition to the Privy Council. Dr. Hewitt paid tribute to Dr. Skottowe's very successful Presidency and the support he had received from the dynamic General Secretary, another Scotsman. He also referred to the sound ability of the Treasurer and to Dr. Sargant, the stormy petrel of psychiatry, who among other things organized the highly successful Maudsley Bequest Lecture Courses. Thanks were due to Dr. Slater who brought great academic distinction to the *British Journal of Psychiatry* and to the learned Dr. Walk, the Association's parliamentarian and librarian.

Dr. Hewitt also paid tribute to the work done by the Divisional and Sectional Chairmen and Secretaries, paying special tribute to Dr. Macrae and the Scottish Divisional Committee of Management for the great work done in connection with the Joint Meeting with the American Psychiatric Association.

In seconding the Vote of Thanks Dr. A. C. Tait supported all that had been said by Dr. Hewitt, and also thanked Miss Cobbing and the office staff for all their work on behalf of the Association during the past year.

The vote was carried by acclamation.

Induction of New President

Dr Skottowe invested Professor Rodger with the Presidential badge, and Professor Rodger conferred the Past-Presidential Badge on Dr. Skottowe.

The following delegates were then presented to Professor Rodger:

Dr. Joseph Wortis representing the American Psychiatric Association and the American Orthopsychiatric Association.

Dr. Jean Titeca representing the Société Royale de Médecine Mentale de Belgique.

Dr. W. G. Burrows representing the Canadian Psychiatric Association on behalf of Dr. D. G. McKerracher, who was prevented by illness from being present.

Dr. L. Frighi representing the Società Italiana di Psichiatria.

Dr. C. A. Crafoord representing the Svenska Psychiatriska Foreningen.

Dr. R. W. Medlicott representing the College of Psychiatrists of Australia and New Zealand.

Dr. N. W. De Smit of the Netherlands Psychiatric Association was later presented to the President.

It was agreed that the parchments for the newly elected Honorary and Corresponding Members who had been unable to attend the meeting should be sent to them with the congratulations and good wishes of the Association.

The President presented the Gaskell Gold Medal to Dr. William Alwyn Lishman and it was agreed that the award to Dr. Sidney Crown who had been unable to attend should be sent to him with the Association's congratulations.

The President presented Dr. Kenneth Lawrence Granville-Grossman with the Bronze Medal and congratulated him upon his success. It was agreed that the Divisional Prize awarded to Dr. May Monro should be sent to her with congratulations.

It was announced that the Maudsley Lecture in 1965 would be given by Professor L. S. Penrose and would be entitled "The Contributions of Mental Deficiency Research to Psychiatry in General". In 1966 Professor O. Ødegaard would lecture on "Changes in the Prognosis of Functional Psychoses since the Days of Kraepelin".

Presidential Address

The President then delivered his address entitled:

"The Role of the Psychiatrist"

The Vote of Thanks to the President for his Address was proposed by Dr. J. R. Rees, seconded by Dr. H. B. Craigie and carried by acclamation.

General Vote of Thanks

Dr. Monro said it was an established custom of which he fully approved that after the Presidential Address the General Secretary should have the pleasurable task of thanking all those people who had done so much in many ways to make the meeting a success. First of all, thanks were due to the President for all his work in the organization of the scientific and social functions. In this he had been ably helped by Mrs. Rodger. In particular Dr. Monro referred to the delightful and pleasant Council Dinner and to the ladies' visit to Loch Lomond, and the forthcoming visit to Glasgow Cathedral, in connection with which special thanks were also due to Dr.

Nevile Davidson, Mr. T. Donaldson Barr and Dr. Bell.

Thanks were due to the Board of Management of Gartnavel Royal Hospital and to the Western Regional Hospital Board for all the help they had given in many ways during the meeting. Dr. Monro referred especially to the Reception at Gartnavel on the previous evening and the splendid lunch preceding that afternoon's session. He mentioned, in particular, Mr. John Dunlop, Chairman of the Regional Hospital Board; Dr. Cyril Bainbridge, the Senior Administrative Medical Officer; Mr. P. Watt, the Secretary; Miss P. Bell; Bailie Braid, Chairman of the Board of Management and Mr. D. E. A. Smith, the Secretary; Dr. Angus MacNiven; Miss Tait, the Matron; and the catering officer, Miss E. Hutchison.

Very special thanks were also due too to the University for giving the Association the use of the New Arts Building and the Council Meeting in the Senate Room, as well as allowing the Annual Dinner to be held in the Hunter Hall. The Association were particularly grateful for the Reception before the Dinner. Thanks was also due for the facilities made available to members to stay at Wolfson Hall. Dr. Monro thanked Dr. R. T. Hutcheson, the Secretary of the University Court; Mr. Bradley, the Assistant Secretary; Mr. Main, the Bedellus, and Miss Hamilton of the College Club, for all their efforts on behalf of the Association.

Dr. Monro further thanked in advance Dr. A. M. Donnet, Chairman of the Board of Management, of the Southern General Hospital, and the Secretary, Mr. D. L. Laing, Dr. A. M. Tait, Miss I. M. Wares, Miss G. V. Hicks and the Catering Officers, Mr. Henderson and Miss Gibbs for the arrangements that were being made for the scientific meetings and hospitality on the following day.

Also in advance, Dr. Monro thanked Sir Peter Meldrum, Lord Provost, and the Magistrates of the City of Glasgow for arranging to receive members and their wives at the Art Galleries. In this connection the Association would also like to thank the Lord Provost's Secretary Mr. Weir, and Mr. Hamilton.

To these and the many other people who had worked so hard and so willingly the Association owed a great debt of gratitude.

Annual Dinner and Reception

Before Dinner Members and their wives were entertained to sherry by the University.

As well as the overseas delegates who had previously been presented to the President, the guests included Dr. and Mrs. Wright, Lord Kissen, Mr. John Dunlop and Bailie Maurice Shinwell.

The following toasts were given:

"The Queen"

"The City and Corporation of Glasgow"

"The Guests"

proposed by Professor W. M. Millar
replied to by Dr. L. D. W. Scott

"The Royal Medico-Psychological Association"

proposed by the Hon. Lord Kissen
replied to by the President

THURSDAY, 15 JULY, 1965

The meetings were held at the Southern General Hospital and members were the guests of the Board of Management of Glasgow South-Western Hospitals for lunch. The following papers were presented:

Neurological Contributions to Psychiatry

"The Measurement of Regional Cerebral Blood Flow with Radioactive Inert Gases." Dr. A. Murray Harper.

"Psychological Sequelae of Head Injury." Mr. W. B. Jennett.

"Psychological Aspects of Myasthenia Gravis." Professor J. A. Simpson.

Psychophysiological and Pharmacological Contributions to Psychiatry

"Brain Physiology in Mental Disorder." Dr. W. Grey Walter, Dr. H. Crow.

"Psychophysiological Aspects of Psychiatric Disorder." Dr. G. S. Claridge.

"The Contributions of Pharmacology." Dr. E. Marley.

At an Open Meeting on the History of Psychiatry, held under the auspices of the Library Committee, the Parliamentary Committee and the Historical Section of the Scottish Division, Dr. H. B. Craigie presented a paper on the History of Scottish Mental Health Legislation and Dr. E. J. C. Hewitt discussed the Work of the Scottish Mental Welfare Commission.

Wives of members were conducted on a tour of Glasgow Cathedral and Provand's Lordship.

In the evening members and their wives attended a Reception at the Art Galleries at the invitation of the Lord Provost and the Corporation of Glasgow.

FRIDAY, 16 JULY, 1965

Section Meetings

A meeting of the Child Psychiatry Section was held at the Woodlands Day Centre.

The Psychotherapy and Social Psychiatry Section met at the University and the following papers were presented:

"EXPERIENCE IN DEVELOPMENT OF A DAY HOSPITAL IN EDINBURGH." Dr. Cap Thomson.

"A HUNDRED SCOTTISH PSYCHOTHERAPISTS." Dr. Gerald Timbury.

THE ROYAL MEDICO-PSYCHOLOGICAL ASSOCIATION AND THE AMERICAN PSYCHIATRIC ASSOCIATION JOINT MEETING, MAY 1965

THE JOINT MEETING of the two Associations was held between 8 and 12 May and constituted part of the Spring Quarterly Meeting of the R.M.P.A. and of the 121st Annual Meeting of the A.P.A.

His Royal Highness the Prince Philip, Duke of Edinburgh, was Patron of the Meeting. Sir David Henderson had been elected Honorary President of the Meeting, but unfortunately his health failed and he died before the date of the meeting.

Dr. Ian Skottowe, President of the R.M.P.A. and Dr. Howard Rome, President of the A.P.A. were Joint Presidents of the Meeting.

On Saturday, 8 May, a Welcoming Wine and Cheese Party was given at the Royal Edinburgh Hospital; on Sunday, 9 May, the official Opening Reception was held at the University of Edinburgh, and on Monday, 10 May a number of Tours, including visits to hospitals, were organized for participants and their wives. Among the hospitals visited were the Royal Edinburgh Hospital; Dingleton Hospital, Melrose; Ailsa Hospital, Ayr; Lennox Castle Hospital; the Southern General Hospital, Glasgow; Bangour Village Hospital; Crichton Royal, Dumfries; Stratheden Hospital, Fife; Bellsdyke Hospital, Larbert; and the Royal Liff Hospital, Dundee. On the Monday evening participants were the guests at a Reception given by the Corporation of the City of Edinburgh.

The Meeting opened on Tuesday, 11 May, at the McEwan Hall, with a Plenary Session at which the Joint Presidents gave addresses on "Trends and Issues in Psychiatry". The following telegram, in reply to a message of loyal greetings from the Joint Presidents, was read to the meeting:

"Thank you for your kind message which I was delighted to receive. I am sure that the outcome of the Joint Meeting in Edinburgh of the Royal Medico-Psychological Association and the American Psychiatric Association will be of the highest value to the medical profession.

Philip, *Patron*"

Dr. Ian Skottowe referred with great sorrow to the death of Sir David Henderson, and read part of a letter he had received from him in January. Sir David had expressed his thanks to the two Associations for what he regarded as a tremendous honour which had given him immense pleasure. Dr. Skottowe added that it was Sir David, more than anyone else, who laid the foundation of the *entente* between British and American Psychiatry and had constantly nurtured this delicate plant until it grew to a firmly-rooted tree. They had lost a great man, a great teacher and a great friend.

On the following afternoon there was a concluding Plenary Session, presided over by Professor Desmond Curran and Dr. Daniel Blain, the Immediate Past-Presidents of the two Associations, and addresses on the "Future of Psychiatry" were given by the Presidents-Elect of the two Associations, Professor T. Ferguson Rodger and Dr. Harvey J. Tompkins.

Between these, eight separate Seminars were held, at Adam House, on the subjects of "Psychopharmacology and other physical treatments", "Genetics", "Social and community psychiatry", "Training psychiatrists to meet changing needs", "Psychiatry of adolescence", "Rehabilitation", "Brief psychotherapy" and "Geriatrics".

On the evening of 11 May, a Reception and Dinner were held at Lauriston Castle, and at the conclusion of the whole meeting, the A.P.A. gave a Farewell Cocktail Party at the Caledonian Hotel, Edinburgh.

The following are summaries of the papers (with three exceptions) read at the Meeting:

OPENING PLENARY SESSION

Trends and Issues in Psychiatry

IAN SKOTTOWE, *Emeritus Consultant, Warneford Hospital, Oxford; President, Royal Medico-Psychological Association*

The outstanding trends in psychiatry in Britain to-day are those which spring from progressive changes in social attitudes, both towards psychiatry and within it; and the outstanding issues are those concerned with attitudes and plans relating to groups of patients; to individual patients; and to the status of psychiatry and psychiatrists.

Groups of Patients

(1) The late Walter Maclay's Adolf Meyer Lecture (1963)[1], which dealt with the now widely known proposals for the run-down of mental hospital beds and the planning of future mental health services in line with observed epidemiological trends in England and Wales, is taken as a starting point.

(2) The proposed new general hospital psychiatric units must be comprehensive—not ivory towers housing a *corps d'élite* of patients and staff—and fully integrated with the rest of the service.

(3) The Registrar General's (1964) figures show that in ten years the increased first-admission rate per unit of population is accounted for chiefly by manic-depressive reactions, and to some extent by psychoneuroses and senile psychoses. The rate for schizophrenia in men is obstinately static and in women only very slightly increased. (Does this have significance for our concepts of schizophrenia?)

(4) What has changed is the attitude of the public towards mental hospitals, and of staff towards patients—not the true incidence of illnesses that now lead to admission in greater numbers than before. These changes were discernible with the Mental Treatment Act (1930), but were greatly enhanced by the advent of phenothiazines and anti-depressant drugs: the patient can tolerate his symptoms, and his relatives can tolerate the patient, with their aid. The concept of the therapeutic community has no doubt helped. This is what I always understood mental hospitals were intended to be.

(5) Growth of extra-mural community services is inherent in our plans. The total number of mentally disordered people receiving care from Local Authorities (England and Wales) increased from 115,000 in 1960 to 140,000 in 1963. These numbers include the mentally ill (contrasted with the subnormal) who rose from 32,000 in 1960 to 55,000 in 1963 (70 per cent increase). There was hostel accommodation for 441 in 1960, 1,523 in 1963; and it is planned to increase it to 15,000 by 1974.

(6) Research is increasing rapidly. The Medical Research Council has ten units engaged on mental health, five of them set up in the past year, which deal with epidemiology, genetics, chemical pathology, brain metabolism, sociology and applied psychology. Expenditure rose from £260,000 in 1959/60 to £510,000 in 1963/64.

The Individual Patient

(7) We may have overemphasized our statistical trends, and our consideration of patients in groups, at the expense of the individual patient. A thought-provoking corrective is seen in Aldrich's (1965)[2] appraisal of British psychiatric practices. British and American trends have diverged since 1939. The main British developments have been in social psychiatry applied to psychotic patients in hospital, whereas in America the emphasis had been on dynamic psychiatry applied to individual ambulant neurotic patients. He ascribes these differences chiefly to the National Health Service. This has boosted mental hospital psychiatry (rightly, we think), but he has some doubt about our out-patient work, in which the general practitioner rather than the specialist is the major purveyor'. It seems that in the U.S.A. the trend is to refer psychiatric patients, however minor their illnesses, to a specialist from the start and to move rapidly from a diagnostic to a therapeutic relationship in which the specialist, not the general practitioner, is in command of day-to-day management, the general practitioner scarcely coming into the picture at all.

(8) But in Britain the role of the general practitioner is firmly entrenched. We would not have it otherwise. We have a cautious mistrust of excessive specialism, and we like to have a man on the spot who knows the family as well as the illness. He may himself accept total responsibility or he may be a kind of therapeutic acolyte of the specialist of his choice; but, wherever he stands between these extremes, he is in charge of day-to-day management. We value dynamic concepts, but we are not, in the main, analytically minded in practice. We are content with the relief or removal of symptoms, especially if

we can keep the patient on his feet, at his job and in his home; and few of us would essay to delve deeply into dynamics in the hope of altering the very character of the patient, though there are a few well-established centres that specialize in such work. The highly selected acceptances are advantageous. Many of us, however, view psychotherapy more as an extension of the doctor-patient relationship than as the application of a doctrine that is rooted in philosophy rather than medicine. In spite of our very different approaches, I am not aware that the burden of neurotic illness is any less on one side of the Atlantic than on the other. No doubt our respective methods are well suited to our respective cultures and societies; and no present differences can diminish our indebtedness to American psychiatry, especially the teaching of Adolf Meyer and his pupils, foremost among whom was Sir David Henderson.

The Status of Psychiatrists

(9) The tendency of psychiatry to extend beyond medical boundaries and of psychiatrists to be wordy, use jargon and dabble in non-medical affairs denigrates our image—so at least many of our critics appear to think. This will be remedied chiefly by the removal of misunderstandings which we ourselves could do much to mitigate. We want to show first and foremost that we are competent clinicians; we know that, in the end, we shall be judged by what we can do for the individual patient. The proposed extension of psychiatry in general hospitals gives us a chance to show our paces.

Already there are signs of a changing attitude towards psychiatrists; but change comes very slowly, and the R.M.P.A. as a body believes that we shall not be accorded our proper status until the Association becomes a Royal College of Psychiatrists. This is our immediate aim; since it is at present *sub judice* it cannot properly be discussed here. But anyone who interprets this as a move to separate psychiatry from medicine as a whole would be profoundly mistaken; for we believe that a good psychiatrist must be a good doctor—in practice and at heart.

REFERENCES

1. MACLAY, WALTER S. (1963). "A mental health service." *Am. J. Psychiat.*, **120**, 209. (September.)
2. ALDRICH, C. KNIGHT (1965). "Psychiatric consultation in general practice." *Lancet*, **1**, 805. (10th April.)

HOWARD P. ROME, *Chief, Division of Psychiatry, Mayo Clinic, Rochester, N.Y.; President, American Psychiatric Association*

A series of profound changes has taken place in American psychiatry during and since the closing years of World War II. The exigencies of that social upheaval have repercussed and been augmented by the turbulent events of the past score of years. The pre-war provincialism and the psychological colonialism of that era have given way to an awakened sense of social relevance. It follows that exclusive preoccupation with intrapsychic phenomena has been replaced by a concern with the many milieux which impinge upon the patient. Thus the community and the mental hospital have interposed many relationships and functions. An open-door attitude to therapy itself has fostered experimentation on a wide scale with a host of alternatives to the dyadic psychoanalytical model. Coupled with alternatives to hospital care there have been alternative versions of that care: half-way houses, day hospitals, night hospitals, variants of the therapeutic community theme, an increased use of foster homes, domiciliaries, small nursing units, etc. The liberal use of the resources and facilities of the community's general hospitals has led to the establishment of psychiatric units within those institutions. An almost equal number of patients are admitted to these facilities annually as are admitted to isolated mental hospitals. Inasmuch as they are physically within the community proper and intimately associated with the operations of the departments of medicine and surgery, they have become aware of needs and patterns of care rarely encountered by remote mental hospitals, such as emergency services, liaison-consultative relationships with schools, the courts, welfare agencies and the other medical and surgical disciplines; an operational policy that advocates intensive treatment and a relatively short stay in the status of an in-patient, the development of a more realistically-oriented recreational-occupational activities programme that includes pre- and on-the-job training, focused rather than escapist activity and, incidental to such programmes, the encouragement of affiliation with groups both structured and informal.

The socio-political response to these attitudinal and technological changes has not only been a growing awareness of what has come to be called "the mental health problem", but with more sophistication there has been more positive response with support, the endorsement of enabling legislation, and the recruitment of the voluntary and professional services of many more persons and groups to the ranks of mental health workers.

Obviously all this has been possible only because of those kinds of social ferments, forces and developments which conduce to change. The sociology of a society in flux has been examined in this light. Thus the study of the relationships between anomie and mental disorders, as well as normative and deviant behaviour at all social levels, from cliques and gangs to classrooms and streetcorners and hospital wards, has brought into clinical psychiatry a social dimension. Organized psychiatric professionals seem to have captured the same spirit for their educational and political activity in behalf of social legislation and reforms needed to improve the lot of the mentally disordered and the mentally retarded and it has yielded some of the advantages foreseen by Dorothea Dix a hundred years ago. So it appears that the issues are not new, the trends have become more acceptable and the innovations which have been present but dormant now diffuse at a faster rate.

SEMINARS

Psychopharmacology and other Physical Treatments

MAX HAMILTON, *Professor of Psychiatry, University of Leeds*

The attitude to other physical treatments has tended sometimes to consider them as a last resort. This is similar to the attitude in former times towards surgical operations. This arises from the belief that such treatments are "more drastic" and entail greater risks. It is difficult to define the former but there is no question that the latter is, by and large, not true. For this reason it would be highly desirable that the use of alternative and supplementary treatments should be made on a basis, not of their nature but of the indications of their use. Because of the traditional outlook, insufficient attention has been paid to research on this problem. Although some work has been done, much more is required.

PETER DALLY, *Physician, Department of Psychological Medicine, Westminster Hospital, London*

There have been considerable therapeutic advances over the past decade, particularly in the drug treatment of schizophrenia and depressive illnesses. These advances have not been accompanied by corresponding degrees of understanding of the physico-chemical mechanisms underlying mental disorders. Treatment is therefore often arbitrary and dependent upon detailed clinical observation. Psychotropic drugs are not curative in themselves, but merely suppress symptoms or break a vicious circle. Patients therefore may need to continue their drugs until a natural remission occurs.

In the treatment of schizophrenia, phenothiazine derivatives have virtually replaced deep insulin therapy. There are numerous phenothiazine derivatives, but the choice of drug is hardly a serious problem, even though one patient may do better on chlorpromazine, another on trifluoperazine. A greater problem is whether treatment should be supplemented by electro shock or by other drugs. After recovery, a schizophrenic patient must usually continue on a maintenance dose of one or other phenothiazine drugs if he is to avoid relapse. Whether he does so will depend very largely upon the follow-up care he receives.

There are two pharmacologically different groups of antidepressant drugs; the monoamine oxidase inhibitors, (M.A.O.I.), and imipramine and its analogues. There is still confusion and disagreement over the possibility of distinguishing reactive or exogenous from endogenous depression, and, partly because of this, trials of antidepressant drugs, controlled or not, have excelled themselves in producing contradictory results. There is now a good deal of evidence for distinguishing two genetically distinct types of depressive illness; and for recognising in a general way that, while reactive depressive symptoms respond best to M.A.O.I., endogenous depressive symptoms are better treated with imipramine or its analogues. All the hydrazine M.A.O.I. are comparable in their effects, although iproniazid is probably more potent than the others. Tranylcypromine, which lacks a hydrazine structure, differs in some respects, perhaps because it has other actions in addition to inhibiting monoamine oxidase. The type of depression responding best to tranylcypromine shows a mixture of endogenous and exogenous features, with an excess of somatic symptoms. Imipramine is most effective in endogenous depressions, particularly when there is retardation. When depression is accompanied by much anxiety or agitation amitriptyline, and perhaps nortriptyline, are often more effective.

Not all depressed patients will respond to antidepressant drugs. A reasonable degree of maturity seems to be important. Children, adolescents and inadequate personalities are not generally helped, and may in fact be made worse by these drugs. E.C.T. should never be withheld if there is much agitation, risk of suicide, or considerable loss of weight, or if a patient fails to respond within a reasonable time to drugs. Antidepressant drugs may be com-

bined with E.C.T., and—provided they have already been given for a week or more—will often reduce the number of shocks required. Continuation of the antidepressant drug after E.C.T. will lessen the chances of relapse. When everything else fails modified leucotomy should still be considered.

BENJAMIN BOSHES, *Professor and Chairman, Department of Neurology and Psychiatry, Northwestern University Medical School, Chicago, Illinois*

We are deep in an era of psychopharmacology. About us are drugs old and new about which various claims are made.

How are drugs developed? How are they discovered? Often the opening of a new field comes as the result of some serendipitous experience. A pharmaceutical company may note the discovery and put the substance through a battery of tests in the hope of marketing a new drug. A chemical may come as the result of a series of systematic studies, but in any case, after the substance is synthesized, animal experiments follow for toxicity, physiologic and psychologic effect. Histopathological studies for tissue damage are done. The substance is tagged with a radioactive label to discover its site of action. Wherever possible an experimental model in the animal is established. In the instance of tranquillizers, the biting or the savagery of an animal is quantified before and after drug intake. Motor activity is recorded, sleep is measured. Finally the substance is ready for trial in man.

But man is not a homogeneous monolith who can be expected to react uniformly to a given substance. One need only expose five men of the same racial background, age, height and weight to a given dose of alcohol. One man wants to fight, another to sing, the third becomes amorous, the fourth is depressed and cries, and the fifth passes out. Each man is his own Pandora box and alcohol has opened the lid.

To this is added that elusive factor in the human, the placebo effect. All of these are contaminants in the evaluation of a drug. However after a clinical experience for a long time in a large number of people of different origins with different ailments, certain constants shake out, and the real action of the drug becomes clear.

Thus no one will doubt that morphine or digitalis has a definite action, or that among modern drugs chlorpromazine or imipramine show specific properties. The author will make no attempt to delineate the action of the group of drugs which are commonly used in the wide spectrum of diseases seen by the psychiatrist because this has been well covered in thousands of articles. He proposes to discuss the so-called adverse effects of these drugs. He does not plan to do this as a "prophet of gloom". If one were to place all emphasis on the undesirable action of therapeutic procedures there would be none of the modern advances in medicine. What is needed is to learn what is safe and what are the limits.

It becomes important to examine not only what these so-called psycho-pharmacological drugs do for psychiatric patients, but to determine what they do to the patients. What is the immediate, what is the long range effect? What is the more remote outcome of drug intake, for example on the foetus of a tense mother who is given anxiety relieving drugs during the gestation? The thalidomide experience shocked the medical world into alertness; but it need not put it into a state of therapeutic nihilism.

The author proposes to examine the drugs commonly used in psychiatric practice, to report the most recent information on the adverse action, and to place the latter in its proper perspective in keeping with current knowledge.

LOTHAR KALINOWSKY, *Clinical Professor of Psychiatry, New York Medical College, New York City*

Psychopharmacology has considerably broadened the indications for the effectiveness of the somatic approach in the treatment of psychiatric illness. It appears, however, that the simplicity of drug administration leads to much indiscriminate use. Indications of the various treatments are not as strictly defined as they should be. Often, particularly in large and understaffed institutions, convenience decides on the choice of treatment. Neuroleptic drugs are frequently given properly to acute patients but continued even if no complete removal of the psychotic symptomatology has been obtained. In such cases ECT is the most reliable means to remove the symptoms. If this fails, insulin coma treatment, the most cumbersome but also the most effective method in schizophrenia, should be considered. In the chronic schizophrenic population of our hospitals the majority of patients is often described as being under "active treatment" even if the same drug, often without proper indication, is given for unlimited periods of time.

While the neuroleptic drugs had an enormous impact on large numbers of chronic schizophrenics, some patients are better off without medication. Too much emphasis has been placed on the objective side-effects of the drugs, such as blood and liver complications, which are actually extremely rare. On the other hand, the subjective discomfort of patients, both psychotic and neurotic, under phenothiazines is a great handicap to their usefulness. The same is

true for the antidepressants. Too much has been made of some of their dangers. More serious is their all too frequent therapeutic failure in patients who are threatened by suicide, and in whom ECT can remove the danger and the patient's suffering almost instantaneously. Unfortunately, modern techniques of convulsive therapy reduce the actual application of this most effective therapeutic tool.

Psychosurgery is badly neglected because of prejudice and because of past errors in its applicability. In properly selected cases the recently developed methods of psychosurgery can lead to extremely gratifying results in the most tormented psychiatric patients.

A more discriminate use of the various treatments is imperative. Better methodology for their evaluation and more reports on individual cases are required to counteract the conclusions from large and often meaningless statistics. If we do not want the great progress made by the introduction of psychopharmaca to end in disappointment, re-evaluation of the various treatments by experienced psychiatric clinicians is urgently needed. Prejudice in psychiatry is not limited to the regrettable schism between the psychodynamic and the somatic approach. Ways must be found for a proper application of all therapeutic measures, and an international exchange of information like the one of this meeting should help to bring this about.

Genetics

L. S. PENROSE, *Galton Professor of Genetics, University of London*

The phenomena which form the material of psychiatry do not lend themselves easily to genetical investigation. Modes of behaviour, ideas and abilities are difficult to measure and do not always have clearly distinguishable categories. The products of genes are specific molecules, but the biochemical effects of mutational changes do not give rise to specific mental reactions. They determine general trends in abnormal behaviour or defective performance. The symptoms of mental disorder observed clinically are the end results of a great variety of interactions between the genetical components of an individual and his reaction to environment. Much variation can be seen even in those conditions which can be shown to be caused by single gene changes. For example, the mental level in untreated phenylketonurics can vary between profound idiocy and, in rare instances, normal intelligence. Moreover, the manifestation of abnormal heterozygotes is usually more variable than that of homozygotes. This is shown by differences in severity and age of onset in Huntington's chorea, Pick's disease and dystrophia myotonica.

The primary genetical aim in all instances of familial mental illness is to establish the nature of the underlying chemical error, as has been done in phenylketonuria and Wilson's disease. Analysis of family data can then establish whether the modifications observed in different people with the same genetical error are caused by general genetical constitution, allelic interaction or environment. Apart from its possible influence on treatment, increased knowledge about these matters will be advantageous in estimating prognosis both for individuals and for their prospective offspring.

ELIOT SLATER, *Director, Medical Research Council Psychiatric Genetics Research Unit, Maudsley Hospital, London*

FRANZ KALLMANN, *Professor of Psychiatry, Columbia University School of Medicine, New York* *

The increased tempo of discovery in the science of genetics during the past decade has had a profound influence on psychiatric thought and research. By elucidating the mechanisms of inheritance and gene action, new cytological and biochemical findings have begun to fill in the details in the aetiological chains of interaction determining normal and abnormal behaviour patterns.

Data obtained from family and twin studies have spurred further research into the contribution of gene-controlled metabolic processes to human behaviour and psychiatric disorder. Among the clinical areas upon which special attention has been focused are the genetic aspects of congenital deformities, sexual maldevelopment syndromes and early total deafness.

The growing problems of population growth have drawn attention to important aspects of population genetics and human evolution. The investigation of differential mating and fertility rates in psychiatric disorders has provided data which form the basis for enlightened and sympathetic marriage and parenthood counselling.

In the broadest sense, the incorporation of genetics into the theoretical frame of reference of psychiatry has served as a point of convergence for physiodynamic and psychodynamic approaches; by proposing a total biological focus for individual differences,

* Prof. Kallmann was unfortunately prevented by illness (which proved fatal) from attending the meeting, and the paper was read on his behalf.

mental health genetics has left behind the old nature-nurture dichotomy while clinically contributing to the true individualization of psychiatric treatment and management.

GEORGE JERVIS, *Director of Research, Kennedy Foundation, New York*

Social and Community Psychiatry

D. H. CLARK, *Medical Superintendent, Fulbourn Hospital, Cambridge*

(Paper summarized under the following headings:)

Psychiatry since 1945—British and American patterns. National Hospital Service with integration of psychiatric and general hospitals. Royal Commission 1954-7. Mental Health Act 1959. Ministry of Health ten-year plan for hospitals and Local Authorities, 1962 and 1963.

Social Psychiatry in the Community. Outpatient clinics. Domiciliary visiting. Co-ordination with Local Health Authorities. Mental Welfare Officers. Patterns of service in different areas. Social Psychiatry within the hospital. Open Doors. Informal Patients. Industrial Workshops. Therapeutic Communities in different hospitals.

PETER SAINSBURY, *Director of Research, Medical Research Council Clinical Psychiatry Research Group, Graylingwell Hospital, Chichester*

Dr. Clark has described the context in which British social and community psychiatry is developing. The noteworthy changes have been in the orientation of our mental hospitals and the importance now attached to social aims and to milieu in therapy; in the provision of alternative, but complementary, forms of patient care, and in fostering interaction with the family, neighbourhood, employer and the community at large. Implicit in these innovations is a confident emphasis on the importance of the patient's social environment, both in the genesis and therapy of mental illness. In this brief paper I wish to refer to some of the factual evidence recording the effects of our social and community services and thereby provide clues as to the veracity of these contentions. Examples will be taken from the Registrar-General's official statistics to illustrate our changing habits in recent years in admitting, discharging, and keeping patients in the mental hospital: they reflect a considerable alteration in attitude.

Next, other studies which have shown the effects that the therapeutic community, rehabilitation programmes, etc. have had on the behaviour of long-stay patients, and in the manifestations of their illness, will be mentioned. By following up patients referred to hostels and to psychiatric wards in the general hospital, the effectiveness of these methods of care is being evaluated by various workers. An assessment of the outcome of the patient's illness in one of the recent community care projects and in a more conventional service, and the effects on the family of caring for mentally ill patients at home, in both, will also be summarized.

More research at all levels and aspects of our mental health services is essential in order to evaluate the consequences of what is being attempted; also to acquire a better understanding of the interaction between social factors and mental illness. This seems especially important, as the investment in social and community psychiatry in Britain appears to have paid a remarkable dividend therapeutically, and provides a stimulus to enquire further into the nature and operation of social factors in mental illness.

ALAN KRAFT, *Director, Fort Logan Mental Health Center, Denver, Colorado*

The most significant social development in psychiatry in the U.S.A. in the recent past was the passage of the Kennedy Community Mental Health Center legislation.

While the Kennedy programme has been widely acclaimed in our country, one large segment of the professional community has been somewhat restrained in its enthusiasm. This group consists of those who have serious concerns about the future role of the public (State) mental hospital.

The new centres have as their purpose to make available comprehensive preventive and therapeutic measures at the local community level.

These centres, it is suggested, should offer early intensive treatment ranging from outpatient consultation, emergency services, partial hospitalization and full time hospitalization. It is hoped and expected that intensive early treatment will prevent chronic mental illness of the proportions we know too well in the "continued treatment wards" of our large mental hospitals.

The extent to which chronic mental illness can be prevented will in large part determine the future of the public mental hospital. If, as hoped, the centres can virtually eliminate the accumulation of chronic cases, then the public hospitals will be freer to explore new vistas for service, including that of serving as community mental health centres. If, however, there continues to be an accumulation of chronic patients, it will undoubtedly be to the public

mental hospital that the community will turn for their care.

There is some evidence that the organization of psychiatric services in the U.S.A. may have encouraged the accumulation of chronic patients. The large mental hospitals were designed to receive large numbers of patients but were not staffed to treat and return them to the community.

There is also reason to believe that chronic mental illness is a phenomenon which has much in common with but is not at all identical to chronic hospitalization.

It has frequently been observed that severely disturbed persons can live outside the confines of a mental hospital. Some observers have postulated that the chronically ill in hospitals are victims of a desocialization process which is superimposed on the disabilities which brought them to the institution. According to this view, chronic schizophrenia as observed in the patient hospitalized for long periods is not simply chronic schizophrenia but a syndrome produced by adjustment to living in an institution for an extended time period.

The Fort Logan Mental Health Center is a new public mental hospital with strong community ties, serving the metropolitan Denver area. Now in its fourth year it receives the bulk of the mentally ill requiring long term treatment. Since it does not transfer unresponsive patients to another facility and since as a new hospital it has no previously accumulated patient population, it is in a position to test the hypothesis that chronic mental illness does not *a priori* require continuous hospitalization. The treatment programme assumes that the patient will have exacerbations and remissions and that the hospital can offer the availability of a variety of treatment modalities to meet the needs of patients at the time of crisis, but that patients can be returned to the community following the crisis.

A review of the four year experience of the Centre tends to support the hypothesis that chronic mental illness does nor require institutionalization continuously for long periods of time.

MARVIN E. PERKINS, *Commissioner of Mental Health Services, New York City Community Health Board, New York*

The City of New York now has had a little over ten years of experience in developing and extending community psychiatric services under the guidance of a Community Mental Health Board. A presentation of views, based upon this experience, is intended as an attempt to provide some appreciation of the problems addressed in applied social and community psychiatry. The scope of the paper is limited to developments within the past decade, in relation to issues affecting the residents of one major North American municipality, as seen from the vantage of a new local governmental organization responsible for the mental health programme.

Recent studies attest the substantial extent of medical care being received by residents of the city, the cost of which is borne in part or wholly by government. A considerable number of persons avail themselves of community psychiatric services, a large proportion of which are rendered as a result of local governmental decision. Comparisons of fiscal and statistical data demonstrate the increasing commitment of local government to arrangements for community mental health services over the past decade.

Estimates indicate that even more persons might well make use of community psychiatric services than the numbers now being served. Planning for the future would appear to need to allow for a growing demand. In addition to this assumption, two others tend to be basically accepted in planning community psychiatric services: (1) that these services will not undergo a radically new course of technical change, whether based on methodological advance or research finding; and (2), that no marked alteration in the medical mission will be precipitated by forces within the society, or from outside.

A consideration of planning leads to the recognition of a feature which may be distinguishing of community psychiatry: the extent of the effort spent in assuring involvement of representatives of the community in the planning of their services. The student of the New York State Community Mental Health Services Act of 1954, with very little examination, discovers this characteristic. Two other more recent examples are also to be cited, in one of which the community representation sought was expert. In the second, the representation achieved was scientifically drawn to include many other groups.

Last year a representative committee of 76 persons concluded a major planning task for the New York City region, after a period of about a year of effort. The work was accomplished for the most part in either the eight sub-committees or their dependent task forces. Four of the sub-committees were organized to cope with planning recommendations in the broad spectrum of services: prevention; out-patient services; in patient services; and rehabilitation. Two were organized to consider the special categorical areas of addictions and mental retardation. One was addressed to the problems of manpower. One was formed to assess the area of integration of services, including intergovernmental and interagency re-

lationships. The New York City Regional Mental Health Planning Committee included distinguished representatives of 22 municipal agencies; 19 voluntary agencies; 15 professional agencies; and 7 State agencies. Twelve individuals were selected for their knowledge, competence and prominence without regard to any agency or organizational connection.

The second example aimed at a different type of participation and by a different group. The New York City Community Mental Health Board two years ago arranged for a special systematic study to be made of public opinion relative to mental health service. The public views seem all too infrequently to be taken into account when new programmes are being planned.

The study was a stratified multistage probability sample of predesignated persons representative of the five million adults in the city. The population consisted of civilian, non-institutionalized adults 20 years old and over living in 1,500 households. Specially trained interviewers, using structured questionnaires in the homes, were able to yield an 87% representative response rate. Information from this study is in hand related to: attitudes toward various types of mental health services; opinions and knowledge about psychiatry; other mental health professions and specialties; attitudes toward ex-mental hospital patients; concepts of mental and emotional disorders; pathways to care; recognition of needs for mental health services; and experience or contact with mental health aid.

Training Psychiatrists to meet Changing Needs

DENIS HILL, *Professor of Psychiatry, University of London*

With the greater efficacy of methods of relieving acute psychosis and with the move of psychiatry into general hospitals and into community care, there must be greater emphasis in the future training of psychiatrists on psychosomatic medicine, the psychoneuroses, and the large field of personality disorders. The psychiatrist of the future must be able to speak with his colleagues in all branches of medicine on terms of equality based on an understanding of their problems; and initially he therefore requires a basic training in medicine beyond that acquired at graduation. The psychiatrist's training should be grounded in human biology in the widest sense, but his specific contribution to medicine lies in the attitudes which he acquires to the patient as a person and to the patient's illness. The psychiatrist's training must therefore be broadly based, but there is room for many types of psychiatrists with separate skills and interests; and provision must be made for them so that certain individuals can pursue certain subjects in depth. Emphasis in education should be placed on the capacity to evaluate evidence—whether this comes from social, psychological or physical sources. Throughout the whole psychiatric training, emphasis should be placed on the understanding of the patient as a sick individual, which knowledge of a dynamic approach to intrapersonal and interpersonal problems provides.

I. R. C. BATCHELOR, *Professor of Psychiatry, University of St. Andrews*

Psychiatry is likely to follow general medicine in its increasing specialization. Many of the present diagnostic and therapeutic functions of the all-purpose psychiatrist will be assumed by the family doctor (G.P.), as medical practice outside the hospitals becomes more concerned with the psychological and social aspects of disease and as the family doctor becomes better equipped to deal with them.

We have been too responsive to social needs and too ready to specialize in an ad hoc, even opportunist, way. From this we have received much stimulus and gained popularity, but, spreading ourselves too broadly and thinly, it has been at the expense of the growth of psychiatry as a scientific discipline.

In the teaching of human biology, greater attention must be given to psychology and sociology. The medical student, earlier than is usual now, should be exposed to a variety of clinical disciplines, to discover his own interests and predilections. He should then be allowed some option in what subjects he pursues and should be able, at a later stage in his undergraduate course, to turn back to study in greater depth one of the sciences basic to the clinical field which has most interested him. The student attracted to psychiatry might return, for example, to psychology or biochemistry or pharmacology. This could be arranged without extending in total time or content the undergraduate course: it would just mean that everyone would cease the fruitless attempt to study everything.

Such a change in the undergraduate curriculum would provide for the post-graduate education of the psychiatrist a firmer scientific basis. The specialist in training should be allowed a wide clinical experience, be instructed in methods of research and in specific therapeutic skills, learn how to exploit the resources of a library, and to carry out under guidance an investigation which will require him to explore intensively some aspects of his subject: this investi-

gation should also become the topic of a written thesis. Broad initially, this training should narrow later in accordance with the individual's particular interests and abilities. Everyone should not be put through the same educational mill. The jumping of stiff examination hurdles far too often becomes an end in itself.

One cannot foretell where the most exciting scientific advances will occur. It is new knowledge and new techniques derived from the basic sciences which are most likely to transform our subject, and we must be constantly alert to detect and to utilize these in our training programmes. The psychiatrist will be able to sustain the pace of scientific advance only if his education continues throughout his working life. A major programme of post-graduate education must be launched when the University Departments of Psychiatry have been given the greatly increased resources which will be required.

One must aim at the most fruitful interaction between social needs and psychiatric resources: for some time ahead we must build up these resources, raise our academic standards and set limits to our service commitments.

M. RALPH KAUFMAN, *Chairman, Department of Psychiatry, Mt. Sinai Hospital, New York*

The world appears to be in a constant state of flux and therefore the impression may exist that there are constantly changing needs which should be met in the field of psychiatry. Throughout the world, particularly since World War II, there have been many apparent changes. According to some, these changes are of such fundamental importance that a completely new orientation in the education of the psychiatrist is necessary. In the United States there is current emphasis on so-called community psychiatry. In part this appears to be the response to an overwhelming series of needs in terms of the numbers of people who require health services from the various personnel under the umbrella of psychiatry. There is a great deal of talk and discussion about the role of the community and all aspects of community services, both as pathogenic and therapeutic factors. There are styles in clothing and apparently styles in psychiatry. It is necessary to differentiate between a style and a fundamental need. As Grinker, quoting Leacock, has pointed out there is a danger of riding off madly in all directions at once. The inability to fulfil the needs of all patients in terms of individual therapy does not mean that such a therapeutic approach is necessarily "bad". Patients may be managed in many ways, but the ability to manage in any given set of circumstances does not necessarily mean that this is the treatment of choice. One wonders how many of the changing treatment patterns so highly recommended are really the most beneficial way of working with a particular patient. There is a need both to look at the current scene and to project, if possible, into the next ten years in order to predict if possible what the actual changing needs will be. Whatever they may be, there are at least three aspects in the education and training of a psychiatrist. There are certain kinds of basic knowledge that are independent of the particular country or hemisphere in which a psychiatrist will function. Since primarily psychiatry is a branch of medicine, it is expected that the psychiatrist will be a well educated and trained physician. As a psychiatrist, the basic knowledge should range from genetics to chemistry, physiology, neurology, anatomy, psychology, behavioural science, and nosology, etc. A second important aspect will be related specifically to the culture of the country or hemisphere in which the psychiatrist will practise, and this will also depend to a certain extent on the image and the role of what a psychiatrist's function in that particular cultural milieu is taken to be. In connection with the above aspects, the contents of the 'curriculum' and the areas to be covered as part of his training become an essential matter for discussion. As an illustration of one such curriculum area in the training of the American psychiatrist, I should like to emphasize the role of psychoanalysis. I have recently discussed this in a brief article in "The Bulletin," Volume 7, No. 4, November 1964, The New York State District Branches, American Psychiatric Association. Within the psychological frame of reference, psychodynamic American psychiatry has as its core some variables of psychoanalysis. American psychiatry, however, has never restricted itself to that one area, but has generally followed the model of Adolf Meyer's psychobiology, with an emphasis on psychoanalytic psychiatry that stems from Freud. This has not inhibited or distorted psychiatry, but has enriched it. A recent trend in American psychoanalysis has been utilized as a focal point for a synthesis of chemistry, physiology and psychology. This is perhaps well illustrated by the work on sleep by men like Charles Fisher. Whereas it is true that some psychiatrists seem to equate the practice of psychiatry with psychotherapy only, by and large American psychiatry is much more broad based both in theory and in practice.

HENERY BROSIN, *Professor and Chairman, Department of Psychiatry, University of Pittsburgh School of Medicine*

Psychiatry of Adolescence

W. WARREN, *Consultant Psychiatrist, Children's and Adolescents' Department, Bethlem Royal Hospital and Maudsley Hospital, London*

In the United Kingdom, the spread and deepening of interest in the psychiatry of adolescence has been mainly a post-war development, partly due to increasing appreciation of the special treatment needs of this age group and so the gradual setting up of in-patient units and out-patient clinics to cater for them. This has made for opportunities for their study in a way that was not possible earlier on. The first two such in-patient units were set up under the National Health Service in 1949; others have since started up and down the country, mostly in the setting of psychiatric hospitals. They have proved a successful venture and there have consequently been heavy demands for admission to them. Recently, the Ministry of Health has advised all Regional Boards in England to set up hospital adolescent in-patient units on the scale of 20 to 25 beds per million of the population for short term treatment and also provision for long term care of adolescents with more chronic psychiatric conditions at perhaps 25 beds per Region.

The regime in established units has followed a fairly uniform pattern that varies according to local circumstances and the outlook of the psychiatrist in charge. They are fairly small, with perhaps up to 20 beds for each sex. The sexes mix for social and educational activities and form a dynamic group which has important therapeutic implications. The arrangements for admission are flexible, with transfer of patients when required to psychiatric wards among adults. An active regime is an important feature, with adequate provision for continued education. Treatment is broadly based and with provision for psychotherapy. Staffing has to be generous; the families of these patients also usually need attention and provision for this and for after care and follow-up is important. These units require associated out-patient clinics and they cannot function in isolation. There are links with the special schools for maladjusted children which are a feature in this country, and with approved schools for delinquents; and also with other social agencies who deal with this age group. Thus, many teenagers need to be placed before or after hospital treatment away from home, and though educational provision is on the whole good for those of school age there is as yet, for instance, shortage of hostel accommodation. It should be added that a number of psychiatrists are now employed in treating adolescents in these other settings.

It is generally considered that the psychiatric disorders to be seen in adolescence do not differ markedly from and overlap those found in younger children or, on the other hand, in adults, but are often coloured by behaviour patterns characteristic of adolescence. Symptoms may be "childish" or "adult" in character as well as "adolescent" and this does not depend altogether on the chronological age of the patient. The aetiology of their disorders is as wide and varied as at other times of life and often dating back to earlier years, adolescence itself having become an intrinsic factor of varying importance. The psychiatrist who deals with adolescents needs adequate training both of the psychiatry of children and of adults. It is not felt necessary to try to create a new specialist in the psychiatry of adolescence; rather to take so narrow a view would seem likely to retard the growth of knowledge.

K. R. H. WARDROP, *Consultant, Forensic Psychiatry Clinic, Glasgow*

Adolescence is not a phase of life suddenly entered and as suddenly left behind, cut off from childhood and adult life. Rather is it a period of gradual transition from one to the other. Similarly the psychiatry of adolescence must not be seen as a water-tight compartment, but as a bridge between child and adult psychiatry. At times the approach and techniques of child psychiatry must be adopted with the adolescent, and at other times the approach of adult psychiatry, and so it is essential that psychiatrists working with this age group have training and experience in both fields. The adolescent age group does have specific problems, which affect its psychiatric disorders, and as it is also work which may be very time consuming, it is probably advisable that some psychiatrists and clinics devote themselves specially to this age group. In particular as regards in-patient treatment it is advisable that there are specialized units for the adolescent, geared to treatment, which may be very long term, and may include educational, vocational and social training, as well as more specific medical and psychiatric skills.

In Scotland the provision of in-patient units for adolescent treatment is minimal. There is one unit with accommodation for 20 adolescent boys near Glasgow, and one near Edinburgh with accommodation for 8 male and 8 female adolescent patients. These units by and large have the most seriously disturbed adolescents, i.e. severely neurotic or pre-psychotic. Also they concentrate on the younger end of the adolescent age range, i.e. 12-16 years. There is no accommodation for older adolescents,

nor for those where the disorder is manifested mainly in disorders of behaviour.

Out-patient experience with adolescents, on the other hand, indicates that two-thirds of cases are referred because of behaviour disorders, this syndrome being the commonest present syndrome of adolescent disturbance. "Behaviour disorder" includes all forms of anti-social behaviour, as well as school or work refusal, absconding from home, pathological lying.

Violent behaviour in adolescents requires special mention. In Scotland this has not become numerically such a problem as in the United States and England, though there has been a tendency to an increase. Cases fall into four categories. (a) Those in which the violence is largely a culturally determined phenomenon in young people from a background where violent behaviour is the social norm. (b) Violent behaviour associated with a specific cerebral dysrhythmia, epilepsy or epileptic equivalents. (c) Violence possibly associated with minor brain damage, occurring in an adolescent where there is much inter-personal tension in the family relationship. (d) Violence arising out of a specific individual conflict in inter-personal relationships, usually extreme hostility to one or other parent.

Some teenage homicide cases recently investigated have come into none of these categories, and represent a group in whom no serious psychiatric disorder is found, but who continue to live in a phantasy "play-acting" world and make no attempt at adjustment to reality. This seems part of a more widespread social phenomenon of this age, which affects the incidence of adolescent disorders, viz. the number of cultural factors tending to prolong the adolescent period and endow it with unrealistic circumstances. Physical maturation and social sophistication make for an earlier onset of adolescence, while increased affluence, the influence of mass media and advertising campaigns tend to create a separate adolescent identity, to some extent hostile to the adult world, and therefore delaying transition into the latter.

Another important social and psychological factor which has recently been receiving attention is the expectation of certain behaviour patterns shown by the adult community towards the adolescent. This applies in general community group-interaction, and also in specific inter-personal relationships in families. As, for example, in the many cases where the parents sub-consciously expect and encourage delinquent behaviour, presumably from deeper unconscious motivations and satisfactions of their own.

This latter affects choice of treatment in adolescents, suggesting that much more attention be paid to the family as a unit, and family group therapy is an appropriate treatment method.

BENJAMIN BALSER, *Director, Psychiatric Research and Training, St. Luke's Hospital, New York*

In the past fifteen years in America there has been a remarkable increase in the interest in adolescent psychiatry on the part of psychiatrists. Before that time there were only a small handful of psychiatrists working with adolescent patients. Now there is a Society for Adolescent Psychiatry in New York which has 240 psychiatrist members. Similar groups have organized in Philadelphia, Chicago and Los Angeles, and there are more psychiatrists working with adolescents today than are working with children. There were few psychiatric hospitals where one could place an adolescent fifteen years ago.

The change has been considerable during these years and now one sees adolescent units in a widespread area. The development of psychiatry in General Hospitals has continued toward greater ease of hospitalization of the adolescent, and in several of the psychiatric units in the New York area the percentage of adolescent patients on the in-patient unit range from 30 per cent. to 40 per cent. of the total patients hospitalized in psychiatry. Out-patient services show similar proportions.

Time will only permit for elaboration of one aspect of adolescent psychiatry in the United States, and for this reason emphasis will be placed on school psychiatry. The development of greater interest in programmes of a psychiatric nature in connection with both private and public schools has received tremendous impetus in the past decade. St. Luke's Hospital in New York has a research programme which is on-going and includes seven different schools. These schools are both public and private, boy and girl, boarding and day schools. There is a psychiatrist in each of the seven schools a half day a week and his work with the schools is on several levels including orientation of teachers and guidance counsellors in his role as a physician and psychiatrist. He does not attempt to tell the teachers how to teach nor does he ask for special dispensation for patients in treatment. He works with the teacher group, not only in individual instances in relation to students, but in a group approach in a mental health workshop. He learns to treat students directly, or through the teacher without seeing the student. The involvement of the parents in the treatment situation is variable. No adolescent, however, is ever accepted for treatment without the knowledge and approval of parents. Guidance people in the schools have been of distinct value in these programmes, and the psychiatrist acts

to supplement or help that individual in the performance of his work with the students.

In the seven schools research programme, residents in training in psychiatry at St. Luke's Hospital, and shortly in other residency training programmes, will rotate through some of the schools for part of their training in this field. Teaching school psychiatry to residents allows for the development of a larger pool of individuals who will be accessible for this work.

DONALD J. HOLMES, *Associate Professor of Psychiatry, University of Michigan School of Medicine, Ann Arbor*

Although adolescents are subject to most of the common psychiatric disturbances which affect adults, they are also subject to some acute emergency disturbances which are more or less characteristic of their age. Delineation of such conditions, whether on predominantly dynamic or phenomenological grounds, seems justified if only as a means for improving the clinician's ability to attach to them a significance which will point to the development of a realistic treatment programme.

Some pitfalls in the appraisal of some adolescent crises are partly due to a tendency to rely on the diagnostic and prognostic significance of certain findings as they have been encountered in experience with adult and child patients. The problems of evaluation and management are additionally complicated by a group of highly characteristic sources of tension to be found between the adolescent and the adult in general, and others which are more specifically identified with relationship between the psychiatrist and his adolescent patient.

Two broad syndromes of adolescence are briefly described, following which some principles are proposed for the relatively prompt evaluation and management of such problems. The first of these was spoken of as "Acute Adolescent Psychosis" by Cross in 1953. The second is appropriately designated the "Pseudo-Delinquency Syndrome". It is suggested that these may be identified through the description of relatively characteristic clusters of clinical features to be found in the psychiatric history, mental status examination, patterns of pathogenesis, and course of the disturbance, and in particular lines of interpersonal stress between patient and examiner.

Some general principles of psychotherapy of adolescents are appropriately highlighted in application to the acutely disturbed youngster. Those discussed include the importance of emphasizing crisis resolution and symptom alleviation rather than the all-too-frequently hypothetical and elusive idea of "definitive treatment"; the importance of activity and intervention as well as of quiet understanding and insight induction; of candour, directness and the judicious application of benevolent medical authority; scrupulous avoidance of "playing the role" (of pompous authoritarian, or other), accompanied by a correspondingly earnest willingness to "fulfil the role" of responsible physician; accordance of a high degree of confidentiality with primary reliance on the patient rather than his parents for facilitating those revisions of personality and circumstance necessary for the restabilization of the family balance; a major emphasis on adaptive potentials, e.g. the carrying out of school work, job, athletics, relationship with family and friends.

One should only turn in the last resort to the words (and associated ideas) "schizophrenia" and "schizophrenic reaction", in connection with those acute states, since they have inevitable implications of severity, chronicity, irreversibility and untreatability. Because of the ease with which they can be confused, a careful distinction is drawn between the adaptively positive value of "regression" as applied to individual ego-functions on the one hand, and, on the other, the multi-function regression to be found in the more severe and lasting disorders.

Finally, some question is raised about a tendency, particularly strong in American psychiatry, to pronounce all human unhappiness, error and aberration as psychiatric illness, and to prescribe treatment as such, even when it is clear that the most effective "treatment" results are achieved in well-conducted schools, youth shelters, training centres, on the job, by "spontaneous remission" and even penal institutions. In relation to the specialized helping agencies it is suggested that the psychiatrist might serve most helpfully as consultant rather than director.

Rehabilitation

W. V. Wadsworth; *Medical Superintendent, Cheadle Royal, Cheadle, Cheshire*

Society equates health with the ability of an individual to work. In this context therefore the problem of psychiatry can be summed up as the problem of the loss of relationship. In a working society we can say that when you can rehabilitate a patient to successfully perform a job of work then you have offered him an opportunity of re-establishing healthy relationships.

In the field of Industrial Rehabilitation the reinstatement of long-term patients into the community can best be arranged on a three-tier basis. Each mental hospital should provide facilities to

perform work of an industrial nature and these units should give the necessary opportunities for every patient to have a realistic assessment made of his working potential. The cream of these workers should then have the opportunity of working in specialized units as provided by the I.T.O. organization and ourselves, where the focus is on a balanced marriage between the patients' clinical state and their working potential. Such specialized units can then act as springboards for patients to be employed as Approved Sheltered Workers under the Ministry of Labour either in the Sheltered Workshop attached to the I.T.O. or by arrangement with industrialists themselves for groups of workers to actually work on the factory floor preparatory to their final discharge.

Evidence is presented in this paper of the success of the applications of such a scheme which is being run at Cheadle Royal in conjunction with the National Health Service and the Local Authority. Details are also presented on a study of the patients' attitude towards the work programme provided at this hospital. It shows a very high percentage acceptance of the work situation, and since the natural response of any individual is to move towards situations they like and to move away from situations they dislike, then on the basis that every response conditions our next response the positive findings in this survey are seen to be most encouraging.

The necessity for the provision of the greatest variety and hierarchy of suitable jobs is stressed. The belief is presented that not only does Industrial Therapy condition a patient to live in society, but it also has an intrinsic value in itself. The hypothesis is presented that it is better to work with three-dimensional objects becouse we live in a three-dimensional world and therefore three-dimensional objects help patients to better interest themselves with identification with this world. Interest implies energy flow and the greater the energy flow outwards the less there is left to energize the phantasy two-dimensional world of the schizophrene.

We must increasingly therefore, make the work situation sufficiently stimulating to conjure the internal identified interest of the long-term patient out into the existential world. This is seen as the challenge with which we are presented in the field of Work Therapy.

J. W. WING, *Medical Research Council Social Psychiatry Research Unit, Institute of Psychiatry, Maudsley Hospital, London*

Medical rehabilitation involves a detailed specification of the disabilities which limit a patient's domestic and occupational functioning, so that methods of reducing them, or of compensating for those which are irreducible, can be planned and evaluated, Much psychiatric illness (even of the so-called "minor" variety) is chronic. Psychological and biological methods of treatment are often more ameliorative than curative, which emphasizes the importance of social factors in management. By making a wide range of specialized environments available and by providing skilled counselling in which the patient and his relatives are advised how to deal with his disabilities, morbidity and the burden on the community can be minimized. The basis of a rehabilitation service should be experienced teams of doctor, nurse and social worker, working both in hospital and in the community, which can formulate and continuously modify a plan of care for each individual with chronic psychiatric disability, and carry it through until the patient is finally resettled. Such teams can only work successfully if the specialist agencies available—hospitals, day centres, hostels, workshops, etc.—are of high quality and sufficiently varied. Hospital wards may be therapeutic communities or they may produce institutionalism, in itself a severely disabling condition. The same is true of hostels and workshops and of the patient's own family.

Most research has so far been carried out in the field of the psychoses and mental subnormality, and preliminary guide-lines are already available for the development of improved services for patients with these conditions. However, much operational research is based on the assumption that administrative indices (such as a decrease in length of hospital stay or prevention of readmission) can be used to judge the success of innovations in services. Examples will be given to show how misleading this assumption can be. There is no substitute for the direct measurement of morbidity in the patient and in his family or other domestic group.

Community services, both in the United States and the United Kingdom, are rarely organized in such a way as to apply the fruits of modern knowledge in rehabilitation. It is typical for patients who have received the most detailed attention in specialized ward environments to be discharged from hospital and given no further attention apart from a routine out-patient appointment or social worker visit. A discontinuity in the rehabilitative process is seen in its grossest form at discharge, but it frequently occurs at other transfers between agencies. So far as schizophrenia is concerned (and it may be true of many other conditions) the whole value of several months' intensive therapy can be lost within a week or two.

The next advance in psychiatric rehabilitation will come from the application of methods which have

been worked out in hospitals to the problems of patients in the community. The problems of organization are immense but only in this way can the "early discharge policy" be justified.

MILTON GREENBLATT, *Superintendent, Boston State Hospital; Professor of Psychiatry, Tufts University School of Medicine, Boston*

The great interest in the use of citizen volunteers arises from the fact that here is an essentially unlimited pool of manpower which, if properly applied, might be of very great significance in the understaffed, impoverished mental hospital.

Our experience at Boston State Hospital is with a large group of citizens of all ages who attempt to aid the hospital in a wide variety of tasks.

a. Within the hospital.
b. On transition between hospital and community.
c. Within the community.

We have experimented for nearly 12 years with the use of student volunteers at the undergraduate level. This programme, initiated by Harvard and Radcliffe student volunteers, first in the City of Boston, has contributed thousands of students, usually on a one afternoon a week basis, to assist a large State hospital in the care of its chronic psychiatric population. Their work has been on the wards as quasi occupational therapists and social leaders, on children's units and as case aides. The latter consists of groups of 8 to 10 students under the supervision of a social worker, each one relating himself to a patient, deepening the relationship with time, and attempting in all ways by "friendship therapy" to aid this patient on his way out of the hospital and into the community. These programmes have been eminently successful. The Case Aide Programme, for example, has successfully rehabilitated some 30 per cent of a large group of chronic mentally ill—i.e. the patients have found stable settlement in the community and most have improved clinically.

The students' interest in hospital work was followed by their interest in providing transition facilities for the patient. Apart from escorting them on trips to the community and helping to resocialize by repeated healthy contacts with the outside world, five years ago the students undertook to set up a joint co-operative student-ex-patient halfway house, supervised by house "mother and father." This facility, too, has an impressive patient rehabilitation record, apart from its remarkable educational effect upon the students and contribution to their personal growth.

The pattern of the student live-ins as a rehabilitative device has been extended recently to another halfway house established on the campus of the Boston State Hospital, and to a night hospital. In this instance the students develop social-recreational programmes for patients in their evening hours and help organize government and other forms of participation in hospital life.

At the present time there are about 125 organizations giving time and effort to the Boston State Hospital. Noteworthy are a carnival held yearly on the grounds of the hospital which plays host to thousands of citizens from the community; a community organization of influential businessmen who obtain outside contracts and raise money for sheltered workshops. While such workshops are not unusual, the participation and direction of community industrialists is a new feature in our area.

We will have the further opportunity to try out highly selected volunteers from President Johnson's Anti-Poverty Programme in the ensuing year.

Important issues, of course, are raised by a large volunteer movement such as the threats to staff, tensions produced in the volunteer, effectiveness of a volunteer as the extension of the professional arm, and the postgraduate educational value of the total effort. These and other issues will be discussed at the conference.

DONALD CARMICHAEL, *Director, Aftercare Clinics, New York State Department of Mental Hygiene, New York*

Although rehabilitation and aftercare services are looked on as synonymous, this is not the actual case. Hospital treatment properly should include earliest possible planning to prepare patients effectively, through rehabilitation, for their return to their local community—family, friends, school, or work—and adjustment in all phases of living.

Rehabilitative measures in the United States have been utilized in dealing with the mentally ill over a ten-year period at most, whereas such measures have been used with the physically disabled for many years. Though the counsellors of the Division of Vocational Rehabilitation had had broad experience in the field, special counsellors were selected by D.V.R. to work with the mentally disabled with little, if any, previous meaningful experience. The professional staffs of our mental hospitals and clinics were likewise with but little understanding of vocational rehabilitation problems. We in aftercare were able to grasp the fundamentals more readily through having had a full-time, well-experienced rehabilitation counsellor on our staff for four years.

A day hospital was established in 1956 and soon proved to be of great value in averting rehospitali-

zation in a large percentage of cases. The day hospital programme provided psychotherapy (individual and group), chemotherapy, and opportunities to explore prevocational activities involving a variety of skills translatable into job prospects.

Acceptance by rehabilitation facilities or job placement agencies of persons with mental disorders is as yet quite limited. Yet there have been reports of surprisingly successful results with the major mental illness group in or from our State mental hospitals. This group consists chiefly of persons (50 to 60 per cent.) with schizophrenia who are still stigmatized by the above diagnosis and even many who are merely former patients of State hospitals. Although vocational and social rehabilitation is being offered to such patients, their numbers are increasing at a relatively slow rate. It is well to note that there has been a sizeable increase in the more serious mental disabilities (psychoses) referred to D.V.R. and a decrease in the number of milder mental disabilities over the past five or six years.

Many facilities providing rehabilitation services, be they counselling, training or job placement, use unjustifiable screening of clients which is so stringent that more are screened out than are accepted. The other side of the coin clearly demonstrates that those "screened out" include many good prospects overlooked.

During the first year of our day hospital's operation we deliberately planned to refer to it only chronic relapsing schizophrenic patients as the most likely to require rehospitalization. It seemed probable that 80 per cent or more of the 80 patients concerned would be rehospitalized. A survey was made of this group and family members covering a period of one and a half years, during which only 21 of the 80 were rehospitalized. We have also noted a tendency in rehabilitation agencies to rule out prospective patients who have shown aggressive behaviour. This group is much more likely to respond favourably than the less active withdrawn patients.

Brief Psychotherapy

D. H. MALAN, *Senior Medical Officer, Tavistock Clinic, London*

There are three fundamental questions which any research on Brief Psychotherapy should be designed to answer:

(1) Which patients are suitable?
(2) What techniques should be used?
(3) What sort of results can be achieved?

The literature shows, at the extreme, two entirely contradictory views on all these questions.

According to the "conservative" view:

(1) Only patients with mild and recent illnesses are suitable;
(2) The technique used should be superficial and in particular should not involve interpretation of the transference;
(3) The results are merely palliative and often temporary.

On the other hand, according to the "radical" view:

(1) Patients with relatively severe and long-standing illnesses are suitable;
(2) The technique used can contain all the essential elements of that of full-scale psycho-analysis;
(3) Results can be quite far-reaching and deep-seated.

In 1954 Dr. Michael Balint got together a research team of trained psycho-analysts to investigate these problems at the Tavistock Clinic. The original views of the team were on the whole conservative. All the evidence from the first 18 cases treated, however, suggested that the radical view was correct. This research and the evidence supporting these conclusions are described and discussed.

DENIS LEIGH, *Physician, Bethlem Royal and Maudsley Hospitals, London*

Brief psychotherapy embraces a wide variety of procedures, ranging from analytically oriented interviewing through the supportive therapies, to the more recent methods of behaviour therapy. Apart from a tiny minority of individuals who undergo a lengthy classical type of analysis, either Freudian or Jungian, the vast majority of psychiatric patients are treated by one or other of these techniques by psychiatrists, who are non-analytically trained. There is no general agreement as to what is meant by "brief", for the number of interviews may vary considerably, as may the length of therapy. The concept of a "brief psychotherapy" is a comparatively recent one and is in some ways spurious, for the length of time that psychotherapy is considered necessary depends a great deal on the particular orientation of the psychiatrist, and the particular goals he sets up. Before Freud, most treatment was directed at symptomatic relief and the early hypnotists paid little attention to the role of the doctor-patient relationship in their 'cures'—it was Freud's discovery of the 'transference neurosis' which led to the prolongation of therapy, which found its fullest expression in the classical analytic procedure. Stekel was an early rebel, reverting to a more rapid type of treatment,

but it was Alexander who provided the impetus for much of the modern work on shortening the therapeutic process, although still preserving the psychoanalytic framework for this brief psychotherapy. More recently the studies of Schultz in Germany, the application of learning theory to the treatment of neuroses, the developments in group therapy and the use of controlled trials have brought into question many of the assumptions on which psychotherapeutic techniques and procedures are based. Specific disorders may need specific therapies, and we may soon be not so much concerned with the length of therapy as with the type of therapy.

SHERVERT FRAZIER, *Chairman, Department of Psychiatry, Baylor University School of Medicine, Houston, Texas*

This paper will concentrate on the methods and manœuvres in brief or reparative psychotherapy, emphasizing the problem of the management of the patient's dependency needs, the definition of goals, and the educative and guidance approaches, with a special reference to the patient's opportunity in brief psychotherapy to compare and evaluate his emotional reactions, and for the therapist to supply clarification and a positive focus. The reorganizing of chaotic feelings into more ordered and reasoned feelings by helping the patient to resume controls will be discussed from the point of view of the patient's as well as the therapist's attitude in psychotherapy.

ELVIN V. SEMRAD, *Director of Psychiatry, Massachusetts Mental Health Center; Clinical Professor of Psychiatry, Harvard University, Boston, Massachusetts*

A review of our cumulative experience in short-term psychotherapy (brief psychotherapy) as we call it, with in-patients and out-patients, at the Massachusetts Mental Health Centre, is compared with the experience of our co-operating colleagues from other centres; prepared primarily for panel discussion with our British colleagues.

That a "little bit of psychotherapy can go a long way" towards specific problem resolution in personality types of sufficient degree of maturity came to our attention in the military situation. The aiding of integration of an overwhelming traumatic event for a person to enable him to return to his optimum functional capacity has been the principle of this work. The application of this principle and extension of it to varying clinical situations and states is the theme of this presentation. The importance of personal diagnostic processes, ego compensation processes and their techniques, as well as ego maintenance processes. their techniques and their vicissitudes, are discussed in this connection. Since in large part our work is in helping resident physicians to learn and develop capacity for work in this area, this factor will be taken into account.

Geriatrics

FELIX POST, *Physician, Bethlem Royal and Maudsley Hospitals, London*

At least 30 per cent. of people over the age of 65 have been found to exhibit psychiatric abnormalities. Disabilities associated with largely irreversible cerebral pathology have an over-all prevalence of some 10 per cent., but their incidence is much smaller below the age of 70, and even after 85 only 30 per cent. of persons are seriously affected by these conditions. Affective psychoses manifest themselves for the first time most frequently between the ages of 55 and 65, but in old age they, as well as schizophrenic and paraphrenic illnesses, make only a small contribution to psychological invalidism in comparison with the minor emotional disorders. Like delinquency, acting-out disorders and conversion hysteria are rarely seen in the elderly. Perhaps on account of trends with rising age towards introversion or pregenital sexuality, minor psychological disorders consist largely of hypochondriacal, obsessive, and anxious-depressive preoccupations, as well as of those associated with senile changes, like miserliness, seclusiveness and suspiciousness. The overall prevalence of minor disorders is probably similar to that found in younger age groups, but family doctors refer increasingly rarely to psychiatrists patients after the age of 45. Thus, our experiences in the management of these mild and undramatic, but very troublesome, conditions are far too small, even though some workers have shown that there are valuable therapeutic approaches to these numerically largest problems of old age.

Many patients with functional psychoses (affective and paranoid) do eventually find their way to the psychiatrist, often only after narrowly failing to swell further the increasing numbers of elderly people who attempt or commit suicide. Considerable advances can be claimed in the treatment of both affective and schizophrenic illnesses in patients over 65. It has been definitely established that they are rarely the precursors of senile or arteriosclerotic dementia. While senile melancholias used to be chronic and often fatal disorders, nowadays only some 10-20 per cent. fail to remit satisfactorily with

electro-convulsive therapy, and some of these respond to psychosurgery. The tendency of affective illnesses to recur frequently presents a more difficult problem. To what extent it will be solved by the use of anti-depressive drugs in first and subsequent attacks remains to be investigated.

Schizophrenic phenomena in late life are largely of the paranoid variety, and do not seriously invade the affective and conative aspects of personality. Even the most bizarre delusional beliefs and experiences, dissolutions of ego-boundaries, and schizophrenic hallucinations can be abolished or diminished by the determined use of phenothiazine (tranquillizing) preparations. With adequate maintenance therapy most patients can be preserved in a state of normal or almost normal personality functioning indefinitely. The close relationship between affective and schizophrenic reaction-types in old age may open up important areas of basic research, but from a practical point of view there is an urgent need to make family doctors more conversant with these and other psychological disorders seen in the elderly. Many avoidable emergencies and many therapeutic disappointments are due to failure of early recognition and of adequate after-care.

R. A. Robinson, *Consultant Psychiatrist, Crichton Royal, Dumfries*

The organic mental illnesses of the elderly have been neglected for the major part of this century because of their supposed irreversibility. This may be true for the essential dementias, presenile or senile for which evidence is accumulating to suggest an heredodegenerative basis. But this group is probably smaller than has been realized.

Numerous studies have shown the high incidence of coincident psychiatric and physical disability in the aged. The latter is often primary in the pathogenesis of mental symptoms. One or other tends to be neglected by the division of medical services into psychiatric or geriatric streams. Similarly, the importance of psychological factors in the development and presentation of organic illnesses is also often overlooked. Only a combined approach can give the necessary therapeutic and research potentials.

The organization of such a service is described, with its emphasis on the participation of the nursing team in all stages of patient care: diagnostic, therapeutic and social.

Current population and morbidity trends emphasize the need for urgency in the investigation of the interaction of psychological and physical factors in the causation of psychiatric illness in old age.

Ewald Busse, *Chairman, Department of Psychiatry, Duke University School of Medicine, Durham, North Carolina*

A person reaching retirement and living in the United States is likely to experience a rapid and extensive shift in his economic status and role in society. The change to a non-employed status is for some quite traumatic while others find it a pleasant change. As in all major life events there are numerous ways in which people respond. Many such possibilities can be anticipated and the unsatisfactory or unhealthy reactions may be prevented or altered by proper methods. The health and adjustment of an older person is the result of the interaction of physical, psychological and social factors. This longitudinal-interdisciplinary study of so-called normal elderly people residing in the community has resulted in the identification of a number of such factors. For example, why do 31 per cent. of those elderly persons in good health, as measured by accepted medical standards, express the belief that they are in poor health? It appears that health self-evaluation is frequently affected by social economic status. However, 11 per cent. of the subjects persist in their evaluations. The persistent pessimist and the persistent optimist do possess identifiable characteristics which are combinations of several variables.

Intelligence rather than physical skill or strength is becoming increasingly important to any person whether young or old as a basis for maintaining a satisfactory social adjustment, Consequently the intelligence of an elderly person must be preserved. Unfortunately, intelligence as defined and measured in this study does, on the average, decline with advancing age. But the extent of the decline is practically nil or relatively little in certain groups of old people, but is serious and precipitous in those in the lower social economic levels. Learning, an aspect of intelligence, also is influenced by age. This comes at a time when a person may be required to learn new and rather complex patterns of behaviour. Failure to learn new ways of coping with the environment often ends in serious trouble.

Alterations in physiological functions and the development of chronic diseases and disabilities constantly threaten the aged person. Psychological devices and behavioural patterns of handling disability can be identified which are relatively successful and serve to preserve the self-esteem of the aged person.

Alvin Goldfarb, *Consultant, Services for the Aged, New York State Department of Mental Hygiene, New York*

A five year follow-up study which related the

characteristics of 1,200 representative institutionalized aged patients to their course, and the course of patients to type and quality of institutional care, has provided information of possible value. Additional information has been found by a controlled study of change with group psychotherapy.

Aged persons with organic mental syndrome constitute the preponderant number of institutionalized aged, because they require more care than can be provided at home. Rational planning for their care and treatment requires information about the course of their disorder. Data are presented which indicate that old age homes, nursing homes and State hospitals are being used by the community as sites for terminal care of the physically and mentally impaired aged. These institutions are very much alike in that all provide basically adequate food, shelter and emergency medical care; the patient populations, although overlapping in characteristics, showed differences in the proportions of behavioural disturbance, physical impairment and severe mental impairment. Death rates appear to be related to these three characteristics. The findings suggest that most institutionalized persons are kept at home for the longest possible time. For some, the disordered state which led to admission was stabilized, but in the preponderant number decline and death occurred in one to five years.

Persons located in State hospitals had the highest death rate, nursing homes followed, and old age homes had the lowest. Death rate was more closely related to the physical and mental functional status of the patient than to the type of institution or to the impressionistically evaluated quality of care. More specifically, the death rate of institutionalized aged persons was most closely related to the presence and degree of mental impairment. Persons free of brain syndrome had the lowest death rate, those with moderate mental impairment followed; and persons with severe degrees of mental impairment had the highest death rate.

The death rate of the patient soon after admission appeared to be related to factors which delayed or facilitated institutionalization. Institutions with a waiting period had a lower death rate for recent admissions than those which were immediately available to applicants. In general persons with living children had a higher death rate than the childless and the never married, suggesting that family protection may hold persons at home until their condition was grave and their nursing needs great.

Many persons in the group which survived for five years showed considerable change, usually for the better, in the mood, content or behaviour disorder associated with their mental impairment. In a small proportion the degree of mental impairment changed, almost invariably for the worse.

In a separate study twenty-four persons who had aged in the hospital and twenty-four persons first admitted in their old age were matched for age and sex; one-half of the two groups were provided a once-a-week group therapy experience for one year. As compared to the matched controls group therapy helped the brain syndrome patients first admitted to a mental hospital in their old age but not as much as it did the persons with "functional" psychoses—those who had aged in the hospital. Improvement was chiefly with respect to depression and alertness.

These studies of death rate, change in mental impairment or in associated mental disorder as related to type and quality of care and the study of the effectiveness of group therapy suggest that when basic care is good, the type of the institution has relatively little influence upon longevity in this greatly impaired group. Death rate and the course of brain syndrome appear to be more closely related to the physical and mental functional status of the individual than to his institutional location.

Implied is the possibility that psychiatric supervision or treatment may make its greatest contribution to longevity and to the preservation of mental functioning in the period preceding institutionalization. The addition of psychotherapeutic techniques to good general medical care in the institution itself does not appear to add significantly to longevity; such care, however, is undoubtedly of value in improving patients' behaviour, dignity and comfort, in preserving staff, family and community morale, and for insuring the delivery of good basic services, including medical care.

CONCLUDING PLENARY SESSION

The Future of Psychiatry

T. Ferguson Rodger, *Professor of Psychological Medicine, University of Glasgow; President-Elect, Royal Medico-Psychological Association*

In Britain the firmest predictions can be made in the area of administration and organization. Dependent as these are on long-term plans, on building for which sites and finance have to be arranged well in advance, present policies are a good indicator of developments over the next 20 years. In this area there are sharp differences between Britain and the United States of America, reflecting divergent political philosophies. Resources in Britain are

allocated almost entirely by Government decision; the diminishing private sector of medicine plays only a very minor role. It is likely for this reason among others, that there will be a continuing disparity between the two countries in the attention given to time-consuming psychotherapy.

It is hard to predict where the next big advance in treatment will come from. Past experience suggests that the revolutionary idea comes from the least expected source. This may not be true in the future. New techniques are providing hard information of an entirely new quality about the nervous system which seems bound eventually to give us explanations of mental disorder.

The usefulness of new work is obscured by an information crisis. Whereas 30 years ago a psychiatrist could have a reasonable knowledge of the whole advancing front of psychiatry, it is now extremely difficult to keep pace with the changes even in a restricted sector. The position is worsened by the multiplication of publications, many of which are redundant.

Our Joint Meeting should perhaps have considered joint action in this field to screen, reduce, condense or collate the flow of information so that its value for progress could be enhanced.

There is a need for a stricter definition of the role of psychiatry. In Britain there is a growing tendency to adopt a more modest stance *vis-à-vis* the public's expectation of what we ourselves can do to ameliorate problems, both individual and social, which are not purely medical, and to form alliances with key persons in the community in a better position, and more numerous than ourselves, to deal with them.

HARVEY J. TOMPKINS, *President-Elect, American Psychiatric Association*

The "tomorrow" of psychiatry is viewed through the twin lenses of emerging patterns of health care as coloured by social, economic and political changes and the increasing prominence of psychiatry as a discipline within medicine wherein it both leads and follows the rest of the medical sciences. An attempt is made to delineate the expanding responsibilities of this segment of medicine stimulated by the general acceptance of the inclusion of mental health as an essentiality in the concept of the total welfare of the individual, family and community. Implications of the various expectancies fostered by the popular acceptance of this belief in the indivisibility of health is analysed, particularly the impact on psychiatry itself and its relations to the rest of medicine and to the other professions in the mental health fields. An evaluation is made of the present status of psychiatry in the United States with special reference to the demonstrated degree of awareness of present and on-coming events, whether local or world-wide, which will help mould the future of psychiatry both as a medical discipline and a social force. Characteristics of psychiatric practice, teaching and research are examined in an effort to determine trends which may be considered significant in auspices, direction, scope and actual content, ranging from the expanding influence and diversification of the role of academic medicine, and its relationship to individual practice, to the more specific and technical areas of psychiatric theory and technique, both of which are responding in diverse ways to multiple forces. Some of these influences derive from added knowledge, with its requirements of new locales for treatment, new equipment and expanded auxiliary services, and also from the necessity of better distribution and conversion of professional manpower, the latter principally due to the need of providing services for the greatest number at the least cost of time, effort and money and without sacrificing quality care. Emphasis, at present and for the foreseeable future, is not only on need for better technical approaches and devices based on sound premises, but also on economy in use. The ability of psychiatry to cope with this challenge, faced by the whole of medicine, is answered by a critical review of the scope of various investigative efforts, the broadening base of an increasing number of training programmes and the instances of imaginative use of service facilities. Deficiencies, when apparent, are primarily due to the accelerating pace of developing needs, amplifying the magnitude of demands, rapidity of change and the "lag" between knowledge and implementation augmented by delays in necessary modifications or elimination of traditional policies and methodology. Advantage will be taken of the presentations and discussions at the Joint Meeting to give specific substance and depth to the portrayal of present day psychiatry and what promises it holds for the future.

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The Library is open to members between the hours of 9 a.m. and 5 p.m. Mondays to Fridays. Books are issued to borrowers during these hours.

The Hon. Librarian will endeavour to obtain, as far as possible, any books on psychiatry and allied subjects required by members.

Library Lending Department Regulations

1. Books shall be lent to members within the United Kingdom and Eire who are not in arrears with their subscriptions.

2. No member may borrow from the Library more than three volumes at one time.

3. Books and journals are sent carriage paid from the Library, but members are responsible for the books from the time they leave the Library until they are received back, and for the return postage.

4. Books damaged or lost while in possession of a member will be repaired at his expense or must be replaced by him.

5. A member shall be entitled to retain a book or periodical borrowed from the Library for a period of twenty-eight days (or longer by special arrangement), unless the book is required by another member, in which case it can be recalled by the Librarian at the expiration of fourteen days.

6. In the event of a member failing to return any book or periodical within seven days after receiving notice from the Librarian (on the expiration of the period referred to in Rule 5), the Library Committee shall be at liberty to purchase another copy, the cost to be charged to such member, who shall not be allowed to borrow another book until the sum thus expended shall have been paid.

7. All communications should be addressed to "The Librarian, R.M.P.A., Chandos House, 2 Queen Anne Street, London, W.1".

Circulation of Journals

The following Journals are available at the Library:

Acta Neuro-Psiquiatrica Argentina.

American Journal of Mental Deficiency.

American Journal of Orthopsychiatry.

American Journal of Psychiatry.

Annales Médico-Psychologiques.

Archives of General Psychiatry.

Archives of Neurology.

Arquivos de Neuro-Psiquiatria.

Arquivos do Departamento de Assistencia a Psicopatas do Estado de Sao Paulo.

Brain.

British Hospital and Social Service Journal.

British Journal of Addiction.

British Journal of Criminology.

British Journal of Medical Psychology.

British Journal of Psychiatric Social Work.

British Journal of Psychiatry (Journal of Mental Science).

British Journal of Social and Clinical Psychology.

Bulletin of the Menninger Clinic.

Comprehensive Psychiatry.

Digest of Neurology and Psychiatry.

L'Evolution Psychiatrique.

Excerpta Medica, Neurology and Psychiatry.

Film User.

Howard Journal.

Il Cervello.

International Journal on Alcohol and Alcoholism.

International Journal of Psycho-Analysis.

International Journal of Social Psychiatry.

Journal of Analytical Psychology.

Journal of Child Psychology and Psychiatry.

Journal of Mental Deficiency Research.

Journal of Mental Subnormality.

Journal of Nervous and Mental Disease.

Journal of Neurology, Neurosurgery and Psychiatry.

Journal of Psychology.

Journal of Psychosomatic Research.

Mental Health.

Mental Hygiene.

Psychiatric Quarterly.

Psychiatry.

Psycho-analytic Quarterly.

Psychological Abstracts.

Revista de Neuro-Psiquiatria.

Revista de Psicologia General y Aplicada.

Revista Psiquiatrica Peruana.

Revue de Médecine Psychosomatique.

Scientific Film Review.

W.H.O. Chronicle.

World Mental Health.

THE ASSOCIATION'S MEDALS AND PRIZES, 1965-66

Attention is specially drawn to the Medals and Prizes which are offered annually by the Association. The conditions of award are set out fully in the Year-Book.

Bronze Medal and Prize

Dissertations for the Association's Bronze Medal and Prize should be forwarded to reach the Registrar not later than 30 April.

Divisional Prizes

Papers certified as eligible for this competition must be forwarded to reach the Registrar not later than 30 April.

Gaskell Medal and Prize

The examination for the Gaskell Medal and Prize is held in May. An entrance fee of £3 3s. is charged, returnable to bonafide candidates. Entrance fees are due by 31 March.

FORTHCOMING CONGRESSES, Etc.

Psychosomatic Medicine

The Third International Congress of Psychosomatic Medicine in the French Language will be held in Paris in July, 1966. The principal theme will be "Fatigue and Relaxation" and there will be physiological, psychological and psycho-sociological sections. Particulars can be obtained from the Société Française de Médecine Psychosomatique, Hôpital Cochin, 27 Faubourg St. Jacques, Paris 14e.

International Association for Social Psychiatry

At a plenary session of the first International Congress of Social Psychiatry, it was decided to form a new international society for individual membership of all professionally trained people in this field. A representative executive committee of 40 members was elected. This in turn elected Dr. Maxwell Jones of Dingleton Hospital, Melrose, Scotland, as Chairman and Dr. H. Beric Wright of the Institute of Directors, London, as Secretary. Other members of the Working Committee are:

A. E. Babayan	U.S.S.R.	J. Prokupek	Czechoslovakia
F. Gokay	Turkey		
E. Lindemann	U.S.A.	B. F. Riess	U.S.A.
A. E. Moll	Canada	J. R. Seeley	U.S.A./Canada
Ø. Ødegard	Norway		
		C. Seguin	Peru

It is proposed to have a further congress in 1967 at which a constitution and rules, etc., will be formally adopted.

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