Life Members Share Wisdom and Our History

AACAP: A Gift in My Life

It took 17 years of waiting and three years in the United States Navy before I entered medical school. Our class was part of the national wave of veterans returning on the GI Bill. We were so glad to be back that we studied everything with enthusiasm and without complaint, loving it all, whether or not we understood it.

Five classmates and I got jobs as interns at the Northampton State Hospital in the break between our second and third years (1948). It was an intense immersion in the world of chronic psychiatric problems treated in a state hospital. I date my commitment to psychiatry to that summer. But the appeal of internal medicine remained through graduation and internship, and I delayed deciding so long to apply for a psychiatry residency that I was lucky to be accepted at the Boston Psychopathic Hospital (later called MMHC) in 1951. There my fascination with psychiatric illness was intensified by fabulous supervision opening up the world of developmental theory exploring the underpinnings of all that we deal with. There I became a disciple of Elvin Semrad.

In my third residency year, I was fortunate enough to persuade my wife to marry me and we went to London, where I had a clerkship in neurology at the Maudsley Hospital. We returned with our one month old son.

Following two years of running adult inpatient wards and supervising residents, I started my fellowship in child psychiatry with Gregory Rochlin, M.D., in 1956. He had just opened a ten beds, five-nights-per-week, locked ward for children up to age 13 years and I was put in charge. I directed it until 1973 when I was appointed director of the 60 bed, full-care Gaebler Children's Unit (for children through age 15 years) at Metropolitan State Hospital. I became superintendent when Gaebler became State Hospital in its own right. I continued there until retirement from DMH in 1989. During those 33 years, I was responsible for the hospital care and treatment of hundreds of children from as young as four to the 16th birthday, with the full range of serious mental illnesses and concomitant behavioral problems, including juvenile murderers.

The 60 beds at Gaebler were the only public beds for children in Massachusetts and the pressure to gain admission was constant. The 16th birthday as the absolute age limit was essential because otherwise obligatory court referrals of 16-18 year olds would have wiped out beds for younger patients and longer term treatment.

One judge demanded that I admit an adolescent over the age limit. I had to refuse the demand in order to protect the hospital's mission. He threatened to cite me for contempt and I might well have been jailed but for the intervention of the Commissioner and his legal counsel. When I stopped running the hospital, my extra systoles dropped from 22/minute to 0.

With this population I was an explorer in the "universe of Childhood Schizophrenia" – a pre-DSM-III comprehensive label that comprised dozens of competing diagnostic concepts – the most durable of which has been Autism. There were intense debates between proponents of different diagnostic theories, as well as about the role of psychotherapy.

Severe behavior problems – assaultive and self-destructive – were frequent. As with the great majority of psychiatric hospitals, pragmatic management required restraint – primarily locked seclusion. I was frequently called on to defend and explain the use of seclusion and restraint. I was also a member of the American Psychiatric Association (APA) task force on the subject. My general comment to critics was (and is) that they regard any restraint as abuse rather than...
recognizing that restraint (which includes hospitalization itself) may be properly used or may be abusively used.

I was always impressed with the deep level of caring and understanding the nursing staff, both at MMHC and Gaebler, had for all of the children, including those that were the most difficult, e.g., assaultive, spitting, and biting. The quality of reacting to the child with compassion allowed the need for restraint to lessen. It was common for children to come to trusted staff when they felt they were near losing control and ask to be put in a room, even to have it locked, to help them maintain control. Virginia Merritt (2011) wrote of the staff’s closeness years later:

“They still meet once a year, the people from that hospital, now a ghostly place, the drive-way chained, tall grass filling in the paths to the picnic grounds where the kids went in the spring. A social worker told me, and it’s been 10 years or more now, ‘I would still trust me life to any of those people I worked there with’.”

In 1967, the greatest surprise and gift of my professional life appeared: the invitation to Fellowship in the Academy of Child Psychiatry. I had thought it was a pantheon of professors; not an organization that a journeyman in the field would aspire to. I reveled in this inexplicable honor, which came as Lawrence Stone, M.D., a friend and colleague in Boston, was leading a group negotiating with Sidney Berman, M.D., president of the Academy, to open up the Academy to membership by application. At my second meeting George Gardner, M.D., (a founder of the Academy) was sitting next to me while Dr. Berman was arguing for opening up. He whispered in my ear, “Some of these old fogeys want to keep the Academy as a private club.” I remained quiet. But the historic change became a second birth for the field.

Membership in the Academy makes me feel more a part of the profession than does my Child Boards Diploma. At meetings, we are colleagues with both leaders and peers. It is like being in a continuing residency, a true place of learning and sharing. Gordon Harper, M.D., and I for years chaired lively meetings of children’s ward directors throughout the country. The commonality of our problems (such as conflicts about restraints) and similarity of our admiration for our ward personnel nourished our morale.

One of the major impediments to productive discussion about conflictual issues in the field is orthodoxy or dogmatic beliefs. I offer the following aphorism: Truth is the fragile child of skepticism, Dogma the brutal spawn of certainty (Gair 1988).

Dogma and orthodoxy are not the way of the Academy. Its only orthodoxy is commitment to the collaborative and ethical pursuit and exchange of knowledge helpful to children, adolescents, and their families in their development and in their disorders.

The Academy holds the field, its members, its patients, and its allies in a Winnicottian embrace. This Lifer is content that child and adolescent psychiatry is in good hands.

References


Dr. Gair has reached the age of aphorisms and is professor emeritus of Psychiatry at Boston University School of Medicine. He was the third chair of the Assembly of Regional Organizations of Child/Adolescent Psychiatry of the Academy and served, with Norbert Enzer, M.D., Robert Stubblefield, M.D., Elissa Benedek, M.D., and Tom Haizlip, M.D., on the committee that produced the Academy’s Code of Ethics (~1981). He received the 2005 APA’s Agnes Purcell McGavin Award for Distinguished Career Achievement in Child and Adolescent Psychiatry. Dr. Gair can be reached at gair33@verizon.net.