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Residential Treatment and the Invention of the Emotionally Disturbed Child in Twentieth-Century America

DEBORAH BLYTHE DOROSHOW

SUMMARY: In the 1930s, children who were violent, depressed, psychotic, or suicidal would likely have been labeled delinquent and sent to a custodial training school for punitive treatment. But starting in the 1940s, a new group of institutions embarked on a new experiment to salvage and treat severely deviant children. In the process, psychiatrists, psychologists, and social workers at these residential treatment centers (RTCs) made visible, and indeed invented, a new patient population. This article uses medical literature, popular media, and archival sources from several RTCs to argue that staff members created what they called the “emotionally disturbed” child. While historians have described the identification of the mildly “troublesome” child in child guidance clinics, I demonstrate how a much more severely ill child was identified and defined in the process of creating residential treatment and child mental health as a professional enterprise.

KEYWORDS: child psychiatry, residential treatment, emotionally disturbed, mental illness

In 1949, nine-year-old Tommy arrived at the Southard School, the children’s division of the famed Menninger Clinic in Topeka, Kansas. A lonely, severely asthmatic child, he did not interact with other children and preferred to play by himself. He was so scared of the world around him that he could not cross the street separating Southard’s two buildings without an adult. Tommy was also “irritable” and had such bad temper tantrums that his parents had to stop talking to one another for long periods just to avert another tantrum. “The parents seemed completely enslaved by

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the child,” noted Dorothy Wright, his therapist and social worker.¹ Despite his Topeka address, Tommy did not live on Earth. According to Wright, he claimed to be a Martian general who “commanded countless space ships, was out to destroy the world, sailed to faraway regions of space, destroyed stars and invaded different solar systems.”² In a series of medical articles about the boy, Tommy’s caretakers would refer to him as “the space child.”³

Tommy’s new home, Southard School, was one of a new group of institutions called residential treatment centers, or RTCs. These centers were unlike any other institution for children. They were typically small and therapeutically oriented, employing a psychiatric model to understand and treat children on a short-term basis. Most RTCs arose from the ashes of other institutions like orphanages, schools for feeble-minded children, and training schools and were reimagined by administrators as therapeutic, short-term centers for these “disturbed” children. They emerged in the very early years of child psychiatry, during a time when child mental health was largely focused on treating mild difficulties like truancy and preventing the development of later juvenile delinquency and mental illness.

Although centers varied in size and focus, RTC professionals identified one another as being involved in the same pioneering project: the treatment of children who had been deemed incorrigible. They hoped that RTCs would provide progressive, therapeutic settings for children who might otherwise have been sent to punitive or custodial institutions. As they admitted these children and tried to understand the roots of their problems, RTC professionals identified a new group of children whom they deemed “emotionally disturbed.” Like Tommy, “emotionally

1. Arthur Mandelbaum, “Presentation for Annual Meeting, October, 1952,” box 16, Annual Meeting—1952, Menninger Archives, Kansas Historical Society, Topeka, Kansas (KSHS), 3.

2. Mrs. Wright, “Presentation for Annual Meeting, October, 1952,” box 16, Annual Meeting—1952, KSHS, 1; Rudolf Ekstein and Dorothy Wright, “The Space Child: A Note on the Psychotherapeutic Treatment of a ‘Schizophrenoid’ Child,” *Bull. Menninger Clin.* 16 (1952): 211–24, quotation on 212.

3. This description of Tommy’s behavior is based on Rudolf Ekstein, “The Space Child’s Time Machine: On Reconstruction in the Psychotherapeutic Treatment of a Schizophrenoid Child,” *Amer. J. Orthopsychiatry* 24, no. 3 (July 24, 1954): 492–506, 492; Rudolf Ekstein and Dorothy Wright, “Comments on a Psychotherapeutic Session with the Space Child,” *Internat. Rec. Med. Gen. Pract. Clin.* 167, no. 11 (November 1954): 592–600, 593; Ekstein and Wright, “Space Child” (n. 2), 212; and Mandelbaum, “Presentation for Annual Meeting, October, 1952” (n. 1), 2–3.

disturbed” children who came to RTCs in the 1940s and 1950s exhibited behavior that was strange or disruptive at home, at school, or in the community. Most of the time, the adults around them had thrown up their hands in defeat. They did not understand the children and had given up trying to manage or help them.⁴

As Ian Hacking has suggested, the confluence of a variety of social and cultural factors at discrete moments in time gives rise to fertile environments for certain “kinds” of people. In this article, I argue that the emergence of residential treatment was integral to the identification of a new kind of person: the “emotionally disturbed” child.⁵ This child arose from a unique child welfare landscape with no room for severely troubled children and was defined by her spectrum of diagnoses and by the dysfunctional home environment from which she came. RTCs arose during a time of intense child mental health reform, meeting a need for treatment that could not occur in the community. In particular, emotionally disturbed children were defined as children who could not be treated in the child guidance centers that formed the core of community mental health care for children.

4. For a more thorough examination of the history of residential treatment, see Deborah Doroshow, “Emotionally Disturbed: Residential Treatment, Child Psychiatry, and the Creation of Normal Children in Mid-Twentieth Century America” (Ph.D. diss., Yale University, 2012). The literature on the history of RTCs is limited to a few studies of specific treatments, individual RTCs, and reflections on the past by participant–historians. See Elizabeth Bromley, “Stimulating a Normal Adjustment: Misbehavior, Amphetamines, and the Electroencephalogram at the Bradley Home for Children,” *J. Hist. Behav. Sci.* 42, no. 4 (Fall 2006): 379–98; Bonnie Evans, Shahina Rahman, and Edgar Jones, “Managing the ‘Unmanageable’: Interwar Child Psychiatry at the Maudsley Hospital, London,” *Hist. Psychiatry* 19, no. 4 (December 2008): 454–75; Lawrence Jacob Friedman, *Menninger: The Family and the Clinic* (New York: Knopf, 1990); Nathan William Moon, “The Amphetamine Years: A Study of the Medical Applications and Extramedical Consumption of Psychostimulant Drugs in the Postwar United States, 1945–1980” (Ph.D. diss., Georgia Institute of Technology, 2009); Madeleine P. Strohl, “Bradley’s Benzedrine Studies on Children with Behavioral Disorders,” *Yale J. Biol. Med.* 84, no. 1 (March 2011): 27–33. For practitioner histories, see Bertram J. Cohler and Daniel H. Friedman, “Psychoanalysis and the Early Beginnings of Residential Treatment for Troubled Youth,” *Child Adolesc. Psychiatric Clin. North Amer.* 13, no. 2 (April 2004): 237–54; Bertram J. Cohler and Patrick Zimmerman, “Youth in Residential Care: From War Nursery to Therapeutic Milieu,” *Psychoanal. Stud. Child* 52 (1997): 339–85; D. Patrick Zimmerman and Bertram J. Cohler, “From Disciplinary Control to Benign Milieu in Children’s Residential Treatment,” *Therapeutic Comm.* 19, no. 2 (1998): 123–46; D. Patrick Zimmerman, “Psychotherapy in Residential Treatment: Historical Development and Critical Issues,” *Child Adolesc. Psychiatric Clin. North Amer.* 13, no. 2 (April 2004): 347–61.

5. Ian Hacking, “Making Up People,” in *Reconstructing Individualism: Autonomy, Individuality, and the Self in Western Thought*, ed. Thomas C. Heller, Morton Sosna, and David E. Wellbery (Stanford, Calif.: Stanford University Press, 1986), 222–36.

In order to further define this new population, RTC professionals sought to classify it. Using psychoanalytic language they had adopted for their own purposes, they loosely categorized children according to their behavior patterns. According to their highly variable system, children were either “aggressive” and “acting-out” or “withdrawn” and “anxious,” labels that the popular media attached to boys and girls, respectively. Although this gendered interpretation did not accurately reflect the children treated in RTCs, it reflected broader cultural concerns about juvenile delinquency, gender norms, and the importance of conformity to cultural expectations. Emotionally disturbed children were also defined by their origin, as RTC professionals invariably traced the etiology of emotional disturbance to disruptions in a child’s home environment. Typically, staff members identified pathological family relationships at the root of emotional disturbance, drawing upon psychoanalytic concepts and terminology to do so. In the process of choosing, classifying, and seeking to understand this new group of children, I argue, psychiatrists, psychologists, and social workers at RTCs made visible, and indeed invented, a new patient population. Children like Tommy had certainly existed before the emergence of residential treatment, but RTCs gave them a label—emotionally disturbed—an explanation for their troubles, and a place to go to solve them.

In their discussions about classification and etiology, RTC professionals articulated a vision of the “ideal” American family and responded to larger cultural tensions about the healthy nuclear family in postwar America. Although suburbanization, the baby boom, and the return of many women to the home after wartime work did contribute to the rise of the nuclear family led by a breadwinning father and homemaking mother, historians such as Elaine Tyler May and Stephanie Coontz have shown that there was no such thing as the “perfect” 1950s family that we often remember with nostalgia. Rather, image was everything; from popular culture to psychological experts, the companionate, loving family supported by parents who fulfilled separate, standardized gender roles became a cultural ideal, if not a reality.⁶ It was this domestic ideal with which RTC professionals grappled as they described how defective family environments had given rise to emotional disturbance.

6. Stephanie Coontz, *The Way We Never Were: American Families and the Nostalgia Trap* (New York: Basic Books, 1992); Elaine Tyler May, *Homeward Bound: American Families in the Cold War Era* (New York: Basic Books, 1988); Arlene S. Skolnick, *Embattled Paradise: The American Family in an Age of Uncertainty* (New York: Basic Books, 1991).

A Web of Welfare

RTCs arose in the 1930s and 1940s as a result of several trends in child welfare and psychiatry. In the early twentieth century, anti-institutional sentiment, foster care and adoption, and newly available state and philanthropic welfare funds increasingly served to keep poor children in homes instead of placing them in institutions like orphanages. Meanwhile, the growing child mental hygiene movement resulted in the creation of a variety of new places for troubled children to get help in the community while simultaneously excluding the most severely troubled. The result was the identification of a population of children defined as “emotionally disturbed”: too ill for the community but for whom traditional institutional placement was felt to be undesirable.

Beginning in the mid-nineteenth century, an enthusiastic generation of reformers, many of them women, became concerned with ensuring the physical and emotional well-being of neglected or mistreated children. By the early twentieth century, the so-called child saving movement was in full swing. Reformers focused on improving the health and welfare of dependent and neglected children by ending child labor, promoting compulsory progressive education, and creating a multitude of agencies designed to help dependent children such as the U.S. Children’s Bureau, founded in 1912.⁷ Meanwhile, other forms of child welfare reform emerged, such as the provision of financial assistance to single women with children in the 1910s and 1920s, continued under the 1935 Social Security Act as Aid to Dependent Children.⁸ As Linda Gordon has argued, these federal and state reform programs promoted the dominant family ideal, with a breadwinning father (even if he was absent) and a dependent mother and child. The preservation of this family, even if imperfect, would prevent children from being placed in institutions, which were objects of suspicion by the early twentieth century.

Increasingly, reformers were characterizing existing institutions as prison-like, military, and devoid of love. At the 1909 White House Conference on the Care of Dependent Children, several hundred child welfare workers expressed their strong opposition to placing children in institu-

7. LeRoy Ashby, *Saving the Waifs: Reformers and Dependent Children, 1890–1917* (Philadelphia: Temple University Press, 1984), 4; Michael B. Katz, “Review: Child-Saving,” *Hist. Educ. Quart.* 26, no. 3 (October 1, 1986): 413–24. On the history of the Children’s Bureau, see Kriste Lindenmeyer, *A Right to Childhood: The U.S. Children’s Bureau and Child Welfare, 1912–46* (Urbana: University of Illinois Press, 1997).

8. See Linda Gordon, *Pitied but Not Entitled: Single Mothers and the History of Welfare, 1890–1935* (New York: Free Press, 1994), chap. 9.

tions.⁹ But during the next decade, most children who lived outside their birth homes were still living in institutions.¹⁰ Another solution was to “place out” children into foster or adoptive families, a practice that was becoming institutionalized by social workers in the 1920s and 1930s.¹¹ As a number of historians of adoption and foster care have recently shown, these practices were used to create new families, often as an alternative to institutionalization. If children could not be part of their biological family, they would at least belong to *some* kind of family.¹²

Child Mental Hygiene and a Spectrum of Ills

One unanticipated result of these changes was that a group of “leftover” children who could not be cared for at home or in a foster or adoptive family emerged as a population in need of intensive treatment.¹³ This “leftover” group of very troubled children also became more visible because adults were looking harder for them. In the early twentieth century, the mental hygiene movement was bringing psychiatry out of the asylum and into the larger community. As Gerald Grob has shown, this movement involved a shift in focus from institutions and treatment to prevention and broader societal reform.¹⁴ Because of its preventive focus, mental hygiene was especially directed toward children, whom psychiatrists deemed the most vulnerable and also the most promising sector of American society.¹⁵ For example, schools became a prime target for mental hygiene

9. Lindenmeyer, *Right to Childhood* (n. 7), 19–20.

10. Ethan G. Sribnick, “Rehabilitating Child Welfare: Children and Public Policy, 1945–1980” (Ph.D. diss., University of Virginia, 2007), 125.

11. Barbara Melosh, *Strangers and Kin: The American Way of Adoption* (Cambridge, Mass.: Harvard University Press, 2002), 3.

12. Ibid.; Ellen Herman, *Kinship by Design: A History of Adoption in the Modern United States* (Chicago: University of Chicago Press, 2008); Sribnick, “Rehabilitating Child Welfare” (n. 10).

13. Norman V. Lourie and Rena Schulman, “The Role of the Residential Staff in Residential Treatment,” *Amer. J. Orthopsychiatry* 22, no. 4 (1952): 798–808, 800. See also foreword, American Psychiatric Association, *Psychiatric Inpatient Treatment of Children: Report of the Conference on Inpatient Psychiatric Treatment for Children Held at Washington, D.C., October 17–21, 1956* (Washington, D.C.: American Psychiatric Association, 1957), xii–xiii.

14. On the emergence of mental hygiene, see Gerald N. Grob, *Mental Illness and American Society, 1875–1940* (Princeton, N.J.: Princeton University Press, 1983), chap. 6.

15. On the mental hygiene movement as it applied to children, see Theresa R. Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada* (Albany: State University of New York Press, 1989), chap. 4. For an overview of child mental hygiene extending through the 1940s, see Joseph M. Hawes, *Children between the Wars: American Childhood, 1920–1940* (New York: Twayne, 1997).

intervention, an opportunity to shape young personalities and prevent later mental disorders.¹⁶

In particular, these efforts focused on the issue of juvenile delinquency, which in the late nineteenth century was still considered a fundamentally legal problem, often stemming from inherited degeneracy. However, a new approach emerged at the turn of the century with the emergence of juvenile courts, which were intended to serve as rehabilitative agencies for children. There, a judge would offer individualized guidance and a probation officer would serve as the child's mentor.¹⁷ Although some courts became mere detention centers for unwanted children, they symbolized an important shift in the way delinquency was understood. No longer the straightforward act of breaking the law, delinquency was starting to become an expression of both psychological and socioeconomic stressors, a reconceptualization that would only continue over the next several decades.¹⁸

In order to treat these children, a network of child guidance clinics was founded across the country, many of them founded by the governmental National Committee for Mental Hygiene and often funded by its closely related philanthropic counterpart, the Commonwealth Fund. As Margo Horn and Kathleen Jones have shown in their histories of the child guidance movement, these clinics were initially intended to treat delinquent, typically working-class children, who were referred there from juvenile courts. But almost immediately, clinic psychiatrists, psychologists, and social workers began to identify a new population of patients: "predelinquent" children. These typically middle-class "troublesome" or "problem" children had minor emotional and behavioral problems ranging from enuresis to temper tantrums and truancy. Most important, they had a better prognosis than delinquent children, many of whom came from poverty and tended to be repeat offenders.¹⁹

The efforts of mental hygiene experts, including child guidance professionals, to identify and treat a vast, previously unidentified population of "troublesome" children had many consequences, both expected and

16. Sol Cohen, "The Mental Hygiene Movement, the Development of Personality and the School: The Medicalization of American Education," *Hist. Educ. Quart.* 23, no. 2 (Summer 1983): 123–49.

17. Judith Sealander, *The Failed Century of the Child: Governing America's Young in the Twentieth Century* (Cambridge: Cambridge University Press, 2003), 21–25.

18. Margo Horn, *Before It's Too Late: The Child Guidance Movement in the United States, 1922–1945* (Philadelphia: Temple University Press, 1989), 12.

19. On child guidance, see *ibid.* and Kathleen Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority* (Cambridge, Mass.: Harvard University Press, 1999).

unexpected. With increased preventive work and efforts to identify and work with “problem children,” experts identified a large number of children requiring help. As one psychiatrist observed, “With the excellent work accomplished by [child guidance], or rather in spite of it, there is a steadily increasing number of children under 15 years of age requiring . . . treatment.”²⁰ For children who truanted from school or did not get along with their parents, child guidance clinics were a perfect fit, allowing children to stay in the community while receiving treatment. And starting in the 1950s, adolescent medicine specialists and family therapists would offer additional ways to treat troubled youth in the community.²¹

But these community-based practitioners were simply not equipped to take care of severely troubled children who could no longer be managed at home or at school. This was particularly problematic for more children who required institutional care, because only a very few state mental hospitals accepted children for treatment, leaving punitive state training schools for delinquent treatment as a frequent last resort.²² As Committee C-2 of the White House Conference on Child Health and Protection found in 1930, “more and more there is left for commitment to the correctional institution only the most difficult cases.”²³ While child guidance clinics were successfully identifying and helping to treat troublesome children in the community, they were simultaneously uncovering a population of severely troubled children who had nowhere to go for the inpatient treatment they required. It was in this context that RTCs emerged.

Most RTCs had previously been other kinds of institutions, like the Southard School in Topeka, which had been a small school for intellectually disabled children, or Bellefaire in Cleveland, which had been a large orphanage. Recognizing the increasing need for institutional care for this newly acknowledged population of children, these institutions transformed themselves into RTCs by changing their missions, their staffing, and often their physical grounds in order to better accommodate severely “disturbed” children. The next task for RTC professionals, as self-described pioneers in the care of “emotionally disturbed” children, would be making sense of the diverse population of children within their walls.²⁴

20. Leo P. O'Donnell, “Prevision of the Development of the New Children's Unit of Rockland State Hospital,” *Psychiatric Quart.* 9, no. 3 (July 1935): 426–35, quotation on 428.

21. Heather Munro Prescott, *A Doctor of Their Own: The History of Adolescent Medicine* (Cambridge, Mass.: Harvard University Press, 1998); Deborah Weinstein, *The Pathological Family: Postwar America and the Rise of Family Therapy* (Ithaca, N.Y.: Cornell University Press, 2013).

22. O'Donnell, “Prevision of the Development” (n. 20), 427.

23. White House Conference on Child Health and Protection, *The Delinquent Child; Report of the Committee on Socially Handicapped—Delinquency* (New York: Century, 1930), 297.

24. For a more detailed discussion of the emergence of RTCs, see Doroshow, “Emotionally Disturbed” (n. 4), chap. 1.

Sorting Children

When Bernice Crumpacker, a social work student at Smith College, arrived at the Child Guidance Home of Cincinnati in 1949, the children she met were a mixed bunch. Eight-year-old Peter tried to provoke the people around him, shouting “nobody likes me” and threatening to jump in front of cars.²⁵ Eight-year-old Aqua, who had chosen her new name, lived in a fantasy world and told others she was an Indian or a cat.²⁶ Six-year-old Robin liked to pretend he was a cowboy or Superman. He had a history of skipping school, lying, and stealing, and “passed through the house like a tornado and had a temper tantrum and screamed at the slightest provocation.”²⁷ This variety of behaviors was not uncommon at RTCs, where children were alike not in the specifics of their actions but in the fact that their behavior was socially unacceptable and disturbing to others. As child psychiatrist Donald Bloch reflected, “while they are *disturbed* children, they are also *disturbing* children.”²⁸

At a basic level, children in residential treatment had failed to adhere to social norms. Children at RTCs failed “to function as socialized members of the community,” as one social work student explained, and “had difficulty in subordinating his wishes to those of the group,” according to two social workers at Hawthorne Cedar Knolls.²⁹ As a result, they had been rejected by every arena of life: school, home, and community.³⁰ Administrators from the Illinois Children’s Home and Aid Society described their target child as “the child who wears out one foster-home after another.”³¹ Bradley Hospital in Providence was “a final protective wall” for the child

25. Bernice Crumpacker, “The Caseworker as Residential Worker: A Dissertation Based upon a Study at the Child Guidance Home, Cincinnati, Ohio” (M.S.S. thesis, Smith College School for Social Work, 1950), 24.

26. *Ibid.*, 25.

27. *Ibid.*, 28.

28. Donald A. Bloch, “Residential Treatment for Disturbed Children,” *Nursing Outlook* 5, no. 11 (1957): 636–38, quotation on 637.

29. Barbara L. Smith, “Programming in a Treatment Home for Disturbed Children: An Analysis of Programming at Pioneer House from December 1, 1946 to June 1, 1947, Evaluating the Relationship of Program Activities To Individual and Group Developments” (M.S.W. thesis, Wayne University, 1948), 16; Herschel Alt and Hyman Grossbard, “Professional Issues in the Institutional Treatment of Delinquent Children,” *Amer. J. Orthopsychiatry* 19, no. 2 (1949): 279–94, quotation on 280.

30. Marvin Bloom and Adrian Cabral, “A Description of a Newly Introduced Group Work Program in a Residential Treatment Setting—The Hawthorne Cedar Knolls School” (master’s thesis, New York School of Social Work, Columbia University, 1954), 7; Joseph H. Reid and Helen R. Hagan, *Residential Treatment of Emotionally Disturbed Children: A Descriptive Study* (New York: Child Welfare League of America, 1952), v.

31. Illinois Children’s Home and Aid Society, *Plans for an Institution for the Treatment of Emotionally Disturbed Children* (Chicago: Illinois Children’s Home and Aid Society, 1946), 2.

whose “parents, physician, social agencies, and child guidance clinics all have been unsuccessful in drawing him back into a normal path of life.”³² For these children, residential treatment was a last resort. Their deviance became particularly worrisome in the decades after World War II, as residential treatment grew remarkably. As Anna Creadick has argued, normality was an aspirational ideal for Americans recovering from the disruption of war. For children at RTCs, being defined as abnormal made them almost un-American.³³

Most RTC professionals divided emotionally disturbed children into two groups: “aggressive” and “acting-out” children, and “withdrawn” or “anxious” ones. When fourteen-year-old Bobby arrived at the Ryther Child Center in Seattle at 1936, he had been relentlessly shuffled from place to place, moving among his maternal grandparents’ home, two foster homes, two boys’ preparatory schools, and two children’s institutions.³⁴ His mother did not want him at home, and he finally arrived at Ryther after his stepfather kicked him out of the house, where he had destroyed furniture and set a fire in the basement.³⁵ Stories like Bobby’s were not uncommon. At the Illinois Neuropsychiatric Institute in the late 1940s, about half of the children “showed aggressive or asocial behavior such as fighting, stealing, temper displays, and destructiveness.”³⁶ At Hawthorne Cedar Knolls, most of the children manifested “aggressive, defiant behavior.”³⁷

Some children in the first category had committed drastic acts. Jerry came to the Ryther Child Center in Seattle after setting his house on fire and cutting up his stepmother’s shoes.³⁸ Eric was a fourteen-year-old boy who arrived at the children’s unit of the Camarillo State Hospital in California after shooting and killing his mother.³⁹ More commonly, “acting-out” children had truanted from school, stolen, lied, or physically

32. Emma Pendleton Bradley Hospital, *Out of Their Misfortune: 25th Anniversary Report of the Emma Pendleton Bradley Home* (Riverside, R.I.: The Hospital, 1956), 3.

33. Anna G. Creadick, *Perfectly Average: The Pursuit of Normality in Postwar America* (Amherst: University of Massachusetts Press, 2010).

34. Helen Renner Brookens, “A Study of Five Children Treated under Ryther Child Center’s Program for the Care of Children with Personality Problems” (M.A. thesis, University of Washington, 1944), 25–29.

35. *Ibid.*, 30.

36. Anne Benjamin and Howard E. Weatherly, “Hospital Ward Treatment of Emotionally Disturbed Children,” *Amer. J. Orthopsychiatry* 17, no. 4 (October 1947): 665–74, quotation on 668.

37. Herschel Alt, *Residential Treatment for the Disturbed Child: Basic Principles in Planning and Design of Programs and Facilities* (New York: International Universities Press, 1960), 30.

38. Brookens, “Study of Five Children” (n. 34), 66.

39. Evelyn Brownstone, “Children’s Services at the Camarillo State Hospital” (M.S.W. thesis, School of Social Welfare, UCLA, 1952), 54.

attacked others. For example, nine-year-old Stephen was a “fearful, scornful and defiant little boy” at the Cincinnati Child Guidance Home who had stolen and skipped school.⁴⁰ Raymond, committed to Camarillo at age eight, was more worrisome. At four, he had attacked a neighboring child, and “was very aggressive, bit and kicked others,” and “would stab at others with sharp instruments.”⁴¹

Another group of children in residential treatment exhibited strange behaviors. Physical habits like bed-wetting were common among these children, as was the tendency to withdraw from others. At the Illinois Neuropsychiatric Institute, these children composed a full half of the population, and “exhibited varying degrees and types of neurotic behavior such as tics, nailbiting, enuresis, infantile speech, feeding problems, and seclusiveness.”⁴² As opposed to “acting-out” or “aggressive” children, these children were described as “passive” and “withdrawn.”⁴³ Bert, an eight-year-old boy admitted to Camarillo in 1952, “seemed to ‘retreat into a shell’” after his little brother was born and was “living in a world of his own,” speaking to others only by copying them. Bert’s behavior caused his dismissal from two schools and continued at Camarillo, where he was “remote, giggling, in poor contact, incontinent of urine and feces, and [requiring] intermittent spoon feeding.”⁴⁴ “Withdrawn” behavior could be bizarre like Bert’s, but it could also be quietly distant. Tommy, the “space child,” tended to isolate himself from others. “He played by himself with his toys, and never clung or cuddled when held,” described his social worker.⁴⁵ A daydreamer, he also seemed depressed and frequently threatened to kill himself.⁴⁶

Although residential treatment professionals often used the binary of aggressive/withdrawn or external/internal behavior to describe their children, plenty of children did not easily fit this mold. Tommy could change in the blink of an eye: “at one moment his voice can be strident [*sic*], harsh with anger, and next soft, warm and thoughtful.”⁴⁷ He had “explosive temper tantrums” and could be “stormy and tyrannical” toward his

40. Crumpacker, “Caseworker as Residential Worker” (n. 25), 25.

41. Brownstone, “Children’s Services at the Camarillo State Hospital” (n. 39), 25.

42. Benjamin and Weatherly, “Hospital Ward Treatment” (n. 36), 668.

43. Alt, *Residential Treatment for the Disturbed Child* (n. 37), 30; “Richman Reports Six Months Service,” *Bellefaiire Bulletin* 1, no. 2 (February 1953), container 18, folder 4, Bellefaiire Archives, Western Reserve Historical Society, Cleveland, Ohio (hereafter BA), 2.

44. Phyllis E. Pfeiffer, “Group IV. Six Children,” in Brownstone, “Children’s Services at the Camarillo State Hospital” (n. 39), 70.

45. Mandelbaum, “Presentation for Annual Meeting, October, 1952” (n. 1), 2.

46. *Ibid.*

47. *Ibid.*, 3.

parents, who were often forced to stop interacting in order to appease him.⁴⁸ Sandy, a youngster at Bellefaire whose father had abused his mother physically and emotionally, had behaved completely differently at school and at home. At school he was timid and afraid of everyone around him, but at home he was “violently aggressive” toward his mother.⁴⁹ Whether their behavior was directed more toward or away from others, children in residential treatment were there because something was awry in their ability to relate to people around them.

While it was children’s behavior that largely got them admitted to RTCs, it was their underlying emotional troubles that most concerned the professionals who treated them. According to RTC professionals, behavior was an outward expression of a deeper disturbance, and it was this disturbance that they hoped to treat.⁵⁰ In making this distinction between emotions and behavior, these professionals urged their colleagues to withhold judgment on the behavior of the children they treated. One child psychiatrist reminded the readers of the *American Journal of Psychiatry* that “troublesome behavior must be accepted as an expression of the child’s difficulty and of what he is able to be at the time,” rather than as an indication of his essential self.⁵¹ His advice was more than empty talk in a scholarly journal; staff members at Southard School were actually told to abide by this standard. The “Child Care Handbook” of the Menninger Children’s Division instructed residential workers there to regard “behavior of children . . . as symptomatic of inner disturbances, and the basic attitude toward the child is a non-judgmental one. There is no ‘naughty’ or ‘bad’ behavior, only symptomatic.”⁵²

The Diagnostic Dilemma

Although RTC professionals embraced the idea that behavior symbolized deeper suffering, observable actions remained essential to sorting children. The process of diagnosis at RTCs involved using psychoanalytic language to describe a child’s behavior. The result was a binary of the

48. Ibid.

49. “Bellefaire,” late 1940s, container 19, folder 7, BA.

50. Child psychiatrist J. Franklin Robinson, director of the Children’s Service Center of Wyoming Valley in Pennsylvania, explained that treatment “centers on his emotional turmoil rather than his overt behavior,” which differentiated RTCs from training and reform schools (J. Franklin Robinson, “The Use of Residence in Psychiatric Treatment with Children,” *Amer. J. Psychiatry* 103, no. 6 [1947]: 814–17, quotation on 814).

51. Ibid., 815.

52. Child Psychiatry Service of the Menninger Clinic, Menninger Foundation, “Child Care Handbook,” May 1957, box 6, Child Care Handbook May 1957, KSHS, 3.

“aggressive” child and the “withdrawn” child as two representative types onto which both physicians and the popular press mapped assumptions about gender and misbehavior.

It was no accident that analytic language became essential to residential treatment. Psychoanalysis, based in large part upon Freudian concepts, had become central to American psychiatry in the first two decades of the twentieth century. But as Nathan Hale and Jonathan Engel have shown, the analytic influence on American psychiatry and culture was both pervasive and eclectic. Although prominent figures like Harry Stack Sullivan were influential, the actual implementation of analytic thought and practice in America was a hodgepodge of different approaches, few of them classically adherent to one school of thought.⁵³ As Eli Zaretsky has argued, American psychiatrists after the war fundamentally viewed psychoanalysis as an opportunity for professional and societal reform. As such, a pragmatic approach, rather than an orthodox one, was necessary.⁵⁴

However, psychoanalysis in some form had become integral to child mental hygiene in the United States. In the late 1920s, Anna Freud in Vienna and Melanie Klein in London had begun separately to write about and practice psychoanalysis on young children, albeit taking fundamentally different approaches to the same patient population.⁵⁵ By the 1930s, most child guidance professionals were operating within a psychodynamic, or modified psychoanalytic, context.⁵⁶ This included social workers, whose training and practice had come to embrace psychodynamic theories, especially an emphasis on the mother–child relationship.⁵⁷ Although they remained peripheral to the core analytic community, they became central to the child guidance enterprise.

The application of psychoanalytic concepts to children would influence not only child guidance, but residential treatment as well. Most RTC professionals had been trained in child guidance clinics and brought

53. Jonathan Engel, *American Therapy: The Rise of Psychotherapy in the United States* (New York: Gotham Books, 2008); Nathan G. Hale, *Freud and the Americans: The Beginnings of Psychoanalysis in the United States, 1876–1917* (New York: Oxford University Press, 1971); Nathan G. Hale, *The Rise and Crisis of Psychoanalysis in the United States: Freud and the Americans, 1917–1985* (New York: Oxford University Press, 1995).

54. See Eli Zaretsky, *Secrets of the Soul: A Social and Cultural History of Psychoanalysis* (New York: Knopf, 2004), chap. 11.

55. See George Makari, *Revolution in Mind: The Creation of Psychoanalysis* (New York: HarperCollins, 2008), chap. 11. Anna Freud took a more empirical approach, emphasizing winning the child’s trust and focusing on traumatic events in the child’s life, whereas Melanie Klein argued that even the very young child had unconscious impulses that might be uncovered through play therapy and transference.

56. Horn, *Before It’s Too Late* (n. 18), 149–54.

57. Engel, *American Therapy* (n. 53), chap. 3.

this basic worldview with them as they created new programs for severely disturbed children. In the process, they chose analytic language and concepts that helped them make sense of the children, typically in a practical manner without attention to formal psychoanalytic theory. For instance, they frequently used the term “maladjustment” to describe a child who was not behaving in accordance with societal standards and “adjustment” to describe a therapeutic success—a child who could conform to cultural expectations and was ready to be discharged home.

The appropriation of psychoanalytic terminology for diagnosis at RTCs was both logical and paradoxical. On the one hand, psychoanalytic language in psychiatry had been common parlance in psychiatry since at least the Second World War, and was institutionalized by the publication of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-I)* in 1952.⁵⁸ On the other hand, much of this language described a person’s internal emotions rather than his or her observable behavior. Furthermore, other than identifying congenital conditions, *DSM-I* did not discuss children at all.⁵⁹ In describing emotional disturbance, RTC professionals appropriated and adapted this language to describe children’s external, observable behaviors.

At RTCs, the diagnostic categories of behavior disorder and neurosis or psychosis were linked to clinical descriptions of “acting-out” and “withdrawn” behavior. “In the primary behavior disorder,” explained Herschel Alt of Hawthorne Cedar Knolls, “the child discharges his conflicts through aggressive behavior. In the psychoneurotic the conflict produces anxiety which remains bound up and expresses itself indirectly through a variety of neurotic symptoms.”⁶⁰ A label of neurosis often indicated a child’s tendency to withdraw from social interactions as well.⁶¹ Psychosis, perhaps the most severe diagnosis bestowed upon “withdrawn” children at RTCs, was a label applied to children who were detached from reality.

This tendency to “sort” children into one of these two categories is starkly evident in a mid-1950s fund-raising pamphlet for the Southard School, which introduced potential donors to the kinds of children they

58. Gerald N. Grob, “Origins of *DSM-I*: A Study in Appearance and Reality,” *Amer. J. Psychiatry* 148, no. 4 (April 1, 1991): 421–31; Ellen Herman, *The Romance of American Psychology: Political Culture in the Age of Experts* (Berkeley: University of California Press, 1995).

59. Committee on Nomenclature and Statistics of the American Psychiatric Association, *Diagnostic and Statistical Manual: Mental Disorders* (Washington, D.C.: American Psychiatric Association, 1952).

60. Alt, *Residential Treatment for the Disturbed Child* (n. 37), 47.

61. Lotte Eichenwald Scharfman, “An Examination of Referrals of Emotionally Disturbed Children to a Resident Treatment Center” (M.S.W. thesis, University of Washington, 1951), 33.

might find there. The first two pages described the (likely imaginary) characters of Dick and Nancy, each of whom needed the school's services for different reasons. First we meet Dick:

"Lick him!"
 "Send him to Sunday School."
 "Put him to work!"
 "Oh, he'll outgrow it."
 And Dick might have gone on:
 to harass neighbors
 to rob a neighborhood store
 to set fire to a garage
 to be sent to a reformatory
 to make crime headlines
 But a wise doctor advised his parents:
 "The Southard School and Hospital can help disturbed children."⁶²

Dick was the prototypical child with a primary behavior disorder, which was marked by delinquent (lawbreaking) behavior, aggression, and "a deviation from the accepted code of morals."⁶³ This diagnosis was the most standard way to describe the "acting-out" or "aggressive" child. In the most extreme cases, a child was labeled as having a "psychopathic personality," which reflected "a chronically perverse adaptation to society."⁶⁴ These children had, according to the administrators of Hawthorne Cedar Knolls, a "deficient conscience . . . defective self-control, primitive emotionality, a high degree of impulsivity . . . [and] antisocial attitudes," among many harsh descriptions characterizing them as almost incorrigible.⁶⁵

62. "The New Southard School and Hospital," box 3, The New Southard School and Hospital (mid-1950s), KSHS, unpaginated.

63. Samuel Lerner, "Selective Criteria for Admission to Hawthorne-Cedar Knolls School: A Dissertation Based Upon an Investigation at the Jewish Board of Guardians, New York City" (M.S.S. thesis, Smith College School for Social Work, 1947), 39; Samuel Finestone and Toby Bennett Bieber, "Status at Discharge and Follow-Up of Twenty Children with Diagnosis of Primary Behavior Disorder Hospitalized at New York State Psychiatric Institute and Hospital" (master's thesis, New York School of Social Work, Columbia University, 1946), 13.

64. Jewish Board of Guardians, *Conditioned Environment in Case Work Treatment: A Monograph of Articles on Hawthorne-Cedar Knolls School, Lavenburg Corner House* (New York: Jewish Board of Guardians, 1944), 41.

65. Ibid. The term was fraught and difficult to distinguish from "delinquency" (itself a vague term) in many cases. Child psychiatrist Ralph Rabinovitch, who directed the child psychiatry unit at the University of Michigan, believed that "'psychopathic' [was] still used as a synonym for delinquent behavior regardless of etiology . . . and [had] no more specific or dynamic meaning than listings of behavior such as stealing, truancy or destructiveness" (Ralph D. Rabinovitch, "Observations on the Differential Study of Severely Disturbed Children," *Amer. J. Orthopsychiatry* 22, no. 2 [April 1952]: 230).

If Dick was the prototypical “acting-out” or “aggressive” child, Nancy was the classic withdrawn child:

“My, I wish our children were as quiet as she is!”
 “Nancy’s always been such a *good* child.”
 “No, Nancy would rather sit with us than go out and play.”
 “Nancy does not seem able to keep up with the rest of the class.”
 And Nancy might have gone on:
 to a dull apathy
 to a silent withdrawal
 to strange compulsions
 to an inability to talk or to eat
 to physical and mental deterioration
 But a wise doctor advised her parents: “The Southard School and Hospital can help disturbed children.”⁶⁶

Not only was Nancy withdrawn, but without immediate assistance, the pamphlet warned, she might have also eventually developed strange behaviors like refusing food and becoming mute. When a withdrawn or anxious (“neurotic”) child’s troubles worsened, he or she might develop schizophrenia, the most extreme variant of neurosis. Childhood schizophrenia was a fairly new diagnosis; it had first been described in the 1930s and 1940s by child psychiatrists who described a group of children with similar behaviors.⁶⁷ These children were uninterested in the environment around them or in other people; some lived in private fantasy worlds. Children with schizophrenia seemed to have blunted emotions, and they often spoke incoherently or not at all. Many had delusions or hallucinations, and evidenced “bizarre,” “primitive” behavior like playing with feces and eating garbage or strange motor tendencies like facial grimaces or catatonia.⁶⁸ One such child, Cindy, was an eight-year-old girl referred to the Children’s Hospital of Cincinnati in 1950 when she began to “clutch” her teachers and “talked in a confused manner.”⁶⁹ At the hospital, she said

66. “New Southard School and Hospital” (n. 62), unpaginated.

67. For early descriptions of childhood schizophrenia, see Howard W. Potter, “Schizophrenia in Children,” *Amer. J. Psychiatry* 89, no. 6 (May 1, 1933): 1253–70; J. Louise Despert, “Schizophrenia in Children,” *Psychiatric Quart.* 12, no. 2 (June 1, 1938): 366–71; Lauretta Bender, “Childhood Schizophrenia,” *Nerv. Child* 1, no. 1 (1941): 138–41; Charles Bradley, *Schizophrenia in Childhood* (New York: Macmillan, 1941); Lauretta Bender, “Childhood Schizophrenia: Clinical Study on One Hundred Schizophrenic Children,” *Amer. J. Orthopsychiatry* 17, no. 1 (1947): 40–56.

68. Bradley, *Schizophrenia in Childhood* (n. 67), 33; Despert, “Schizophrenia in Children” (n. 67), 369.

69. E. Janet Allen, “Casework with the Parents at the Child Guidance Home: A Dissertation Based upon an Investigation at the Child Guidance Home, Cincinnati, Ohio” (M.S.S. thesis, Smith College School for Social Work, 1951), 24.

that her grandmother, who was not present, was talking to her and that the doctor had three eyes. She also seemed catatonic with “a waxy flexibility and fluidity of movement.”⁷⁰ She was admitted to the Child Guidance Home in Cincinnati several months later, with a diagnosis of hysterical psychosis, a variant of schizophrenia.⁷¹

While discrete diagnoses like primary behavior disorder and schizophrenia did exist, it was much more common to use a combination of diagnostic phrases to describe a child. A brief examination of children at the Cincinnati Child Guidance Home in 1950 illustrates this pattern. For example, eight-year-old Peter, the child who tried to get attention by threatening to jump in front of a car, was diagnosed as having a “neurotic behavior disorder with marked feelings of anxiety and possible suicidal features,” a label that drew upon many diagnostic concepts (neurosis, behavior disorder), an emotion (anxiety), and a behavioral observation (suicidal).⁷² Stanley, a nine-year-old boy who had been a client of the juvenile court for stealing and truanting, had a “primary behavior disorder with aggressive tendencies,” a diagnosis that used a description (aggressive) to further classify the behavior disorder, likely related to his “delinquent” behavior of stealing and truanting.⁷³

Labels like “schizophrenic” or “neurotic” were not static. They might fluctuate several times throughout a child’s stay. Staff members at Hawthorne Cedar Knolls considered a diagnosis merely “a frame of reference or a working hypothesis.”⁷⁴ Eleven-year-old Herbert was admitted to the child psychiatry unit at Bellevue Hospital in 1941 because of mutism, tantrums, stealing, and truanting. He was a loner who did not interact with other children, “hid in corners, cooked his own food and threw things at other members of the family.”⁷⁵ At first, the staff called him “mentally ill, depressed and possibly schizophrenic,” but when he was discharged after some improvement, his diagnosis was amended to “mixed psycho-neurosis, depression with comment ‘Psycho-genis [*sic*] mutism but schizophrenia even mental deficiency has not been ruled out,’” which was likely related to his poor intelligence testing results.⁷⁶ When he was reexamined

70. *Ibid.*, 25.

71. *Ibid.*

72. Crumpacker, “Caseworker as Residential Worker” (n. 25), 24.

73. *Ibid.*, 25.

74. Alt and Grossbard, “Professional Issues in the Institutional Treatment of Delinquent Children” (n. 29), 281.

75. Edna J. Baer, “Study of Seven Schizophrenic Children: Inquiry into Family Background and Current Adjustment of Seven Children Who Were Patients in the Bellevue Children’s Ward” (master’s thesis, New York School of Social Work, Columbia University, 1943), 32.

76. *Ibid.*, 33.

approximately one year later, the psychiatrist noted his “frozen behavior” and decided that “his behavior [seemed] now to point more towards his being schizophrenic.”⁷⁷

Bad Boys and Quiet Girls

Was it an accident that “Dick” was an aggressive, “delinquent” boy and “Nancy” was a quiet, “good” girl? Probably not. For example, a social work student at Ryther in Seattle suggested that “our culture demands greater conformity of girls than boys,”⁷⁸ and a Massachusetts RTC psychiatrist observed that boys displayed “socially obnoxious and aggressive behavior,” while girls were more likely to have behavior “of a rather passive character.”⁷⁹ These characterizations were part of a long history of gendering behavior and mental illness and reflected new ideas about juvenile delinquency in popular culture.⁸⁰

In the popular literature on residential treatment, delinquent boys were common protagonists. When *Life Magazine* wrote about the Ryther Child Center in 1947, it chose to profile seven-year-old Butch, who had started setting fires in his foster home. The accompanying photo essay, consisting of re-created incidents during Butch’s stay, showed the boy kicking staff members, running naked through the hallways, running away, being brought back to the center sedated, and ripping up a pair of pajamas.⁸¹ Eleven years later, a feature story in *Harper’s Magazine* described “The Case of the Furious Children,” the boys living at the National Institutes of Health’s child psychiatric unit. Even the title shocked the reader, who was told that “the ‘acting-out’ child . . . is an island of wild emotion in a hostile world. . . . Every impulse, however fantastic, must be gratified immediately and violently. . . . Two dark roads stretch before him—disastrous mental illness or delinquency blending into adult crime.”⁸² Certainly,

77. Ibid., 38.

78. Scharfman, “Examination of Referrals” (n. 61), 6.

79. Thaddeus P. Krush, “State-Subsidized Care and Treatment of Mentally Ill Children in Massachusetts,” *Amer. J. Psychiatry* 109, no. 11 (May 1, 1953): 817–22, quotation on 819.

80. For example, Kathleen Jones showed how many girls were referred to child guidance clinics for shoplifting or sexual promiscuity while boys were sent for truancy and stealing (Jones, *Taming the Troublesome Child* [n. 19]). In the 1910s and 1920s, Elizabeth Lunbeck has argued, women treated in psychopathic hospitals were similarly criminalized and medicalized for their seemingly “hypersexual” behaviors (Elizabeth Lunbeck, *The Psychiatric Persuasion: Knowledge, Gender, and Power in Modern America* [Princeton, N.J.: Princeton University Press, 1994]).

81. “Bad Boy’s Story,” *Life*, May 12, 1947, 107–14, photographs on 108–9.

82. Alan L. Otten and Charles B. Seib, “The Case of the Furious Children,” *Harper’s Magazine*, January 1958, 56–61, quotation on 56.

many of the boys there had committed arson and had attacked others, but alarmist statements like this branded them as threats to society and made residential treatment seem like a lifesaving, compassionate measure.⁸³

Other articles were less blatant but similarly equated delinquency with boys and inwardly directed pathology with girls. In her 1950 story on Hawthorne Cedar Knolls in the *New York Times*, Gertrude Samuels consistently used “he” and “his” to describe the arrival of a typical “delinquent” child and presented two boys as representative case studies.⁸⁴ Two articles about the Ryther Child Center presented models of passive girls: Martha was a fiercely independent little girl who didn’t want to interact with others, and teenage Ann was self-involved and obsessed with her appearance.⁸⁵ In one *Chicago Tribune* feature on the University of Michigan’s child psychiatry unit, the author described Bobby, “who made a habit of stealing big trucks”; Jackie (a boy), a fire setter; Joe, the child who had chopped down several cottages with an ax; and “little Roberta, who turned her frustrations inward until her disturbed emotions resulted in severe ulcerative colitis.”⁸⁶

Articles like these further reinforced the public perception that boys in residential treatment were “bad” and girls were more quietly, inwardly disturbed. In part, this perception reflected broader cultural concerns about delinquent boys, which were at an all-time high in the 1950s. Movies like *Rebel Without a Cause*, *The Wild One*, and *Blackboard Jungle* suggested that teenage male delinquency was everywhere and could strike innocent victims at any time.⁸⁷ Although many boys in residential treatment were not yet teenagers like the characters in these movies, delinquency was so strongly gendered in postwar American culture that journalists’ bias toward covering bad boys (at the expense of their quiet or bizarre counterparts) is understandable. In contrast, the Academy Award-nominated 1956 film *The Bad Seed*, based on the best-selling novel and Broadway

83. Roger Greene, “‘Case of the Furious Children’: We Don’t Know Why They Hate,” *Chicago Tribune*, July 19, 1959, E6. It is notable that the *Harper’s* article was described in the *Chicago Tribune*, based far away from the NIH campus in Bethesda, Maryland, suggesting that the article was widely read and commented upon.

84. Gertrude Samuels, “A New Road for the Juvenile Delinquent,” *New York Times*, April 23, 1950, SM6.

85. Lillian J. Johnson, “Making over Martha,” *Parents’ Magazine*, March 1948, 26–28; Lillian J. Johnson, “A Girl Named Ann,” *Parents’ Magazine*, November 1947, 35–37.

86. Joan Beck, “Can ‘Bad Kids’ Be Saved?,” *Chicago Daily Tribune*, February 27, 1955, K19.

87. Nicholas Ray, *Rebel Without a Cause* (Warner Brothers, 1955); Laslo Benedek, *The Wild One* (Columbia Pictures Corporation, 1954); Richard Brooks, *Blackboard Jungle* (Metro Goldwyn Mayer, 1955). On concerns about juvenile delinquency in the 1950s, see James Burkhardt Gilbert, *A Cycle of Outrage: America’s Reaction to the Juvenile Delinquent in the 1950s* (New York: Oxford University Press, 1986).

play, depicted emotional disturbance hiding beneath a calm exterior. In the film, a loving mother gradually realizes that her sweet, seemingly perfect daughter Rhoda has secretly murdered a classmate who beat her in a school penmanship competition. Over the course of the movie, Rhoda seems happy and untroubled by her classmate's death, suggesting that deep disturbance could exist beneath a veneer of absolute normality.⁸⁸ Given this cultural attention to the dangerous potential of the acting-out boy and his more quietly disturbed female counterpart, it is not surprising that journalists focused on these children in their coverage of residential treatment.

Of course, the relationships among clinical practice, popular media coverage of residential treatment, and cultural depictions of bad boys and quiet girls were not straightforward. After all, Dick and Nancy appeared in a publication by Southard School. Even if their two types were not necessarily representative of RTC populations, administrators were likely aware of their strong cultural valence for potential donors. Even *The Bad Seed's* Rhoda Penmark had an aggressive, violent core underlying her placid appearance. Indeed, a closer look at children in residential treatment suggests that stereotypes and gender ratios do not tell the whole story. In my review of over sixty case studies from the medical literature, archival materials, and social work theses, "withdrawn" boys were described as much as "aggressive" or "delinquent" boys (as described by the authors), as were "withdrawn" and "aggressive" girls.⁸⁹ Yet for Americans reading mainstream newspapers and magazines, the gendered nature of emotional disturbance was hard to miss.

A third kind of child was by definition neither the "bad boy" nor the "quiet girl." This child so brazenly defied gender norms that even if he or she exhibited other symptoms, this form of cultural defiance garnered the bulk of clinical attention. Wilma was depressed, assaulted other children in her detention home, and had "uncontrollable temper outbursts."⁹⁰ It was not these symptoms that the University of Michigan

88. William March, *The Bad Seed* (New York: Rinehart, 1954); Maxwell Anderson, *The Bad Seed: A Play in Two Acts* (New York: Dodd, Mead, 1955); Mervyn LeRoy, *The Bad Seed* (Warner Bros. Pictures, 1956).

89. Obviously, this is not a systematic set of case studies. However, I still believe it warrants serious consideration as all of the sources were clinical and represented both children who were being presented for academic evaluation (journals, social work theses) but also reviews of unsorted new groups of children who were being admitted to RTCs. For a complete list of sources, see Doroshov, "Emotionally Disturbed" (n. 4).

90. Ralph D. Rabinovitch, Janet Bee, and Barbara Outwater, "The Integration of Occupational and Recreational Therapy in the Residential Psychiatric Treatment of Children: A Symposium," *Amer. J. Occup. Therapy* 5, no. 1 (1951): 1–8, quotation on 2.

child psychiatry unit focused on, but her decidedly unfeminine behavior. On the ward, “she refused to wear girl’s clothes, and for the most part remained unkempt. The male attendants reported that her behavior was particularly bizarre and unpredictable in their presence.”⁹¹ That the staff members focused on these observations, particularly the nuanced latter, illustrates the great attention RTC staff paid to gender nonconformity. It was not Wilma’s violent assaults on other children that they worried about, but her distaste for dresses and good grooming.

The popular media loved the gender nonconforming child. In 1955, *Time* featured the story of Jim, a fifteen-year-old boy who had been sent to Ryther Child Center by a juvenile court after an arrest for indecent exposure in which he was found in women’s clothing.⁹² In Cleveland, local television station WNBK broadcast the fictional “Portrait of Elaine,” which depicted the workings of Bellefaire.⁹³ “Elaine” was a teenage girl who refused to talk to the boys at Bellefaire and whose personal hygiene and behavior were so poor that it “deliberately seemed to destroy her chances for dating with the boys on or off campus.”⁹⁴ She seemed to defend her boyish image, pelting a snowball with a rock inside it at one boy who asked her why she wore pants all the time.⁹⁵ Going beyond the “quiet boy” or “aggressive girl,” children like Jim and the fictional Elaine so blatantly defied gender norms that their gendered behavior in itself constituted their emotional disturbance.⁹⁶ Featured in popular media, their transgressions served only to reinforce traditional gender norms in children’s behavior.

Broken Homes, Broken Children?

After describing and classifying disturbed children, the next task for RTC professionals was to explain how they became disturbed in the first place. One prime suspect was what RTC professionals (and Americans, more

91. Ibid.

92. “Medicine: Psychiatry at Work,” *Time*, June 27, 1955, <http://www.time.com/time/magazine/article/0,9171,823823,00.html>, accessed November 12, 2011.

93. “Portrait” was the eighth part of “Mr. Muldoon’s Hall of Fame,” a series that highlighted the work of local community organizations. William D. Ellis, “Mr. Muldoon’s Hall of Fame . . .” TV Script #8, Chapter Eight: “Portrait of Elaine,” WNBK, January 14, 1957, Stuart Buchanan, producer, McCann-Erickson, container 19, folder 7, BA.

94. Ibid., 10.

95. Ibid., 15.

96. On journalistic attention to gender (non)conformity, see Joanne J. Meyerowitz, *How Sex Changed: A History of Transsexuality in the United States* (Cambridge, Mass.: Harvard University Press, 2002).

generally) referred to as a broken home. This vague, all-encompassing term could refer to any aspect of family dysfunction, but child welfare professionals largely employed it to describe families affected by physical dislocation. Especially common in discussions of broken homes were those affected by divorce, desertion, illness, or death. By the postwar period, the pathological potential of these homes was a well-accepted fact.⁹⁷

Popular culture references to broken homes and the troubled children they produced were plentiful. Comic book superheroes of the 1940s and 1950s were internally tormented and driven to fight crime after their intact homes had been destroyed. Superman was an orphan from an obliterated planet with unlimited strength—except when kryptonite made him completely vulnerable. Batman's rage derived from seeing his parents murdered by a mugger when he was a young boy, and Spiderman's angst-ridden sense of social responsibility was formed after a criminal he had let go murdered his uncle Ben.⁹⁸

Children from all kinds of "broken" homes composed a large proportion of RTC populations. In 1947, the director of Seattle's Ryther Child Center estimated that 85 percent of their children came from "homes broken by divorce, separation, death or institutional commitment," while 75 percent of Bellefaire's children were estimated to come from similar backgrounds in the same year.⁹⁹ These "broken homes," explained Eva Burmeister of the Lakeside Children's Center in Milwaukee, were "marked by strain, tension and anxiety. . . . All this makes for an emotional disturbance."¹⁰⁰ The language of "broken" homes displayed professionals' implicit judgments about which kinds of homes were unhealthy and, by proxy, which kinds of homes gave rise to well-adjusted children. The ideal home, they believed, had two married parents living under the same roof.

RTC professionals' concept of the "ideal" American family reflected larger cultural tensions about the healthy nuclear family in postwar America. During the war, politicians and advertisers had called upon

97. Thomas P. Monahan, "The Trend in Broken Homes among Delinquent Children," *Marriage Fam. Living* 19, no. 4 (November 1957): 362–65; Ivan L. Russell, "Behavior Problems of Children from Broken and Intact Homes," *J. Educ. Sociol.* 31, no. 2 (November 1957): 124–29.

98. On comic books and American culture, see Bradford W. Wright, *Comic Book Nation: The Transformation of Youth Culture in America* (Baltimore: Johns Hopkins University Press, 2001).

99. Lillian J. Johnson and Joseph H. Reid, *Evaluation of Ten Years Work with Emotionally Disturbed Children* (Seattle: Ryther Child Center, 1947), 3; "Bellefaire (The Cleveland Jewish Orphan Home) Report on Examination, December 31, 1947," container 7, folder 1, BA, 10.

100. Eva E. Burmeister, *Roofs for the Family* (New York: Columbia University Press, 1954), 18.

Americans to fight on the front lines and the home front for the sake of the democratic American family.¹⁰¹ This discourse only intensified during the Cold War, when the nuclear family was called upon to be a tool of domestic containment against communism.¹⁰² The companionate, loving family supported by parents who fulfilled separate, standardized gender roles became a cultural ideal, if not a reality.¹⁰³ The power of this cultural ideal influenced professionals at RTCs, who assessed children based on the “intactness” of their homes and ultimately sought to repair “broken” families.

Disturbed Families Make Disturbed Children

For residential treatment professionals, “broken” homes might contribute to a child’s problems, but the real trouble could be found only by digging much deeper, into the interactions between family members. Reflecting on the first ten years of Ryther Child Center’s existence in 1947, executive director Lillian Johnson and social worker Joseph Reid acknowledged that as many as 85 percent of the children the center treated were from “broken” homes. But these homes, they argued, were not the primary cause of emotional disturbance. Rather, broken relationships had created “broken” homes, damaging the children who lived there in the process.¹⁰⁴ For example, they explained, a home “broken” by divorce had been a pathological environment long before the actual divorce. A child growing up in that home “probably had not lived in an atmosphere of happiness and contentment prior to the divorce,” and that atmosphere had contributed to the child’s problems.¹⁰⁵ In their efforts to understand the etiology of emotional disturbance, RTC professionals pointed to pathological family relationships, especially those especially involving the parent(s)–child dyad, as the most common inciting cause. Rather than pointing to a child’s disturbed mind or character, RTC professionals placed the deviant, disturbed child at the center of a dynamic relational web.

This approach moved beyond the individual pathology of the child and looked toward the family as a pathological object. In this way, resi-

101. Robert B. Westbrook, “Fighting for the American Family: Private Interests and Political Obligations in World War II,” in *The Power of Culture: Critical Essays in American History*, ed. Richard Wightman Fox and T. J. Jackson Lears (Chicago: University of Chicago Press, 1993), 195–221.

102. May, *Homeward Bound* (n. 6).

103. Coontz, *Way We Never Were* (n. 6); Skolnick, *Embattled Paradise* (n. 6).

104. Johnson and Reid, *Evaluation of Ten Years Work* (n. 99), 14.

105. *Ibid.*, 16.

dential treatment was closely related to family therapy, which began to emerge in the 1950s. Family therapists, most of whom had been trained as psychoanalysts, pointed to dysfunctional family interactions, rather than specific individuals, as the source of mental illness; to them, the family was itself the patient.¹⁰⁶ RTC professionals made no such claims; the child was still their patient. But their etiological models of emotional disturbance focused on family interactions, suggesting that individual children were not inherently pathological. Because disturbance was rooted in interactions, even the most difficult child was not hopeless.

In the most common type of pathology, the parents' own emotional troubles influenced their behavior toward their child. The head of Hawthorne Cedar Knolls' parent organization described this process in which "parental tension . . . is transmitted by a kind of contagion to the child . . . a disturbed parent imposes his particular problem on the child as a kind of self-treatment."¹⁰⁷ These "contagious" problems might include things like marital dissatisfaction, unplanned pregnancies, poor relationships with their own parents, and a lack among fathers of "stimulating and expanding work or play outlets for themselves."¹⁰⁸ Professionals' attempts to understand this process were steeped in the conceptual language of psychoanalysis. As Stanislaus Szurek, director of the Langley Porter children's unit, explained, "The idea was that perhaps . . . all forms of mental disorder in childhood had not only their genesis, but also their maintenance, in the child's early and continuing experience with . . . the parents. These conflicts of parents stemmed from *their own* early childhood experience" (emphasis mine).¹⁰⁹ According to this so-called contagion model of emotional disturbance, the parents' own childhood relationships with their own parents would simply play out in their own parenting, and on and on.

If any child owed her disturbance to "contagious" parental troubles, it was Deborah M., a nine-year-old girl admitted to Bellefaire in 1954. A "tense, anxious child," Deborah suffered from bed-wetting and nightmares and had "severe temper tantrums when did she did not have her way."¹¹⁰ A look at her parents explained it all. Deborah's father, "a cold,

106. Weinstein, *Pathological Family* (n. 21).

107. Joseph Lander, "The Role of Residential Treatment for Children Symposium, 1954; 3. When Does an Agency Refer a Child to a Residential Treatment Center?," *Amer. J. Orthopsychiatry* 25, no. 4 (1955): 675–78, quotation on 675.

108. Barbara J. Betz, "A Psychiatric Children's Ward," *Amer. J. Nursing* 45, no. 10 (October 1945): 817–21, quotation on 820–21.

109. Reid and Hagan, *Residential Treatment of Emotionally Disturbed Children* (n. 30), 217, emphasis added.

110. "The Story of Dorothy M.," *Bellefaire Bulletin* 2, no. 1 (Fall 1954), container 18, folder 4, BA, 2.

reserved man,” stayed away from his daughter and left the child-rearing to his wife. She, in turn, “began to resent her marriage and the sacrifice of her career. She unconsciously looked upon Deborah, her first-born, as the symbolic cause of it all,” interpreted the Bellefaire staff.¹¹¹ The lack of love from her father and resentment from her mother, the article continued, made Deborah hate her parents, believe she was simply “no good,” and behave poorly.¹¹²

Sadly, social workers and psychiatrists too often described how a parent trying to deal with his or her own problems could inflict actual trauma upon a child. Samuel, a “noisy, hyperactive, aggressive” twelve-year-old boy from Des Moines, was referred to Bellefaire in 1942. Samuel’s mother had not wanted any children, and as a result “she [was] reported to have beaten him almost daily, to have threatened at various times to disown him, to put him into a reform school, or even kill him.”¹¹³ This heartbreaking description of Samuel’s background is particularly revealing because it is grounded in an assumption that the mother’s abuse was caused by her disinterest in having children.

Although parental pathology could be the impetus for physical or emotional abuse, RTC professionals were careful to explain that it was the interaction between parent and child that resulted in a child’s resulting disturbance. Kevin, a boy at Pioneer House who was preoccupied with “carnage and slaughter,” came from a home where he had been “beaten, threatened with a shotgun, booted, thrown into the drainage ditch behind the house, and locked in the woodshed for long intervals without food” by his stepfather.¹¹⁴ Kevin lived in “abject terror” of the man and told a camp counselor that he hated his stepfather.¹¹⁵ Vera Kare, the social work student who analyzed his case, concluded that Kevin’s behavior was an unconscious response to his abuse: “terrorized by the stepfather, yet powerless, Kevin evidently sought an avenue of partial escapade by attempting to remain an infant.”¹¹⁶ Although the abuse emanated from

111. *Ibid.*

112. *Ibid.*

113. “Applications Considered by Local Board, January 25, 1942 to April 26, 1942,” in “Bellefaire Trustees’ Meeting,” April 26, 1942, container 6, folder 4, BA, 6.

114. Vera Kare, “A Study of the Adjustment of a ‘Problem’ Child in a Group Therapy Home for Pre-delinquent Boys, Pioneer House, September, 1946–June, 1948” (M.S.W. thesis, Wayne University, 1948), 28, 36.

115. *Ibid.*, 28. Most social work graduates who wrote about RTCs in their theses specifically stated that they were not attempting to draw any conclusions, but merely wished to present raw case material. This makes them excellent primary sources for my purposes, but also requires the reader to read between the lines. Typically, the student would provide a complete family history and then describe the child’s symptoms, drawing an implicit link between the two.

116. *Ibid.*, 84.

a parent, Kare was arguing that it was Kevin's reaction to the abuse that resulted in his symptoms. Emotional disturbance was rarely a one-way road; instead, RTC professionals believed, it resulted from the dynamic interplay of parents and child.

Disturbance could also result from a lack of interaction between parent and child, a state that child mental health professionals called deprivation. As child psychoanalysis grew in the 1940s, leaders in the field focused their attention on the relationships between mothers and children and their effects on children's emotional development. During her work at the Hampstead Nurseries in rural England during World War II, where children had been taken from their parents to ensure their safety, Anna Freud observed that children seemed to regress developmentally without their mothers. In England, as Michal Shapira has shown, this pathological separation and the psychoanalytic theories used to understand it became critical to the cultural project of affirming British democracy during and after the war.¹¹⁷ In the United States, psychoanalysts David Levy and Margaret Ribble used analogies to vitamins and food to describe the physical and emotional sustenance that children needed from their mothers to develop properly.¹¹⁸ As Eduardo Duniec and Mical Raz have demonstrated, these analysts used metaphors derived from nutritional deficiency diseases, themselves a rising object of medical study, to describe the catastrophic effects of deficient parental nurturing.¹¹⁹ Researchers pointed to example after example of children abandoned by their mothers, physically and emotionally.

The most famous proclamation of the critical mother-child bond came from British psychiatrist and psychoanalyst John Bowlby. Commissioned by the World Health Organization to study homeless children, he examined research from child analysts and examined many institutions and foster homes; the resulting 1951 report, *Maternal Care and Mental Health*, was not so much a study of homelessness but a manifesto declaring the importance of maternal love and caregiving early in life.¹²⁰ The report was widely reported upon in the professional and popular press; Bowlby would build the rest of his career on the assertion that "maternal care . . .

117. Michal Shapira, *The War Inside: Psychoanalysis, Total War, and the Making of the Democratic Self in Postwar Britain* (New York: Cambridge University Press, 2013).

118. Marga Vicedo, *The Nature and Nurture of Love: From Imprinting to Attachment in Cold War America* (Chicago: University of Chicago Press, 2013), 26.

119. Eduardo Duniec and Mical Raz, "Vitamins for the Soul: John Bowlby's Thesis of Maternal Deprivation, Biomedical Metaphors and the Deficiency Model of Disease," *Hist. Psychiatry* 22, no. 1 (2011): 93–107, esp. 93.

120. John Bowlby, *Maternal Care and Mental Health* (Geneva: World Health Organization, 1951); Vicedo, *Nature and Nurture of Love* (n. 118), 37.

is essential for mental health.”¹²¹ A subsequent study of 150 children demonstrated that children became emotionally damaged not only when they were abandoned but also when they were cared for by hostile or unloving mothers. The physical presence of a mother, he was arguing, was insufficient to ensure a healthy childhood and ultimately, a functional adult life.¹²² While Bowlby had referred in passing to mother love as a biological instinct in the early 1950s, he found this model increasingly appealing as criticism of his findings grew. As Marga Vicedo has demonstrated, Bowlby’s use of ethological theory based on animal research helped his theories gain cultural currency and survive a barrage of criticism over the next two decades.¹²³ The converse of maternal attachment, of course, was maternal deprivation, which had the potential to jeopardize a child’s natural development.¹²⁴

Ten-year-old Brian presented a classic case of deprivation. His mother worried about hurting her “frail,” colicky infant son, who was so difficult to toilet train that she became “disgusted and couldn’t bear to touch him.”¹²⁵ When his baby sister was born, she began to ignore him completely. Brian had such difficulty expressing himself and relating to others that his nursery school deemed him intellectually disabled. When he was admitted to the Cincinnati Child Guidance Home in 1951, Brian became upset when he had to share a staff member’s attention and gave orders like “Don’t tuck me in” and “Don’t kiss me goodnight.”¹²⁶ In analyzing his behavior, social work student Angela Baird focused almost entirely on the deprivation she believed Brian had suffered. According to Baird, Brian was trying to gain the attention he had lacked as a child. His “attempts to obtain affection, attention and recognition,” she explained, “[indicate] the amazing extent to which he sought dependency gratification which had previously been withheld.”¹²⁷

The final theoretical framework used by many RTC professionals to explain emotional disturbance defined disturbance as a consequence of interrupted normal development. Because of strife in the family, this

121. Bowlby, quoted in Vicedo, *Nature and Nurture of Love* (n. 118), 38.

122. Ibid.

123. Vicedo, *Nature and Nurture of Love* (n. 118).

124. On the multiple theories of deprivation and how they shaped American social policy in the 1960s, see Mical Raz, *What’s Wrong with the Poor?: Psychiatry, Race, and the War on Poverty* (Chapel Hill: University of North Carolina Press, 2013).

125. Angela Baird, “Behavior and Anxiety in Disturbed Children: A Dissertation Based upon an Investigation at the Child Guidance Home of Cincinnati” (M.S.S. thesis, Smith College School for Social Work, 1951), 36.

126. Ibid., 36–37.

127. Ibid., 38.

theory argued, a child's development was halted, resulting in behaviors that were inappropriately young for the child's age.¹²⁸ As a fund-raising pamphlet for the Menninger Children's Division explained, "the emotionally ill child is not able to make the sort of emotional growth which is necessary to progress from the very dependent infant to the independent adult."¹²⁹ The developmental framework overlapped closely with other etiological models of emotional disturbance, as in the case of Martha, a four-year-old girl admitted to the Ryther Child Center in the late 1940s for a strange case of severe eczema that seemed to worsen at stressful times. The little girl was fiercely independent, refusing all help from adults, and was covered in bandages to prevent her from scratching the eczema. Ryther director Lillian Johnson described her case in detail for the readers of *Parents' Magazine*.¹³⁰

Martha's early background was one of deprivation caused by her mother's own parental issues. When Martha's mother was in the hospital giving birth to her, her own mother died. Psychologically unable to breast feed or care for her newborn, she stayed in the hospital for an extra month receiving nursing help. Reasoned Johnson, "her own bottled-up emotion cut off from the youngster the love and warmth she should have had."¹³¹ The result was unintentional deprivation: "There was no cruelty, no neglect. There was simply a lack of that vital nourishment in the way of love which is so essential to a child's growth."¹³²

At first Martha stayed away from the staff members and other children. But one day after lunch, she walked over to the staff table and leaned against the knee of a female staff member, which they took as a sign that she was reaching out for affection. Soon afterward, Martha began to act like a toddler, sucking her thumb, sitting in the laps of staff members, and eating in a high chair.¹³³ She demanded that staff members help her take baths and get dressed, prompting one staff person to comment, "Sometimes it is nice to be a baby again, isn't it, Martha?"¹³⁴ When her parents came to visit, they were baffled by this infantile behavior. But as the staff explained to them, it was perfectly normal: "Patiently we explained to them that you cannot skip periods in life's development, that this child had never had normal babyhood and that now she was going back to relive

128. Burmeister, *Roofs for the Family* (n. 100), 20.

129. "Can a Child Be Mentally Ill?," box 3, Can a Child Be Mentally Ill? (58–59), KSHS.

130. Johnson, "Making over Martha" (n. 85).

131. *Ibid.*, 120.

132. *Ibid.*

133. *Ibid.*, 122–23.

134. *Ibid.*, 124.

what she should have had at the age of one or two, that this was a part of therapy and that they must trust us.”¹³⁵ Because Martha’s development had halted quite early, it was essential that she go back and reexperience each developmental stage in order to “fix” her stunted personality. Gradually Martha returned to behavior more appropriate for a four-year-old, her eczema cleared, and her family reunited happily. Martha’s story illustrates how deprivation, a parent’s own troubles, and stagnated development could all come together to create emotional disturbance. The only solution, RTC professionals believed, was to reverse these troubles to restore normal affection and development. For readers of Martha’s story, the damaging effects of deprivation were clear, but so was the potential of treatment to undo them. Even for the most troubled children, the article implied, a happy home life was within reach.

The Dangers of Blame

Johnson took care to state that Martha’s deprivation was not due to any intentional actions by her parents. Although she acknowledged that parents were often the cause of emotional disturbance, she warned against placing blame on them: “Blame is a queer word. . . . Intentionally they would never have injured anyone. But out of the complexity and hurt of their own lives they failed to meet the needs of their child.”¹³⁶ This might have been a surprising statement for the readers of *Parents’ Magazine*, who were used to hearing about mothers who were to blame for their children’s problems.¹³⁷ Historians have given much attention to the emergence and persistence of often vicious “mother blame” in the 1940s and 1950s.¹³⁸ However, residential treatment professionals went out of their way to warn the public and other mental health professionals against the dangers of mother blame and parent blame more generally. Even if disturbance originated in the parent–child relationship, they argued, identifying

135. *Ibid.*, 125.

136. *Ibid.*, 120, 122.

137. For example, a 1950 story, “Watch Your Child’s Mental Growth,” told cautionary tales of mothers who pushed their children to succeed in school and at play so much that the children were not able to learn on their own and test their curiosity (Gladys G. Jenkins, “Watch Your Child’s Mental Growth,” *Parents’ Magazine*, March 1950, 44–45, 128–30).

138. See, for example, Molly Ladd-Taylor and Lauri Umansky, eds., “Bad” Mothers: *The Politics of Blame in Twentieth-Century America* (New York: New York University Press, 1998) and Rebecca Jo Plant, *Mom: The Transformation of Motherhood in Modern America* (Chicago: University of Chicago Press, 2010).

this relationship as a causal factor need not be associated with blame.¹³⁹ Their efforts to acquit mothers and focus on troubled relationships flew directly in the face of a prevalent, often vitriolic cultural discourse about bad mothers and instead sought to involve both parents in a more productive, forward-looking conversation about what might be done to restore healthy family relationships.

Blame, RTC professionals argued, was counterproductive to treatment. Ralph Rabinovitch of the University of Michigan's child psychiatry unit advised in the *New York Times* that "simply to blame and threaten parents is not only useless, it tends to discourage these parents from seeking the help they often need desperately."¹⁴⁰ Frequently, parents already felt very guilty and believed they had caused their children's problems. In a Bellevue group for parents of schizophrenic children, parents were overheard blaming themselves for their children's problems, saying things like "I should never have been a father," "I guess we didn't prepare him for reality," "We never know what we're really doing to our children," and "Maybe we're mentally sick ourselves."¹⁴¹ The three psychiatrists who ran the group reflected, "These parents feel responsible for the child's illness and are overwhelmed with anxiety. . . . Sometimes professional advice they have received has tended to confirm or intensify their guilt feelings. Some relate having been told that the child's maladjustment results from their own neurosis and that they are the ones who need treatment."¹⁴² With perceptions such as these, it is understandable why parents would be hesitant to seek care for their children, knowing that professionals might augment the shame they already felt.

Navigating around blame could be tricky. Langley Porter's director suggested that the parent be told, "I have a hunch that all or much of your child's difficulty is in some way connected with some difficulties you are experiencing" and that the professional offer to help with the parent's own problem which would likely help the child as well.¹⁴³ A social

139. S. A. Szurek, "The Family and the Staff in Hospital Psychiatric Therapy of Children," *Amer. J. Orthopsychiatry* 21, no. 3 (1951): 597–611, 599. Szurek, director of the Langley Porter children's unit, argued that it was "a particularly pervasive and often insidiously disguised misconception . . . [that] to look for conflicts in the parents and to make an effort to help them resolve their conflicts is equated with 'blaming' them for their child's disorder" (*ibid.*, 599).

140. "New Home Urged to Aid Upset Child," *New York Times*, November 17, 1954, 35.

141. Harris B. Peck, Ralph D. Rabinovitch, and Joseph B. Cramer, "A Treatment Program for Parents of Schizophrenic Children," *Amer. J. Orthopsychiatry* 19, no. 4 (1949): 592–98, quotation on 594.

142. *Ibid.*, 594.

143. Szurek, "Family and the Staff" (n. 139), 601.

work student at the Cincinnati Child Guidance Home suggested being sympathetic to these parents, who “are in a vulnerable position” because “popular education—the magazines, P.T.A. speakers and others—point to the parents as the root of all children’s ills.”¹⁴⁴ Regardless of professionals’ attempts to tread carefully, many parents likely felt blamed for their children’s disturbances. This is unsurprising, given that RTC professionals located the origin of emotional disturbance in a dysfunctional family. But it is telling that they went out of their way to caution against the use of unilateral parent blame. At the very least, it suggests that they were aware of the predominant mother-blaming thread in psychiatry and popular culture and sought to characterize themselves as an enlightened alternative.

In this article, I have demonstrated that the emergence of residential treatment centers in the 1940s and 1950s enabled child mental health professionals to identify and define a new kind of person: the emotionally disturbed child. Whereas professionals had served and identified troublesome children in child guidance clinics, RTCs were created to meet the needs of children too ill to be managed in the community. They provided a novel environment specifically constructed for children so troubled that their schools and even their own parents had rejected them.

RTC professionals categorized the children’s deviant behavior according to the binary of “aggressive” and “acting-out” or “quiet” and “withdrawn,” categories that mapped loosely onto the psychoanalytic concepts of neurosis and behavior disorder. Although journalists tended to describe boys in RTCs as “bad” and girls as “quiet,” images that circulated more broadly in popular culture, in reality these categories were far less gendered. Despite its imperfections, this diagnostic system helped residential treatment professionals sort children by their patterns of behavior, which they then hoped to trace back to dysfunctional patterns of family interaction.

For the next three decades, RTC professionals would give their time to a cause that others had by definition deemed hopeless. As for Tommy, after several years of inpatient and outpatient therapy at Southard School, he uneventfully began attending Topeka High School. As his social worker later recollected, he reassured her that he would be able to handle public school, telling her, “Look Dorothy, I can handle all of [this].”¹⁴⁵ Another case worker noted with relief that Tommy had even found a group to sit with at lunch.¹⁴⁶ Although not all children had as much success as Tommy,

144. Allen, “Casework with the Parents at the Child Guidance Home” (n. 69), 19.

145. Wright, “Presentation for Annual Meeting, October, 1952” (n. 2), 2.

146. David Hallowitz, “Presentation for Annual Meeting, October, 1952,” box 16, Annual Meeting—1952, KSHS, 2.

the concept of emotional disturbance would shape how mental health professionals and the American public understood what it meant to be an abnormal child and, by extension, a normal child.



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