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The Clinical Origins of American Child Psychiatry: Two Case Studies of Residential Treatment, 1931-1950

by

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I

Introduction

In the first half of the twentieth century, the practitioners of the new field of child psychiatry took control of the treatment of children's mental ills and gained specialty status within medicine. Histories of medical specialization most frequently note the institutional, economic, and interprofessional forces that influence specialization.[1] How the clinical sphere encourages and accommodates the growth of specialty status is an important subject of historical inquiry. This study examines the content of the doctor-patient encounter in early child psychiatry. It analyzes how and suggests why the activities that took place in the clinical sphere were integral to the consolidation of the profession of child psychiatry.

Child psychiatry has received less attention than adult psychiatry from historians, and only a few histories delineate its path to professionalization.[2] The origins of the profession are usually traced to the children's clinics opened by child guidance workers at the beginning of the twentieth century.[3] These clinics gave psychiatrists with an interest in children a site in which to practice their trade. By midcentury, children's mental ills were treated by this new set of medical practitioners. However, while the child guidance movement gave impetus to child psychiatry, the growth of the profession required more

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[1]B. Bridgman Perkins, "Shaping Institution-based Specialism: Early Twentieth-century Economic Organization of Medicine," *Social History of Medicine* 10 (1997): 419-435; George Weisz, "Medical Directories and Medical Specialization in France, Britain, and the United States," *Bulletin of the History of Medicine* 71 (1997): 23-68.

[2]Several works are exceptions to this statement. See Margo Horn, *Before It's Too Late: The Child Guidance Movement in the United States, 1922-1945* (Philadelphia: Temple University Press, 1989); Stella Chess, "Child and Adolescent Psychiatry Come of Age: a Fifty Year Perspective," *Journal of the American Academy of Child and Adolescent Psychiatry* 27 (1988): 1-7; Kathleen W. Jones, "The Development of Psychiatric Interest in Children: A Social History of American Child Psychiatry," in *Handbook of the History of Psychiatry,* eds. Edwin Wallace and John Gach (Yale University Press, forthcoming) 1-94; Bertram Slaff, "History of Child and Adolescent Psychiatry Ideas and Organizations in the United States: A Twentieth Century Review," in *Adolescent Psychiatry: Developmental and Clinical Studies.* eds. Feinstein, *et. al.*, vol. 16 (Chicago: University of Chicago Press, 1989), 31-52; William Ll. Parry-Jones, "Annotation: The History of Child and Adolescent Psychiatry: Its Present Day Relevance," *Journal of Child Psychology and Psychiatry* 30, no. 1 (1989): 3-11.

[3]Jones, "The Development of Psychiatric Interest in Children," 1-94; William Healy and Augusta F. Bronner, "The Child Guidance Clinic: Birth and Growth of an Idea," in *Orthopsychiatry, 1923-1948: Retrospect and Prospect* (American Orthopsychiatric Association, 1948), 14-49.

than the opportunity for clinical encounters. New meanings were attached to children's mental lives once studied by medical professionals, and new responsibilities accrued to the medical profession when children's mental ills came under its control. The relationship that developed between child and psychiatrist provided the opportunity for the growth of a new medical expertise. These novel doctor-patient interactions and their legitimation within a new profession are the subjects of the work that follows.

One component of the novel child-psychiatrist interaction was a new style of clinical reasoning. I define a style of clinical reasoning as the habit of cognition a doctor uses when thinking about a patient. Children came to be treated by new professionals because certain modes of perception, based on new methods of analysis and newly formulated knowledge, gained legitimacy. Historians of adult psychiatry have described the emergence of new styles of clinical reasoning, and have analyzed the relationship of these reasoning styles to professional developments. Arnold Davidson, for instance, argues that a uniquely psychiatric style of reasoning changed the profession in the nineteenth century. In an examination of the psychiatric invention of diseases of perversion, Davidson delineates the explanatory rubric that allowed psychiatrists to turn these non-medical attributes into medical diagnoses. When perversions were defined as diseases, the psychiatrist's thinking about the patient changed. When the clinical encounter between doctor and patient changed, new psychiatric identities emerged.[4]

Child psychiatrist Louis Lurie alluded to the growth of child psychiatric styles of reasoning when he described his profession in 1948:

> Psychiatry, like other arts and sciences, is not a single universally-accepted body of theory and practice. Instead, there are several schools of thought whose hypotheses regarding the nature of mental functioning differ radically and lead to diverse attitudes and practices with respect to the selection of

[4]Arnold I. Davidson, "Closing Up the Corpses: Diseases of Sexuality and the Emergence of the Psychiatric Style of Reasoning," in *Meaning and Method: Essays in Honor of Hilary Putnam*, ed., Boolos (Cambridge: Cambridge University Press, 1990): 295-325.

> patients and their treatment....In studying the activities of any particular program of child psychiatry, therefore, the nature of its basic assumption must be taken into account, for the types of children that are sought as patients and the services rendered to them are logical -- if not always deliberate -- derivatives of a theory of psychiatry.[5]

Lurie, like Davidson, recognized that theoretical orientations alter the clinical sphere and modify the physician's role. This study will investigate two reasoning styles in child psychiatry, the process of disease-definition in the clinical sphere, and the picture of the patient that emerged from each orientation. Since these reasoning styles were developed during the formulation of professional boundaries and the articulation of specialty knowledge, their content was linked to the development of an identity for the profession itself.

The study begins with an overview of child psychiatry in America in the early decades of the century, and concludes with a close examination of the clinical sphere. The first section describes the position of child psychiatrists in child guidance clinics, where they found an opportunity to diagnose children's behavior. Then, I argue that child psychiatrists, by offering residential treatment, utilized the hospital as a site of professionalization. In residential treatment facilities, child psychiatrists discovered diseases to treat, convincing treatments for those diseases, and the expertise to administer these treatments to their patients.

The third and fourth sections of this paper are case studies of two child psychiatrists in residential treatment centers. The residential clinics provided an institutional base for the consolidation of professional power, but the individual child psychiatrist's theory determined the approach taken there. Charles Bradley of the Emma Pendleton Bradley Home in Providence, Rhode Island and Stanislaus Szurek of Langley Porter Clinic in San

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[5]Louis A. Lurie, "Residential Homes in Orthopsychiatric Practice," in *Orthopsychiatry, 1923-1948* (Washington, D.C.: American Osrthopsychiatric Association, 1948), 484-493, 484.

Francisco, California both ran residential treatment centers for emotionally-disturbed children. Bradley constructed his child psychiatric style of reasoning by appropriating social norms, and he treated his children's problems with biological interventions. Szurek espoused a comprehensive psychoanalytic theory of problem behaviors, and intervened in the unconscious life of the child. Comparing the two will bring into relief that each approached his clinical work with his own presuppositions, and each gathered a narrow range of evidence for and against these presuppositions. Both also managed to engineer clinical settings that reinforced rather than challenged their assumptions. Ultimately, they constructed clinical spheres where their new specialty could claim a unique expertise and an unimpeachable authority.

Two case studies provide a selective view of the profession, but the perspective may allow for broader questions to be raised about the practice of psychiatry, both child and adult. First, noting the interdependence of the clinical setting and psychiatric theory will introduce doubts about the scientific status of psychiatry. "Scientific" implies not methods based merely in physiology or neurochemistry, but one by which universalizable and reproducible knowledge is gathered. The conclusions drawn in each clinic were determined by the assumptions of each child psychiatrist. His status, rather than the strength of the evidence, facilitated the labeling of his theory as scientific. As these case studies will show, the knowledge base built from clinical information was neither universalizable nor reproducible, because it was anchored to the particularities of the clinical setting and the views of the psychiatrist in charge.

Second, this study will attempt to sketch the position of the patient in the psychiatric encounter. It will question whether the voice of the patient is subsumed when psychiatry insists upon scientific status. Both clinics reduced their young patients to the descriptors the theory considered relevant. The children were quieted and their stories were curtailed by the exigencies of a theory which prioritized a small number of variables. Further, because they were subject to psychiatric authority within the hospital, the children participated in a game

they could not control. I hope that the experience of these children will raise some questions about the position of the psychiatric patient in psychiatry, particularly in the hospital.

Last, because this study describes its beginnings, it will raise issues relevant to the profession of child psychiatry. Though it will not analyze the nature of the relationship between the origins of a profession and its contemporary practice, the importance of power to early practitioners of child psychiatry will be emphasized. I will argue that clinical encounters between children and psychiatrists were necessary but not sufficient for the growth of the profession. According to this argument, child psychiatry did not emerge fully in the child guidance clinics, where psychiatrists were asked to share power with other professionals, but in the residential treatment facilities, where child psychiatrists constructed an impervious authority. The establishment of a monopolized power within a clinical sphere was an important component of professionalization. These arguments are relevant to the history of child psychiatry, and to the manner in which its clinical priorities are established.

Since this study concerns both theory and practice, the research draws from many sources. Published articles from medical journals and textbooks provide clinicians' ideas; the tenor of clinical practice is more difficult to recapture. Patient records are one way to consider how theory and practice interface in the clinic. As Guenter Risse and John Warner argue, patient records permit "a systematic exploration of the relationship between medical ideas and medical activities."[6] Since patient stories are used to exemplify practice rather than reconstruct it precisely, patient confidentiality is placed above historical exactitude. The actual names of the patients, on occasion their genders, and insignificant details of their clinical history have been changed to conceal their identities. While the entire fabric of clinical practice cannot be reproduced, these patient stories provided some conclusions

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[6]Guenter B. Risse and John Harley Warner, "Reconstructing Clinical Activities: Patient Records in Medical History," *Social History of Medicine* 5, no. 2 (Aug 1992): 183-205, 199.

about the role of theoretical concepts and the status of the patient in the children's psychiatric hospital.

Finally, I should outline my interest in this project. First, like most medical students, I tend to identify with the patient more than with the physician. My interest in this study lies less in the vicissitudes of the profession of child psychiatry, in which I am not invested, than in the experiences of the children. Second, by moving from a position of ignorance to one of decision-making in the clinics during medical school, I noted first-hand how a student-physician's power is constructed in the clinical sphere. As a future psychiatrist, I am occupied by the challenge of developing a conscientious style of practice. Psychiatric intervention at its finest leads a patient to her voice, but does not compel accommodation to a professional interpretation of events. I am drawn to the stories of Bradley and Szurek, and to the story of child psychiatry, because the finest intentions and knowledge came together in the profession, yet the outcome was occasionally unusual. I hope that the study that follows treats the doctors and the clinics fairly, yet sheds light on the implications of the work.

II

Child Psychiatry to Midcentury

1

Child Guidance

The field of child psychiatry did not originate in the treatment of childhood illnesses, but in late nineteenth-century attempts to characterize the child who fell short of normal. The first medical and psychological researchers studied the abnormal child in either the classroom or the court. First, the child was studied as a pupil.[7] Some of the first classroom experiments by physicians and psychologists began in British schools in the 1880s.[8] Lightner Witmer, founder of the Psychological Clinic for children in 1896 in Philadelphia, combined psychological and medical evaluations of slow-learners, then helped teachers instruct these children.[9] The first psychology test, Alfred Binet's intelligence quotient test, measured a child's innate capacity to learn. Published first in 1905, it was diffused and revised over the following decades, in part due to the influence of Henry Goddard's advocacy of the test for "feeble-minded" children at the Vineland Training School. When the child was recognized as a deficient subject in the classroom, medical and psychological criteria were used to characterize his deficiency.

In the early twentieth century, the young law offender also became an object for psychological and medical study. The work of Michel Foucault describes these

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[7]Carolyn Steedman, "Bodies, Figures and Physiology: Margaret McMillan and the Late Nineteenth-Century Remaking of Working-Class Childhood," in *In the Name of the Child: Health and Welfare, 1880-1940*, ed. Roger Cooter (London: Routledge Press, 1992), 19-44.

[8]Harry Hendrick, "Child Labour, Medical Capital, and the School Medical Service, c. 1890-1918," in *In the Name of the Child*, 45-71.

[9]Kathleen W. Jones, "The Development of Psychiatric Interest in Children: A Social History of American Child Psychiatry," in *Handbook of the History of Psychiatry,* eds. Edwin Wallace and John Gach (Yale University Press, forthcoming) 1-94; William Healy and Augusta F. Bronner, "The Child Guidance Clinic: Birth and Growth of an Idea," in *Orthopsychiatry, 1923-1948: Retrospect and Prospect* (American Orthopsychiatric Association, 1948), 14-49.

investigations as indicative of a shift from a punitive to a therapeutic style of social control, necessitating the construction of a character type, the delinquent.[10] Psychologists and physicians were intimately involved in the description of the juvenile delinquent. For them, the young delinquent in America became "a lens through which to view the future and...a means by which to control it."[11] Institutions began to reflect the belief that the young delinquent differed from the adult, and the first age-limited juridical body was established in Chicago in 1899. Psychologists played a more important role in the Juvenile Court than lawyers, as the goal broadened from establishing guilt or innocence to helping a child regain her role in "a 'good family home.'"[12] The Chicago innovators hoped to understand instead of merely punish deviant children.[13]

School failures and juvenile crime were the first motivations for psychological study of the child. Medical study of the child's psyche drew support from the child guidance movement. After the turn of the century, lay activists and philanthropists encouraged the study of childhood deviancy within a movement which made deviancy and mental disease synonymous. In 1909, Clifford Beers founded the National Committee for Mental Hygiene to eliminate both mental illness and delinquency in adults, in part through work with children. A group of Chicago philanthropists and social reformers spearheaded the formation of the first child guidance clinic. Many of the reformers, like Jane Addams of Hull House and Julia Lathrop, who became head of the Federal Children's Bureau, had lobbied for the formation of the juvenile court system. They proposed a five-year study of delinquents from a medical, psychological and social viewpoint. In the words of Addams, the aim was "to get to the root of the exact causes that make children go wrong."[14] William Healy (1869-1963), a neurologist by training, was recommended by William James and

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[10]Michel Foucault, *Discipline and Punish: The Birth of the Prison*, trans. Alan Sheridan (New York: Pantheon, 1977).

[11]John R. Sutton, *Stubborn Children: Controlling Delinquency in the United States, 1640-1981* (Berkeley: University of California Press, 1988), 2.

[12]John Sommerville, *The Rise and Fall of Childhood.* (Beverly Hills: Sage Publications, 1982), 206.

[13]Jones, "The Development of Psychiatric Interest in Children," 8.

[14]Jones, "The Development of Psychiatric Interest in Children," 31.

Adolf Meyer to coordinate the research on childhood delinquency at the new and aptly named Juvenile Psychopathic Institute.[15] Healy examined records for children in the Juvenile Court of Chicago and compiled social, psychological and medical data in a search for the causes of delinquency. While his 1915 book *The Individual Delinquent* was considered an important criminology text, it used a psychodynamic perspective to argue that a child's environment and relationships influence his subsequent behavior, and he suggested psychoanalysis may provide effective treatment for delinquency.[16]

Healy's work inspired similar projects in the 1920s, and the involvement of medical doctors increased. In 1922 the Commonwealth Fund for medical research joined the National Committee for Mental Hygiene to provide eight child guidance clinics with financial support for five years. Local support opened several more clinics in later years. These clinics broadened their subjects of intervention to include not only the child in arrears with the law, but the unruly child who was disruptive at home or school, the predelinquent. The clinics began, as well, to try to "alter undesirable behavior and social traits," according to Samuel W. Hartwell, a psychiatrist from Buffalo.[17] Fears of social unrest and personal anxieties stirred by World War One produced a "congruence between parental preoccupations and the experts' themes" which propelled the work of the clinicians.[18] During the 1920s, psychiatrists who worked with children practiced almost exclusively at these community child guidance clinics.

Two attributes of child guidance clinics made them inadequate locales for the professionalization of child psychiatry. First, the outpatient clinics were primarily diagnostic centers. Psychologists and social workers utilized tests and interviews to characterize a child's difficulties. The clinic then consulted with government agencies and

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[15]George E. Gardner, "William Healy, 1869-1963," *Journal of American Academy of Child Psychiatry* 11 (1972): 1-29.

[16]Jones, "The Development of Psychiatric Interest in Children," 30-33.

[17]John C. Burnham, "The Struggle Between Physicians and Paramedical Personnel in American Psychiatry, 1917-1941," *Journal of the History of Medicine* (Jan 1974): 93-106, 98.

[18]Cathy Urwin and Elaine Sharland, "From Bodies to Minds in Childcare Literature: Advice to Parents in Inter-War Britain," in *In the Name of the Child*, 174-199, 175.

private charities to link the child to appropriate services.[19] The 'diagnostic study' followed by cooperative treatment suited the expertise and the interests assembled in the clinics. The problems addressed in the clinics, as well, were not necessarily conceptualized as diseases; they were not aberrations from the normal, but deviations within the normal range. Interventions in the clinic were generally characterized as attempts to accommodate a child to her environment, not rid her of pathology.[20] Child psychiatrists, trained to treat diseases, confronted a philosophy in clinics that differed from that of their medical training.

Second, the child guidance clinics were distinctly multidisciplinary. Healy himself had insisted on the utilization of a 'clinical team.' His clinic utilized a social worker, a psychologist, and a physician who collaborated jointly on the study of a child. Subsequent clinics remained a multidisciplinary staff. Medical professionals never assumed control of the clinics, even after decades of operation, and the aims of cooperation overcame any movement to consolidate leadership in a single professional. A cadre of workers cooperated on a relatively level playing field wherein each contribution seemed important to the comprehension of complex and obscure problems. The "team became the hallmark of child guidance work."[21]

Psychiatrists found a home in child guidance clinics, but they were in no position to mold them to their desires. In the 1920s, neurologists and endocrinologists still treated most outpatients with nervous and mental disorders.[22] The Great Depression only augmented the economic precariousness of outpatient psychiatric practice, and intensified the interprofessional wrangling for control of the patient pool. Medical colleagues did not universally experience psychiatrists' incursions into the treatment of childhood diseases as beneficent. Joseph Brennemann, a distinguished pediatrician, articulated his colleagues' distrust and anger in a lecture entitled, "The Menace of Psychiatry." From the intelligence

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[19]Jones, "The Development of Psychiatric Interest in Children," 24.

[20] William Ll. Parry-Jones, "Annotation: The History of Child and Adolescent Psychiatry: Its Present Day Relevance," *Journal of Child Psychology and Psychiatry* 30, no. 1 (1989): 3-11, 7.

[21]Jones, "The Development of Psychiatric Interest in Children," 16.

[22]Burnham, "The Struggle Between Physicians and Paramedical Personnel," 98.

quotient to the Oedipus complex, Brenneman criticized what he saw as attempts by psychiatrists to turn all deviations from the norm into pathologies. He was deeply concerned by "the over-organization" of children's lives by a new set of experts. Brennemann accused psychiatrists of authoring and enforcing 'models' of childhood development. He also argued that they encroached on the family problems he felt competent to treat. Ultimately he did not disagree that maladjustments existed, just that they should be treated by pediatricians.[23]

As Brennemann's critique indicated, the knowledge bases of the specialties were vaguely-defined. To replace an *ad hoc* system of specialization, where any general practitioner with a few years in a specialty hospital could claim specialty status, boards were organized in the 1930s to standardize the knowledge a specialist had to acquire prior to certification.[24] The American Board of Psychiatry and Neurology was formed in 1934. At the same time, the medicalization of new conditions provided specialists with new types of patients. Menopause, for instance, was described by doctors and popular writers as a medical condition in the 1930s, and the new 'disease' gave specialists new areas of expertise.[25] Similarly, delinquency allowed psychiatrists to organize their expertise around novel problems. In 1923, Karl Menninger wrote to 26 psychiatrists encouraging them to form a "centralizing organization of the representatives of the neuropsychiatric or medical view of crime."[26] The American Orthopsychiatric Association emerged as a medical body concerned with conduct disorders and behavior disorders, and in 1930 the *Journal of the American Orthopsychiatric Association* was founded.

The intellectual foundations of a profession of child psychiatry accumulated slowly

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[23]Joseph Brennemann, "The Menace of Psychiatry," *American Journal of the Diseases of Children* 11, no. 2 (Aug 1931): 376-402.

[24]Paul Starr, *The Social Transformation of American Medicine* (New York: Basic Books, 1982), 222-24; Susan E. Bell, "A New Model of Medical Technology: A Case Study of DES," *Research in the Sociology of Health Care*, vol. 4 (JAI Press, 1986), 1-32.

[25]Bell, "A New Model of Medical Technology," 16.

[26]Bertram Slaff, "History of Child and Adolescent Psychiatry Ideas and Organizations in the United States: A Twentieth Century Review," in *Adolescent Psychiatry: Developmental and Clinical Studies*. eds. Feinstein, *et. al.*, vol. 16 (Chicago: University of Chicago Press, 1989), 31-52, 33.

in the first decades of the century. The popularity of Freudian psychology in the 1920s, the training of American psychiatrists in Europe, and the emigration of European psychoanalysts in the 1930s encouraged study of the genetic, or early childhood, influences on adult behavior. Adolf Meyer's theory of psychobiology, which traced an adult's coping style to her childhood experiences, also stimulated interest in child psychology and in preventive work.[27] Children became analysands in their own right in the 1930s with Anna Freud's *Introduction to the Technic of Child Analysis* and Melanie Klein's *The Psychoanalysis of Children.*[28] Yet, no textbook of child psychiatry was published until 1935 when Leo Kanner's *Child Psychiatry* appeared, which went through three subsequent printings.[29] To a significant extent, Kanner's text marked the first consolidation of a knowledge-base for child psychiatrists.[30]

Child psychiatry would not survive as a profession, however, if its practitioners were unable to differentiate themselves from the non-medical personnel who also elaborated their expertise in child guidance clinics. The 1930s was a period of interprofessional negotiation among mental health workers. Social workers, for instance, gained status in the 1930s by fashioning themselves as therapists; psychiatrists were embracing this role in the same decade. John Burnham argues that the example of non-medical mental hygienists did more to encourage professionalization in adult psychiatry than competition from medical colleagues.[31] Adult psychiatrists united in opposition, as when successive presidents of the American Psychiatric Association in 1932 and 1933 explicitly attacked the intrusions of non-medical personnel into psychiatry.[32] The same was

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[27]American Psychiatric Association and the American Academy of Child Psychiatry, *Psychiatric Inpatient Treatment of Children* (Washington D.C.: American Psychiatric Association, 1957), xi-xvii.

[28]Anna Freud, *Introduction to the Technic of Child Analysis* (New York and Washington: Nervous and Mental Disease Publishing Co., 1928); Melanie Klein, *The Psychoanalysis of Children* (New York: Norton, 1932).

[29]Leo Kanner, *Child Psychiatry* (Springfield: Charles C. Thomas, 1935); Leo Kanner, *Child Psychiatry*, third ed. (Springfield: Charles C. Thomas, 1957).

[30]Slaff, "History of Child and Adolescent Psychiatry."

[31]Jones, "The Development of Psychiatric Interest in Children," 32.

[32]Burnham, "The Struggle Between Physicians and Paramedical Personnel," 98, 102, 104.

true for child psychiatrists, for whom power-sharing with non-physicians was routine. The non-medical members of the health care team in child guidance clinics -- psychologists, social workers, and educational experts -- encouraged child psychiatrists to form their own institutions and legitimate their own expertise. To retain a role in the treatment of children's mental ills, child psychiatrists had to define and defend their position.

2

Residential Treatment

Residential treatment facilities emerged during these professional boundary negotiations. Though some opened in the 1920s and 1930s, residential treatment of emotional and behavioral disturbances in children became a well-established treatment modality from the mid-1940s through the 1950s.[33] Residential facilities flourished because they borrowed stature from the medical hospitals they resembled, and positioned themselves as comprehensive treatment centers for the most severe disorders. As I will argue, residential homes provided child psychiatrists with their locus of professionalization. Child psychiatrists moved out of the multidisciplinary realm and found their own.

They were not opened by self-serving child psychiatrists as vehicles for professionalization, and only gradually became child psychiatric turf. They evolved from orphanages, reformatories, hospitals, and guidance clinics, and were fostered by several different medical and non-medical organizations, sometimes with the assistance of private or public charities.[34] The new homes became institutional bases for child psychiatrists by incorporating psychiatric personnel and psychiatric orientations. Most hired child psychiatrists as directors in the 1930s and 1940s and organized their programs around

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[33] *Psychiatric Inpatient Treatment of Children* , xvi.
[34] *Psychiatric Inpatient Treatment of Children*, v.

psychiatric knowledge, both biological and psychotherapeutic. In the residential homes, child psychiatrists found a space in which to elaborate their subspecialty's identity. These institutions' directors transformed the conditions treated in outpatient clinics into the diseases around which their special function could crystallize. By insisting that aggressive therapy accompany diagnosis, they sculpted for themselves a therapeutic identity. Finally, many child psychiatrists conducted psychiatric research in these institutions, and thus articulated the knowledge-base of their new profession.

Some residential facilities opened with patients taken from other medical professionals. The first psychiatric consultation ward for disturbed children, opened in 1930 by Leo Kanner at Johns Hopkins Hospital, provided joint management of children by hospital psychiatrists and pediatricians, and allowed psychiatrists to conduct research in the unit.[35] A few state hospitals opened facilities for children. The Arthur Brisbane Treatment Center in Allaire, New Jersey evolved from the children's ward of the New Jersey State Mental Hospital in Marlboro. In 1946 the state institution moved into Arthur Bribane's refurbished private residence, complete with a pool, tennis court, lake, garden, and woods. In spite of its bucolic surroundings, "The administration of the Center and the entire care of the children is at all times under medical direction."[36]

Frequently, residential facilities prioritized the child psychiatrist's biological knowledge. Some psychiatrists argued that child guidance teams investigated emotional causes of misconduct too thoroughly and elided potential physical causes. To child psychiatrist Louis Lurie, the primary role for residential treatment was to provide extensive medical evaluations.[37] Most outpatient clinics lacked medical labs and equipment, and some allotted little time for physical exams. In response to these complaints, the Child Guidance Home of Cincinnati, established in 1920, provided complete medical work-ups

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[35]Slaff, "History of Child and Adolescent Psychiatry," 35.

[36]Joseph R. Reid and Helen R. Hagan, eds., *Residential Treatment of Emotionally Disturbed Children: A Descriptive Study* (New York: Child Welfare League of America, 1952), 1.

[37]Louis A. Lurie, "Residential Homes in Orthopsychiatric Practice," in *Orthopsychiatry, 1923-1948* (Washington, D.C.: American Osrthopsychiatric Association, 1948), 484-493.

for child guidance patients. Opened with hospital and community funds inside Cincinnati's Jewish Hospital, the Home delivered an exhaustive battery of medical tests, not psychological interviews. Children received neurological, endocrinological, otolaryngological, dental, visual, and audiometric evaluations; urine, blood, throat and nose swabs were cultured; and roentgenograms of the heart, lungs, sinuses, and bones were examined. Blood cholesterol, calcium, phosphorus and liver enzymes were quantified; pneumoencephalograms and EEGs were read; and urine androgen and estrogen were assayed. Biological research was also conducted on the wards.[38]

Child psychiatrists came to direct most of the non-medical residential facilities by virtue of their psychotherapeutic credentials. Several former orphanages, like Bellefaire, founded in Cleveland in 1868, and the Children's Service Center of Wyoming Valley, in Wilkes-Barre, Pennsylvania, became psychotherapeutically-oriented residential treatment centers.[39] The Children's Service Center replaced its director, a social worker, with a child psychiatrist in the mid-1940s.[40] At the same time Bellefaire's director lamented that "the greatest weakness of our program is the insufficient psychiatric time."[41] Reformatories and private training schools for delinquents, too, evolved into psychiatric residential centers. One was the Hawthorne-Cedar Knolls School in Hawthorne, New York, which opened in 1906 as a private training school for delinquent children. By the mid-1930s, the School provided individualized psychotherapeutic treatment by psychiatrists or case workers.[42]

The organizers of these institutions conceptualized treatment in a number of ways, but always made it a priority. Psychiatrists in the early twentieth century were as aware as today's historians that the over-burdened nineteenth-century asylums were more custodial

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[38]Lurie ,"Residential Homes," 493.
[39]*Residential Treatment of Emotionally Disturbed Children*, 21.
[40]*Psychiatric Inpatient Treatment of Children*, xiii.
[41]*Residential Treatment of Emotionally Disturbed Children*, 48.
[42]*Psychiatric Inpatient Treatment of Children*, xiv.

than therapeutic.[43] Also, these new institutions hoped to offer what outpatient clinics did not, cures for mental ills. The type of treatment delivered could be medical, reformative, or psychotherapeutic. Bellefaire was arranged as a series of cottages, each staffed by a married couple, or "cottage parents," who were to foster group living.[44] The Child Guidance Home of Cincinnati, reorganized in 1948 by the Department of Psychiatry at the University of Cincinnati College of Medicine, used psychotherapy to teach parents "the interrelatedness of the child's problem with their own."[45] The attendants on the wards served as 'better mothers' to the children. The Brisbane Center prioritized medical diagnostic tools like electroencephalograms and somatic treatments like narco-therapy, hormone treatments, and electro-shock.[46] One survey concluded that the only thing these facilities shared was this commitment to treatment and "a total approach to therapy," far-distanced from custodial or diagnostic settings.[47]

Providing treatment required identifying disease. Child psychiatrists in residential centers occupied themselves with the discovery of new childhood diseases. In turn, the study and treatment of these new psychiatric syndromes, which became endemic in the residential facilities, made work for the new profession. Post-encephalitic behavior disorder exemplified the new breed of diseases that child psychiatrists began to characterize and manage in residential settings. Encephalitis lethargica, a viral brain infection, and its sequalae in children were unknown prior to World War One. An encephalitis epidemic after the War left a number of children with dramatic character changes, termed "pernicious activity" or post-encephalitic behavior disorders.[48] As Jeckyl became Hyde, the children apparently turned from gentle cherubs to conniving monsters. Reports indicated that the

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[43]Richard W. Fox, *So Far Disordered in Mind: Insanity in California, 1870-1930* (Berkeley: University of California Press, 1978), 17.

[44]Resi*dential Treatment of Emotionally Disturbed Children*, 48.

[45] *Ibid.*, 64.

[46] *Ibid.*, 7-8.

[47] *Ibid.*, v.

[48]Earl D. Bond and G. E. Partridge, "Post-Encephalitic Behavior Disorders in Boys and their Management in a Hospital," *American Journal of Psychiatry* 83 (1926): 25-104.

children's intellect remained intact, but they became distractible, emotionally labile, hyperactive, and entirely uncontrollable. They suffered from "deteriorating moral habits," refusing absolutely to go to church or school, defying authorities, and throwing bricks through windows. Some set fires, most tormented other children, and all had done some stealing. The courts were filled with such children, and some worried that the streets, too, were overrun with them. Child psychiatrists lamented that proper residential care facilities were unavailable. General hospitals rejected these children because their hyperactive behavior bothered other patients. State mental hospitals turned them away because of their ages, and institutions for the feebleminded would not accept them because they were too intelligent.[49]

Three child psychiatric residential facilities, all with some degree of medical supervision, opened in the 1920s to treat and study children with post-encephalitic behavior disorders. The Franklin School of Philadelphia, which opened in 1924 on a ward of the Pennsylvania Hospital, was the first to treat some of these "extraordinarily bad boys."[50] Prior to its closure in 1935, its directors published a large review of the treatment offered there. In the same decade, the Children's Ward of the Psychiatric Division of Bellevue Hospital in New York City, which would become one of the largest units and a prominent research center, opened under the direction of Lauretta Bender.[51] The Children's Service at Kings Park State Hospital in Kings Park, New York also treated post-encephalitic behavior disorders.

Childhood schizophrenia was also 'discovered' and characterized in these new institutions, and this compelling new problem shifted institutional and professional priorities. Howard Potter worked in a home for the mentally retarded when he described the syndrome in 1933.[52] Bender and her coworkers at Bellevue began longitudinal studies

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[49]Bond and Partridge, "Post-Encephalitic Behavior Disorders in Boys," 26, 33.
[50]*Ibid.*, 28.
[51]Jones, "The Development of Psychiatric Interest in Children," 40-41.
[52]Slaff, "History of Child and Adolescent Psychiatry," 36; H. W. Potter, "Schizophrenia in children" *American Journal of Psychiatry* 89 (1933): 1253-1270.

of childhood schizophrenia in 1934. Charles Bradley from the Bradley Home in Providence, Rhode Island published the first monograph devoted to childhood schizophrenia in 1941.[53] Leo Kanner's important 1943 study, "Autistic Disturbances of Affective Contact," also emerged from a hospital, not a child guidance clinic.[54] Several homes which opened to serve the mentally retarded, like the Southard School of the Menninger Clinic in Topeka, altered their admission criteria to provide residential treatment for emotionally-disturbed and schizophrenic children. The Sonia Shankman Orthogenic School at the University of Chicago followed a similar trajectory. By 1946, under the direction of Bruno Bettleheim, the Shankman School limited admission to children with behavioral and emotional problems, and became a forerunner in milieu therapy for childhood schizophrenia.[55] In this manner, childhood schizophrenia attracted a highly cohesive cadre of researchers in hospitals and residential homes, many of whom became leaders in the profession of child psychiatry, like Kanner, Bender and Margaret Mahler.

As the remainder of this study will describe, the treatment centers placed many of the "problem children" previously treated in non-medical arenas under medical scrutiny. Parents often brought children to guidance clinics with complaints of "poor schoolwork, difficulty in reading, frequent fighting, failure to adjust in the group, [and] refusal to mind or running away" (94-5). Child guidance workers agreed on neither how to characterize this behavior nor its relevance. Children like this might be termed "maladjusted," or be labeled as having "undesirable behavior tendencies." [56] In journals and patient records, child psychiatrists began to refer to behavior disorders as more specific entities. Yet,

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[53]Charles Bradley, *Schizophrenia in Childhood* (New York: The MacMillan Company, 1941); A.J. Gianascol, "Psychodynamics Approaches to Childhood Schizophrenia: A Review," in *Clinical Studies in Childhood Psychoses: Twenty-five Years in Collaborative Treatment and Research*, ed. S. A. Szurek and I. N. Berlin (New York: Brunner/Mazel Publishers, 1973), 65-84, 73-4.

[54]Jones, "The Development of Psychiatric Interest in Children," 45; Leo Kanner, "Autistic Disturbances of Affective Contact," *Nervous Child* 2 (1943): 217-250.

[55]Jones, "The Development of Psychiatric Interest in Children," 42; *Psychiatric Inpatient Treatment of Children*, xi-xvii.

[56]Committee on Classification of the American Neurological Association, *A Classification of Neurological, Psychiatric, and Endocrine Disorders* (New York: American Neurological Association, 1928), 3, 39.

diagnostic manuals did not exist to distinguish the symptoms that comprised a behavior disorder from those of a maladjustment or a tendency, for instance.

In search of diagnostic clarity, some researchers tried to gauge the significance of these behaviors by examining how they clustered together. Luton Ackerson, a research psychologist trained at the Illinois Institute for Juvenile Research, compiled an inventory of the problematic behaviors reported by parents and childcare workers. He made lists of his study population's deviant activities, like depressed mood, worrisomeness, apprehensiveness, seclusiveness, staying out late, loitering, and slovenliness. Asking himself, "Is a notation of *truancy from home* more serious than a notation of *stealing*? Is *seclusiveness* more serious than *disobedience*?", Ackerson put his inventory to use to indicate "the relative 'seriousness' or 'ominousness' among these traits." He did so by quantifying how commonly traits were present in the same child.[57] Ackerson assessed the relevance of bad behaviors by noting which other traits the child was likely to have:

> Lack of interest in school showed consistent moderate correlations in the .20's with eight behavior difficulties: irresponsibility, laziness, inefficiency in work, play, etc., truancy from school, disobedience, rudeness, and (calculated for boys only) threatening violence and (calculated for girls only) overinterest in the opposite sex.[58]

In spite of its questionable utility, Ackerson's ratings might clarify the definition of a behavior problem. Further, this study characterized the disorder according to patterns in symptomatology, for these patterns seemed to hint at etiologies.

Many pediatricians and child guidance workers considered bad behavior psychologically-motivated. Child psychiatrists, in fact, saw it as their professional role to

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[57]Luton Ackerson, *Relative Importance and Interrelations Among Traits*, vol. 2 of *Children's Behavior Problems: A Statistical Study Based Upon 2,113 Boys and 1,181 girls Examined Consecutively at the Illinois Institute for Juvenile Research* (Chicago: University of Chicago Press, 1942), 81.
[58]Ackerson, *Children's Behavior Problems,* 449.

alert others to "the great part played by emotional factors in delinquency."[59] They advanced psychological explanations for behaviors as they expanded their professional knowledge-base. One psychiatrist argued that "Hyperactivity is a mode of self-expression" and can generally be treated as "a phase in the child's development."[60] Psychiatrists at Bellevue used psychoanalysis to understand bad behavior.[61] Leo Kanner's text elaborated on the psychological meaning of children's activities. He did not mention pharmacologic interventions until his 1957 edition of *Child Psychiatry*, and then he insisted medication should only be used as an adjuvant to psychotherapy.[62] Pediatric texts and journals also outlined psychotherapeutic approaches to child and family.

However, physicians agreed that organic syndromes also could cause stereotypical behavioral aberrations. As mentioned, post-encephalitic behavior disorders provided a prototype for these conditions.[63] Doctors also argued that in "the great majority of cases," epilepsy altered the intellect and personality. Intellect ceased to progress, "indeed, a definite regression" ensued. The imagination would decline and interests would narrow to "the bare necessities." Speech slowed and "answers [became] stereotyped, even nonsensical." The epileptic suffered unhappiness and discontent that "[hung] on persistently." The easily offended, stubborn, picky, and suspicious epileptics made "miserable playmates and eventually [withdrew] more and more into themselves." Some turned to "reckless violence, in a blind destructive impulse," and many ended in an "epileptic dementia."[64] Yet, even in organically-based behavioral problems, some physicians claimed that "the hyperactive child quiets down like other children if he is given the chance."[65]

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[59]James J. Waygood. "The Pediatric Approach in the Prevention of Behavior Problems," *Pennsylvania Medical Journal* 44 (Aug 1941): 1440-41, 1440.

[60]John A. Russell, "The Hyperactive Child," *American Journal of Diseases of Children* 63 (Jan 1942): 94-101, 94-5.

[61] Lauretta Bender and Frances Cottington, "The Use of Amphetamine Sulfate (Benzedrine) in Child Psychiatry," *American Journal of Psychiatry* 99 (July 1942):116-21.

[62]Leo Kanner, *Child Psychiatry*, 3rd ed. (Springfield: Charles C. Thomas Press, 1957), 255.

[63]Russell, "The Hyperactive Child," 100.

[64]M. Pfaundler and A. Schlossmann, *The Diseases of Children*, vol. 5, trans. and ed. M. G. Peterman (Philadelphia: J. B. Lippincott Company, 1935), 303.

[65]Russell, "The Hyperactive Child," 98; Bradley, "Problem Children and EEG Diagnosis," 773.

This study will examine in detail two child psychiatrists with strong opinions and volumes of data on questions like these. Charles Bradley of the Emma Pendleton Bradley Home in Providence, Rhode Island and Stanislaus Szurek of Langley Porter Clinic in San Francisco, California both ran residential treatment centers for emotionally-disturbed children, the majority of whom were diagnosed with behavior disorders. The theory and practice which derived from their philosophies of child psychiatry will be examined in depth. While their idea of disease and treatment could not seem more divergent, both valued the residential approach to children's treatment as medically proper and developmentally advantageous for the child.

Charles Bradley saw residential treatment as a natural extension of any other work in child psychiatry. Though "residential therapy is often discussed as something apart from other aspects of the practice of child psychiatry," he found the precepts to be quite similar.[66] He named two advantages to residential treatment for disturbed children. First, it would give them a measure of normalcy, for they would live in an accepting environment and could participate in normal childhood activities. Bradley imagined that residential centers could provide the social ties that maladjusted children found difficult to forge in the larger society, and his Home encouraged socialization. Second, because the Home was run by medical professionals, it could apply particular treatments to a child's medical conditions.[67] Charles Bradley conceived of child psychiatry as a thoroughly medical profession with strong links to other hospital specialties. He considered behavior disorders to be complications of physical maladies like infections. He utilized medical instruments like the electroencephalogram to diagnose a child's behavior. He also treated behavior disorders with medications.

Like Bradley, Stanislaus Szurek considered inpatient treatment an intensification of outpatient child psychiatric work rather than a separate type of intervention. He felt that

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[66]Charles Bradley, "Indications for Residential Treatment of Children with Severe Neuropsychiatric Problems," *American Journal of Orthopsychiatry* 19 (1948): 427-431, 427.
[67]Bradley, "Indications for Residential Treatment," 427, 429.

"Treatment in any psychiatric facility is rooted in medicine and based on biological data and principles."[68] Treatment for Szurek was organized around a biological disease concept, and could involve medical therapeutics. Yet, he considered it "clear that ... the biological approach, is but one aspect of the total treatment situation."[69] In fact, Szurek theorized behavior as determined by both manifest and intrapsychic parent-child conflicts, not organic disease. His diagnosis and treatment involved psychoanalysis, and he thought medical data distracted a doctor from the more significant contents of the child's unconscious. Utilizing radically different types of expertise, both child psychiatrists prioritized the advantages of medical care and environmental treatment for behavior disorders. Further, as this study will argue, both took the institutional arena and molded it to suit their preferences for the new profession of child psychiatry.

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[68]S. A. Szurek, "Survey of Inpatient Programs for Psychotic Children," in *Inpatient Care for the Psychotic Child*, The Langley Porter Child Psychiatry Series: Clinical Approaches to Problems of Childhood, vol. 5 (Palo Alto: Science and Behavior Books, Inc., 1971), 2-21, 5.

[69]Szurek, "Survey of Inpatient Programs for Psychotic Children," 5.

III
Charles Bradley and the Emma Pendleton Bradley Home

The Emma Pendleton Bradley Home in Providence, Rhode Island opened its doors in the early 1930s. It expressed the preventive zeal of the child guidance movement while it rejected the equivocal role the movement offered child psychiatry. The Home adopted an unambiguous purpose and a well-established identity by taking both the asylum and the hospital as models. Clinging to old institutions for safety and echoing new ones for prestige, it offered prevention to the community without taking too many risks. The medical specialty of child psychiatry found its patients and its position in hospitals like the Bradley Home.

1
The Home the Community Built

Private wealth and an enthusiasm for medicine built the Bradley Home. George Lathrop Bradley and his wife Helen willed their estate to found a care facility in the name of their only child, Emma Pendleton Bradley (1879-1906). Emma became sick in 1887 with what may have been encephalitis. The illness left her with seizures, mental retardation and permanent neurologic deficits. Unable to find a proper residential care facility for their daughter (apparently homes for mentally retarded children were not sufficient) and enthusiastic about the promise of medicine and science, the Bradleys willed their estate to found a home for children like Emma.[70]

In 1923, after Helen Bradley's death, a board of trustees was organized to establish

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[70]Michelle Johnston with Christine Lamar and Deborah Shea Porrazzo, *Out of Sorrow and Into Hope: The History of the Emma Pendleton Bradley Home* (Providence: Levy Library of the Emma Pendleton Bradley Home, 1991), 10-13; Maurice Laufer, "Emma Pendleton Bradley Home," in *Residential Treatment of Emotionally Disturbed Children: A Descriptive Study* (New York: Child Welfare League of America, 1952), 94-119.

the residential facility. The six-person board contained five lay members and one physician, Arthur Ruggles, the superintendent of the Butler Hospital for the Insane. Ruggles (1881-1961), who became the first superintendent and chief of staff at Bradley, had trained in Germany and Munich before World War One as a Freudian. Work at the Bradley Home dovetailed with his desire to shift his career from asylum keeping to a brand of preventive psychiatry more in keeping with the mental hygiene movement. His work in schools and with children led to his 1946 appointment as president of the National Committee for Mental Hygiene (NCMH), a position from which he continued to advocate community psychiatry and dynamic theory.[71] Ruggles served as superintendent at the Bradley Home for ten years, and in 1941 left to serve another community, the United States army, as a consultant in psychiatry to the secretary of war.[72] His self-appointed replacement was Dr. Charles Bradley.

Charles Bradley lacked the asylum experience and community health orientation of his supervisor, but his influence on the Home would be more pervasive and permanent. Ruggles appointed Bradley as the first medical director of the Home in 1933. Charles, the grand-nephew of George Bradley, was born in Pittsburgh in 1902. He graduated from Moses Brown School, Cornell University and Harvard Medical School. He interned at the Pennsylvania Hospital and did his residency at Babies Hospital in New York. He came to Bradley a year after it opened "in hopes of participating in his family legacy."[73] Apparently a quiet and introspective man, he was also deeply religious, and less social than his well-heeled relatives.[74]

Ruggles and Bradley took hold of an institution whose architecture echoed the most trustworthy and familiar of locations for psychiatric practice, the asylum. Ruggles's Board

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[71]Ian Robert Dowbiggin, *Keeping America Sane: Psychiatry and Eugenics in the United States and Canada, 1880-1940* (Ithaca: Cornell University Press, 1997), 112-13.
[72]Johnston, *Out of Sorrow and Into Hope*, 21-27.
[73]Johnston, *Out of Sorrow and Into Hope*, 22.
[74]Walter A. Brown, "A Great Pioneer of Child Psychiatry," *Providence Sunday Journal*, 28 December 1997, p. F7.

sold the Bradley's urban house and purchased a bucolic plot of land off a rural road five miles east of Providence.[75] In spite of Ruggles's rhetoric about moving psychiatry into the community, the model for the Bradley Home was a fortress concealed in the woods. The thirty-five-acre refuge would eventually accommodate playing fields and a pond for skating and swimming.[76] The Board could have moved it yet further from the eyes of neighbors, however, for nearby East Providence residents objected to the construction of an asylum in their midst. Construction began only when their protests quieted.

The two headed a thoroughly medicalized institution. When it opened in April 1931, founders hailed it as the first neuropsychiatric hospital organized for the residential treatment and study of children's neurologic and psychiatric disorders. They boasted that it was uniquely able to provide state-of-the-art medical diagnoses, comprehensive medical care, and advanced research into the young residents' maladies.[77] They considered its spacious grounds ideal for long-term rehabilitative care of crippled children, and curative recreational care for mentally disturbed ones. The Board members praised the Home as the first medical institution to serve this particular group of children, but by treating both mental and physical disorders at once, the Home became a hybrid of the asylum and the hospital, and defined a new cohort of children in need of psychiatric care.[78]

The Home's target patient population was young and stayed for years at a time. The Bradley children were admitted under twelve years of age.[79] Frequently twice as many boys as girls were in residence.[80] Bradley had fifty beds, but a stable group of patients, for by 1937 only 300 children had been treated; that is, on average, four new patients arrived

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[75]Charles Bradley, "A Children's Hospital for Neurologic and Behavior Disorders," *Journal of the American Medical Association* 107 (1936): 650-653, 653.

[76]Laufer, "Emma Pendleton Bradley Home," 95.

[77]Bradley, "A Children's Hospital," 650; Charles Bradley, "Pioneer Hospital for Children's Behavior Disorders," *Modern Hospital* 50, no. 5 (May 1938): 68-72, 69.

[78]Wallis Howe and Charles Neergaard, "Providing the Best in Mental Care for Rhode Island Children," *The Modern Hospital* 37, no. 4 (Oct 1931): 63-66, 63; Charles Bradley, "The Behavior of Children Receiving Benzedrine," *American Journal of Psychiatry* 94, no. 1 (1937): 577-85, 578.

[79]Bradley, "A Children's Hospital," 652.

[80]Bradley, "Pioneer Hospital," 69; Bradley, "The Behavior of Children Receiving Benzedrine," 578.

each month.[81] Staff expected that children would not respond to treatments shorter than six months in length, and parents were told to prepare for a one- to two-year-long stay. Children did stay at the Home for an average of six to eighteen months. In accordance with the provisions of George Bradley's will, 50 percent of the children were drawn from the small state of Rhode Island.[82]

This lengthy and intensive care was delivered for a mix of problems. Bradley described the children as a group who could not live harmoniously outside of the hospital:

> The majority were alert, intelligent youngsters with no physical disabilities, but whose behavior in the community had been of a type either sufficiently disturbing to bring them into conflict with their families and the school authorities, or else of such a nature that their own future development as well-adjusted adults seemed jeopardized.[83]

The newspapers preferred to stress that the children had "nervous diseases" like "the after effects of sleeping sickness, brain tumors, behavior problems requiring special treatment, epilepsy and various injuries and disorders of the nervous system."[84] In reality, children with deficits in neurologic functions were treated next to children in conflict at home and school. Until around 1942, when admission criteria began to change, the Bradley Home admitted children with four conditions: brain injuries like spastic infantile paralysis (cerebral palsy), post-encephalitic behavior disorders, convulsive disorders, and emotional disorders "too severe for proper care" outside of the hospital.[85]

Neurologic diagnoses may have predominated in the early years of the Bradley Home, but behavior disorders were the single largest diagnostic category. A survey from

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[81]Bradley, "Pioneer Hospital," 69.
[82]Laufer, "Emma Pendleton Bradley Home," 112; Bradley, "A Children's Hospital," 652.
[83]Bradley, "Pioneer Hospital," 69.
[84]Johnston, *Out of Sorrow and Into Hope,* 17.
[85] Laufer, "Emma Pendleton Bradley Home," 94; Johnston, *Out of Sorrow and Into Hope*, 22; *Psychiatric Inpatient Treatment of Children*, xv.

1936 revealed that a third of the patients were diagnosed with a behavior problem, one quarter with a convulsive disorder, a fifth with birth injuries to the nervous system resulting in paralysis or motor incoordination, and another fifth with mild mental deficiency. Chorea, post-encephalitic behavior disorders, a progressive muscular dystrophy, and congenital syphilis were present in a small number of patients. Many of these children with neurologic diagnosis also carried secondary diagnoses of a behavior disorder. Throughout the thirties, behavior disorders could account for up to two-thirds of the admission diagnoses.[86]

Far from finding others 'like them', the children were even 'misfitted' to their bedmates in the Home. Neurologically disabled kids lived in the same halls as emotionally disturbed, disruptive, and angry ones. "Children were also in residence at Bradley who presented serious conversion symptoms such as paralysis, inability to swallow requiring tube feeding, and other gross symptoms requiring much physical attention."[87] In 1938, maladjusted children were admitted alongside one girl with chronic progressive chorea on the left side of her body; a child with cerebellar ataxia, cerebral infantile spastic diplegia and mental deficiency; and a four-year-old with quadriplegic cerebral spastic infantile paralysis.[88] The children with motor weaknesses practiced rehabilitative exercises, like pushing a weighted wagon, in the same yard where children with a "specific reading disability" or school failure spent their recesses.

If the children shared few outward symptoms, though, they shared their stigmatization. Warning that the hospital would be "dealing with the problems ... that other people have failed on, the worst problems in our community," a colleague of Bradley's insisted the children posed an urgent and intractable threat.[89] The community of East Providence protested less out of concern for community security than out of fear "that the

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[86]Bradley, "A Children's Hospital," 650-51; Bradley, "Pioneer Hospital," 69.
[87]Laufer, "Emma Pendleton Bradley Home," 96.
[88]Patient Records, The Bradley Hospital, Providence, Rhode Island.
[89]Bradley, "A Children's Hospital," 653.

institution would be filled with irresponsible and violent persons." Simultaneously they feared the children would contaminate their neighborhoods, and "some of the people had visions of insane children running up and down the streets."[90] Bradley remained optimistic, blaming misinformation for the community's negative reception of the Home, specifically the "vague nature of the term 'nervous'" and "the fallacious public conception that social stigma and degeneracy are associated with anything 'mental.'"[91] The stigma of nervous and mental diseases demanded an efficient remedy, but the citizens could settle for an efficient enclosure. The Bradley Home obliged the community, cordoning itself away from the community, while attacking the problems of nervous and mental diseases with the aggressivity of the modern hospital.

2

Social Norms at the Home

By co-opting familiar codes of residential care, the Home eased into new territory while clinging to well-established standards of legitimacy. Bradley Home administrators engineered an institutional identity which combined the best aspects of asylum moral treatment and reformatory training. Accordingly, cooperation in the milieu and proper reeducation structured the intervention of the Home. Group living and proper socialization purported to make reparations for the inequities these children experienced outside the hospital. Those denied normal childhood experiences could regain them in a safe, rarefied institutional world. In this manner, the Home's therapeutic orientation instantiated both the values of the larger society and the precepts of other children's facilities.

Group living at the Bradley Home played off the distinction between 'inside' and 'outside' the hospital, between an engaging milieu and the ostracizing community. Drawing

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[90]Johnston, *Out of Sorrow and Into Hope,* 17.
[91]Bradley, "Pioneer Hospital," 68.

the child into the milieu of the hospital was the primary mode of treatment. Materially and emotionally, the child's former life was replaced with an institutional one. Parents were instructed not to visit the hospital for two weeks after their child was admitted, "as it is believed a child needs that period in which to become adjusted to separation."[92] A typical patient received a visit from one parent every few weeks.[93] Drawing the child inside also meant replacing her belongings, which were kept away from the dormitories. Even clothing was "considered a part of therapy," and the school took the child on a shopping trip "if a parent cannot be persuaded to provide the style of clothing the staff believes a particular child should have."[94] The Home provided the child with a new living environment by enforcing distance from his or her former life.

The new loyalties within the Home were based on an extreme degree of communal living where small social groups structured play and school. A child could be denied admission if a compatible group did not have a vacancy, for the new patient could not "negate the positive values of the group."[95] Children slept six to a large room, and shared common bathrooms. The children ate with their designated groups. Parents, too, transferred their loyalty from their child to her group; the school advised, for instance, that they send enough candy for the child's entire group.[96] In the 1940s, when 'milieu therapy' was conceptualized, group living was considered one of the Home's most significant therapeutic interventions. For some patients, it was the sole treatment offered by the institution. The treatment record for Bob, a patient with a behavioral problem in residence at the Bradley Home for more than two years, listed no other interventions.[97]

When advocating group living, Bradley argued that his children could be 'normal,' but he never argued with the values or priorities of the larger community that had judged

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[92]Laufer, "Emma Pendleton Bradley Home," 102.
[93]Charles Bradley, "Indications for Residential Treatment of Children with Severe Neuropsychiatric Problems," *American Journal of Orthopsychiatry* 19 (1948): 427-431.
[94]Laufer, "Emma Pendleton Bradley Home," 106.
[95]*Ibid.*, 101.
[96]*Ibid.*, 95, 101, 104.
[97]Patient Records, The Bradley Hospital, Providence, Rhode Island.

them defective. He considered it acceptable that a child with a convulsive disorder or brain damage was not welcomed by other children.

> A few major convulsions in the classroom or on the playground frequently lead to permanent exclusion from [childhood] activities. The noisy, erratic, hypermotile, or delinquent behavior of the child with organic brain damage often excludes him from sharing the community activities of other of his age. The withdrawn, autistic child whom parents and teachers cannot reach is understandably left out of many an active program.[98]

Though he did not question the logic behind these ostracisms, Bradley insisted that "Some participation in the ordinary activities of childhood is essential to mental health."[99] By surrounding the child with equally marginal playmates, he asked his children to imagine a share of normalcy. At the Bradley Home, each child, "no matter how handicapped," would take part in hockey, scouting, and swimming.[100] As if to taunt them for their physical abnormalities, the recreational director was "a young man whose physique inspires the admiration of the children."[101] At times this seemed to require a extreme blindness to the children's difficulties. For instance, when one girl with poor social adjustment arrived at Bradley, a "busy schedule with the other children was started for Hattie immediately, and no issues were raised or restrictions imposed as a result of the 22 severe convulsions she had during her first eight days in the hospital."[102] Involvement in 'normal' activities meant competing only with other 'abnormals,' and thus never questioned the categories into which the children were parceled.

The Bradley Home also reinstated a highly structured schedule for children who

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[98]Bradley, "Indications for Residential Treatment," 428.
[99]*Ibid.*, 428.
[100]Bradley, "Pioneer Hospital," 70.
[101]*Ibid.*, 72.
[102]Bradley, "Indications for Residential Treatment," 429.

had failed to thrive in the structure of their communities. As would a reform school, the institution enforced conformity in children who had refused to conform to the rules at home, making the Bradley Home "perhaps more like an educational institution than most people realize."[103] The solution to the child's previous difficulties in education or training was to simply uphold stricter standards. On the wards and dining rooms "Instruction in speech, posture, behavior and character" were given.[104] Proper grooming was stressed, particularly for girls. Hattie, whose unattractiveness on admission was considered a symptom of her illness, succeeded at Bradley by losing 30 pounds and becoming "physically much more attractive." As a reward she "received a permanent wave and more attractive clothes suited to her improved posture and figure," and she was congratulated for taking such pride in her appearance.[105]

Most aspects of the child's reward and punishment system were linked to triumphs or failures at conformity, and just like on the outside, children were ostracized if they continued to rebel. Meals were eaten with the child's group, "except for those assigned to individual tables because their behavior is unacceptable for group eating."[106] Ned was punished for trying to flee the Home by being "dropped from all activity for two one-week periods."[107] Rewards were given to children who achieved congenial group relations and a polite demeanor. The 'honor table' rewarded polite children with public privileges:

> A child from each of the three older groups is chosen by the guides [supervising adults] to sit there for a week. The choice is based on who has tried hardest to meet acceptable standards in dining room behavior. One of the 'honor' children says Grace at each meal. Children at the 'honor table' have the privilege of inviting an adult 'guest' to eat at their table.... The 'honor table' may also have seconds on dessert, a privilege

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[103]Charles Bradley, "Education in a Children's Psychiatric Hospital," *The Nervous Child* 3, no. 4 (July 1944): 327.
[104]Howe and Neergaard, "Rhode Island Children," 66.
[105]Bradley, "Indications for Residential Treatment," 430.
[106]Laufer, "Emma Pendleton Bradley Home," 104.
[107]Patient Records, The Bradley Hospital, Providence, Rhode Island.

not given the others.[108]

The Home rewarded socialization, virtually insisted upon conformity, and did not question whether shame and ostracism had not contributed to the child's problem in the first place.

The schoolroom served as the central reformatory locale. Here a child's true worth was measured according to her capabilities and labors -- or lack thereof. The relevance of the schoolroom to treatment at the Bradley Home cannot be overestimated. Its significance originated in Bradley's assumption about the outward appearance of the bright child. The connection between intelligence and conformity and between dullness and disruption were theoretical certainties for Bradley never undermined in practice. In spite of the number of intelligent children at his home for misbehavior, Bradley maintained that "the child of normal or superior intelligence will cooperate more effectively with teachers ... than the child who is mentally dull."[109] He made the schoolroom the primary site at which the gaze of the expert judged the child's present adjustment and future potential. School behavior was closely scrutinized and recorded in detail in each child's hospital notes.[110]

School failures or set-backs were commonly listed as reasons for admission, but Bradley only enforced more structure and regimen. Each child took an achievement test to determine his grade level, and the staff psychologist conducted detailed psychometric testing to identify areas of intellectual skill and educational abilities. The efficient classroom, for fifty children, was staffed by three full-time teachers. Children attend school most weekdays and throughout the summer, though those up to their grade level may receive vacation time "in recognition of their achievement." Discipline must have been strict, for it was claimed that "There are very few behavior difficulties reported in school."[111]

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[108]*Ibid.*, 104.

[109]Charles Bradley, "The Spastic Child: A Training Program," paper in collection of the Levy Library, the Bradley Hospital, Providence, Rhode Island, 105.

[110]Patient Records, The Bradley Hospital, Providence, Rhode Island.

[111]Laufer, "Emma Pendleton Bradley Home," 109; Bradley, "Pioneer Hospital," 71.

The Bradley Home turned its retreat into a mirror of the outside world. It provided a child with the salve of normalcy denied her by the outside only by gathering her with other abnormals. It reinstated a structured social life which had been the location of her difficulties on the outside. Once again, it punished her with exile when rules were broken. She was forced to be normal by establishing distance from the normal things she could not attain. No aspect of the Home questioned that those roles had been one source of the child's difficulties.

3

Medical Abnormalities in the Hospital

The Bradley Home's treatment began by enforcing socialization to group norms. Yet, the educational aims of the institution took a back seat to its medical ends.[112] Admitted children, considered abnormal and undisciplined, were first and foremost sick. Children came in and went out based on physicians' assessments. They were initiated with medical tests, and treated with medical therapeutics. They lived in a building designed as a hospital, and became the subjects of medical research. The Bradley Home may have sweetened its medicine with the precepts of nineteenth-century institutions, but like other residential facilities, it identified its regimen with the prestigious medical center, not the custodial asylum or the penal reformatory. This identity was more substance than form. As I will argue in the next section, the medical orientation of the Home colored the lens through which the children's problems were considered, and it allowed Charles Bradley to construct a professional identity that capitalized on familiar sources of prestige. The hospital-like Home bulwarked Bradley's concept of child psychiatry.

The children's conditions were medicalized. They were referred to the Home from a physician, and in the views of the Home's supervisors they were in need of medical

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[112]Bradley, "Education in a Children's Psychiatric Hospital," 327.

treatment.[113] They were greeted by nurses in starched-white uniforms and the tiled halls of a hospital.[114] The most extensive testing they received was biological. "Regardless of the complaint," from poor reading to spastic paralysis, a complete history of past illnesses, a physical exam, laboratory tests of blood and urine, tests for infectious diseases, X-rays, and lumbar punctures were routine or frequent.[115] The most common interventions involved medicines. The Bradley Home made medications "a matter of daily routine for so many patients in the hospital" that Alice, a child with tics and maladjustment, took three: benzedrine, phenobarbital and Dilantin.[116] Grace received phenobarbital, Dilantin, bromide, mebaral, and benzedrine. Hattie received Dilantin, bromide, and Dexedrine for a convulsive disorder and emotional problems. Harriet was given four days of typhoid vaccines as 'fever therapy' for a movement disorder in her arms.[117]

The Bradley Home was a hospital, in addition, because it was a locale for medical research. The institution had well-equipped labs, and its staff considered the clinical facilities opportune for research.[118] Linking the Bradley Home to other medical institutions through its science not its service, the founders insisted the Home would "be considered to have failed in its purpose" if it did not produce research results.[119] They argued that individual physicians, too, should use the institution to gain a foot-hold in the research community.[120] These men sought prestige through a brand of science that conflated the clinic and the lab, and their ambitions were consistent with 1930s medicine, when, as Susan Bell has argued, "physicians who wanted to be at the top of the profession had to do

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[113]Bradley, "A Children's Hospital," 653.

[114]Johnston, *Out of Sorrow and Into Hope*, 21-22, 24.

[115]Mortimer D. Gross, "Origin of Stimulant Use for Treatment of Attention Deficit Disorder: Letter to the Editor," *American Journal of Psychiatry* 152, no. 2 (Feb 1995): 298-99; R.B.H. Gradwohl, *Clinical Laboratory Methods and Diagnosis: A Textbook on Laboratory Procedures with their Interpretation*, 3rd ed. (St. Louis: C. V. Mosby Company, 1943).

[116]Charles Bradley and Margaret Bowen, "Amphetamine (Benzedrine) Therapy of Children's Behavior Disorders," *American Journal of Orthopsychiatry* 11 (Jan 1941): 92-103, 94.

[117]Charles Bradley. "Indications for Residential Treatment," 430; Patient Records, The Bradley Hospital, Providence, Rhode Island.

[118]Bradley, "Pioneer Hospital," 68, 72; Bradley, "A Children's Hospital," 650.

[119]Howe and Neergaard, "Rhode Island Children," 65; Johnston, *Out of Sorrow and Into Hope*, 19.

[120]Johnston, *Out of Sorrow and Into Hope*, 23.

research."[121]

Since their competitors were medical men, Bradley Home staff researched medical interventions. In 1935, just two years after coming to the Home, Bradley published a design of a child-sized chair, with straps and padding for holding the child upright, to administer air encephalography. The hour-long procedure consisted of placing the child under anesthesia, injecting air into the spinal column, and taking a radiograph of the skull.[122] The first clinical laboratory for electroencephalography research was established at the Bradley Home. Psychologist Herbert Jasper was hired in 1933 to study electroencephalographic diagnosis of children's neurologic problems.[123] Bradley's studies on benzedrine and Dexedrine sulfate began in the mid-1930s and continued throughout the 1950s. Jasper and Bradley correlated their findings in the 1940s. Both the Rockefeller Foundation for Medical Research and federal funds supported Jasper's EEG studies and Bradley's work on benzedrine throughout the war.[124] By 1945, Bradley Home physicians produced seventy-five publications, but not one concerned the psychology or sociology of children's disturbances.[125]

Finding themselves in a world distinct from the child guidance clinics, physicians took control. They coordinated the interdisciplinary staff of lab technicians, nurses, attendants, teachers, and psychiatric social workers. Like nineteenth-century asylum superintendents, Ruggles and Bradley conducted all medical and managerial affairs, communicating with referring doctors and parents and consulting with specialists. They performed admission interviews and diagnostic tests, and they ordered menus and medications for each child.[126] Yet, hierarchy, uniforms, and equipment make a hospital

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[121]Susan E. Bell, "A New Model of Medical Technology: A Case Study of DES," *Research in the Sociology of Health Care*, vol. 4 (JAI Press, 1986), 1-32, 10.
[122]Johnston, *Out of Sorrow and Into Hope*, 23-4; Charles Bradley, "An Encephalography Chair for Children," *Journal of Pediatrics* 7, no. 3 (Oct 1935): 512-515.
[123]Laufer, "Emma Pendleton Bradley Home," 115.
[124]Johnston, *Out of Sorrow and Into Hope*, 24-5.
[125]Laufer, "Emma Pendleton Bradley Home," 94-119.
[126]Bradley, "Pioneer Hospital," 70-72.

only if the patients agree to be sick, and the physicians at the Bradley Home ensured that the children complied. The next section describes how children's maladjustments became medical maladies that only physicians were qualified to treat.

4

The Diagnosis of Bad Behavior

The definition of a behavior problem in the Bradley Home came from theories of maladjustment. Charles Bradley based his diagnostics on Leo Kanner's adaptation of Adolf Meyer, which argued that the mentally ill patient showed "an abnormal form of reaction to his experiences," or an "inadequate reaction to the situations in which his life has placed him."[127] The name given to this condition changed over time: until around 1941, most of the misbehaving children admitted to the Bradley Home were diagnosed with "maladjustment, problem state in a child," a category accepted by neurologists and psychiatrists alike.[128] By around 1941, these same children began to have "primary behavior disorders." At the Bradley Home, that diagnosis was given by all doctors beginning around 1941, but with an idiosyncratic frequency, and by Charles Bradley more often than others. After 1941, the diagnosis "maladjustment, problem state in child" continued to be used, though, and patient records reveal no obvious differences in symptomatology, concurrent illnesses, or physical findings between the maladjusted and the behavior disorder children. Thus, maladjustment became a primary behavior disorder sometime in this period, though the symptoms changed little.[129] The diagnosis, I will argue, was given following a child's conflict with parents or society, and its characteristics were constructed in social settings. Yet the diagnosis of a primary behavior disorder was

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[127]Charles Bradley, *Schizophrenia in Childhood* (New York: The MacMillan Company, 1941), 5-6.
[128]Committee on Classification of the American Neurological Association, *A Classification of Neurological, Psychiatric, and Endocrine Disorders* (New York: American Neurological Association, 1928).
[129]Patient Records, The Bradley Hospital, Providence, Rhode Island.

constituted by biological signs which bounded the social construction into a medical model.

Hattie was a typical maladjusted Bradley patient. Both her convulsive disposition and her insolent behavior -- she was rambunctious, selfish, and bothersome to those around her -- motivated admission. Bradley described her as "an obese, unattractive girl" admitted "because of demanding, irritable behavior since early childhood and repeated severe grand mal convulsions over the previous two years." She had been excluded from school and all outside activities because of her convulsive disorder, and since then continually complained that she felt unhappy. She interested herself in nothing but food, "for which her appetite was enormous." Hattie's parents were "of superior intellect and education" and Hattie's neighborhood was considered good. Hospitalization came as a relief to the neighborhood and the family, for Hattie's father's work was suffering from his preoccupation with her behavior, and Hattie's mother was continually fighting with her. Plus, "the neighbors, though sorry for the family, were fearful of Hattie's seizures and intolerant of her irritable, self-centered behavior."[130]

Another maladjusted child, ten-year-old Bill, kept to himself and expressed peculiar ideas. The description of his malady was equivalent to the set of social categories he had violated, for Bill came to the Bradley Home because of "poor school progress, stubbornness, failure to mingle with other children, and excessive daydreaming which was combined with the expression of many fantastic ideas." Bill's parents, like Hattie's, were "intelligent people of high ideals," but in response to Bill's behavior they were too "rigid and exacting."[131] Bradley argued that hospitalization was indicated to improve his social skills with other children, advance him in school, and grant him some freedom from his fastidious home environment. Of the children admitted with behavior disorders, three-quarters were boys.[132]

At the Bradley Home, conflicts with parents and teachers were the most common

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[130] Bradley, "Indications for Residential Treatment," 429.
[131] Bradley, *Schizophrenia in Childhood*, 112.
[132] Bradley, "Pioneer Hospital," 69; Bradley, "The Behavior of Children Receiving Benzedrine," 578.

indicators of behavior problems. Like Bill and Hattie, many children came to the Home from caretakers who found their temperaments alien and infuriating, and their differences with them irreconcilable. Children were frequently admitted from foster homes when they were difficult to manage. Becky was admitted twice to the Bradley Home, in 1938 and 1939, for failure to adjust to her foster parents. She had been "high-strung and nervous since infancy," and had already been admitted to Bradley after a fight with her first foster parents. Prior to her second admission, she had become "extremely negativistic," in particular, they felt, toward them. They complained that she did not "come home from school soon enough," that she no longer kept her room tidy, and that her dress soon after arriving at their home became slovenly. She was late for meals, began to steal change, and "refused to do the few household tasks assigned," asking "Do I have to?" or "Must I?" When her schoolwork became sloppy and she lost her motivation to achieve in the classroom, Becky's foster parents relinquished her to the hospital. Becky, the Bradley staff agreed, was pathologically "impudent and negativistic toward her foster parents."[133]

Difficulties in the schoolroom were a common reason for a child to receive a diagnosis of a behavior disorder and be admitted to the hospital. Ned, a patient with a history of seizures, was admitted as maladjusted due to truancy, lack of classroom discipline, and poor progress in reading and spelling. He was admitted a second time because he had to repeat every grade once or more. "He is inattentive, instigates others, fails to complete his homework, and gets up to leave the classroom without permission." Norma, admitted in 1938, was also diagnosed with maladjustment because she had shown "poor behavior in school." Her restlessness, inattentiveness, temper tantrums and disobedience necessitated hospitalization. With five months in residence at Bradley she improved her schoolwork and was considered ready for discharge.[134]

These disorders were constituted in social settings where a child's behavior violated

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[133]Patient Records, The Bradley Hospital, Providence, Rhode Island.
[134]Patient Records, The Bradley Hospital, Providence, Rhode Island.

norms. Just as childhood schizophrenia was discovered in institutions, behavior disorders were defined in the communal milieu, most frequently in the classroom. Bill's "social maladjustment" developed only gradually, but "were apparent" when he started school at five years old. He misbehaved more in school than elsewhere, was often tardy, never completed his tasks, made noises, openly masturbated and teased his teachers.[135] Bob came to Bradley at the age of nine for almost two years with a primary behavior disorder, a conduct disturbance, and dementia praecox. Though considered normal until he was four years old, it was noted when he entered kindergarten that he was "different from other children."[136] These disorders were identified once children had competed with others and failed to conform to a teacher's rules. Violating the rules of a structured social setting, or resisting indoctrination into that milieu, revealed a pathology that formerly had not been recognized.

Bradley avoided naming the diagnostic criteria that made up these medical illnesses, but he admitted that his concepts of health and illness were based on social norms. The healthy, well-adjusted child presented "no outstanding problems because [his] behavior [conformed] reasonably well to accepted social standards," but if this child's behavior began to "deviate from accepted standards, a behavior problem [was] said to have arisen."[137] Bob became more ill as his behaviors became more antisocial: he was admitted when he was "extremely negativistic, took no care of himself or his personal belongings." In the hospital, his "seclusive" behavior indicated the presence of disease.[138] Not only did Bob have to be around other children to get his disease recognized, but its severity was gauged by social norms. This social construction of illness was consistent with Bradley's emphasis on conformity and participation in his hospital.

Yet, just as the foundation of the Home mirrored the image of a hospital, behavior

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[135]Bradley, *Schizophrenia in Childhood*, 112.
[136]Patient Records, The Bradley Hospital, Providence, Rhode Island.
[137]Bradley and Bowen, "Amphetamine Therapy," 102.
[138]Patient Records, The Bradley Hospital, Providence, Rhode Island.

disorders were fundamentally biological conditions to Charles Bradley. In Bradley's diagnostic schema, the child's biological state described her behavior best, and different children's behaviors were considered similar if the children's neurologic diagnoses were the same: the egocentric epileptic or the disruptive learning-disabled child differed from "the hyperactive, irritable, aggressive, destructive [behavior] often seen in children with convulsive disorders or with structural damage to the central nervous system."[139] Biological categories served as umbrella terms for sets of symptoms, as when the "organic reaction type" was identified as the child who "since infancy, in every environment in which he has found himself" was irritable, hyperactive, and restless. Though her behavior and mood varied "unexplainably from time to time," the underlying organic factor served as an explanatory framework.[140] It also provided a causative link to disparate symptoms. Cynthia's illness, hyperactivity and quarrelsomeness, originated in and progressed out of an old streptococcal infection, according to Bradley Home doctors. Ned's seizure disorder explained why he was aggressive to younger children and performed poorly in school. Accordingly, admission histories often began with childhood illnesses and any history of convulsions, then described the behavior that led to hospitalization.[141] Once children's social deviances were considered diseases, the organic variable linked the symptoms together and ordered clinical phenomena.

The electroencephalogram (EEG) played a pivotal role in turning social aberrations into biological flaws. The local culture of the hospital encouraged the use of the EEG and determined the type of information that was gleaned from it. Joel Howell calls "local culture" the factor which "shapes medical care through personal, informal contacts among caregivers in a specific institution."[142] The technology was used in the Bradley Home to

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[139]Bradley and Bowen, "Amphetamine Therapy," 93; Bradley, "The Behavior of Children Receiving Benzedrine," 577-85.

[140]Charles Bradley, "Problem Children: Electroencephalographic Diagnosis and Pharmacologic Treatment," *Connecticut State Medical Journal* 6 (Oct 1942): 773-777, 774.

[141]Patient Records, The Bradley Hospital, Providence, Rhode Island.

[142]Joel D. Howell, *Technology in the Hospital: Transforming Patient Care in the Early Twentieth Century* (Baltimore: The Johns Hopkins University Press, 1995), 234-236.

add a physiologic patina to these children's diseases. Physicians like Bradley fought to get it used, then embraced it, because it dovetailed precisely with the other goals of the Home, including the medicalization of maladjustment. Physicians in other settings, because they recognized the language and method, absorbed this local technique into the larger medical culture.

Because of his experiments with EEGs and benzedrine, Bradley was later cited as a pioneer discoverer of hyperkinetic impulse disorder, a syndrome which shares some elements with the contemporary diagnosis of attention deficit hyperactivity disorder.[143] Though he never used either appellation, Bradley recognized that hyperactive, aggressive, distractible kids with variable moods, a short attention span, and inconsistent school performance sometimes showed "abnormalities in the electroencephalogram."[144] Nonetheless, returning to the ground floor with Bradley, hyperkinetic impulse disorder evolved from maladjustment when doctors deployed particular medical tools to study the child. EEG readings attached an organic signifier to maladjustment, which was nothing more than a socially-defined set of behaviors, and it allowed physicians invested in medical perspectives to argue that it was primarily a biological condition.[145]

In the same time period that the diagnosis of a primary behavior disorders was becoming more uniform, EEG readings were routinized. Children with maladjustment were not routinely given EEGs in the 1930s. As late as 1938, Norma was admitted with school failure and given psychological tests and a medical exam, but no EEG. By 1942 this had changed, and every child with a behavior disorder received an admission EEG. After a few years of data, Bradley Home doctors claimed they detected universalizable patterns in them. In 1942, Cynthia's EEG showed some normal and some abnormal rhythms, a recording judged "similar to that of other behavior problem children." Schizophrenic patterns of

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[143]Eric Denhoff and Maurice Laufer, "Charles Bradley -- An Appreciation," in *Minimal Brain Dysfunction: A Developmental Approach,* by E. Denhoff and L. Sterm (New York: Masson Patterson Company, 1979), 1-3.

[144]Bradley, "Problem Children: Electroencephalographic diagnosis," 775.

[145]Denhoff and Laufer, "Charles Bradley -- An Appreciation," 1-3.

EEGs were also identifiable at the Bradley Home by mid-1942. Doctors no doubt took clues from Bob's behavior when reading his EEG, for in spite of the uncertainty surrounding the clinical symptoms of schizophrenia at this time, they concluded that his "Record, though not characteristic, has some elements suggestive of the so-called schizophrenic activity." As EEG readings gained this remarkable prophetic power, the medical records reserved less space for psychometric tests and more for EEG results.[146] The EEG patterns, like psychometric tests before them, scribbled concurrence with clinical judgments in the first years of their use.

The EEG did not provide clinicians with information used to manage a child's disease. Wayne's EEG was mostly normal in 1942, but benzedrine was the treatment of choice. Ned's work-up for organic disease, including his EEG, turned out negative, but phenobarbital was tried anyway and discontinued only because of side effects. In spite of Cynthia's characteristic EEG reading, she was not given benzedrine.[147] It is not surprising that EEGs alone determined neither disease nor treatment when first introduced into clinical use. As Jack Pressman argues, technologies like EEG do not engender one fixed utility, but contain a malleable set of clinical meanings that change with the context of use.[148] Bradley claimed EEGs differentiated problems that resulted from a child's environment from those that were a consequence of brain pathology. He also used EEGs to prove that misbehavior was a neurologically-determined condition. In the process, EEG provided him with a framework from which to view the behavior of the children on his ward. The EEG was a medical tool that gave Dr. Bradley special expertise and an apparent clarity of vision within his hospital.

Bradley relied on EEGs to provide him with a specialist's diagnostic acumen in differentiating psychogenic from organic behavior disorders. The EEG recording

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[146]Patient Records, The Bradley Hospital, Providence, Rhode Island.
[147]Patient Records, The Bradley Hospital, Providence, Rhode Island.
[148]Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998), 456.

constituted a legible clinical sign, as opposed to an ambiguous clinical symptom, for abnormal recordings "cannot...be produced by psychological means alone." Why was such a differentiation of "significant and of practical clinical interest"? Regardless of the outcome, the child was managed identically. The positive EEG turned worried parents into Bradley's allies because it reassured them that the child's misbehavior was not "entirely a result of [their] own misdirected parental zeal." Conversely, a negative EEG revealed that "a child's problem is entirely the result of faulty handling on the part of his parents or teachers," and made hospitalization even more important.[149] Further, whether the EEG indicated psychological or organic causation, benzedrine brought about "improvement in both types" of behavior disorder. The "sense of stimulation, well-being, and confidence" glossed difficulties no matter where they came from "to a degree that conflicts, though still present, [were] no longer irritating and distressing."[150] While Bradley used EEGs to prove his diagnostic acumen, their results never called his treatments into question.

On a more fundamental level, Bradley used EEGs because they substantiated that misbehavior was a neuropathological, not just a social, phenomenon. Bradley supported his own categorizations when those children he diagnosed as severely misbehaved by social criteria turned out to have abnormal EEGs.[151] Like the later researchers who valued his work, Bradley recognized that the EEG tightened neurophysiological boundaries around diagnostic categories like behavior disorders. The "important electrical signs of brain function given by the electroencephalogram" could lead to more precision in diagnosing the 'organic reaction type' in the child who consistently behaved irritably, hyperactively, aggressively, distractedly, and with variations in mood.[152] If a group of children could be identified on the basis of similar clinical characteristics, recognition of

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[149]Bradley, "Problem Children: Electroencephalographic diagnosis," 774.

[150] Bradley and Bowen, "Amphetamine Therapy," 101.

[151] Bradley, "Problem Children: Electroencephalographic diagnosis," 774.

[152]Herbert H. Jasper, Philip Solomon, and Charles Bradley, "Electroencephalographic Analyses of Behavior Problem Children," *American Journal of Psychiatry* 95, no. 1 (1938): 641-657, 641; Bradley, "Problem Children: Electroencephalographic Diagnosis," 774.

EEG abnormalities in these children lent their variable symptoms an apparent unity as a biological entity. The abnormal reading turned a hodge-podge of social deviances into neurologic disease; or, as his socially-determined psychopathologic theory described it, "an abnormal electroencephalogram is an indication of a poorly integrated, poorly stabilized, or immature central nervous system which proves a handicap in social adjustment."[153] All of these strains of evidence legitimated Bradley's clinical expertise as a diagnostician because neurologic evidence seemed to support his categorizations of anti-social behavior.

Ultimately, because his mastery of the complex tracings proved the power of his approach, he seemed to believe the EEG was a legible replica of a child's behavior. He indicated that abnormal behavior ought to be reflected in an abnormal EEG, yet he was surprised that exact patterns and localizations in the EEG did not usually correlate with behavior. He was also incorrect to assume that the child's altered behavior on medications would be reflected in "commensurate changes in the electroencephalographic patterns."[154] Ultimately, he indicated that misbehavior or poor school performance were really tiny seizures, sub-clinical but identifiable with EEG. Describing his patient Ted, an eleven-year-old aggressive boy with difficulties in school,

> The electroencephalogram showed that on his good days his brain waves were normal, while on days when he made mistakes and was particularly difficult to handle, his brain waves were erratic. Armed with the newer medicines that control convulsions and nervous disorders, we work with such children -- and often achieve striking results.[155]

Bradley thought benzedrine might treat Ted's EEG abnormalities instead of his behavioral difficulties. Ted's EEG readings were more compelling and significant to a physician

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[153]Bradley, "Problem Children: Electroencephalographic Diagnosis," 774.
[154]Charles Bradley, "Benzedrine and Dexedrine in the Treatment of Children's Behavior Disorders," *Pediatrics* 5 (Jan 1950): 24-37, 25.
[155]Clifford A. Shaw, "Arithmetic Pills" (n.p., n.d.) Levy Library, The Bradley Hospital, Providence, Rhode Island.

whose orientation they justified.

In summary, the EEG legitimated Bradley's clinical vision of behavior disorders as biological entities. Or, as he explained, "The clinical value of the electroencephalogram lies in the fact that it frequently ... reveals central nervous system instability or disease not otherwise demonstrable."[156] Regardless, in retrospect it is clear that Bradley did not "reveal" the true biological nature of behavior disorders with EEGs. He characterized behavior as medical by unleashing medical tools and searching for patterns that matched his social criteria. As he investigated particular paths and not others, his successive analyses found answers that suited his questions. Because they were determined by his clinical orientation, they achieved his clinical purposes. Maladjustment gained a biological basis because it was investigated with biological tools.

While the children's biological profiles were drawn in great detail, other aspects of their situations went unexplored. Sally, for instance, was admitted to the Bradley Home at six years old for bad behavior and nervousness. She had seemed normal until three years earlier when she began to be mischievous and anxious, "and from then on was almost uncontrollable. She seemed unable to remain quiet a moment," and displayed some motor tics. Two months before admission she set two fires in her family's home. Sally ran away from home, used obscene language, and stole money from her mother. She destroyed property and drove other children from her company. Sally's diagnostic work-up attended to the details of her biology, and no more than hints appeared in Sally's chart about her difficult relationships. Sally stayed away from school until a late age in part due to her "mother's fear of having her cross the street alone." Her caregivers at Bradley never explored whether her mother's anxieties drove any of Sally's other behaviors. Her parents may have been more than simply timid, however, and admitted that they tried several types of punishment on Sally, "including severe beatings."[157] Since Sally's relationships, not

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[156]Bradley, "Problem Children: Electroencephalographic Diagnosis," 773.
[157]Patient Records, The Bradley Hospital, Providence, Rhode Island.

just her neurophysiology, could determine her behaviors, these hints could have been complete stories. Bradley's priorities, however, dictated otherwise.

The elision of Sally's story will return as we examine the treatments recommended by Dr. Bradley and his staff. Charles Bradley constructed a therapeutic identity which built upon the advantages he gained by using medical diagnostics. As E.D. Pellegrino argues, physicians are most closely identified with their therapeutics.[158] Bradley, too, found an expertise no other staff member could challenge through medical therapeutics. The story of the use of benzedrine at the Bradley Home reveals how this specialist gained a professional identity through therapeutics.

5

Bradley's Therapeutic Expertise

Carl received a rather atypical treatment regimen at the Bradley Home, but its balance of elements might seem to indicate that therapeutic expertise was dispersed among several staff members at the Home. His treatment from March 1941 to August 1942 was listed on the discharge summary as

> 1) School, with individual instruction from March, 1941 to August, 1942.
> 2) Psychotherapeutic interviews for two months, March to May 1941.
> 3) Benzedrine sulfate 20 mg daily at 7:00 am from March 16, 1941 until discharge.[159]

The following section will reveal, however, that the last of these interventions was formulated to trump the rest.

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[158]E.D. Pellegrino, "The Sociocultural impact of twentieth-century therapeutics," in *The Therapeutic Revolution*, eds. M. J. Vogel and C. E. Rosenberg (Philadelphia: University of Pennsylvania Press, 1979), 245-66.

[159]Patient Records, The Bradley Hospital, Providence, Rhode Island.

As mentioned, school provided a barometer by which to measure a child's clinical progress, and it was a convenient therapeutic realm when others failed. Good school progress indicated a good response to hospital treatment, and frequently indicated when a child could be discharged; it was not a coincidence that "Most make good progress in school during their residence and reach their normal grade level by the time they are discharged."[160] Ned, for instance, admitted for a "specific reading disability," was instructed individually until he could perform at the reading and arithmetic levels appropriate to his age, and he was then sent home. For children who could not come into the hospital, Bradley recommended to parents to encourage the child to excel at school. Follow-up advice for Alice, for instance, told her to improve her work in the fifth grade, and "If schooling is not successful she is to return to the Bradley Home for another period of schooling and treatment."[161]

Psychotherapy was used very rarely in the Home through the mid-1940s. The use of psychotherapy at the Bradley Home was estimated from a careful chart review of all patients admitted in 1938 and 1941, and from a random sample of records from other years. This method allows for only tentative conclusions, but the results are comparable to the practices described in published sources. Physicians, a nurse, and a psychologist carried out occasional psychotherapy, play therapy, or art therapy according to the "needs of each child."[162] In general, therapeutic interviews occurred infrequently and inconsistently, and were not necessarily delivered according to the child's diagnosis or symptoms.[163] A rare patient prior to 1940 did receive therapeutic interviews. Alice, a child from a comfortable social background admitted for tics and maladjustment in 1938, was the only patient among those reviewed who received psychiatric interviews throughout her stay at the hospital, though at what interval interviews took place cannot be determined. The

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[160]Laufer, "Emma Pendleton Bradley Home," 109.
[161]Patient Records, The Bradley Hospital, Providence, Rhode Island.
[162]Bradley, "A Children's Hospital," 652.
[163]Patient Records, The Bradley Hospital, Providence, Rhode Island.

reasons for this anomaly are not stated in Alice's chart. Patients who did receive psychotherapy often received it for only a brief period of time. Frank, a patient admitted with a convulsive disorder and a behavior disorder, was in the hospital for a year and a half but received psychotherapy for only two months. Wayne, admitted in 1942, received psychotherapeutic interviews for his behavior disorder for four months of an eight-month stay. Charts indicate that less than a third of patients had psychotherapy noted as a modality of treatment, and the great majority received it for a brief portion of their stay.[164]

The third of Carl's treatments, benzedrine sulfate, was the most novel of the therapeutic armaments used at the Bradley Home. That it was a pharmaceutical did not make it unique. Asylum psychiatrists in the nineteenth century commonly used drugs to keep their patients sedated. Potassium bromide and chloral hydrate, introduced in 1869, were joined by a number of other drugs after asylums abandoned the use of physical restraint: paraldehyde was introduced in 1884, sulfonal in 1886, and phenobarbital in 1903. These drugs gave sleep or relaxation to the anxious patient, but they did not alter the course of a disease, and did not correct the specific aberrations the disease caused. Not until the early twentieth century were somatic psychiatric interventions understood to be effective against particular conditions the way anti-toxin, for instance, was with diphtheria. Anti-toxin counteracted the biological activity of diphtheria toxin and was of no use in other illnesses; non-specific therapies minimized symptoms of several different disorders. Malaria treatment of general paresis, introduced in 1917, was one of the first specific treatments in psychiatry. Insulin shock, metrazol shock, and electric shock in the 1930s also seemed to provide a measure of specificity to somatic interventions.[165] Psychiatric drug use, however, remained largely non-specific, and not until chlorpromazine was introduced in 1952 did psychiatrists begin to define some drugs as able to counter particular disease manifestations. This study, however, will discuss how amphetamines were used

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[164]*Ibid.*

[165]Erwin H. Ackerknecht, "The History of Drug Treatment of Mental Diseases," *Transactions and Studies of the College of Physicians of Philadelphia*, 5th ser., 1, no. 3 (Sept 1979): 161-170.

by child psychiatrists in the 1930s and 1940s as therapies, not symptom-relievers, able to modulate the aberrations caused by disease.

Amphetamines were introduced as psychostimulants, but a handful of research psychiatrists began to investigate their psychological and disease-specific effects. Amphetamines appeared on the American market in 1932 as an ingredient in a nasal decongestant, and were used as early as 1936 by college students trying to stay awake to study.[166] Prior to 1937, there were almost no published reports of the effects of medications upon emotion, especially in children.[167] Researchers began to try benzedrine, racemic amphetamine sulfate, on psychiatric patients, and debated whether the drug caused non-specific behavioral changes, or actually altered the emotional responses at the root of psychopathologies.[168] Abraham Myerson tried benzedrine on adults in 1936, but was uncertain about its effects in neuroses because he considered remission and exacerbation intrinsic to the conditions.[169] Paul Schilder used benzedrine in conjunction with psychoanalysis, and became convinced that it changed "the deep libidinous attitudes" of his adult patients.[170] The debate continued in children's hospitals. Lauretta Bender and Frances Cottington treated children at Bellevue with benzedrine to facilitate psychotherapeutic insight, while one physician in a reform school for federal delinquents used it primarily to control the most unmanageable of his charges.[171]

Charles Bradley published the first study of benzedrine for children's behavior

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[166]Charles O. Jackson, "Before the Drug Culture: Barbiturate/Amphetamine Abuse in American Society," *Clio Medica* 11:1 (1976): 47-48.

[167]Bradley, "The Behavior of Children Receiving Benzedrine," 577.

[168]*Child and Adolescent Psychiatry: A Comprehensive Textbook* (Baltimore: Williams and Wilkins, 1991), 775.

[169]Abraham Myerson, "Effect of Benzedrine Sulfate on Mood and Fatigue in Normal and In Neurotic Persons," *Archives of Neurology and Psychiatry* 36 (Oct 1936), 816-822, 817.

[170]Paul Schilder, "The Psychological Effect of Benzedrine Sulphate," *Journal of Nervous and Mental Disease* 87 (May 1938): 584-587.

[171]Lauretta Bender and Frances Cottington, "The Use of Amphetamine Sulfate (Benzedrine) in Child Psychiatry," *American Journal of Psychiatry* 99 (July 1942):116-21; Lauretta Bender, *Child Psychiatric Techniques: Diagnostic and Therapeutic Approaches to Normal and Abnormal Development Through Patterned, Expressive and Group Behavior* (Springfield: Charles C. Thomas Publisher, 1952), 293; S. R. Korey, "The Effects of Benzedrine Sulfate on the Behavior of Psychopathic and Neurotic Juvenile Delinquents," *Psychiatric Quarterly* 18 (1944): 127-37.

disorders in *The American Journal of Psychiatry* in 1937, and his study series became the most frequently cited evidence on amphetamine effects in children.[172] Bradley's research argued that benzedrine modulated his patient's emotions and treated the specific symptoms of behavior disorders. The following section will argue that Bradley's delineation of a therapeutic identity for the amphetamines also enumerated his professional identity as a child psychiatrist. Drug use proved Bradley's notion of the psychopathology of behavior disorders as specific biological flaws resulting in symptoms of social maladjustment. Bradley also used his research to show that a psychological response to the drugs could be deduced from the children's behavior. Beyond these results, his studies also argued that a psychologically-minded physician, the child psychiatrist, was better qualified to manage behavior disorders than any other member of the clinical team.

Bradley's *sine qua non* of behavior disorders, poor sociability, was the usual indication for benzedrine treatment. The priorities of the clinic's social world dictated the indications for its use such that all of the study subjects who received benzedrine deviated from group norms.[173] Bradley tried benzedrine on children who violated his preference for sociable and group-oriented children. His first study included thirty children from five to fourteen years old with a range of diagnoses from "specific educational disabilities, with secondarily disturbed school behavior" to "the retiring schizoid child" or "the aggressive, egocentric epileptic child."[174] Symptoms were more consistent indications than diagnoses. If a child's behavior "was of the hyperactive, irritable, aggressive, destructive type," she would receive the drug, as would children with "seclusive tendencies, self-absorption and other so-called 'schizoid' traits." Any child who "uniformly and characteristically showed aggressive, assaultive, hyperkinetic behavior disorders," those who "appeared pathologically shy, withdrawn, and underactive," and those who displayed "isolated

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[172]Charles Bradley, "The Behavior of Children Receiving Benzedrine," *American Journal of Psychiatry* 94:1 (1937): 577-85.
[173]Bradley and Bowen, "Amphetamine Therapy," 93.
[174]Bradley, "The Behavior of Children Receiving Benzedrine," 577-8.

symptoms and problems, such as habit spasm, specific educational disabilities,[and] multiple delinquency" received benzedrine.[175]

Consistent with the social indications for treatment, Bradley interpreted benzedrine as helpful when it improved cooperation and group living. Positive outcomes were measured in increased sociability or "improvement from the social viewpoint."[176] The improved children "were conducting themselves with increased consideration and regard for the feelings and opinions of those about them." If anti-social or egotistical behavior was pathological, a child was "usually considered to be improving when he [began] to engage in activities which [were] useful and helpful to himself and those around him."[177] Also, for the children who isolated themselves, a "widening of interest in things around them" indicated a positive response to the drug. The children were kept on the drug because with it they were "much more acceptable members of the community."[178]

Drug therapy seemed to shift children along the spectrum of sociability back to a norm that served as a sort of physiological homeostatis. The child's position on the sociability spectrum became the biological aberration that the drug could treat. Withdrawn children became "stimulated" to "a more active and successful participation in conventional childhood activities" as frequently as hyperactive children quieted; both returned to "a more 'normal' adjustment."[179] Even children with isolated difficulties in the classroom improved academically. Bradley's concept of the biology of social deviance gained further cache as the benzedrine work was correlated with Jasper's EEG results. Testing disruptive children with abnormal EEGs, Bradley was encouraged that "all but one of these children with 'seizure waves' became distinctly subdued under the influence of benzedrine." Linking all the evidence, the "impaired cortical function" provided a putative biological flaw at the root

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[175]Bradley and Bowen, "Amphetamine Therapy," 93, 102, 93.
[176]Bradley, "The Behavior of Children Receiving Benzedrine," 579; Bradley, "Problem Children: Electroencephalographic Diagnosis," 775.
[177]Bradley and Bowen, "Amphetamine Therapy," 95, 97.
[178]Bradley, "The Behavior of Children Receiving Benzedrine," 579.
[179]Bradley, "Benzedrine and Dexedrine," 25, 35.

of the social maladjustment that benzedrine treated. A stimulating drug, "might tend to arouse this impaired cortical activity and alleviate any behavior disorder resulting therefrom."[180] The drug, because it was used and interpreted in a setting where social variables indicated biological flaws, provided physiological substantiation for concepts of normalcy. Benzedrine appeared capable of altering the specific aberrations, the anti-sociabilities, the diseases of behavior caused.

The classroom constituted the ultimate arena where the well were differentiated from the sick. Bradley admitted that good school performance had "practical importance" for his patients, but the classroom was a highly symbolic arena, as well.[181] Run by adults and engineered for efficiency and cooperation, the classroom was a microcosm of the social system that determined Bradley's clinical priorities. If the poor pupil -- inefficient, disruptive, inattentive -- exemplified Bradley's sick child, success in the classroom equaled wellness. That benzedrine preferentially extirpated school failures provided further proof of the pathology of school difficulties. Further, benzedrine's success in the classroom reinforced that it was a curative locale. For Ned, who had been aggressive with others, "benzedrine sulfate made an obvious improvement in ... general behavior, and especially school progress." Ned's discharge recommendations included placement in a special classroom in a public school; "Benzedrine sulfate medication is to be held in reserve and to be resumed if school progress is not satisfactory." Sally, after her mother complained of her restlessness, was told by the staff to "send her to school, and [to] also make arrangements for the second child to go to nursery school." Later the staff recommended resuming treatment with benzedrine, "suggesting rather strongly that it would tend to quiet her and make her more easily manageable."[182]

As schoolroom criteria became the child psychiatrist's treatment guidelines, the social and emotional factors of the child's experience were discounted. Only after the third

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[180]Bradley, "The Behavior of Children Receiving Benzedrine," 583.
[181]Bradley and Bowen, "School Performance," 787.
[182]Patient Records, The Bradley Hospital, Providence, Rhode Island.

and fourth social work visits to Sally's home was it noted that the home was untidy, the children were dirty, and disciplinary measures were extreme and inconsistent; the social worker concluded that "little real intelligence [was] used in handling the children." It was finally noted that the mother was overburdened, in part, because she was unemployed, and frustrated in her job search. She had kept her children from school, she said, because she had not been able to buy clothes for them. Again, the protocol of the Bradley staff visits did not routinely analyze these aspects of Sally's story, and, in spite of all the interventions that may have been helpful to the family at that time, no new advice was given. Sally's mother was told, once again, to remain compliant with benzedrine treatment and send the children to school: in the Bradley visitor's words, "I told her I thought school was very important and hoped that the child would start in this fall."[183]

Yet, though social adjustment and school performance were these clinicians' primary concerns, benzedrine was ultimately determined to be a psychological drug. Bradley used sedatives for hyperactivity and impulsivity, but steered his benzedrine evaluations away from descriptors that might reveal it to be a psychostimulant, or a simple energizer. Bradley consistently characterized the children's behavioral responses to benzedrine as psychological. Outward behavioral changes were recast to sound like inward emotional changes, as when children "expressed their irritability in group activities by noisy, aggressive, domineering behavior," or cried more easily "as though their emotions were more easily aroused." If benzedrine made children more compliant in the clinic, Bradley assumed a link between social adjustment and psychological improvement. A socially-adjusted child had "superficially the appearance...of a child whose mood swings had become diminished."[184] His conclusions characterized it as a subtle mood-modulator. Children "responded to benzedrine by becoming distinctly subdued in their emotional responses" or by "effectively exerting more conscious control over their activities and

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[183]Patient Records, The Bradley Hospital, Providence, Rhode Island.
[184]Bradley, "The Behavior of Children Receiving Benzedrine," 579-80.

expression of their emotions."[185] He concluded that therapy was frequently "accompanied by a sense of well-being."[186]

Since it was his model for social relations, Bradley investigated emotional responses to benzedrine in the classroom. Here, accelerated intellectual activity was interpreted as an effect of benzedrine's modulation of emotion. His first studies revealed that some children treated with benzedrine were able to learn more quickly, particularly in math class, where their work improved in "speed of comprehension, degree of accuracy and quantity of output."[187] These improvements were thought to be a result of improved motivation and readiness for schoolwork, not benzedrine's stimulant effect. If teachers described a "definite 'drive' to accomplish as much as possible" and a tendency "to spend extra time completing additional work," Bradley concluded benzedrine "improved the inclination rather than the ability" to perform the task at hand.[188] He believed "these drugs influence children's behavior by altering their emotional reactions to distressing situations," like classroom tasks.[189] The second and third studies also looked to the schoolroom to characterize benzedrine's psychological effect, and his conclusion remained that "amphetamine sulfate primarily influences intellectual performance by altering the emotional attitudes of the individual toward his task."[190] The accelerated intellectual engagement was an indirect result of "the effect of the drug on the emotional state of the subject."[191]

Yet, the children's emotional responses to benzedrine were never systematically elicited; all of these psychological assessments of drug effect were speculations. Bradley argued that a child's behavior might be influenced if he knew he was an object of study, so

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[185]Bradley and Bowen, "Amphetamine Therapy," 95.
[186]Bradley, "The Behavior of Children Receiving Benzedrine," 579.
[187]Bradley, "The Behavior of Children Receiving Benzedrine," 582.
[188]*Ibid.*, 578, 582.
[189]Bradley, "Benzedrine and Dexedrine," 36.
[190]Bradley and Bowen, "School Performance," 787; Charles Bradley and Emily Green, "Psychometric Performance of Children Receiving Amphetamine (Benzedrine) Sulfate," *American Journal of Psychiatry* 97, no. 1 (1940) 388-394.
[191]Bradley and Bowen, "School Performance," 782.

children were not asked.[192] Since "questioning the children in regard to their subjective feelings was studiously avoided in all instances," a psychiatric nurse recorded the children's spontaneous remarks. Statements like "I have joy in my stomach," "I feel peppy," and "I feel fine and can't seem to do things fast enough today" were incorporated into the studies as representative emotional responses to the drug.[193] The classroom studies drew their psychological data from a process of elimination: since psychometric test results were largely unchanged on the drug, Bradley concluded that psychological variables must have determined which children improved in school.[194]

The psychological descriptors developed to characterize benzedrine's effect distanced it even further from the tonics and sedatives in the pharmacopoeia. Bradley created a clinical language of behavior disorders that incorporated psychological categories and behavioral phenomena. "Subdued" or "stimulated," for instance, were redefined to imply that psychological well-being accompanied social adjustment. The subdued response could indicate merely that a child became less active, but Bradley stressed that it was a more subtle descriptor:

> The term is employed in a social rather than a physiological sense. Many children began to walk and move quietly in contrast to previous noisy running and rushing about. A number spoke in a normal or lowered voice instead of shouting raucously. Some of these same children, instead of quarreling and arguing boisterously, began to avoid expressing differences of opinion ... children appeared subdued because they began to spend their leisure time playing quietly or reading, whereas formerly they had wandered aimlessly about antagonizing and annoying others.[195]

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[192]Bradley and Bowen, "Amphetamine Therapy," 94.
[193]Bradley, "The Behavior of Children Receiving Benzedrine," 579.
[194]Bradley and Green, "Psychometric Performance," 394.
[195]Bradley and Bowen, "Amphetamine Therapy," 95.

In later studies, subdued reactions indicated emotional improvement as well. Six-year-old Harold became subdued on benzedrine, for he was "much more quiet ... and [was] definitely less irritable." In school he was "far less negativistic," and he was more attentive.[196] The word "subdued" indicated a child's social adjustment to the hospital, and the emotional contentment that was presumed to accompany it.

Similarly, Bradley defined as "stimulated" those who appeared more alert, showed more initiative, and generally "gave the impression of being more self-sufficient and mature. They also appeared happier and more contented."[197] Bill came to the hospital for extreme shyness, for speaking in very low tones, and because he preferred to play alone. Once "stimulated" on benzedrine, he became a "closer member" of the group and showed "general social adjustment." He began to swim voluntarily, and "was more friendly and showed greater interest" in group activities.[198] Benzedrine allowed these social characteristics to acquire psychological significance; Bradley articulated this clinical "wisdom" in a newspaper article: "Most children who are in difficulty are unhappy. One may steal, another may run away, a third may have trouble in school. Give him medication that makes him feel better and he no longer has to raise hell because he is feeling badly."[199]

The psychological effect of benzedrine was a product of the assumptions of investigators in the same way that its disease-specific effect was determined by the social norms they prioritized. The therapeutic identity invented for benzedrine suited the aims of the researchers. One motivation to construct a psychological and disease-specific identity for benzedrine has been noted: psychological effects distanced benzedrine from managerial drugs, and because it seemed to attack the roots of anti-sociability, benzedrine treatment did more than sedative or tonic administration. However, researchers sought to do more than distinguish benzedrine as a new kind of drug. Benzedrine's disease-specific and

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[196]Bradley, "Benzedrine and Dexedrine," 28.
[197]Bradley and Bowen, "Amphetamine Therapy," 96.
[198]Bradley, "Benzedrine and Dexedrine in Behavior Disorders," 28.
[199]Shaw, "Arithmetic Pills."

psychological therapeutic identity provided an ideal vehicle for professional advancement in the interdisciplinary Bradley Home. Benzedrine, prescribed by a physician, was not only a medical treatment but a complex modulator of emotion. Only Charles Bradley could claim the credentials to administer and manage a therapy with these attributes.

Bradley's view of benzedrine reflected his concept of a child psychiatrist, and his research sought to bring out the most important aspects of that professional identity. Though he valued its psychological achievements, Bradley looked forward to a more scientific child psychiatry. Bradley valued the insights of psychology, the most well-established intellectual framework for his profession in these decades, and utilized his profession's psychological precepts. His expertise in psychology qualified him to interpret -- or invent, in the absence of data -- the psychological effects of benzedrine, and encouraged him to place the children's classroom progress in his own psychological terms, rather than the teachers' or the psychologists' intellectual ones. Bradley, though, lamented that the "development of child psychiatry tended to focus attention on emotional conflicts and other strictly psychological mechanisms as being the exclusive causes of all children's personal difficulties," and his research sought to approximate child psychiatry to a more medical model.[200]

Bradley believed that exploring behavior with medical tools would shed new light on misbehavior. Prior to the contributions of child psychiatrists,

> physicians usually attempted to dismiss children's behavior disorders as being the result of immorality in the child or faulty discipline on the part of the parent. Rarely could these problems be understood medically as the sequelae of damage to the central nervous system or the results of physical illness, such as endocrine deficiency.[201]

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[200]Bradley, "Problem Children: Electroencephalographic Diagnosis," 773.
[201]Bradley, "Problem Children: Electroencephalographic Diagnosis," 773.

Biological categories and descriptors were a more helpful way to understand these manifestations than the psychological or intellectual terminologies used by social workers or psychologists. EEGs and drug treatments also gave child psychiatrists lessons to teach to generalists, including pediatricians, since diagnoses and treatments like these were "closely related to methods used in the general practice of medicine." The child psychiatrist's special attributes, like Bradley's air encephalography chair, were described in their journals and textbooks, and allowed the specialist to appear as an expert with tools that were already familiar to referring physicians. If, as Bradley said, "Child psychiatry [was] ... too widely separated from general medicine," drugs and electroencephalograms would bring it epistemologically and therapeutically closer.[202]

These interventions placed him a position to master both the psychological and the biological aspects of behavior disorders more expertly than any other staff member. Bradley appreciated that his children lived in supportive groups, that they received "adequate attention for any personality disorders," and that they learned in the best of all possible classrooms; but Bradley's medical intervention accomplished what the teachers and the psychologists never could. He was aware of this power, as his comments about the classroom effects of benzedrine reveal. He feared that it might demoralize the teachers to witness that "a single daily dose of benzedrine [produced] a greater improvement in school performance than the combined efforts of a capable staff working in a most favorable setting."[203] His work on behavior disorders modeled the eclectic professional identity child psychiatrists wanted to seize for themselves: they were physicians who treated biologically-based pathologies of behavior with medications that caused emotional changes a psychiatrist had to interpret. As his research reveals, Bradley grasped these attributes for himself, and in the process argued that children's behavior disorders "can be competently evaluated only by physicians adequately trained in child psychiatry."[204]

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[202]Bradley, "Problem Children: Electroencephalographic Diagnosis," 773.
[203]Bradley, "The Behavior of Children Receiving Benzedrine," 582.
[204]Bradley, "The Behavior of Children Receiving Benzedrine," 583.

IV

Change and Continuity: Child Psychiatry at Midcentury

In spite of the contemporary reader's familiarity with Bradley's medical approach to behavioral problems, debates about the organic and psychological aspects of misbehavior were far from settled. Another researcher of behavior disorders claimed that the presence of organic factors was "often difficult to prove."[205] EEG results might be helpful, but only in the child with a significant medical history, extreme behavior, or neurologic defects. Organic explanations were often "a most welcome and a too simple explanation" for a child's misbehavior. Regardless of what EEGs or benzedrine offered, this researcher argued from a dynamic perspective that "A fearful child is often a hyperactive child."[206]

Nonetheless, Bradley's contemporaries agreed with him that child psychiatrists were experts in the field of behavior, even if behavior was interpreted from a psychoanalytic perspective. One pediatrician *cum* child psychiatrist stressed for his pediatric colleagues the intricacies of psychotherapy and the complexities of behavior and emotion. While at the beginning of his career "it was his belief that even as severe a nervous symptom as stuttering should remain within the therapeutic domain of the practicing pediatrician," he wanted his colleagues to understand that "full blown" behavior or personality disorders should only be treated by a child psychiatrist.[207]

Psychiatry in the mid-1940s was about to enter a period of unprecedented expansion. The crusade for psychiatric care for children, begun in the interwar years, experienced its largest growth in outpatient and inpatient services after World War Two.[208] As patient services expanded, child psychiatrists acquired professional recognition from

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[205]John A. Russell, "The Hyperactive Child," *American Journal of Diseases of Children* 63 (Jan 1942): 94-101, 95.
[206]*Ibid.*, 96, 97.
[207]Joseph C. Solomon, "Treatment of Behavior and Personality Disorders of Children," *Archives of Pediatrics* 58 (Mar 1941): 176-193, 176.
[208]William Ll. Parry-Jones, "Annotation: The History of Child and Adolescent Psychiatry: Its Present Day Relevance," *Journal of Child Psychology and Psychiatry* 30, no. 1 (1989): 3-11, 8.

colleagues. Child psychiatrists organized a professional organization in 1953, the American Academy of Child Psychiatry, and they gained subspecialty status in 1959 when the American Board of Neurology and Psychiatry created a subcommittee for child psychiatry.[209]

A growing interest in the psychoanalytic study of the child paralleled the professional expansion. Child psychiatrists argued that World War Two lent urgency to the efficient management of children's emotions because family disruptions could heighten stress and precipitate behavioral problems.[210] Most commonly these difficulties were given psychoanalytic interpretations. Even the Bradley Home shifted its therapeutic balance toward the psychological. The "spastic children" began to leave the Home early in 1942, and the facility took in more children with severe mental disorders. By 1956, the hospital limited admission to children with emotional disorders and children with physical disabilities with concurrent emotional or personality problems. In 1946, the year that Stanislaus Szurek came to Langley Porter, Maurice Laufer replaced Charles Bradley as clinical director of the Bradley Home. Laufer, a pediatrician, began to train in psychoanalysis.[211]

Nonetheless, World War Two should not be considered a watershed in the evolution of child psychiatry.[212] Charles Bradley's work on amphetamines and electroencephalograms continued, and garnered more attention from pediatricians, after the War. He accepted a prestigious appointment to begin a department of child psychiatry at the

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[209]Kathleen W. Jones, "The Development of Psychiatric Interest in Children: A Social History of American Child Psychiatry," in *Handbook of the History of Psychiatry,* eds. Edwin Wallace and John Gach (Yale University Press, forthcoming) 1-94, 2.

[210]Ruth J. L. Gilbertson and Helen Sutton, "A Children's Psychiatric Service," *American Journal of Nursing* 43, no. 6 (June 1943): 570-572.

[211]Maurice Laufer, "Emma Pendleton Bradley Home," in *Residential Treatment of Emotionally Disturbed Children: A Descriptive Study* (New York: Child Welfare League of America, 1952), 94-119, 94-99; American Psychiatric Association and the American Academy of Child Psychiatry, *Psychiatric Inpatient Treatment of Children* (Washington D.C.: American Psychiatric Association, 1957), xi-xvii, xv; Michelle Johnston with Christine Lamar and Deborah Shea Porrazzo, *Out of Sorrow and Into Hope: The History of the Emma Pendleton Bradley Home* (Providence: Levy Library of the Emma Pendleton Bradley Home, 1991), 25.

[212]Roger Cooter makes a similar argument in "Medicine and the Goodness of War," *Bulletin of the Canadian Society for the History of Medicine* 7, no. 2 (1990): 147-59.

University of Oregon Medical School. Laufer, despite his psychological bent, specialized in cerebral dysfunctions that impaired learning and behavior. He became the first certified operator of the electroencephalogram in Rhode Island, and a leading expert in Bradley's new disease, childhood hyperkinetic impulse disorder.[213] Research projects at the Bradley Home continued to investigate the biology of behavior, and included studies of diencephalic function in children, anticonvulsant therapy, and ACTH treatment in schizophrenia.[214]

The following section on Stanislaus Szurek's work at the Langley Porter Clinic in San Francisco will outline in more detail the themes noticed at the Bradley Home. While their clinics opened more than a decade apart, the careers of Bradley and Szurek overlapped. They treated similar children in the same time period in residential centers. Szurek's approach to child psychiatry was formulated during Bradley's first years at the Home, and Bradley's work continued throughout Szurek's directorship at the Langley Porter Clinic. The clinics of Bradley and Szurek are simultaneous rather than successive configurations of child psychiatry. While distinctions will be noted between the two locales of residential treatment, the Langley Porter Clinic case study will more emphatically argue that the techniques utilized by child psychiatrists in residential treatment centers consolidated their professional identities. As Bradley and Szurek will reinforce when apposed, child psychiatry professionalized by defining a group of pathologies, a locus of intervention, a technique of diagnostic acumen, and an expertise beyond other workers in the clinic. That Szurek and Bradley were allowed to strategize to demarcate their realms, on opposite coasts, indicates that similar attributes were necessary to consolidate professional power. That the tools used were so distinct, and that the two physicians never engaged one another in a debate about the common issues they managed, also indicates how capable individual physicians were to construct a clinical realm to suit their needs.

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[213]Johnston, *Out of Sorrow and Into Hope*, 27-9.
[214]Laufer, "Emma Pendleton Bradley Home," 115.

Consequently, this portrayal of Szurek's work at the Langley Porter Clinic displays the intellectual divergences within child psychiatry that the cohesive therapeutic web at the Bradley Home concealed. Yet I shall argue that this intraprofessional diversity was no impediment to professional advancement within the clinical sphere. Szurek's relevance to the history of the professionalization of child psychiatry lies not in his espousal of psychoanalytic approaches but in his deployment of similar strategies to win control of his clinic. By again attending to the configuration of authority within the hospital, this parallel case will address more clearly the elements that emerge within the doctor-patient relationship to allow a new type of medical expertise to gain control over the clinical realm.

V

Stanislaus Szurek and the Langley Porter Clinic

1

A Clinic Falls Together

The Langley Porter Clinic, a large inpatient and outpatient clinic within a university medical complex, was destined to stand at the intersection of a multitude of governmental and professional interests. Robert Langley Porter, dean emeritus of the University of California School of Medicine, solicited state officials and the California State Department of Mental Hygiene to build a psychiatric clinic on his campus in the 1930s. His ally in the department was Aaron Rosanoff (1879-1943), a Cornell-trained psychiatrist with an interest in eugenics, who was instrumental in the construction of the San Francisco clinic and a psychiatric institute in Los Angeles.[215] Rosanoff, set to assume the position of director of institutions for California in January 1939, pledged that construction of a clinic would be "one of the first, if not the first, of the enterprises to be undertaken" by his office.[216] When he assumed the directorship, the California State Legislature authorized construction, and provided funds to build the institute in exchange for land from the University.[217] The State Department of Mental Hygiene and the University of California were to jointly administer the institution via a policy-coordinating board of trustees appointed by the governor.[218]

The Langley Porter Clinic emerged from the enthusiasms of 1930s psychiatry,

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[215]California Department of Institutions, *Annual Statistical Report of The Langley Porter Clinic* 1, 1943.
[216]Aaron Rosanoff to Langley Porter, Letter dated 16 December 1938, Box L-h "Langley Porter Institute History," Archives, University of California, San Francisco.
[217]Department of Institutions to Robert Sproul, Memo dated September 1940, Box L-h "Langley Porter Institute History," Archives, University of California, San Francisco.
[218]S. A. Szurek, "Langley Porter Clinic, Children's In-Patient Service," in *Residential Treatment of Emotionally Disturbed Children: A Descriptive Study* (New York: Child Welfare League of America, 1952), 200-221.

whose adherents saw the novelty of somatic treatments and the allure of psychiatric research as paths to a brighter future. Rosanoff, optimistic about the possibility of curing chronic mental illness through treatments like insulin shock, argued that medical hospitals like Langley Porter could administer somatic treatments acutely; he predicted early treatment could save the state at least two million dollars a year.[219] Porter argued that the Clinic would encourage psychiatric research at the medical center. The new institution heightened the presence of psychiatry on the campus, allowing teaching and training programs to expand, but somatic therapy and research remained priorities for the new Department of Psychiatry. One neurologist, watching his department crowded out of the Clinic, felt his profession had been "subverted" by the power-base the psychiatrists had acquired.[220]

However, Porter also included in his justifications for the Clinic the preventive concerns and the environmentalism of the child guidance movement. Trained as a pediatrician, Porter maintained a career-long interest in children's psychiatric disorders, and believed that a link existed between a parent's psychological state and a child's behavior disorder.[221] Since Porter felt it was "known that many times mental disorders are caused by the distorted attitudes and reactions developed during childhood," children's treatment might prevent adult mental ills before they set in.[222]

Most of the parties involved agreed that a modern psychiatric clinic could help the mentally ill regain health and community status. Porter, laying the cornerstone of the Clinic on 5 April 1941 claimed that "No one truly believes that it is right to treat the excited, the confused, or the alienated as criminals."[223] Echoing Bradley's confidence in the power of

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[219]Joel Braslow, *Mental Ills and Bodily Cures* (Berkeley and Los Angeles: University of California Press, 1997), 201 n. 15.; Szurek, "Children's In-Patient Service," 200.

[220]History of Health Sciences Department, *Conversations with Dr. Robert B. Aird: The Origins of Neuroscience at UCSF*, UC San Francisco Oral History Series, no. 2 (San Francisco, The Regents of the University of California: 1995), 39-40.

[221]"Langley Porter Monthly Report," December 1959, Box AR 91-109, Archives, University of California, San Francisco.

[222]*Annual Report* 1, 1943, 92.

[223]Langley Porter, "Address by Langley Porter upon the Laying of the Cornerstone of the Psychiatric Hospital at the University of California at San Francisco," 5 April 1941, Box L-h "Langley Porter Institute History, Archives, University of California, San Francisco.

public education about mental diseases, Porter envisioned the scientific and modern hospital as a powerful force for enlightenment. However, as the following will illustrate, as thoroughly as Bradley's claims warranted examination, the realities of the internal world of the Clinic must question whose concerns, those of the patients or those of the professionals, guided the Clinic.

The Langley Porter Clinic was a 'pioneer,' like the Bradley Home, forging a trail for psychiatry from the countryside back into the city, from huge state institutions into the center of modern medical complexes. A separate hospital, yet equipped with research facilities, neurosurgical wards, and a consulting staff, the resources assembled were available in only a small number of other institutions.[224] In 1949, only a dozen large psychiatric research institutes existed.[225] Yet, the Clinic was the first hospital of its kind on the edge of the geographic frontier, isolated from East Coast psychiatry, literally perched in the Far West.[226] The psychiatry practiced at Langley Porter took its cues from this locale. The staff remained at the center of orthodox psychiatry, practicing the highest-tech of somatic treatments and the most orthodox of analytic therapies; but many of the staff seemed to covet an intellectual independence that allowed medical anthropology and renegade researchers to thrive there. Stanislaus Szurek represented the pioneering psychiatrist as much as the orthodox one. His work was well-respected and frequently quoted, yet was one piece of a psychiatry now considered to have veered too far afield.

Like the state hospitals that came before it, the Clinic must have met a need while creating one, for it filled its wards as soon as they opened. In its first year of operations, with inpatient units half full, Langley Porter handled 403 new inpatients, one-fifth of all admissions to mental hospitals in the state of California.[227] The children's outpatient

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[224]Szurek, "Children's In-Patient Service," 200-21.

[225]Jack D. Pressman, *Last Resort: Psychosurgery and the Limits of Medicine* (Cambridge: Cambridge University Press, 1998), 164-65.

[226]Dora Shaw Heffner, "The Langley Porter Clinic: Dedicatory Ceremony," 13 February 1943, Box L-h "Langley Porter Institute History," Archives, University of California, San Francisco.

[227]Karl Bowman to James S. Dean, Original Budget Request, The Langley Porter Clinic, 25 Sept 1944, Box L-h "Langley Porter Institute History," Archives, University of California, San Francisco.

services, named rather reminiscently the Child Guidance Outpatient Clinic, saw over one hundred patients in its first year. The small children's ward, with a capacity of sixteen beds for children under twelve years old, opened in 1944, and its services were in steady demand within a few years. Eighteen patients were treated in 1947, and twenty-six patients in 1950.[228]

Personnel shortages delayed the opening of several of the wards, including the children's ward, and kept others understaffed.[229] Besides the handful of short-term nursing trainees moving through the wards, nursing and attendant staff turned over frequently. Attendants were particularly difficult to hire: from 1946 to 1947, fifty-one attendants were hired for nineteen positions.[230] The children's ward was also staffed by a shifting crew of physician trainees, residents in pediatrics and psychiatry, who stayed between three and six months. By 1949 a stable core of attending psychiatrists had developed, but most of the staff spent less time on the ward than the children.[231] Stanislaus Szurek came to Langley Porter from the Illinois Neuropsychiatric Institute to direct the children's unit in 1946. He stayed for twenty-eight years.[232]

The children under his care differed in every manner from the adults on the wards downstairs. Eighty percent of the adult patients were admitted with manic depression, schizophrenia, or a psychoneurosis.[233] Children under twelve with those diagnoses were extremely rare. The vast majority of young inpatients were diagnosed with a primary behavior disorder, and were usually given a secondary diagnosis like a neurotic trait, a

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[228]California Department of Institutions, *Annual Statistical Report of The Langley Porter Clinic* 3, 1945; California Department of Institutions, *Annual Statistical Report of The Langley Porter Clinic* 7, 1949; California Department of Institutions, *Annual Statistical Report of The Langley Porter Clinic* 5, 1947; California Department of Institutions, *Annual Statistical Report of The Langley Porter Clinic* 8, 1950.
[229]California Department of Institutions, *Annual Statistical Report of The Langley Porter Clinic* 2, 1944, 5; Original Budget Request, 25 Sept 1944; *Annual Report* 1, 1943, 92.
[230]The Langley Porter Clinic, Annual Nursing Report, 30 June 1947, Box AR 91-109, Archives, University of California, San Francisco.
[231]*Annual Report* 7, 1949, 137.
[232]*Annual Report* 3, 1945.
[233]*Annual Report* 7, 1949.

habit disorder, or a conduct disturbance.[234] Of nineteen patients one year, fourteen had primary behavior disorders.[235] In 1948, all but one of the children carried a diagnosis of a primary behavior disorder. The children were also quite young, and sometimes half were under four years old. The gender ratio of the ward tended to be more evenly divided than at the Bradley Home. Their lengths of stay were as long on average; in a survey in 1951, the average time spent at the Clinic was fifteen months. The children's mean age at admission was 6.6 years old, slightly younger than the mean age of the Bradley Home patients.[236]

The hospital utilized medical treatments for ill adults regularly and aggressively. Wet sheet packs and continuous tubs were common means of patient control and treatment. Adults and adolescents over twelve years old received electric shock, sleep narcosis, insulin shock, and medications (usually sedatives). In 1944, eighty-four patients, most with depression and involutional melancholia, received 833 electric shock treatments (an average of almost ten per patient), and thirty-five patients received 1,740 insulin shock treatments (almost fifty each).[237]

The children's unit, on the fourth floor of the hospital, restricted its interventions to psychological methods.[238] The treatment was interpersonal and psychotherapeutic. The staff believed that even the most severe disorders could be improved with psychotherapy. In addition, each interpersonal contact was thought to have "*potential* therapeutic value."[239] Further, because Szurek hypothesized that a child's pathology originated in psychological conflict with his or her parents, treatment involved concurrent psychotherapy with one or both parents.[240] In fact, analytic psychotherapy with parents was the primary mode of treatment, for children usually saw their therapist less than once a week, and the session

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[234]*Annual Report* 7, 1949; *Annual Report* 2, 1944.
[235]*Annual Report* 5, 1947.
[236]California Department of Institutions, *Annual Statistical Report of The Langley Porter Clinic* 6, 1948; Joseph R. Reid and Helen R. Hagan, eds., *Residential Treatment of Emotionally Disturbed Children: A Descriptive Study* (New York: Child Welfare League of America, 1952), 313.
[237]Original Budget Request, 25 Sept 1944; *Annual Report* 2, 1944.
[238]Szurek, "Children's In-Patient Service," 208.
[239]*Ibid.*, 217.
[240]*Ibid.*, 217.

often consisted of play therapy only.[241] Though the children themselves had to stay in the hospital, the treatment orientation emphasized the "intrafamilial character of children's psychiatric problems" to be relieved by adequate interpersonal contacts and psychotherapy.[242]

As at the Bradley Home, staff at Langley Porter hoped to disguise that the ward was a hospital. Its detention windows and tile flooring, identical to the wards below, were masked with painted murals. The central rooms were filled with toys and an indoor slide. The nurses did not wear uniforms. Szurek extended his dislike of all things medical to the hospital tools Bradley embraced. While each child received a routine battery of physical exams and lab tests, and psychiatrists examined their medical histories for signs suspicious of organic disease, Szurek considered extensive medical tests detrimental to a child's mental health.[243] In one instance, he argued that an electroencephalogram could encourage misbehavior. If an aggressive child's outbursts of impulsiveness engendered impatience in the adults around him, such reactions served "to deepen his own discouragement with himself."[244] This only encouraged more vengeful acts. The frustrated doctor may then question whether the child acted out of a seizure disorder, and may perform an EEG:

> The electroencephalogram is then sometimes read as showing a generalized cerebral dysrhythmia that offers some room for clinical interpretation of possible epileptic equivalent. If the child learns something of this, either directly or from the hesitant attitude of the doctor or from other adults thereafter, his impulsiveness is apt to be increased, because there seems to be an additional reason why he cannot help what he does. He now feels he almost has a medical sanction for his actions.[245]

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[241] *Annual Report* 7, 1949.
[242] *Annual Report* 8, 1950, 10.
[243] Szurek, "Children's In-Patient Service," 201, 208.
[244] S.A. Szurek, "Psychiatric Problems in Children," in *Psychosomatic Disorders and Mental Retardation in Children*, eds. S.A. Szurek and I.N. Berlin, The Langley Porter Child Psychiatry Series: Clinical Approaches to Problems of Childhood (Palo Alto: Science and Behavior Books, Inc., 1968), 6-26, 14.
[245] Szurek, "Psychiatric Problems in Children," 14.

Medical tests gave ambiguous results, and they could impede a child's progress. Szurek's schema turned Bradley's trust in EEGs into an act of unconscious iatrogenic injury.

The distance between the approaches of Bradley and Szurek paralleled the contrast between upstairs and downstairs in the Langley Porter Clinic. A fifteen-year-old girl was referred to Langley Porter by her hometown doctor. Diagnosed with schizophrenia of "malignant type," she was given forty-two insulin shock treatments in her four-month hospital stay and discharged "recovered."[246] Had she been three years younger, her treatment would have drawn her mother into analytic psychotherapy, and may have kept her at Langley Porter for a year or more. The contrasts are illustrative of the bold lines drawn around psychiatric wards based on therapeutic orientation. Each psychiatrist could fit the patient to her outlook, and determine disease and treatment with remarkable independence. The next section will describe how practice failed to inform theory, while theory dictated every detail of practice.

The contradictions between practices, adult and child psychiatry or Bradley and Szurek, indicate that the means and ends that defined child psychiatry remained fluid. Bradley and Szurek's patients were still new subjects of psychiatric inquiry; their techniques were distinct from adult treatments, but were not uniform throughout the profession; and their diagnostics were in flux, differing according to practitioner in symptomatology and etiology. The field was so unsettled that practitioners rarely debated these issues openly -- Bradley and Szurek never did. In part, this was because the questions were incompletely formulated, and collegial networks formed within therapeutic orientations, not the larger profession. The child psychiatrist's clinic became her first and most relevant proving ground. Szurek's power over his ward was exercised to prove the legitimacy of his own expertise. Within his tightly-controlled clinic and within his relationships with his malleable patients, he sculpted the attributes of a medical specialist by

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246*Annual Report* 2, 1944.

finding special diseases to treat, a targeted treatment, and the expertise to apply it.

2

Evidence of Disease

Szurek's patients were similar to Bradley's, a motley group of children who had dumbfounded their parents and confused other doctors. Langley Porter's panoply of eccentric children were also too rowdy or too reclusive to fit in at home or school. One six-year-old boy was brought into the clinic because his parents "were baffled by his extremely distractible hyperactivity, his inability to learn at school, destructiveness, pugnacity and defiance of authority."[247] Frederick was admitted because he was withdrawn and "occasionally [stared] absently into space." Kathy, a girl who had experienced a violent childhood and abandonment by both parents, was brought in by her grandmother because she had had "No spontaneous bowel movement for two years"; she was found to be malingering. A few patients, like Charles, seemed to have a behavior disorder until testing revealed a mentally deficiency.[248] Occasionally a child with epilepsy was brought to the ward.[249]

Some children were admitted with intense fears and hysterical attacks that frightened their parents. May was admitted for her "unappropriate [sic] emotion; withdrawal from contact with other children," and experiences which were thought to be hallucinatory. She had developed a fear of mice, and fell into a terror after seeing one at home. After observation, the ward staff found no evidence for schizophrenic hallucinations, and diagnosed her with a behavior disorder. William, admitted in 1947, became frightened on a train trip, and since then "would cry and shake without reason; out

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[247]Stanislaus Szurek, "Notes on the Genesis of Psychopathic Personality Trends," *Psychiatry* 5 (1942): 1-6, 3.
[248]Patient Records, Langley Porter Psychiatric Institute, San Francisco, California.
[249]California Department of Institutions, *Annual Statistical Report of The Langley Porter Clinic* 4, 1946.

of contact a good deal; fear of lights and noises." June was admitted after two weeks of "attacks of screaming and fears." Since coming home from school frightened one day, "She [had] been grabbing at her mother, biting her mother in a terrified fashion and asking her mother to help her." June refused to eat and vomited any liquid she swallowed.[250]

Ostensibly these children had little in common, and the heterogeneous symptoms defy easy categorization. Bradley unified them according to their degree of sociability. Szurek found their unity in an etiologic model. In spite of the complexity of their clinical presentations, he saw coherence and order:

> The idea was that perhaps all degrees and 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 conflictual attitudes of the most important people in its life -- generally the parents.[251]

Szurek constructed a spectrum of psychopathology ranging from disorders caused by mild parental conflicts to those caused by very intense parental conflicts. He had reduced clinical symptoms to a quantity, the amount of conflict, and arranged a nosology of psychopathology from zero to infinite. Psychotic disorders different from behavior disorders only by degree; "similar, but much more intense, factors were possibly at the root" of schizophrenia.[252] While Bradley insisted that socially-determined behavioral standards divided the sick from the well, Szurek defined psychiatric problems through an analysis of the parent-child relationship.

According to Szurek, all psychopathology was postnatal and psychogenic, and originated in a child's earliest relationships. While a child had specific "genetically-acquired

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[250]Patient Records, Langley Porter Psychiatric Institute, San Francisco, California.

[251]Szurek, "Children's In-Patient Service," 217.

[252]S. A. Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," *American Journal of Orthopsychiatry* 26 (1956): 519-543, 519; Maleta J. Boatman and S. A. Szurek, "A Clinical Study of Childhood Schizophrenia," in *The Etiology of Schizophrenia* ed. Don D. Jackson (New York: Basic Books, 1960), 390-440, 390.

potentialities," her degree of mental health was determined by her early environment and her relationships with her parents: "The human animal becomes the kind of human being that his immediate personal, familial environment and later social situation permit him to develop into."[253] A child remained healthy if his parents were well-adapted, because he formed a secure identification with those adults. When he was surrounded by "conflict-engendering attitudes of other persons" he internalized severe and long-lasting "maladaptive integrations."[254] These would express themselves in deficiencies in behavior and in psychopathology.

For their parts, the parents had to maintain conflict-free unconsciouses. The healthy parent held an unconscious image of the child that was insulated from that parent's own anxieties. In a conflicted or ambivalent parent, the unconscious child-image contained conflicting desires. Since the image was unresolved, the child only fleetingly met the parent's desires. This struggle also took place in the actual parent-child relationship, as the child alternatively acquiesced and defied the parent's wishes. Neediness and anxiety in a parent enmeshed the child in a struggle to satisfy the parent's unconscious, a fight the child could not win for the parent. The conflict could lead to schizophrenia, school phobia, or delinquency, according to other factors, but the fundamental dynamic, from conflicted parent to child-in-conflict, remained the same.[255]

In behavior disorders, according to Szurek, "Parental fantasy guides the child's course of action."[256] Parents provided "unwitting sanction or indirect encouragement" for delinquency.[257] The "more important parent," the one on whom the child was most

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[253]Szurek, "Psychiatric Problems in Children," 16-17.

[254]S. A. Szurek, "A Note on the Rationale of Treatment in Child Psychiatry," in *Psychosomatic Disorders and Mental Retardation in Children*, eds. S. A. Szurek and I. N. Berlin, The Langley Porter Child Psychiatry Series: Clinical Approaches to Problems of Childhood (Palo Alto: Science and Behavior Books, Inc., 1968), 2-5, 3-4.

[255]Adelaide M. Johnson, Eugene I. Falstein, S. A. Szurek, and Margaret Svendsen, "School Phobia," *American Journal of Orthopsychiatry* 11 (1941): 702-711, 703.

[256]Adelaide M. Johnson and S. A. Szurek, "The Genesis of Antisocial Acting Out in Children and Adults," *Psychoanalytic Quarterly* 21 (1952): 323-343, 337.

[257]Adelaide M. Johnson and S. A. Szurek, "Etiology of Antisocial Behavior in Delinquents and Psychopaths," *Journal of the American Medical Association* 154, no. 10 (6 Mar 1954): 814-817, 814.

dependent, was "seen unconsciously to encourage the amoral or antisocial behavior of the child." Through "unconscious permissiveness or inconsistency toward the child," the child learned to act out the parents' forbidden impulses.[258] At least one, and sometimes both parents at once, according to Szurek, "derive unconscious, and less frequently conscious, vicarious gratification of their own poorly integrated forbidden impulses in unwittingly sanctioning and fostering such behavior in the child."[259] The neurotic needs of the parent were gratified when he or she can unconsciously convince the child to act out.

The evidence for this formulation was gathered through interpretations of a parent's attitude during an interview. When the child was brought for treatment, "A smile of tacit but unwitting approval often belies a parent's complaints of impulsive and daring behavior."[260] Interpretations of the parent-child dynamic led Szurek to suspect Stevie's father was the origin of his son's misbehavior. Through observation and intuition, Szurek gathered proof that Stevie's "disorder", his habit of running away from home, provided his father with unconscious pleasure. The suspicion arose because Stevie's father could relate in great detail his son's various explorations. During the interview the father prompted Stevie to tell the story of his most recent sojourn from home, "and, when the child guiltily hesitated, [he supplied] an intriguing reminder." The father, who appeared fascinated to Szurek, prompted Stevie occasionally, then angrily cut him off and said, "now do you see what I mean, Doctor?" Stevie, like the doctor, "could not fail to sense his father's keen interest and pleasure in his tale upon each return home, despite the inevitable whipping."[261] A more careful interview with the father revealed that he had been forced to quit his job as a transcontinental truck driver. Once the impression was gained in the interview, and since subsequent information could not contradict it, his son's disorder was understood as a source of compensation elicited by the father.

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[258]Johnson and Szurek, "The Genesis of Antisocial Acting Out," 324.
[259]Johnson and Szurek, "Etiology of Antisocial Behavior," 814.
[260]Johnson and Szurek, "The Genesis of Antisocial Acting Out," 332.
[261]*Ibid.*, 331, 332.

Szurek, as commonly as did Bradley concerning his own investigations, insisted that this type of clinical research uncovered scientific facts. Parental conflict imparted to the child was the "major etiological determinant" of antisocial behavior.[262] The reactions of a child to her caregiver's internal vacillation were "as predictable as those from the administration of thyroid hormone to a normal person."[263] These mechanisms occurred "with the frequency, regularity and predictability of a well-defined psychological mechanism determining human behavior."[264] Even regarding the debated syndrome of schizophrenia, Szurek considered the evidence definitive and consistent.[265] Szurek not only utilized the rhetoric of science, he felt his practice differed only in its objects of investigation.

In actuality, the etiologic model developed through an empirical practice, or a habit of clinical observation. As Bradley made a habit of reading EEGs until patterns began to emerge, Szurek routinely investigated behavioral problems by noting a parent's reaction. Szurek did not try to conceal that he developed his etiologic model in this manner. His work with children and parents at the Institute for Juvenile Research in Chicago was structured to gather evidence for this hypothesis and no other. His clinical team gained practice at looking for parental neurosis through concurrent therapy with parent and child, and not surprisingly "encountered then no child in such outpatient work whose parents were not also in severe conflict."[266] As most scientists would, he insisted that the evidence imposed itself upon him, stating that "Almost literally, in no instance in which adequate psychiatric therapeutic study of *both* parent and child has been possible has it been difficult to obtain sufficient evidence" for this theory of causation.[267] It became a guide for his subsequent work, in which he expected to find "no child with mental disorder without a

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[262] *Ibid.*, 339.
[263] Johnson and Szurek, "Etiology of Antisocial Behavior," 816.
[264] Johnson and Szurek, "The Genesis of Antisocial Acting Out," 327.
[265] Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 529.
[266] *Ibid.*, 519.
[267] Szurek, "Notes on the Genesis," 5.

transiently severe, or more chronic but intensifying, disorder of both parents."[268] If Bradley happened upon the EEG, embraced it in diagnostic practice, then enlisted colleagues to help him elaborate patterns; Szurek constructed his own theories according to his preferred course of investigation.

Both employed reductionism in the collection and analysis of this data. Reductionism has been described as an attitude to investigation in which one part of a system is taken as the determinant of that system's state. In John Burnham's words, reduction was "a relentless pursuit of the idea that knowledge of components led to knowledge of causes."[269] To Bradley and Szurek, one characteristic about the child could identify the cause of the child's difficulties. Both reduced the child-as-system, an interaction of countless psychological and physiological variables, to a single signifier. As discussed below, the child's fundamental unit, defined by each physician distinctly, became the point of intervention when trying to control the phenomena, or, as Szurek and Bradley might say instead, treat the child.

Nowhere was his reductionism more evident than in Szurek's comments about mothers. Szurek often claimed that all psychopathology came from the mother, the child's behavior comprising only "a tremendously magnified mirror opposite of the mother's attitudes."[270] He described even the normal woman as quixotic, anxious, and dishonest. The most neurotic was constantly subject to irrational regressions and enmeshing identifications with her child. A mother was frequently "struggling against her own more or less unknown but disagreeable impulses towards her child." She reacted "with vacillation to his every whimper," and when asked about her ambivalence she was sure to react with "defensive resentment."[271] For Szurek, if a child learned dishonesty, it was undoubtedly from his or her mother. If she was pleased to receive too much change from the grocer, she

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[268]Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 528.
[269]John C. Burnham, *Paths into American Culture: Psychology, Medicine, and Morals* (Philadelphia: Temple University Press, 1988), 12.
[270]Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 533.
[271]Szurek, "Psychiatric Problems in Children," 21, 22.

could expect that her child would learn to cheat. If she asked her children to understate their ages to purchase cheaper movie tickets, she could no longer "expect them to be honest."[272] The most neurotic women encouraged their children to act out, skip school, and steal.

To Szurek, a father could also become neurotic, but usually in response to legitimate pressures or his anxious wife. A normal father experienced external stressors, not internal anxieties, like absence from home due to military service, long hours at work or study, or financial burdens. His anxieties alone were rarely a problem for his children, but his wife reacted to his stress in a manner which exemplified "the internal neurotic component in her personality," demanding "omnipotent, all-loving care and tenderness from her husband" in his time of stress, or retaliating by becoming sexually unresponsive.[273] He alone was not "pathogenic," and only his wife sickened their children; his neurosis merely "played into the mother's difficulties and led to greater disturbance and frustration in her, and thus indirectly to greater conflict in the child."[274]

Szurek's advocacy of maternal pathogenesis reveals that his practice, like Bradley's, borrowed status from influential socio-cultural values. Bradley's diagnostic equipment and biological theories instantiated an image and a technique that capitalized on the prestige of science and technology. Szurek's theories found their legitimation in a culture which prioritized and upheld patriarchal values. Szurek's attitudes were reinforced by influential forces inside psychiatry as well. Szurek cited scores of other researchers who presented opinion and evidence that concurred with his own.[275] Psychoanalytic theories that traced the origin of schizophrenia to shortcomings in the mother also proliferated in this same period.[276] To today's reviewers, Szurek clearly scapegoated the mother and ignored not only his own responsibility for her marginalization, but also the particular burdens that

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[272]Johnson and Szurek, "Etiology of Antisocial Behavior," 815.
[273]Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 531, 532.
[274]Johnson et al., "School Phobia," 708; Szurek, "Psychiatric Problems in Children," 6-26.
[275]Szurek, "Psychiatric Problems in Children," 20; Jones, "The Development of Psychiatric Interest in Children," 35.
[276]Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 534.

it placed on her. Yet, if anatomical and biological methods of inquiry into psychopathology were to be as thoroughly critiqued as patriarchal values have been, Bradley's theories might appear as dependent upon social and cultural values.

Nonetheless, historians of psychiatry should more closely examine theories of maternal pathogenesis in psychiatry. Two interpretations of these theories have been forwarded: first, that shifting gender roles in the fifties, including women's entrance into the workplace, allowed psychiatry to take refuge from change in regressive and sexist theories; second, that the aim of establishing psychoanalytic therapy as a mode of treatment necessitated scapegoating the mother.[277] Evidence can be found in Szurek's work for either explanation. He argued that women's liberation caused strife in their marriages. He was also interested in using psychotherapy for psychiatric treatment.[278] Yet these explanations are not adequate. Which changes in gender roles allowed psychiatrists to call mothers pathogenic? Why did psychiatric theory exchange ambiguity for clarity just as gender relations were being renegotiated? Why, as well, did psychotherapeutic interventions frequently involve gender-bias? Did this have to do with their practitioners or their practice? The intraprofessional and socio-cultural forces which converged in these blame-the-mother treatises need to be separated and elucidated in depth, for without an understanding of how psychiatric theory interfaces with cultural values, it cannot be defended when those values are questioned. To today's reader, Szurek's attitudes are quaint at best and malignant at worst, but for him they were well-evidenced and prudent. Only a few clues are left to explain that disparity.

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A Treatment Aimed at the Cause

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[277]Carol Eadie Hartwell, "The Schizophrenogenic Mother Concept in American Psychiatry," *Psychiatry* 59 (Fall 1996): 274-297.

[278]Szurek, "Notes on the Genesis," 1-6; Szurek, "Psychiatric Problems in Children," 18.

Since he located pathology differently, Szurek's treatment would intervene in an entirely different system than Charles Bradley's. Bradley stepped into the social world of the child when her healthy socialization was threatened. He introduced a physical barrier, the walls of the hospital, between the child and the social world, separating her from the forces that had determined her inadequacies and frustrations. By isolating a child from the site of tension, residential treatment "can assure a child of prompt acceptance and early opportunities for social participation and self-expression." The familial relationships, since they were not the determining etiologic factor, did not require manipulation: "Many problems that involve tense parent-child relationships are undoubtedly best worked through on an outpatient basis, with children and parents living together and learning to accommodate to one another through continued intimate contacts."[279] The pathological social life of the child, however, should and would become the site at which his intervention was considered therapeutic.

Szurek inserted his doctoring into a differently-located pathological lesion. He intervened between the pathological parent and the manipulated child. Admission to the hospital was "sought, suggested, and advisable" when this most crucial system was in danger of dissolving.[280] The "vicious circle of guilt already indicated to be operating" between parent and child insisted a doctor place a therapeutic wedge between them.[281] If Bradley's children had to come into the hospital when relations with school teachers were so tense that expulsion was eminent, in the system of the family, Szurek stepped in "where the parents' and child's tolerance for each other may be strained to the breaking point by the conflict."[282]

Admission to the ward was considered a simple realignment of family priorities, or

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[279] Charles Bradley, "Indications for Residential Treatment of Children with Severe Neuropsychiatric Problems," *American Journal of Orthopsychiatry* 19 (1948): 427-431, 431.
[280] S. A. Szurek, "The Family and the Staff in Hospital Psychiatric Therapy of Children," *American Journal of Orthopsychiatry* 21 (July 1951): 597-611, 603.
[281] Johnson et al., "School Phobia," 707.
[282] Szurek, "The Family and the Staff," 603.

"an incident in the total psychotherapeutic work with the family," rather than an actual extraction of the child from the home.[283] The result was the establishment of a fixed but invisible power over the family system. Szurek's hand disappeared as his intervention filtered silently into the subjectivities of the family members and the patient. Intervening into the family's psychology made Szurek's authority stable even in his physical absence or in the child's absence from the hospital. Because the physician's grip rested on his psyche rather than his body, control of the child's disorder was no longer predicated on his physical enclosure.

Bradley's rural and rarefied retreat became Szurek's open ward. The walls at Langley Porter were permeable to its patients. Initially, staff kept the ward unlocked, though this policy had to change when the children wandered downstairs and disrupted the adult patients.[284] Since the urban hospital complex provided little room for play -- other than a small playground, an indoor slide, and a sandbox on a screened porch -- the clinic arranged community outings.[285] Weekends and summer days usually included a field trip to nearby parks, the zoo, public swimming pools, factories or museums. Picnics and hikes became more frequent as the nursing staff grew. The children eventually traveled to a movie theater in the neighborhood every Wednesday afternoon.[286]

Since Szurek's therapeutics functioned inside the family, not beyond it, the work of parenting was to continue while the child was in the hospital.[287] Staff considered it important that "the parent assume as much responsibility as possible" while their child was hospitalized. Parents initiated their children to the hospital ward when they first arrived, and no limitations were placed on their subsequent visits; most would come and go unannounced. In fact, they were encouraged to take their children out of the hospital

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[283]Szurek, "Children's In-Patient Service," 206.
[284]Szurek, "Children's In-Patient Service," 201.
[285]*Annual Report* 5, 1947.
[286]*Annual Report* 7, 1949; Szurek, "Children's In-Patient Service," 209; The Langley Porter Clinic, Biennial Report of the Nursing Services, 30 June 1954, Box AR 91-109, Archives, University of California, San Francisco.
[287]*Annual Report* 2, 1944.

periodically for shopping trips and visits home. Most children did take "paroles" from the hospital each weekend and holiday for a day or two. Parents also provided clothes and did laundry for their child during the stay on the ward.[288]

Additionally, Langley Porter relied on psychological care from the family during a child's stay. The hospital did not provide a cohesive social world like the Bradley Home. Children like Alvin failed to improve on the ward because their parents relinquished all responsibility for their children's emotional care to the staff. Alvin's parents, whom he called "Gale and Wally," visited briefly one at a time every two weeks of his long stay. Unlike most of the other children, they did not bring him home over the holidays or on weekends. "Thursday afternoon when the day crew left he became panicky, ran to all the doors, tried the knobs and when he couldn't open them he started kicking at them and crying." When the other children left he would wander the halls asking for each and every absent child by name. Alvin spent the week of Christmas on the ward "very unhappy and most tearful, wandering aimlessly about the ward asking for nurses and children who were away." Alvin might have flourished at the Bradley Home with a full schedule of social activities. At Langley Porter he was incredibly lonely, saddened by his exile from family life, and dissatisfied with the transient relationships in the hospital.[289]

Alvin's experience shows how Szurek's psychoanalytic treatment discounted the child's needs. His strategy placed the child in a ward where female caregivers coddled him while his mother was coaxed into therapy. The locus of pathology was the mother, not the young ward patient, and Szurek studied her more completely than the child. For instance, a mother demanded admission for her eight-year-old boy "of exceptionally high intelligence" after he was expelled from school. He was on the ward only a few weeks before the mother herself decided she needed psychiatric care.[290] Helen, a nine-year-old patient, was admitted in 1946 but discharged unimproved after two weeks, because the mother agreed to

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[288]Szurek, "Children's In-Patient Service," 209-211.
[289]Patient Records, Langley Porter Psychiatric Institute, San Francisco, California.
[290]*Annual Report* 2, 1944, 8.

stay in psychotherapy after she left the hospital. Lewis, admitted for school phobia, was ready to go home in three months, but when discharged, his mother "requested that she continue coming to see her therapist, even though she would not bring the child."[291]

Albert's experience provides a particularly dramatic example in which a mother was blamed for the pathology in her child, and several significant events in the child's life were disregarded.[292] Albert was an older child asked to leave school because of persistent restlessness, defiance, and emotionality. At home he was contentious with his siblings, threw tantrums, destroyed belongings, and ran away. He had suffered from a speech impediment as a young boy, and was teased incessantly at school. He had recently broken two bones, and spent weeks in the hospital. His parents separated months before his admission because Albert's father started living with the woman next door. Albert and his mother watched him go into the neighbor's house instead of their own. In short, a number of factors in Albert's recent past gave him reason to communicate anger and destructiveness.

Albert's treatment went poorly. He spent fourteen months in the hospital because his mother "never fully accepted [her] therapist's impression that her troubles could be a determining factor in the patient's behavior problems." Her character flaws, like "her inclination toward a passive role," and her unresolved anger, like "her suppression of resentment in...her relationship to a domineering older sister" were the primary factors uncovered to explain Albert's difficulties. Szurek concluded that her son's impulsive behavior was the result of an "indecisive, sometimes, too indulgent mother, whose suppressed resentments the patient may be acting out." In spite of the fact that the father's behavior had been so significant in Albert's life, there is no evidence that he was ever engaged in therapy, or even interviewed, when Albert was admitted.[293]

This case history begs the question: why did Albert need to come into a residential

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[291]Patient Records, Langley Porter Psychiatric Institute, San Francisco, California.
[292]*Annual Report* 8, 1950.
[293]Patient Records, Langley Porter Psychiatric Institute, San Francisco, California.

treatment center? Essentially, adult women on the residential treatment staff tried to provide Albert with better mothering. If the children at the Bradley Home urged one another on with group competition and rewards for sociability, kids at Langley Porter could count on "close physical contact with an adult." Nurses thought that most of the children had "a very limited ability to play with others," and that "staff must give these children considerable personal attention." They helped them wake in the morning, helped them bathe and groom themselves, and held their hands through school and meals. Nurses held the children in their laps for long periods of time. The majority of time during the day was devoted to unstructured play assisted by nurses. If a child was too anxious, he was accompanied by an adult off the ward.[294] The ever-present adults, not the social group, cushioned the child from the outside world.

Nurses assumed the role of surrogate mother and won the competition for the child's affection. She was a better "parent-substitute" for the inadequate mother. Nurses gave the impulsive child "the experience of love previously denied him" in a manner that was "spontaneous, ungrudging" and unconditional.[295] Unlike the mother, the children's behaviors tended "to be accepted with less defensive anxiety and resentful efforts at suppression."[296] She was better because she had been educated in "the factors in his past that have caused his maladjustment," or poor mothering. Some of the children came to recognize her superiority, and picked a nurse to call "Mother." The nurses were not shy to admit their victories, admitting that "A mother who already feels frustrated because of her inability to manage her child is likely to feel more inadequate than ever when she learns that her child is being successfully managed by a nurse whom the child calls 'Mother.'"[297]

The classroom, too, became a microcosm of the child's most important sphere, her

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[294]Szurek, "Children's In-Patient Service," 209

[295]Szurek, "The Family and the Staff," 80.

[296]S. A. Szurek, "Dynamics of Staff Interaction in Hospital Psychiatric Treatment of Children," *American Journal of Orthopsychiatry* 17 (1947): 652-664, 663.

[297]Ruth J. L. Gilbertson and Helen Sutton, "A Children's Psychiatric Service," *American Journal of Nursing* 43, no. 6 (June 1943): 570-572, 571.

relationship with her mother. Several of the children were admitted for school phobias, which in Szurek's formulation meant that the teacher had become "a diluted form of the mother." Szurek explained the syndrome as a transference of rage from the mother to the teacher. If a child grew frustrated with his mother's disciplining, but had to check his expressions of anger because of his dependence on her, the "child's rage inhibited toward the mother can now find expression through displacement" onto the teacher.[298] The hospital classroom, in contrast to his mother's disciplining, remained unstructured and individualized. Langley Porter teachers worked patiently and supportively with each child.[299] For Bradley the school room symbolized the social world where children learned to comply with the priorities of adults; at Langley Porter, the site was another locale where the faulty mother-child relationship could be outdone. Either way, the children responded equally well: "their behavior is often far more acceptable in the schoolroom than on the ward."[300]

Shaped by their own insistent clinical orientations, each child psychiatrist constructed a therapeutic world which honed in to some pathogenic site; everything else was left alone. The child became locked to the doctors' visions, dealt structure if he advocated it, or handed a mother if he felt that mattered. The children were hollow receptacles for the his preferences. Consequently, the clinical world was bound to mirror theory. These clinics were inhabited by live patients, but because they were heard only through a filter of expectations, what their doctors heard confirmed rather than challenged theory. Further, the patients' own stories could not recognized through the obfuscating presuppositions. Szurek and Bradley's air-tight therapeutic orientations allowed them to see the patient, like Szurek's neurotic mother did, as the image of their fantasies.

Their orientations were informed by professional ambitions. Each child

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[298]Johnson et al., "School Phobia," 706.
[299]Szurek, "Children's In-Patient Service," 210; Grace Ahlers, Report of Children's Ward School, 1952, Box AR 91-109, Archives, University of California, San Francisco.
[300]Szurek, "Children's In-Patient Service," 210.

psychiatrist's assumptions ordered their clinical observations, and gave them an apparent diagnostic perspicacity, or the skill of a specialist. Through theory, each gained interpretive acumen over clinical data other physicians found perplexing. In this sense, both found a way to explain a child's confusing behavior with only indirect information about him or her. Both learned about the child without directly engaging him or her. Replacing a child with an EEG or the mother's psychology, gave them diagnostic skills their colleagues lacked. In essence, Bradley and Szurek became specialists not by knowing their patients, but by deciding where else they could gather information about them. These schemes gave them apparent insight into clinical phenomena sufficient to cloak them in a specialist's aura.

4

The Status of a Specialist

Szurek did not talk with a child in an effort to comprehend his or her difficulties. His interpretation of the mother determined his assessments. If Bradley read a child's psychological state through his motor activities, Szurek discovered the feelings of the child in the psyche of the parent. Ten-year-old Lewis was admitted for refusing to go to school. Once the mother was investigated,

> It was felt that the fear and panic in the child in regard to both being unable to go to school and leaving the house correspond very closely to the disorganization in the personality of the mother. The...mother's own anxieties and conflicts in regard to [Lewis's] leaving home were consequently perpetuated in the child.[301]

Lewis's fear and panic were merely representative of his mother's. Though he was the patient, his experiences or impressions were less important.

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[301]Patient Records, Langley Porter Psychiatric Institute, San Francisco, California.

This strategy explained clinical problems that other medical doctors found perplexing. A four-year-old patient was brought to the clinic with retarded speech and extreme impulsivity. The patient had not learned to talk until two or three years of age, and his attention was so poor during testing at another clinic that a psychologist had told his parents that "it was impossible to state how retarded he was in mental development." Other physicians told his parents to settle for a diagnosis of chronic encephalitis, and to accommodate themselves to his "subnormal" condition. The specialist consultant, Szurek, uncovered an extreme neurotic dependency between mother and child, and then dismissed previous physician's assessments as misinformed.[302] Another child was referred with a learning disability and possible epilepsy, but psychotherapy gradually convinced his mother "that he is not subnormal," in spite of the diagnoses of the spate of doctors who had previously seen her son. Szurek's diagnosis concluded that the problem was in her imagination, in her "deep pleasure in her martyr-like submission to his whims...her disgust with this in herself and her consequent fear that either the child or she herself or both were in some way 'abnormal'."[303]

Szurek utilized his psychogenic hypothesis to as readily explain the spontaneous behaviors that Bradley considered small seizures. The tantrums and isolated peccadilloes were not discharges of neuron groups, but replications of flaws in the parent's psyche. He called "superego lacunae" the isolated lesions in the conscience of the misbehaved child which correspond to the points of conflict in a parent's psyche.[304] Szurek stressed that the superego lacuna was not a "generalized weakness of the superego," but a specific and identifiable defect. The superego deficit revealed itself "in circumscribed areas of behavior" like stealing, truancy, or sexual acting out, though the child remained perfectly behaved in other areas.[305] Stevie's father's thwarted need to travel became a lacuna in Stevie's

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[302]Szurek, "Notes on the Genesis," 3.
[303]*Ibid.*, 4.
[304]*Ibid.*, 2.
[305]Johnson and Szurek, "The Genesis of Antisocial Acting Out," 323.

conscience, allowing him to satisfy his father's wish. The child inherited his misbehavior from his parents with high specificity.

The impulsivity of the children's outbursts encouraged Bradley to suspect seizures. The superego lacunae theory allowed Szurek to explain random behaviors as the result of lesions in the conscience, not neuronal groups. With slight haughtiness, he dismissed the facile explanation of his colleagues:

> It is this apparent urgency of their impulsive needs, and this inability to modify their behavior despite usually educative experiences which leads many to consider their characteristics as a peculiar defect in constitution or structure.[306]

With as much assurity as Bradley's EEGs could provide, his consistent interpretations from a psychological model provided Szurek with useful perspectives on chaotic clinical manifestations.[307]

Neither consolidated their clinical experiences into a guide to improve diagnostic accuracy. Both Szurek and Bradley avoided enumerating the set of symptoms that constituted a disease. Instead, they spread their expertise widely, implying that no symptom was beyond their grasp. Bradley noticed indications that a child was poorly socialized. Szurek, distrustful of both Kraepelin diagnostics and psychoanalytic categorizations, considered mental ills dynamic entities. Since intrapsychic conflicts changed, the natural history of a mental illness included changing symptom clusters over time, as exemplified by the woman with childhood school phobia who subsequently acquired several other phobias.[308] One point in time was not sufficient to clarify the clinical picture.

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[306]Szurek, "Notes on the Genesis," 2.
[307]Szurek, "Notes on the Genesis," 5.
[308]Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 522-523; Johnson et al., "School Phobia," 702-711.

Since no fixed criteria existed, any number of troublesome activities, including "fire-setting, stealing, truancy, and unacceptable sexuality" were manifestations of a psychiatric disorder and fell under the doctor's purview.[309] Since Szurek's etiologic model explained the gamut of psychopathology "extending as a gradient from the psychoses at one end through the variety of neuroses ... to the psychopathic personality syndromes ... at the other end," so too did his clinical expertise.[310] Asserting himself as an expert on everything from "predelinquency" to psychosis, he exercised social control over habits from skipping school to promiscuity.[311]

How could his colleagues identify the disorders he was qualified to treat? Only Szurek himself could fully characterize the disorder. In his model, diagnosis occurred within the analytic interview once he spied the putative agent, a parent's neurosis. The psychological meaning of a symptom, not its presence or absence, was its most important characteristic, but only intensive psychotherapeutic work could elucidate the meaning of a child's behavior.[312] Bradley, too, treated the conditions he uncovered through interpretive work, the reading of the pattern of scribbles on an EEG tape. Both sold themselves as uniquely perspicacious, and claimed to have expertise their colleagues could not match.

Szurek's demands to a monopoly of clinical expertise pried open a space only the child psychiatrist could fill. To his other medical colleagues, confronted with a problem child, he conveyed the gravity of the situation first, saying, "A child's conscience is made, not born."[313] Next, he warned against dismissing the problem, because

> The parent whose own superego is defective will say, 'My child will outgrow this fault.' Often, it is the parent who is not involved in the acting out who finally

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[309]Johnson and Szurek, "Etiology of Antisocial Behavior," 814.

[310]Szurek, "Children's In-Patient Service," 217.

[311] S. A. Szurek, "The Role of Clinicians in the Treatment of Juvenile Delinquents," reprint 1943, in *The Antisocial Child: His Family and His Community*, eds. S. A. Szurek and I. N. Berlin, The Langley Porter Child Psychiatry Series: Clinical Approaches to Problems of Childhood (Palo Alto: Science and Behavior Books, Inc., 1969): 86-92.

[312]Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 524.

[313]Johnson and Szurek, "Etiology of Antisocial Behavior," 815.

> insists upon treatment for the child. 'He will outgrow it' is the permissive protective attitude that keeps the problem active.[314]

Finally he argued that an extreme degree of suspicion was the only prudent attitude, for these were "consciously well-intentioned parents, whose unconscious needs were unwittingly inviting disaster upon the family."[315] Even the most respectable families could not be exempted, for "It is amazing to discover the extent to which intelligent families of respectable status" also accept or encourage improper behavior.[316] Their "subtle permissions and encouragements defy detection" until both parent and child can be "studied intensively by one experienced in ferreting out significant clues." Szurek insisted that "Only the experienced observer," namely himself, "will detect the clues and pursue them with such oblique and subtle questioning as will yield the truth."[317] Such arguments convinced his colleagues these problems were important, and that specialized knowledge was essential to addressing them.

Yet, the substance of this expertise was remarkably distinct between east and west coast child psychiatrists. The accouterments of Bradley's expertise were his fortressed asylum and his medical tools. Szurek had no such encampment, and he engaged in none of the symbolic activities -- dispensing medications or interpreting physiologic tests -- of a physician. Szurek's expertise was constructed without a single visible tool; his status was as invisible as his coercive grip over his patients. It was predicated on completion of a successful psychoanalysis. The "skill of the therapist" stemmed from "his having resolved more or less thoroughly remnants of pregenital conflicts from his own childhood experience."[318] This is Szurek's most consistent claim to authority. Not Bradley's tools,

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[314]Johnson and Szurek, "The Genesis of Antisocial Acting Out," 333.
[315]*Ibid.*, 328.
[316]Johnson and Szurek, "Etiology of Antisocial Behavior," 816.
[317]*Ibid.*, 815, 816.
[318]Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 540.

but "analytic training, or some equivalent, ... is the best equipment for a psychiatrist."[319]

This psychic freedom granted him clinical skills incisive enough to put a scalpel to his patient's worries. Since psychotherapy aimed to reduce anxieties, "For this purpose a much greater relative freedom from similar anxieties is required of the therapist."[320] Ultimately, "the greater and more thorough the resolution of the therapist's personal problems, the greater the chance" that therapy with the patient will be successful. To know where the problem could be found, and how to proceed in the clinic was a matter of expertise unknowable to parents or staff as well. Unlike the others, the therapist's attitudes could and should be "undistorted by fantastic anxieties."[321]

Szurek found these distorted fantasies not only in his patients, but in the rest of his clinic staff. Just as Bradley's expertise placed him above the other experts in his Home, Szurek claimed a more superior expertise than rest of his staff, the occupational therapists, social workers, teachers, nurses, attendants, and psychologists who cooperated with him in patient care.[322] Szurek read their psyches and unconsciouses just as he would with his neurotic mothers. For example, he described cooperating with a social worker to treat a delinquent boy. Szurek began to believe that the social worker harbored conflicted feelings about the boy, both empathic and hostile, and, in Szurek's words, "For one reason or another -- often because he was not clearly aware of his own conflict -- the social worker had not voiced his divided feelings to the boy." The social worker's "unspoken and unacknowledged" feelings "almost inevitably" resulted in an instance of continued failure by the boy.[323] Szurek resumed treatment with the boy alone.

This was not simply an attitude that applied while working on a team. Szurek

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[319]Szurek, "The Role of Clinicians in the Treatment of Juvenile Delinquents," 87.
[320]S. A. Szurek, "Remarks on Training for Psychotherapy," *American Journal of Orthopyschiatry* 19, no. 1 (Jan 1949): 36-51, 37.
[321]Szurek, "Childhood Schizophrenia: Psychotic Episodes and Psychotic Maldevelopment," 537.
[322]Szurek, "Children's In-Patient Service," 204.
[323]Szurek, "The Role of Clinicians in the Treatment of Juvenile Delinquents," 77.
[324]Szurek, "Children's In-Patient Service," 204, 217.

functioned as the psychotherapist for the residents and fellows he supervised on his ward. Since he assumed that psychotherapists needed "some therapeutic resolution of those tensions evoked by contact with patients," Szurek allowed his training staff to use their weekly conference time with him, during which the child's care was to be discussed, to pursue analysis of their own anxieties, even those relating to personal relationships.[324] This therapy, in which Szurek became privy to his trainees' insecurities, "is usually accepted as a way of learning."[325] He insisted that the purpose was to "enable therapists to understand and in part resolve their own anxieties and reactions to the child's disturbance,"[326] or confront the "possible threats to one's personal security in the present."[327] Yet, such a relationship, which imposed Szurek's power over the psyches of his inferiors, must have been difficult for young trainees. For Szurek, the powerful position this put him in consolidated his power and left him with an unimpeachable authority over his colleagues.

Szurek counseled the rest of his staff during morning rounds. Each morning, the nurses and attendants were invited into Szurek's office and asked to describe their impressions of the child's behavior on the previous day. Szurek asked them to elaborate on their subjective responses and speculate on the meaning of the child's behavior. The conference incorporated all the elements of a psychoanalytic interview: Szurek encouraged "further elaboration by repeating a phrase," then provided interpretations of the staff's impressions by "suggesting several alternative motivations or feeling tones implied in the description of the patient's behavior." He then gave "sympathetic acknowledgment" of the difficulties of tolerating these children and recognized "the drain upon one's emotional reserve in certain types of trying occasions." The nurses and attendants could even meet individually with Szurek for "the discharge of uncomfortable feelings not only toward

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[324]Szurek, "Children's In-Patient Service," 204, 217.
[325]Szurek, "Training for Psychotherapy," 50.
[326]Szurek, "Children's In-Patient Service," 207.
[327]Szurek, "Training for Psychotherapy," 37.

some patient, but also toward other members of the staff."[328] In his publication, Szurek outlined this technique for his colleagues, encouraging them to use it on their wards as well, to discharge tension and keep morale high. This colonization of a coworker's subjectivity was yet another technique to overtake the crowded clinical field at Langley Porter.

The consolidation of Szurek's power at clinical rounds was more than a symbolic victory. Szurek's case conference placed him at an infinite distance from the child guidance team. The example provides an apt conclusion to this study of power and professionalization in child psychiatry. William Healy himself, the neurologist whose work spurred the child guidance movement, instituted the use of case conferences in child guidance clinics. Szurek and Healy sat at different round tables, however. In Healy's model, psychiatrists, other medical specialists, psychologists, social workers, and others met around a table to share information on a case and communicate an assessment of a child.[329] Each specialist was to communicate an equally important, though distinct, point of view. Milwaukee psychiatrist Gilbert Rich described the case conference in the child guidance clinic as the culmination of a team effort to characterize the child in a multifaceted manner. Dr. Rich said

> the presentation of the case in a conference held in a mental hygiene clinic is not a monologue; it isn't a solo performance by one person. We recognize our patient has been studied from different angles, and we let each person present a different angle.[330]

Szurek's case conference exemplifies the shadow of this concept that arose in children's residential centers. As child psychiatry professionalized, the clinics where a child had been

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[328]Szurek, "Dynamics of Staff Interaction," 654.
[329]John C. Burnham, "The Struggle Between Physicians and Paramedical Personnel in American Psychiatry, 1917-1941," *Journal of the History of Medicine* 29 (Jan 1974): 93-106.
[330]Burnham, "The Struggle Between Physicians and Paramedical Personnel," 100.

analyzed according to a number of variables became a stage set by the therapeutic orientations of physicians. They stopped regarding the child from every angle, and chose one singly, conceptualizing the child within these confines. They muted the contributions of others, and elaborated a clinic to reaffirm their presumptions. They gained control of the field because they had defined it, delineated it, and imposed their monopolized knowledge on patients and colleagues alike.

VI

Conclusions

The journey from William Healy to Stanislaus Szurek and Charles Bradley can only be impressionistically reconstructed. Regardless of the questions that remain, I have argued, first, that child psychiatry took control of the management of children's disturbances within the residential treatment centers. Second, I have outlined the process by which this establishment of authority proceeded. It occurred within the clinical realm, and when child psychiatrists defined the diseases they treated, described them in terms that drew on legitimate sources of power, identified a mode of intervention, and claimed expertise over the other workers in their clinics. Within their hospitals, and within their relationships with patients, they consolidated authority and brought status to their new profession.

These conclusions are relevant to the history of specialization in medicine. The dynamics of the physician-patient relationship can add one more perspective to an examination of the process of specialization. In the history of child psychiatry, in particular, clinical encounters provided the opportunity for professionalization, but the power child psychiatrists found in residential hospitals solidified the profession's status. For Szurek, a professional identity was based on a skeptical attitude toward parents and a broadly-applied theory of psychopathology; for Bradley, it included a biologization of the child, and socially-defined criteria of therapy. Each won control from competitors and constructed a clinical sphere where his authority was reinforced. Specialization requires institutions and economic reinforcements, but its process is also instantiated in the encounter between the physician and the patient. In child psychiatry, a monopolized power was an important component of this encounter.

These conclusions are also relevant to the history of the psychiatric patient. Apposing Bradley and Szurek's approaches while recognizing their patients' similarities

illustrates that taking control of the encounter always prioritized the perspective of the physician, not the patient. The mechanisms of the seizure -- medications, technologies, psychotherapies, hospitalizations -- were dissimilar, but both prioritized their own expertise by formulating a specific vision of health and illness, and placing the child within his spectrum of psychopathology, reducing the patient to anonymity in the process. Once the child was situated, physicians' concerns turned to their own interpretations of the symptoms, not the child's experience.

In the midst of the grasp for professional power, the child became a receptacle for psychiatric theory, and a pawn to its interventions. Why was Sally shuttled in and out of the Bradley Home, put on benzedrine and tested with lumbar punctures, if her mother could not afford to feed and clothe her? Why was Alvin's abandonment from his parents inconsequential to his hospital care? Both doctors oversimplified their patients' motivations and paid attention to only a small piece of their experiences. Why did these children choose eccentricity as the best behavior, even to the point of excluding themselves from family and peers? What were they trying to communicate to their parents and their physicians? Their doctors did not answer these questions in their patient notes or their published works. The voice of the patient is too quiet in this history, and the weight of theory is too substantial.

Also, if we step out of the historical context of professionalization, these case studies illustrate why contemporary psychiatrists must be cognizant of their historical roots. Psychiatrists retain the power to place their patients within categories and prioritize a narrow view of their maladies. The relevant questions and the significant complaints are still determined by the physician. The criteria of health and illness, still constructed and upheld by societal norms, are codified within the psychiatrist-patient encounter. Psychiatric patients can still become prisoners to psychiatric theories, hospitalized, diagnosed and treated according to professional therapeutic preferences. Children are particularly vulnerable to the desires of those who claim to protect them, and they are easily ignored because, like most psychiatric patients, they are difficult to understand. The child

psychiatrists examined here detailed and structured their patients lives in accord with their own professional interests, and their stories reveal how readily this can occur in clinical practice.

Finally, the scientific status of psychiatry can be challenged by the practices described here. If scientific knowledge is reproducible and universalizable, the knowledge gathered at the Bradley Home and the Langley Porter Clinic was institutionally determined and contingent upon presuppositions. The knowledge can be more correctly labeled as a set of evaluative judgments, not scientific truths. Evaluative judgments are decisions that reflect a strong commitment to one therapeutic orientation over another, regardless of the level of proof supporting that orientation. As David Healy warns, "Commitment to only one model of therapy would reduce a clinician to the level of an astrologer or a reflexologist."[331] Nonetheless, commitment to a model of therapy is both necessary and common in medicine, for an orientation focuses and prioritizes information that would otherwise remain unorganized. However, in this study, these evaluative judgments oriented not simply the therapy, but the view of the child, the environment of the clinic, and the identity the child psychiatrist developed. Bradley and Szurek both used the rhetoric of science to disguise clinical preferences as powerful truths.

I will conclude with one final note about the knowledge-base of the profession. These child psychiatrists determined their orientations with remarkable intellectual independence. Bradley and Szurek made decisions within their hospitals, not within a larger professional community, about appropriate diseases and appropriate treatment. Was the larger profession no more than an aggregate of personal preferences padded with clinical data? Bradley and Szurek's practices were certainly more than this. However, that the two orientations did not have occasion to collide hints that child psychiatry frequently worked from precepts that were tested in clinical spaces that had been engineered to

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[331]These conclusions draw from ideas presented in David Healy, *The Antidepressant Era* (Cambridge: Harvard, 1997), 218.

reinforce presuppositions. Methods of proof like clinical trials and laboratory research matter only when a debate -- even an extremely ideological one -- is allowed to take place and the invested professionals agree on the proper orientation to a problem. If consensus is not reached, professionals can recognize the issues of contention. A debate between Szurek and Bradley never occurred. Child psychiatry gained professional status without a discussion and without an examination of which method of inquiry constituted the best approach to clinical issues. Children's mental ills were analyzed and characterized, and their comings and goings were controlled, before the profession agreed what knowledge legitimated that power and how the power should be used.

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