The Progressive Past of Residential Treatment of Emotionally Disturbed Children

In January 1949, 9-year-old Betty stepped through the doors of the Cincinnati Child Guidance Home. For the next 2 years, the Home would attempt to treat her severe emotional and behavioral problems in an experimental approach called residential treatment. After 4 years of child welfare and child guidance interventions, the Home was a last resort.

Betty’s home life was a mess. When she was 3, her “promiscuous” mother had deserted the family, and her father, an alcoholic, was gone most of the time. The house was so messy that the family was evicted over and over.1 Two foster homes later, Betty arrived at a local child guidance clinic, where the staff noted her “extreme stubbornness, destructive behavior, vomiting, soiling, and diurnal and nocturnal enuresis.”1 Betty’s third foster mother, Mrs F, resented having to care for this “defective” child. She regularly beat Betty, who had blank staring spells and skipped school. Fed up with this behavior, Mrs F begged the child guidance clinic to admit the girl to a psychiatric hospital.1

Looking back, we might imagine that Betty would have been sent away to a state mental hospital or a punitive custodial institution for delinquent girls. Twenty years earlier, this might have been the case,2 but, in fact, Betty had a very different experience than what we might expect. The Cincinnati Child Guidance Home, where Betty was admitted, was a new, radical alternative for children like her. One of a small number of new inpatient treatment facilities for emotionally disturbed children called residential treatment centers, it was intended to treat difficult children for whom outpatient interventions had failed. Today, the early years of residential treatment have largely been forgotten. But a look back at Betty’s experience reveals a progressive experiment to provide integrated, intensive treatment of children otherwise deemed hopeless.

At the Home, Betty encountered a new model of care. Residential treatment, on the rise in dozens of centers all over the country, adopted a child-centered, nonpunitive approach to help children develop healthy ways of interacting with others. Ultimately, staff members hoped to reintegrate children into the larger community by providing corrective and educational experiences in a homelike setting. They believed that the children’s problems, which they called “emotional disturbances,” had resulted from growing up in a pathologic home environment. Residential treatment would give the child relief from this environment and an opportunity for a “corrective living experience,” as child psychiatrist and Home director Othilda Krug explained.3 To treat these incredibly challenging children, the Cincinnati Child Guidance Home employed three psychiatrists, two psychiatry residents, several case workers, and three residential workers to work with the children around the clock.4

The Home’s therapeutic milieu was a carefully designed environment intended to help each child experience...
security, love, and limits within a homelike environment. Ultimately, the staff hoped Betty would learn how to form healthy relationships with adults and other children, a skill that would help her reintegrate into the community after discharge. This process began by establishing an environment that approximated a middle-class home, with “gay and attractive” bedrooms, “filled in every corner with toys and other things dear to each child.” The residential workers were to play the role of parent substitutes, helping with daily tasks like eating and using the bathroom and offering nurturing in difficult times, as with children who had trouble falling asleep at night. Their task was easier said than done: to love these “unhappy, angry, or frightened” children and make them feel secure, confident, and able to safely express their emotions. This required not the punitive, rigid tone of custodial institutions or reformatories, but a permissive, “warmly spontaneous” approach that placed the child’s needs first while setting limits on destructive or otherwise out-of-control behavior. These limits, imposed not by corporal punishment but by firm persuasion and redirection, were intended to foster the child’s psychological growth. For Betty, the milieu served many purposes. Two of the residential workers assumed mothering roles, comforting her at night when she was gripped with fear. When Betty became out of control and attempted to attack those around her, the staff used “firm but gentle protective restraint” to help her calm down.

Although the milieu was intended to resemble a home, it could never replace one. While the child stayed at the Home, the staff worked intensively with his or her parents to help them understand how their own troubles were closely connected to their children’s and how different approaches to parenting might reduce tension in the home. Regular weekend visits home helped families start to implement these new tactics and prepare for an easy transition after discharge. These policies illustrated the Home’s belief that the child did not exist apart from a family, and that treating one meant treating the other.

Despite this approach, the Home felt that Betty’s foster mother was a lost cause, and used casework interviews with Mrs F to help her understand that Betty would not be returning home. The staff felt strongly that Betty’s problems would not fully be solved until she became part of a stable, loving home, and looked forward to finding her a new set of foster parents. Nevertheless, they watched Betty make significant strides in her ability to interact with other children. She performed well in school and “became more outgoing and friendly, and appeared calm and well behaved.” Her enuresis and staring spells abated, and she became a close friend to many of the other children, forming an orchestra with them and calling herself “Miss Betty, the conductress.” By separating her from a toxic home environment, the staff believed they had reintegrated her into a community of her peers and saw the absence of her original symptoms as a sign of success.

Why does Betty’s story seem so idealistic to us today? The Home did not successfully treat all its children, and Betty herself was not able to return home. Is it because stories like hers suggest an unhurried time when physicians focused on maintaining a permissive, loving attitude toward the most intractable children? Although hindsight is viewed through rose-tinted glasses, it is useful to acknowledge that the progressive experiment of residential treatment promoted ideals we still strive for in clinical care, like integrated, team-based care for the whole child. But above all, Betty’s story serves to remind us of the value of the past. In practicing medicine, we are tempted and perhaps even obligated to believe that we are always improving, that each advance takes us closer to achieving an abstract ideal of perfection. But Betty’s story suggests that our past holds moments of inspiration and progressive thinking. Perhaps, then, we might look to the past as a source of guidance and inspiration as we face an uncertain future.

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