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Children's Mental Health in the United States:
The Development of Child Psychiatry at Johns Hopkins, 1890-1945

by

Alysia Young Han

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Requirements for the degree of

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in

History

in the

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of the

University of California, Berkeley

Committee in charge:

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Professor James Vernon

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Fall 2012

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ABSTRACT

Children's Mental Health in the United States: The Development of Child Psychiatry at Johns Hopkins, 1890-1945

by

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Doctor of Philosophy in History

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This dissertation tracks the development of child psychiatry as a medical specialty as it emerged at Johns Hopkins University from 1890 to 1945. This was a fitful process that often defied the logic of specialization. Previous histories locate the beginnings of child psychiatry to the Commonwealth Fund child guidance clinics of the 1920s. Yet, by defining the emergence of child psychiatry within this specific setting, such histories emphasize the process of medical professionalization as prerogatives of elite philanthropists who sought to develop rational bureaucratic solutions to social problems. Thus, child psychiatry emerges out of a drive towards further specialization and results in the “medicalization” of social problems. Instead, this dissertation begins in the Progressive era with child welfare reformers and Adolf Meyer whose psychiatry resonated with progressive concerns of social cohesion and efficiency. Although progressive reformers lost traction in the 1920s, Meyer continued to espouse progressive ideals through his teachings and practice of psychiatry until the 1940s. Thus, psychiatry at Johns Hopkins was never fully reduced to problems within the individual, as was the tendency of psychoanalysis.

Child psychiatry developed at Johns Hopkins out of efforts to avoid further specialization in medicine. Pediatrician Edwards Park sought to train doctors who could treat the “whole child,” including behavioral problems, which were becoming the purview of psychiatrists, psychologists and social workers. At the same time, Meyer sought to secure psychiatry's place within the medical community as a means to bridge the mind-body divide. Thus, Meyer and Park appointed Leo Kanner to a psychiatric clinic within the Harriet Lane Home, the pediatric hospital at Johns Hopkins, in order to teach pediatricians and medical students to manage common behavioral problems. In practice, pediatricians referred the large majority of behavioral cases to Kanner, setting the groundwork for a specialized field. With the publication of the influential textbook *Child Psychiatry* in 1935, Kanner gave a name and domain to the field.

CHAPTER 1

Introduction: Children's Mental Health in the United States: The Development of Child Psychiatry at Johns Hopkins, 1890-1945

The period between 1890 and 1945 marked a watershed in children's health and welfare in the United States. Childhood became a heavily studied and regulated period of life. Previously, psychiatrists rarely came into contact with children except for frank cases of insanity, epilepsy, or idiocy.¹ By the end of the period, parents, teachers, and social workers among many others conceived of everyday childhood problems in psychiatric terms. Despite the enormous influence of psychiatry on childhood, the discipline of child psychiatry arose in a fitful and unexpected way.

I trace the development of child psychiatry as a medical specialty as it emerged at Johns Hopkins University from 1890 to 1945. Through his work at the Harriet Lane Home, Johns Hopkins' pediatric hospital, psychiatrist Leo Kanner (1894-1981) wrote the first textbook on child psychiatry in English in 1935 and identifying one of the first child-specific psychiatric disorders, infantile autism, in 1943.² Sometimes referred to as the "father" of child psychiatry, he has surprisingly received scant attention from historians of child psychiatry. Partly this might be attributed to the misconception that Kanner worked mainly with highly disturbed children because he was at an academic hospital, and thus was out of the "mainstream" of child psychiatry.³ In fact, the vast majority of children seen by Kanner exhibited common behavior disorders and came from a wide variety of socioeconomic and ethnic backgrounds. His mentor at Hopkins, Adolf Meyer (1866-1950), by contrast, has received more attention because of his influence on the mental hygiene movement in the first half of the twentieth century.⁴

¹ Michael Neve and Trevor Turner, "History of Child and Adolescent Psychiatry," in Michael Rutter and Eric A. Taylor (ed.), *Child and Adolescent Psychiatry*, (Oxford: Blackwell Science, 2002) p. 387.

² Leo Kanner, *Child psychiatry*, (Springfield, Ill: C.C. Thomas, 1935) and Leo Kanner "Autistic disturbances of affective contact," *Nervous Child*, 2, (1943), p. 217-250.

³ Margo Horn, *Before It's Too Late: The Child Guidance Movement in the United States, 1922-1945*, (Philadelphia: Temple University Press, 1989), p. 115.

⁴ See Margo Horn, *Before It's Too Late*, Kathleen W. Jones, *Taming the Troublesome Child: American Families, Child Guidance, and the Limits of Psychiatric Authority*. (Cambridge, Mass: Harvard University Press, 1999), Theresa R. Richardson, *The Century of the Child: The Mental Hygiene Movement and Social Policy in the United States and Canada* (Albany, N.Y: State University of New York Press, 1989), Christine M. Shea, *The Ideology of Mental Health and the Emergence of the Therapeutic Liberal State: The American Mental Hygiene Movement, 1900-1930* (Diss. Urbana, Ill. Ann Arbor, MI: UMI, 1981), and Barbara Sicherman, *The Quest for Mental Health in America, 1880-1917* (New York: Arno Press, 1980).

Kanner's light historical footprint may also be explained by previous historical emphasis on the Commonwealth Fund child guidance clinics. These clinics were important sites for popularizing children's mental health along with other philanthropic programs of the 1920s such as parent education programs and child development institutes funded by the Laura Spelman Rockefeller Memorial. However, child guidance clinics were only one site in which psychiatry and social work encountered children. Within these histories, these clinics become a microcosm for the relations between three groups of professionals: psychiatrists, social workers, and psychologists. Explanations such as psychiatrists' turn to psychodynamic therapy because it was more "medical" and "scientific" make little sense outside this microcosm.⁵ Psychoanalysis made little headway in the general medical community prior to the Second World War. The developments in the child guidance clinics do not explain how child psychiatry became a medical specialty. Because Kanner's career does not fit within the history of the child guidance clinics, his contribution to the field is anomalous, a strange position for the "father" of a field.

To place Kanner within a history of child psychiatry, I begin with child welfare reformers and Adolf Meyer of the Progressive era (c. 1890-1920).⁶ Meyer developed his theory of psychobiology in the context of progressive concerns of social cohesion and efficiency. Although progressive reformers lost traction in the 1920s, Meyer continued to espouse progressive ideals through his teachings and practice of psychiatry until the 1940s. Thus, psychiatry at Johns Hopkins was never fully reduced to problems within the individual, as historians have characterized psychiatric practice in child guidance clinics. This opens up a new way of understanding how child psychiatry emerged. Rather than a tendency towards reductionism, child psychiatry arose out aspirations within medicine to attend to the needs of the "whole child." That child psychiatry became a specialized field of medicine despite initial intentions to mitigate further specialization is part of the historically contingent nature of its development.

Historians have pointed out the elusive and contradictory aspects of American Progressivism, questioning if something coherent to be called an era or movement existed at all.⁷ Two progressivist themes singled out by historian Daniel Rodgers – social bonds and social efficiency – are useful for making sense of the diverse interests within child welfare in the early twentieth century. As argued by Kathryn Kish Sklar, Seth Koven, and Sonya Michel, middle-class women reformers used the ideology of social bonds to improve conditions for the working class. By extending their domestic responsibilities of nurturing children into the public sphere, women advocated child welfare legislation that

⁵ Margo Horn, *Before It's Too Late*, p. 152.

⁶ Variation exists as to dates of American Progressivism. I follow the chronology of child welfare histories, in which women reformers organized to pass legislation beginning in the 1890s through the waning of reform impulse in the 1920s.

⁷ Daniel T. Rodgers, "In Search of Progressivism," *Reviews in American History*, Vol. 10, No. 4, (1982), pp. 113-132.

developed the government's responsibility for human welfare.⁸ These women professed a faith in scientific efficiency, advocating dissemination of scientific childrearing and housekeeping principles through infant-welfare stations and the Children's Bureau, for example.

At the same time, however, the faith in efficiency and medical expertise opened up reformers' activities to attack as amateurish and unscientific.⁹ Historian Hamilton Cravens divides child-saving efforts into two phases: Progressive child-saving (1890-1915) and professional child-saving (1915-1930). These divisions roughly correspond to two groups: predominantly women reformers and predominantly male scientists. Through generous funding by large-scale philanthropy, child-saving thoroughly transformed into a professional and scientific project, prioritizing research over reform.¹⁰ Margo Horn's history of child guidance clinics also explains professions as the prerogatives of elite philanthropists who sought to develop rational bureaucratic solutions to social problems. Thus, child psychiatry is shaped by the drive towards "professionalization" and results in the "medicalization" of social problems.¹¹

Theresa Richardson and Christine Shea further the explanation of professionalization of children's mental health experts as part of a hegemonic process. Thus, elite's ensure social stability through sponsorship of a professional class that renders conformity to social norms as a matter of individual health.¹² Similarly, Nikolas Rose sees the creation

⁸ Kish Sklar, Kathryn, "The historical foundations of women's power in the creation of the American welfare State, 1830-1930," and Seth Koven and Sonya Michel, "Introduction: 'Mother Worlds'", in Seth Koven and Sonya Michel (ed.), *Mothers of a New World: Maternalist Politics and the Origins of Welfare States* (New York: Routledge, 1993) and Ladd-Taylor, Molly, *Mother-work: Women, Child Welfare, and the State, 1890-1930* (Urbana: University of Illinois Press, 1994). On the other hand, Tony Platt and Steven Schlossman argue that Progressive child-saving, especially in the domain of juvenile justice, was not an example of social progress by liberal reformers as much as a conservative attempt to salvage traditional values such as domesticity and ways of life within agricultural communities. See Tony Platt, *The Child Savers: The Invention of Delinquency* (Chicago: University of Chicago, 1969) and Steven Schlossman, *Love & the American Delinquent: The Theory and Practice of "progressive" Juvenile Justice, 1825-1920* (Chicago: University of Chicago Press, 1977).

⁹ See Julia Grant, *Raising Baby by the Book: The Education of American Mothers* (New Haven: Yale University Press, 1998) and Rima Apple, *Perfect Motherhood: Science and Childrearing in America* (New Brunswick, N.J.: Rutgers University Press, 2006).

¹⁰ Cravens, Hamilton, "Child-saving in the age of professionalism, 1915-1930," in Joseph M. Hawes and N. Ray Hiner (ed.), *American childhood: a research guide and historical handbook*, (Westport, Conn: Greenwood Press, 1985), 415-488.

¹¹ Margo Horn, *Before It's Too Late* and Kathleen Jones, *Taming the Troublesome Child*.

¹² Theresa Richardson, *The Century of the Child* and Christine Shea, *The Ideology of Mental Health*. In a more general look at the Rockefeller foundation, Lily Kay and E. R. Brown also examine the philanthropy's project on "social control." Kay, Lily E. *The Molecular Vision of*

of child and family experts as means of governing through experts. However, this is less a hegemonic process as much as one taking place in the early twentieth century as part of the state's interest in creating socially responsible, healthy citizens, as citizens increasingly came to rely on the state as guarantor of social rights and progress.¹³ Working from a Marxist perspective, Christopher Lasch views attributes the rise of family experts such as child psychiatrists to the erosion of the autonomy of the private family. This parallels trends in which workers lost autonomy to engineers and capitalists.¹⁴

However, the loss of reformist energy in the 1920s, marking the end of the Progressive era, has also been attributed to forces other than an inevitable process of bureaucratization and professionalization that crowded out social reformers. For example, Michael McGerr considers the Republican backlash against progressive reforms and a middle-class culture, especially among the youth, that valued individual fulfillment and leisure as reasons for declining interest in reform activity.¹⁵ Julia Grant refers to consumerist ethos and the loss of moral connotations of domesticity in the post-suffrage era as reasons for waning interest in reform.¹⁶ Schlossman attributes the enthusiasm for parent education programs amongst the middle-class to the boredom of educated mothers who found some intellectual satisfaction in the tenets of scientific motherhood.¹⁷

In refutation of the inevitable process of reductionism in medicine, Jack Pressman reveals the influence of Adolf Meyer's psychobiology in the Rockefeller Foundation's bioscience program in the 1930s and 1940s. Rather than reading the Foundation's interest in psychiatry as a means for "social control," Pressman argues that the program encouraged a holistic study of human life, including the social sciences and the humanities, in order to improve human welfare. Thus, the dominance of laboratory-based medicine of today is more accurately situated in the peer-review process of government grants in the post-war period.¹⁸

Life: Caltech, the Rockefeller Foundation, and the Rise of the New Biology (New York: Oxford University Press, 1993) and E.R. Brown, *Rockefeller Medicine Men: Medicine and Capitalism in America* (Berkeley: University of California Press, 1979).

¹³ Nikolas S. Rose, *Powers of Freedom: Reframing Political Thought* (Cambridge, United Kingdom: Cambridge University Press, 1999), esp. chap 3.

¹⁴ Christopher Lasch, *Haven in a Heartless World: The Family Besieged* (New York: Basic Books, 1977).

¹⁵ Michael E. McGerr, *A Fierce Discontent: The Rise and Fall of the Progressive Movement in America, 1870-1920* (New York: Free Press, 2003).

¹⁶ Julia Grant, *Raising Baby By the Book*, p. 40

¹⁷ Steven L Schlossman, "Before Home Start: Notes toward A History of Parent Education in America, 1897-1929," *Harvard Educational Review* 43.3 (1976): 436-67.

¹⁸ Jack D. Pressman, "Human Understanding: Psychosomatic Medicine and the Mission of the Rockefeller Foundation," in Christopher Lawrence and George Weisz (ed.), *Greater Than the Parts: Holism in Biomedicine, 1920-1950* (New York: Oxford University Press, 1998): 189-210.

Like Pressman, this dissertation reconsiders the narratives of reductionism and professionalization as driving forces in medicine. Although psychiatrists, social workers, and pediatricians also contended with professional pressures, this did not necessarily lead to reductionist answers. Thus, Adolf Meyer stressed the importance of bridging the mind-body divide in medicine as a means of furthering psychiatry's acceptance within the medical profession. Similarly, the social workers of the child guidance clinics embraced psychoanalysis an intellectually rigorous means of empathizing with their clients as much, if not more, than its importance in furthering professional ambitions. Pediatricians looked to psychiatry as a means of addressing the whole child as much as a means to protect their market on the concerns of the middle-class. I demonstrate that the development of the specialty of child psychiatry emerged within specific institutions and shifting professional imperatives of psychiatrists, social workers, and pediatricians at Johns Hopkins from 1890 to 1945.

In chapter two, I introduce Meyer's theory of psychobiology as an attempt to create a totality of facts about each individual patient in order to create an explanatory narrative of illness. As Meyer searched for pathological antecedents in life experiences, he believed that childhood was a critical period for observation and intervention as a means of preventing mental illness. As an influential figure of the mental hygiene movement, Meyer sought to broaden psychiatry's utility in social institutions such as schools and charities. Examining a school survey of one of Baltimore's public schools undertaken by the clinic staff in 1916 and case records of children from the Baltimore Family Welfare Association who were examined at the clinic, I find that Meyer's psychobiology fell short of its promise to offer individualized solutions. Researchers and clinicians had difficulty using the assiduously collected facts, and instead relied on simpler measures such as intelligence testing for their assessments.

In chapter three, however, I argue that social workers in the 1920s pioneered the use of psychoanalysis because of their dissatisfaction with psychobiology. Through a study of the short-lived Course on Social Economics at Hopkins (1919-1929), I show the development of social work as it sought to attain professional standing. College-educated women pursued graduate studies in social work, which offered a potentially intellectually satisfying career. Social casework shared several qualities with psychobiology, especially its insistence on fact-gathering and an attempt to create personalized solutions. Social work gained tremendously as a profession with the popularization of mental hygiene and the training opportunities at the Commonwealth-sponsored child guidance clinics of the 1920s. Social workers found psychoanalysis much more useful in their work with clients than the fact-gathering technique. They pioneered work on parental attitudes towards their children and the use of transference in the clinic.

Chapters four and five focus on Leo Kanner's position and work at the Harriet Lane Home. I show that despite attempts to reduce specialization in medicine, Kanner's clinic

ultimately led to a medical specialty. Pediatrician Edwards Park sought to train doctors who could treat the “whole child,” including behavioral problems, which were becoming the purview of psychiatrists, psychologists and social workers. At the same time, Meyer sought to secure psychiatry’s place within the medical community as a means to bridge the mind-body divide. Thus, Meyer and Park appointed Leo Kanner to a psychiatric clinic within the Harriet Lane Home, the pediatric hospital at Johns Hopkins, in order to teach pediatricians and medical students to manage common behavioral problems.

In practice, pediatricians referred the large majority of behavioral cases to Kanner, setting the groundwork for a specialized field. With the publication of the influential textbook *Child Psychiatry* in 1935, Kanner gave a name and domain to the field. I argue that Kanner began to incorporate psychoanalytic techniques, those developed largely by social workers in the child guidance clinics, to meet the needs of middle-class parents who were well-read in popular child guidance literature. The adoption of psychoanalytic principles further separated child psychiatry into its own specialty. The institutional structure also significantly contributed to Kanner’s other major contribution, the identification of autism. His position within the elite pediatric hospital gave him access to puzzling cases referred to the Hopkins pediatricians by practitioners throughout the country. Through these referral networks, Kanner confirmed eleven cases of a new syndrome over the course of six years. This was among the first specific childhood psychiatric disorders, furthering the need for specialists.

A Brief Introduction to the Beginnings of Child Welfare in Baltimore

Like other American cities of its size, Baltimore’s population doubled between 1870 and 1900. It was the sixth largest city in the United States in 1900. Rural whites from Maryland accounted for the majority of the increase, followed by African Americans from Maryland, Virginia, and North Carolina as well as immigrants from Europe. People came to Baltimore to work in the new industries of clothing manufacturing, canning, and steel as the city sought to industrialize its economy instead of relying on commerce and banking. The new population encountered housing shortages and non-existent sanitation, creating conditions for disease and poverty.¹⁹

Baltimore’s reform movement was comprised of civically minded men and women, with a majority coming from the upper class, who sought to improve conditions within the city. Men’s activities focused on reforming the city government by creating popular

¹⁹ James Crooks, *Politics & Progress: The Rise of Urban Progressivism in Baltimore, 1895 to 1911* (Baton Rouge: Louisiana State University Press, 1968) and Charles Hirschfeld, *Baltimore, 1870-1900: Studies in Social History* (Baltimore: Johns Hopkins Press, 1941).

support to overthrow boss rule. Women concentrated their energies towards child welfare reforms.

The lead women's reform group, the Arundell Good Government Club, formed in 1896 and was comprised of upper class women and professionals such as doctors. The upper class composition of the club reflects its parent organization, the Arundell Club, which was an elite women's group dedicated to the "promotion of individual self-culture."²⁰ The Good Government Club was the first women's association in Baltimore involved in civic issues. Unlike the parent organization which limited membership to upper class women of Baltimore's Social Register, the new club opened its doors to women who interested in the charter of "honest, efficient and economical administration,"²¹ provided she was nominated by a member of the Arundell Club.

Although members worked for child welfare reforms, they held a diversity of opinions. Not all members supported woman's suffrage or mother's pensions. Mary Richmond (1861-1928), a middle class woman who later became a future leader in social work, supported child welfare reforms but had little sympathy for children as impassioned other women reformers.²² Richmond served as general secretary of the Baltimore Charity Organization Society (COS), and her attitude towards children in the 1890s reflected the COS' concern with reducing "sentimental" charity to the poor. For example, Richmond was particularly passionate about removing child beggars from the streets. She found that more than half of regular beggars were children, which she believed was directly related to parental laziness. This reasoning also informed her understanding of other forms of child labor including factory work and newspaper boys. She also felt this way about "married vagabonds," or husbands who left their wives temporarily. Richmond opposed any type of outdoor relief such as mother's pensions. Again, a blameworthy individual such as an irresponsible drunkard of a father should be found and made to pay for his charges.

However, Richmond was crucial for organizing compulsory education legislation. She initiated the study of school attendance in Baltimore which became the basis for gaining popular support for legislation. Miss Florence Peirce, a volunteer of the COS, visited 2800 families and found that over twenty-five percent of children were not in school. The report blamed parental indulgence for children's poor attendance: children were kept at home to run errands and take care of younger children. They also worked in the canning and packing facilities from May through October. The lack of regulating in attendance was particularly damaging for these poor children, because school was "the chief disciplinary force of their lives." Peirce also pointed out the danger of children in

²⁰ Lilian Welsh, *Reminiscences of Thirty Years in Baltimore* (Baltimore: The Norman, Remington co, 1925) p. 62.

²¹ *Ibid.*, 66.

²² Mary Richmond's career is further discussed in chapter 3.

the streets who “loaf in the streets, playing craps” and bully other children from going to school.²³ Peirce concluded that the chief cause for nonattendance and irregularity was parental indifference to education and the “temptation of industrial opportunities”. She found only 22 out of 426 cases nonattendance were a result of poverty.²⁴ Even insufficient clothing was not a legitimate excuse as teachers or their friends, as a personal gift, generally could provide clothing for children.²⁵

However, gaining popular support for the legislation proved difficult. Despite the fact that the wife of the newly appointed school superintendent, James Van Sickle, was the chairman of the Arundell Club School Attendance Committee, Van Sickle commented to the press that a compulsory education law was needed but that “Baltimore is better off in not having a compulsory education law than it would be if it had a dead-letter law” if the city were not fully committed to the law.²⁶ Former Mayor Ferdinand Latrobe said that he was “doubtful as to our right to go into people’s houses and take their children to school by force.” He continued, “Compulsory education may work very well in Boston and other places, but people have to be educated up to such things, and I do not believe our people here are so far advanced as that.”²⁷

Although compulsory education would take much longer to become popularly accepted, the bill passed in 1902 through support of prominent Baltimore men including Daniel C. Gilman, President of Johns Hopkins University, a state senator, and the Baltimore Federation of Labor.

Passage of the bill was just the beginning of the process to ensure compulsory education. Pressuring the city to appoint attendance officers was among the first priorities. Over the next ten years, women reformers lobbied for the creation of a parental school and juvenile court as a threat against truancy, an effective child labor law, and health inspection within the schools, among many others.

Children were increasingly brought before physicians and other experts. Children who applied for a work permit required a medical examination and a basic education test. For those who failed, a series of further investigations were initiated such as referral to the new Henry Phipps Psychiatric Clinic for evaluation where Adolf Meyer encouraged the schools to make use of his clinic.

²³ Baltimore Charity Organization Society, 18th Annual report, 1899, p. 33.

²⁴ “Laws for Child Labor,” The Baltimore Sun, Dec 20, 1901, p. 6.

²⁵ Baltimore Charity Organization Society, 18th Annual report, 1899, p. 33.

²⁶ “Doubts if it Would Work”, The Baltimore Sun, Dec 21, 1901, p. 7.

²⁷ Ibid.

CHAPTER 2

Adolf Meyer and the Social Potential of Children, 1913-1925

In a 1915 article for the progressive social magazine *The Survey*, psychiatrist Adolf Meyer proposed his ideal of community mental hygiene. Entitled “Organizing the Community for the Protection of its Mental Life”, Meyer argued for the salutary effects of close-knit communities. Lamenting the lack of such community spirit in America, Meyer envisioned its creation through a psychiatrically trained school physician and a few local helpers who would befriend teachers, playground workers, charity workers, physicians, and ministers. The physician would thus come to know the “social fabric” of the district and would foster “constructive habits of wholesome life for community and individual.”²⁸ Occupation, recreation, and social interactions were the mainstay of treatment in the psychiatric hospital, and their continuation was invaluable for not only discharged patients but also for protecting the mental health of the community at large.

This article was a reprint of Meyer’s address to the 1915 National Conference of Charities and Corrections held in Baltimore. Meyer was among the new wave of psychiatrists in the early twentieth century who sought to expand the discipline from the isolated institutions for the chronically mentally ill to urban hospitals attending to the psychopathology of everyday lives in the community. The 1915 meeting represented Meyer’s thoughts at the apogee of his career. The Henry Phipps Psychiatric Clinic at Johns Hopkins opened in 1913 under his leadership, and the mental hygiene movement he helped found was beginning to gain national traction. That Meyer chose to talk about school children at his 1915 address, underscores the important role they were given in the new psychiatry. Children were both sites for early intervention in mental disease as well as gateways into the mental health of the communities in which they lived.

Meyer’s optimism about the mental hygiene of children and communities was balanced by his conservatism. He was wary of legislation and preferred that communities take responsibility for their own members. He viewed the social world as a circumscribed community that had a place for each individual. Much of mental illness, and even larger scale social unrest, resulted from an individual’s mismatch of ambition and abilities. The

²⁸ Adolf Meyer, “Organizing the Community for the Protection of its Mental Life,” *The Survey*, XXXIV (1915), 557-560. Reprinted in Eunice Winters (ed), *The Collected Papers of Adolf Meyer Vol IV*, (Baltimore: The Johns Hopkins Press, 1952), p. 196.

key to mental health was finding the proper balance, enabling an individual to find his or her place in the community. He entrusted the schools with this task of helping each child “find the best level and direction of ambition adapted to the individual endowment.”²⁹ Meyer believed that psychiatry, as a scientific study of an individual’s strengths and weaknesses, should work closely with schools to fulfill this duty.

In this chapter, we look at the approach to and treatment of children at the Phipps Clinic from its opening in 1913 to the mid 1920s. This marks a discrete period in the history of child psychiatry. These children were among the first to be psychiatrically evaluated as outpatients, i.e. non-committed, non-hospitalized, before the establishment and popularization of the Commonwealth funded child guidance clinics from the mid 1920s. Most histories of child psychiatry focus on the inner workings of these clinics, with the established and gendered division of labor of doctors meeting with child patients, social workers dealing with mothers, and psychologists applying intelligence testing.³⁰

Psychiatric work with children at the Phipps clinic during the period of 1913 to the mid 1920s had aspirations of social amelioration, beyond the walls of the clinic, as part of the tail end of Progressive child welfare measures. The all-encompassing scope and indeterminateness of Meyer’s psychiatric theory, called psychobiology, ultimately limited its utility as a means for social uplift. Psychiatric attention to an individual did not easily translate onto the larger scale of schools or social agencies. An examination of two practices, a large-scale survey of a school district and clinical work with children referred by a social agency, reveals the difficulties and compromises encountered by psychiatrists, social workers, and their patients in implementing psychobiology.

²⁹ Adolf Meyer, “Mental and Moral Health in Constructive School Program,” in Eunice Winters (ed), *The Collected Papers of Adolf Meyer Vol IV*, (Baltimore: The Johns Hopkins Press, 1952) p. 363.

³⁰ For example, Margo Horn’s *Before It’s Too Late* (1984) focuses exclusively on the Commonwealth Fund and details the workings of their Philadelphia clinic. Horn’s emphasis is largely on the decision-making at the level of those running the philanthropy and their evolving commitment to training medical professionals. In the other main monograph on this topic, Kathleen Jones’ *Taming the Troublesome Child* (1999) follows the Judge Baker Child Guidance Clinic in Boston over a period from 1920-1945, which served as a model for the Commonwealth Funded clinics of the later 1920s. This clinic, run by William Healy and Augusta Bronner, ran along similar lines to Chicago’s Juvenile Psychopathic Institute, which was the first psychiatric clinic associated with a juvenile court established in 1909. Thus, the emphasis was similarly on delinquency at first, although Jones tracks the changes over time to middle-class children with behavioral issues. For Jones, the engine of change was the development of a youth culture from the 1920s onwards which led adolescents into conflict with their parents in all classes. Child guidance flourished because of middle-class parents who simply found parenthood baffling and difficult.

At another level, Meyer's psychiatric thought had limitations because it was influenced by late nineteenth century charity aims to eliminate dependency and delinquency through moral guidance of individuals and progressive ideals of invigorating neighborhoods in the urban morass. He believed that attending to individual children would lead to improvements in the child's community. Psychiatry never became the socially uplifting force because the wholesome, bounded community that Meyer envisioned ceased to have resonance in interwar America. However, the child's home would absorb much of the social impetus of this new psychiatry.

Part I: Adolf Meyer, Psychobiology, and Mental Hygiene

How children came to be psychiatric patients is in large part related to the transformation of psychiatry in the early twentieth century. Adolf Meyer (1866-1950), a Swiss neuropathologist, was among the leaders of this change in American psychiatry. Meyer completed his medical studies in Zurich and wrote a thesis on the reptile forebrain under August Forel. He came to the US for possible career opportunities, following a possible job lead at Chicago. Although this position fell through, he began work as a pathologist at a two thousand bed state hospital in Kankakee, south of Chicago.

This experience was productive on several fronts. First, Meyer realized he could make a significant contribution to American psychiatry given the disorganized state of patient care as compared to his training in Europe. The introduction of a case file for each patient rather than a logbook of all patients was a large step forward. This was the beginning of his interest in the histories of these patients as potential clues for their psychopathology. He also forged relations with Hull House reformer Julia Lathrop, later first head of the US Children's Bureau, who made regular trips to Kankakee as part of her work as position on the Illinois State Board of Charities. He also was introduced to the writings of William James and John Dewey whose emphases on a concrete and practical psychology particularly influence on Meyer's developing theory called psychobiology as discussed below.

From Chicago he worked at the state hospital in Worcester, Massachusetts, and then as director of the Psychopathic Institute of the New York state hospitals. It was during this work in large state systems that he became interested in the problems of "aftercare", or how psychiatric patients fared after discharge from the hospital. As Meyer began to think of mental disease as related to an individual's faulty adjustment to his environment, he became interested in the pathological conditions of a patient's life outside of the hospital. He promoted the collaboration of social organizations to help aid the adaption of the patient back to his or her home and family.

He devised a grouping of particular "reaction types" to stresses in the environment as the basis for mental illness. Faulty habits in living were the basis of pathological reaction

types. In one of his early articulations of his theory of psychobiology, he attributed dementia praecox, or schizophrenia, to a faulty reaction-type of withdrawal into inactivity and fantasy. Children who daydreamed were particularly prone to dementia praecox later in life. Thus, healthy habits of concrete activity and “meeting life’s challenges” directly should be inculcated early in childhood, as mental illness was largely an accumulation of faulty habits.

Meyer’s psychobiology has been described as eclectic because of his tendency to utilize certain aspects of several different theories.³¹ He was opposed to what he perceived as teleological or closed theories that predicted a patient’s course. He found Kraepelin’s description of specific disease entities such as dementia praecox as fatalistic. Similarly, he disagreed with fully hereditarian theories such as degeneracy. Important to Meyer was the patient’s ability to acquire wholesome, healthy habits.

He also disagreed with the role of the unconscious in psychoanalysis. Instead, he firmly believed in the utility of observable facts and records of behavior or actions. Although he shared some aspects of behaviorism, Meyer believed that behaviors had meaning that was informed by a patient’s life history. One of his teaching exercises of medical students and residents consisted of a structured autobiography as a means to explain how a person came to his current situation. In terms of working with a patient, he similarly believed that “a thorough search into antecedents, into the temporary situation and into the prospects, i.e. into the facts constituting the human biography, proves to be the only rational way to deal with most of the difficulties of mind.”³²

He developed a graphic device called the “life chart” on which a doctor could record the important facts of each person. These facts included an “inventory of the assets and determining factors” of a person’s life such as “emotional assets, the interests, leanings and curiosities, ambitions, likes and dislikes, as well as the purely intellectual assets or knowledge.”³³ Culling through the inventory, a physician would be able to assess a person’s level of functioning and how this might be improved. An imbalance between a person’s ambitions and capacities constituted the fundamental basis of most mental disease. The patient’s acceptance of these facts formed the basis of therapy. Meyer believed that most diseases are “chargeable to the unwillingness or inability to face realities of makeup and situation and to shape one’s life in keeping with them.”³⁴

Meyer’s insistence on facts and objectivity blinded him to the inherently subjective act of determining what constituted facts and of putting the facts together as a narrative. On the

³¹ Gerald Grob, *Mental Illness and American Society, 1875-1940* (Princeton: Princeton University Press, 1983), p. 116.

³² Adolf Meyer, “Mental and Moral Health in Constructive School Program,” p. 362.

³³ Ibid. p. 367.

³⁴ Ibid. p. 361.

other hand, his method also suffered from an incoherence resulting from the attempt to know the “total situation” of a patient. These weaknesses become evident in reviewing how psychiatrists at the Phipps implemented psychobiologic principles.

When Meyer was called upon to lead the new psychopathic hospital at Johns Hopkins in 1909, he was eager to implement his ideas about the nature of mental illness and the collaboration with social workers. The psychopathic hospital was urban and thus closer to the communities from which the patients came than the fortresses of state hospitals. He believed this connection to the community was crucial for understanding the situation that gave rise to the illness and implementing means to modify the situation.

And he further advocated the possibility of prophylaxis of mental disease, which he called “mental hygiene.” Describing the aims of the new psychopathic hospital of the Phipps Clinic, Meyer addressed the International Congress of Medicine in London in 1913: “Today I can foresee more and more clearly a psychiatry and psychopathology working in the pre-institutional phase, in the schools, in the mental hygiene of the communities, and in the families... This decentralization and refocusing of psychiatry in the centers of community life... is the most important *new* aim of the new type of institutions...”³⁵ Despite the anticipation, Meyer’s conception of mental hygiene suffered from difficulties of implementation on a large scale and an arbitrariness on the individual scale that limited its utility.

Part II: The Locust Point Survey

One of the legacies of the Progressive reformers in Baltimore and other cities in the US was compulsory education. In Baltimore, the law required children to attend school until the age of 16, although they could apply for a work permit to leave school by 14 if they had achieved academic proficiency of the fifth grade level. Although the legislation was first passed in 1902, attendance only began to be more seriously enforced starting in 1912. The increase in school children was met with a chronic lack of funding for adequate facilities and teachers’ salaries. On top of these material concerns, there was much debate about what and how children, who previously dropped out, should now be taught. Classrooms were a heterogeneous mixture of ages and ethnicities. Students of all ages could be found in the same graded classroom, as children differed in educational background, proficiency in English, and academic abilities.

As these circumstances were common in urban areas in the first two decades of the twentieth century, centralization and efficiency became important issues for school administrators. School boards employed educational professionals to undertake extensive

³⁵ Adolf Meyer, “The psychiatric clinic, its aims,” in Eunice Winters (ed), *The Collected Papers of Adolf Meyer Vol II*, (Baltimore: The Johns Hopkins Press, 1952) p. 204).

surveys of school systems as a means towards objective, efficient management.³⁶ Among the findings of the school surveys was the large number of children who were “retarded” in their scholastic aptitude for their age. The standard of age-grade classrooms and age-appropriate curriculum developed out of these large-scale surveys.³⁷

The reasons attributed to this retardation were multiple. Some pedagogic professionals such as Leonard Ayres pointed to the inappropriate level of the curriculum. Others placed the difficulty in the students themselves. The widespread use of intelligence testing in public schools began after World War I. Historian Paula Fass argues that the IQ was the perfect tool for the bureaucratic school systems that were mandated to educate all children. Administrators grouped children according to their IQ, which was thought to be an immutable quality that forecast their academic potential. Tracking children into vocational or various academic routes, however, had consequences for their economic futures.

The situation faced by Miss Persis Miller, a principal of a public school in Baltimore, in 1914 is illuminative of concerns of these burgeoning schools. How she approached the problem of backwards children illustrates the strange mixture of expert opinion and traditional moral guidance in the schools as well as in psychiatry during this period. As experts grappled with new, ostensibly objective, techniques such as intelligence testing and a psychobiological inventory of a student’s life, their interpretations were grafted onto traditional values of character and thrift and contemporary eugenic concerns.

Public school 76 was located in Locust Point, an industrial, economically depressed, and geographically isolated neighborhood of Baltimore. Miller had been principal of the school for four years when she approached Meyer in 1914 for assistance. She had already identified and separated certain students into two classes. The first class consisted of twenty-two “subnormal” students who were significantly older than others because of repetition of grades. The second class consisted of students who had behavioral problems such as “showing off” and “all sorts of disagreeable, smarty actions” but were not as obviously backwards as the other group of students.

Miller had financial concerns about students’ lack of progress. She calculated that repetition of grades wasted “\$3555.93” by the public schools “because not one of them could do any school work.” Additionally, these students disproportionately absorbed the energy of the attendance officers and teachers and disturbed the other children.³⁸ She also felt a “grave responsibility” in separating these children from the standard

³⁶ Paula Fass, *Outside In* (Oxford: Oxford University Press, 1989) p. 39.

³⁷ *Ibid*, p. 43. Fass attributed the age-grade standard to an “infatuation with a kind of scientism of numbers” of these professional educators.

³⁸ Miller, “A community school in a large city system,” *Progressive Education* (February 1938), p. 102.

curriculum and wanted to know “what a scientific checkup would show.”³⁹ These two classes were geared towards manual training such as needlework and housekeeping for girls and chair caning and shoe repair for boys. Miller was hopeful that these classes would at least keep the students’ attention and attendance, if not impart some vocational skills.

At the same time, Meyer had secured funding from the hospital’s benefactor Henry Phipps to undertake a community survey. In his address at the opening of the Clinic, Meyer pronounced, “I consider it of the greatest importance that the clinic make itself responsible for the mental health work of a fairly well circumscribed unit of population, so as to make possible studies of the social situation and of the dynamic factors which lead to the occurrence of mental derangements which must be attacked for purposes of prevention.”⁴⁰ His plans expanded beyond psychometric testing of school children. Instead, he envisioned an extensive project of door-to-door surveying of each child’s home conditions. Miller, interested in the possibility of revitalizing the community through the school, agreed.

Social surveys were a popular form of research that particularly resonated with Meyer’s psychobiology. Just as these surveys such as the Pittsburgh Survey of 1908, funded by the Russell Sage Foundation, sought to discover and exhibit all social facts of a city, Meyer’s approach to psychiatric illness consisted of an exhaustive history of a patient’s life in order to appreciate the capacities and limitations of each person. The therapeutic aspect of the data gathering consisted of having the community or patient confront the facts and modify behavior in a rational way.

Dr. C. Macfie Campbell, head of the out-patient dispensary at the Phipps clinic, oversaw the investigation, but most of the work was undertaken by four social workers Miss S. Jean, Mrs. Margaret Ware, Miss. M. Moore, and Miss M. Pope. The researchers created two cards for each child, a card for school progress and another with facts of the home situation. Given Meyer’s emphasis on obtaining all facts of a case, a child would not be classified as subnormal based upon intelligence testing alone. Thus, researchers ostensibly based their assessment of a child’s functioning on the material from both cards, including a multitude of factors such as physical health, heredity, and emotional characteristics. However, as we will see below, intelligence testing heavily influenced their judgments.

Two social workers reviewed the progress of each child with the teachers. In cases with any question of inefficiency, a child underwent intelligence testing. Miss M. W. Moore worked for two years with psychologist H. H. Goddard at the Vineland Training School

³⁹ Ibid.

⁴⁰ Meyer, “The aims of a psychiatric clinic” in Eunice Winters (ed), *The Collected Papers of Adolf Meyer Vol II*, (Baltimore: The Johns Hopkins Press, 1952) p. 194.

in New Jersey and Ellis Island before administering the test to over half of the 1, 281 school children in Locust Point. Although Goddard reported the accuracy of the test after examining 2,000 normal children in New Jersey, others such as Ayres and Thorndike questioned his results as well as the utility of the test.⁴¹ In Locust Point, testing revealed a disproportionate number of “retarded” children as compared to the number of children showing a mental age beyond their chronological age. Thus, Campbell argued that the standards of the test were “too severe for a population like that of the Locust Point,” and urged caution in interpreting the results.⁴²

The two other social workers, S. L. Jean and Margaret Ware, visited each home in the district to gather data about each child’s home life. They collected data on each person who lived in the house with regards to age, birthplace, religion, and occupation. They estimated the heredity of a child by the “mental level of the mother, and the industrial efficiency of the father.”⁴³ And they tried to ascertain approaches to parenting including “affection, encouragement, severity or repression,” and evidences of any “neurotic symptoms, peculiar moods or behavior at home.”⁴⁴

Although invasive, Campbell noted that the “co-operation of the community was excellent; in remarkably few cases was there any suspicion or antagonism shown to the field-workers. The fact that the workers introduced themselves as coming in the interest of the children smoothed the way.”⁴⁵ Some parents likely did express discontent about creating a record of facts of a “personal nature.” However, Meyer felt confident that these concerns were merely “false fears” and parents would actually feel “an everlasting gratitude to him who shows them where their child will succeed.”⁴⁶

Despite the wealth of data obtained, the information of most concern to the investigators appeared to be the results of the intelligence testing and information about other family members that was then tabulated under “heredity.” Campbell outlined three different groups of subnormal children, based upon their “prospective social efficiency”. The first group consisted of the twenty-two children identified by Miss Miller who showed an average of 5.5 years of retardation based upon the intelligence test. Campbell doubted that these children would ever become self-supporting adults and instead required supervision because they were “specially liable to recruit the ranks of the vagrants, the

⁴¹ See H.H. Goddard, “Two Thousand Normal Children Measured by the Binet Measuring Scale of intelligence,” *Pedagogical Seminary*, (1911) pp. 232-259. E.H. Thorndike, “The Significance of the Binet Mental Ages,” *Psychological Clinic*, (December 1914).

⁴² C. Macfie Campbell, “The subnormal child; a survey of the school population in the Locust Point district of Baltimore,” *Mental Hygiene*, I (1917) p.103.

⁴³ *Ibid.*, p. 100

⁴⁴ *Ibid.*

⁴⁵ *Ibid.*, p. 101.

⁴⁶ Adolf Meyer, “The Mental and Moral Health in Constructive School Program”, p. 366.

alcoholics, the prostitutes and the delinquents.” He based his judgment upon traces of information about family members such as a mother’s immorality, low mentality, or alcoholism; siblings who were also over-age for their class; or a family member with epilepsy.⁴⁷ These children should be identified and segregated as early as possible, ideally in protected colonies that would prevent their propagation.

A second group of seventy-eight children had slightly higher intelligence than the first group and showed an average retardation of four years. These children were not as obviously mentally deficient as those in the first group, and Campbell predicted that these children would generally drift along in the lowest social level of their community. Unlike the children in the first group who required segregation to maintain their safety, this second group of children could benefit from training “to find satisfaction in simple activities which were not without economic value.” Barring special recognition and training of these children, he forecast a dismal life as “parents in squalid homes, living in irregular relationships with companions with cognate defects, a constant drain upon the facile and short-sighted charity of the community, drifting through life aimlessly and rather pitifully, reproducing without care and handing over to others their defective offspring...”⁴⁸

Finally, Campbell identified a third group of sixty-six children, whose “deviations from normal are not so striking,” with an average retardation of three years. With proper training, these children might enjoy “fair economic efficiency.” Without some modification to the curriculum, however, these children had potential to become more detrimental to society than either of the other groups precisely because of their higher intelligence. Campbell felt this group, more than the other defective groups, deserved the attention of the school because of the possibility of helping them.

A review of the data from the Phipps survey reveals the types of information that was largely ignored in Campbell’s evaluation.⁴⁹ They found that foreign-born people comprised a quarter of the population, mainly from Germany, Poland and Hungary. Most families lived at subsistence levels with earnings barely covering expenses. Most children after the age of fourteen left school to work in various industries including glass and furniture factories or packing houses. Children and mothers of immigrant families often migrated to the country in the spring and summer to pick fruit and vegetables and then returned to work in the canning industries. The employment affected attendance as these children left school early in the spring and started school late in the fall. This employment was necessary because it could double the income of a family, especially in the low-wage and inconsistent work of stevedores.

⁴⁷ C. Macfie Campbell, “The subnormal child,” p. 118-120

⁴⁸ Campbell, “The Subnormal Child”, p. 111.

⁴⁹ Adolf Meyer Papers, II/473/2, Pathfinder Survey, Feb 24, 1916.

Despite these economic difficulties, investigators attributed poor physical or mental health of the children to inherited “constitutional limitations” or poor training within the home. Although Meyer and Campbell consistently refuted the use of intelligence testing as the sole determinant for estimating the potential of a child, their method of trying to understand all of the “life facts” of a person inadvertently led to similar results. Under the constraints of a large-scale survey, they were not able to operationalize the life inventory of each child, and their conclusions relied heavily on IQ and the perceived mentality of a child’s family members. Furthermore, even under the most ideal circumstances, their philosophy of individualizing education meant “sizing up” what an individual could reasonably learn and then teaching to that level. Like progressive educators as described by Fass, in Meyer’s impulse to make education accessible to all individuals had the perverse effect of making education less democratic.⁵⁰

To a large extent, Campbell’s deductions from the data were consistent with contemporary work on heredity and intelligence, which were at the height of popularity in the first two decades of twentieth century America.⁵¹ H. H. Goddard’s 1912 study, *The Kallikaks*, demonstrated the inheritability of mental defect and its connection with deviance and dependency. The “menace” posed by the mentally deficient is clearly evident in Campbell’s dire forecast of these school children.

However, Meyer and, to a lesser degree, Campbell avoided legislative solutions for segregating the mentally deficient. Instead, they expressed optimism in the ability of a parent, teacher, and community to properly train and care for these children. Campbell stressed the importance of cooperation between the school and the home. Emboldened by the experience of the home surveys, he argued that involvement of the teacher or social worker in the home not only would improve children’s school progress but also benefit the whole household.

Addressing the problem of a “nest” of ten houses in the Locust Point community with a disproportionate number of subnormal children, he explained it was “not necessary for us to be fatalistic nor to feel that we have to wait for some complex social reorganization to bring improved conditions into the homes...”⁵² Rather, Campbell sanguinely believed

⁵⁰ Paula Fass (*Outside In*) argues that the widespread use of the intelligence testing after WWI equipped the schools to handle ever larger numbers of children. Educators could nod to the perceived individual needs of each child by creating various academic tracks based on IQ. Because children from immigrant or poorer backgrounds tended to score lower IQs, education was tailored to perceived abilities of these groups of children. Thus, democratic education, or the education of each individual according to his or her abilities, became less democratic as administrators sought efficiency in the movement to educate all.

⁵¹ See James Trent, *Inventing the Feeble Mind* (Berkeley, CA: UC Press, 1994).

⁵² C. Macfie Campbell, “A city school district and its subnormal children,” *Mental Hygiene*, 2 (1918) p 241.

psychiatrically trained school officials could meet the problems of “the alcoholic father, of the wayward sister, of adolescent conflicts.” Going beyond the individual home, Campbell posited that these school officials might also access “a large untapped reservoir of benevolence” in the community.⁵³

As discussed below, Campbell viewed the psychiatric dispensary as the hub of “organic connections...with the life of the community.”⁵⁴ Working with the school offered psychiatrists a sanctioned entrée into the homes of the community.⁵⁵

Part III: The Out-patient Dispensary

One of the innovations of the new urban psychopathic hospital was the out-patient dispensary. Initially conceived as a means to help facilitate the transition from life on the ward to life in the community, the dispensary also attended to milder cases of mental distress where hospitalization was not necessary. Campbell, the first director of the dispensary, outlined the different approach to these patients as opposed to patients on the hospital ward:

In the dispensary the practical demands of the patient stand in the foreground, and these demands usually require the investigation of a whole situation and not merely that of the patient as a unit; the attempt to modify this situation, which is essential for the satisfactory treatment of the case, takes one from the dispensary into the home and brings one face to face with the vital problems of the mental hygiene of the community.⁵⁶

Campbell and his successor, Dr. Esther Richards, who oversaw the dispensary from 1920-1951, actively promoted public interest in children’s mental health. Richards attended monthly case conferences and served as a board member of various local children’s organizations including the Family and Children’s Society, formerly the

⁵³ Ibid., 243.

⁵⁴ C. Macfie Campbell, “The mental health of the community and the work of the psychiatric dispensary,” *Mental Hygiene*, 1 (1917) p. 583.

⁵⁵ Writing in 1938, Miller wrote that the survey had given “some cause for satisfaction. Science had confirmed our professional judgment.” The two groups of students she identified indeed fared poorly on the intelligence testing. In 1933, Dr. Ruth Fairbank of the Phipps clinic resurveyed the subnormal students, now adults. The majority was still living in Locust Point or in Baltimore. To the surprise of the researchers, this group had no significantly higher incidence of dependency or delinquency than the average population. These results were publicized in articles in a few popular magazines including *Time*, “Medicine: Morons into Citizens” (May 8, 1933) and *Good Housekeeping*, “Science Stubs its Toe” (January 1934). These articles in addition to Fairbank’s article in *Mental Hygiene* (1933), attributed the success of these students to the personality of one teacher who taught the students “good old-fashioned morality, ...principles of decency, ...and clean-mindedness.”⁵⁵ Her main text was the Bible.

⁵⁶ C. Macfie Campbell, “The Role of the Psychiatric Dispensary” *American Journal of Insanity* 71 (1914-15), p. 439-440.

Charity Organization Society and the Henry Watson Children's Aid Society. She also met teachers and children weekly at School 76 beginning in 1918. She frequently gave public lectures on mental hygiene. The lectures she delivered to parents at Baltimore's branch of the Child Study Association formed the basis of her book, *Behavior Aspects of Children's Conduct* (1932).

Children posed unique challenges to psychiatrists. Campbell found them at first "shy, uncommunicative, on the defense."⁵⁷ The mainstay of psychiatric technique, eliciting the patient's account of his or her story, proved difficult to obtain from children. Social workers often provided important data from interviews with the family and information obtained through home visits. Additionally, psychiatrists viewed children's behavioral problems, particularly in children who had normal intelligence, as a result of "faulty habits fostered by bad hygiene of the environment." Children's pathology revealed the incipient stages of diseases seen in adults. Treatment consisted of proper training in the home or a change in environment altogether, rather than intensive self-reflective work, as characterized physician's work with adults.

Unlike adults who generally came to the clinic on their own accord, children were brought to the clinic because of difficulties they posed to adults. During the first ten years of the clinic, schools, social agencies, and other Hopkins dispensaries such as pediatrics, referred the majority of child cases rather than parents. Writing about the first year's experience of the dispensary in 1914, Campbell expressed surprise at the large number of children: "By far the largest group is that of children under 16 years of age... No more important nor more fundamental problems are brought before the dispensary than those furnished by this group of cases, which even numerically is so striking; it raises important questions as to the relation of the functions of the dispensary to the work of other social agencies."⁵⁸ Children's cases at the Phipps dispensary consistently comprised between a third and a half of all cases in the dispensary from 1913 through 1940.⁵⁹

In this section, I examine how Campbell and Richards evaluated individual cases. These particular cases are from the records of the Family and Children's Society (FCS) of Baltimore, and thus give a sense of how psychiatrists worked with social agencies during the period of 1915-1925. What emerges is a somewhat idiosyncratic picture of how experts approached children's minds. Mental hygiene's aspiration to create a socially cohesive community in part worked by removing some children from society for the sake of their protection and the protection of society. As children, they posed danger in

⁵⁷ C. Macfie Campbell, "The work of the out-patient department of the Henry Phipps Psychiatric Clinic," *Bulletin Johns Hopkins Hospital*, 25(1914) p. 154.

⁵⁸ C. Macfie Campbell, "The relation of social and economic factors to mental hygiene," *American Journal of Public Health*, 6 (1915), p. 440.

⁵⁹ Adolf Meyer papers I/3256, letter from E. Richards to Meyer, April 3, 1944.

potentia. At the same time, mental hygienists' concern for potential dangers at times left families and other children in precarious circumstances.

The Problem of Feeble-mindedness

As in the case of the Locust Point survey, children with difficulties in school posed a common problem. However, their evaluation in the clinic, as opposed to a survey, could yield significant hardship for the family. For example, the mother of William, a fourteen year-old Polish boy, brought her son to the FCS office to get a work permit.⁶⁰ William's father had deserted his wife and five children, and the mother took the children to the country to pick berries from May through September. The mother reported that the season was poor, and they barely had enough money to pay for food. The canning season was upon them and she wanted William to work, along with herself and her eldest son. The social worker then explained the child labor law to the mother and told her to send William to school.

After he was denied a work permit the following year, the social worker visited the home and found all the children at home because they did not have appropriate clothes for school. The mother also said that William has been smoking and she had threatened to put him into St. Mary's Industrial School unless he stopped. A few months later, the mother mentioned "incidentally" that William skips school because he cannot keep up. This prompted the social worker to visit the school where the teacher reported that he was "industrious and doing fairly well but that he was over-aged for his class." Upon the social worker's urging, William was brought to the Phipps dispensary for an evaluation.

Dr. Campbell gave William an intelligence test that revealed a six-year retardation. He strongly recommended manual training at the Rosewood School for the Feeble-minded outside of Baltimore. He warned of William's bleak future as an adult defective but if he went to the training school, he might "develop a fair degree of practical ability and be docile and able to meet the ordinary social requirements." This would allow him to "be much more efficient, than if at the present time he were allowed to drift into the usual occupation of these children without any safeguards."⁶¹

William's mother refused to commit her child to Rosewood, insisting that the family needed his help. However, the social worker threatened that the family would not receive any further assistance if she refused. When the mother came a week later to refute the claims of her hoarding money that a neighbor made against her, the social worker again

⁶⁰ Family and Children's Society (FCS), Johns Hopkins University, MS 360, Box 36, Case 35. I have adopted my own numbering system for the case records. Researchers with permission to access the files may contact me for specific case numbers.

⁶¹ FCS Case 35. Letter from Dr. Campbell to Federated Charities, Polish District, Dec 6, 1915.

insisted that the agency would not give her any assistance unless she “showed a better spirit of cooperation” by having William committed to Rosewood.

However, social agencies exercised coercion inconsistently. In the case of Betty, a fifteen year-old girl of a German family, the mother’s refusal was not challenged.⁶² The family was on relief from the FCS and the German Society after the father committed suicide. Betty did not attend school regularly because she cared for the three younger children when her mother worked in a packing house. The social worker spoke with the teacher at the parochial school who said she had excused the girl from school because she made little progress and doubted that “she had the mentality to make even a good domestic.” However, her conduct in school was good. The social worker arranged to have Mrs. Miller of School 76 assess the child scholastically. After a half day of observation, the teacher endorsed her limited scholastic capacity and agreed that Betty should be allowed to have a work permit.

The situation might have been similar to William’s family after Betty’s mother complained to the German Society social worker that Betty was “on the street entirely too much.” This information was relayed to the FCS worker who did not feel it was necessary to have Betty examined at the Phipps because it was “a well known fact” that the girl was feeble-minded. The worker felt it could be worthwhile to send Betty for an evaluation at Rosewood, but the mother refused to allow this because “[Betty] is a little hard to manage, she is not really bad and when she works, she brings home her money”. There is no evidence that the agency pushed this further. Unlike William, Betty, despite her feeble mind, demonstrated the ability to work and bring home her earnings.

Industrial Adjustment

When children were not considered feeble-minded, psychiatrists often recommended manual training or “industrial adjustment” through work for older children with behavior problems. Meyer believed that concrete activity was a proper form of therapy for most mental ill. In these cases of neurosis, as opposed to feeble-mindedness, psychiatrists demonstrated more interest in the child’s individual assets and weaknesses, but the psychobiological approach also could betray the subjective nature of professional judgment as opposed to the deceptive clarity of an IQ.

For example, thirteen year-old Ralph was brought to the Phipps dispensary by the FCS worker in 1923 because of behavior problems at a boarding home.⁶³ His mother had died when he was six years old and his father sent him to St. Mary’s Industrial School for four years. After his father remarried, the child returned to live at home but was

⁶² FCS Case 34.

⁶³ FCS Case 7.

uncontrollable and eventually committed as a ward of the FCS after assaulting a three year old girl. In the boarding homes, he stole money and food.

After Dr. Richards measured his intelligence in the normal range, she wrote to the FCS that “the conduct disorder for which [Ralph] was brought to us does not seem to me to be serious. You reported that he has stayed away from the boarding home when sent on errands and refused to give an account of where he had gone. The writing of a ‘shady’ note which was attributed to him by the school teacher does not seem to call for any particular investigation. Such things are all too common in every school....” She instead ascribed his difficulties to being compared unfavorably to another child in the boarding house.

Two years later he came to the attention of the FCS again because he was failing in school. The social worker felt it was “hard to get at his real feelings or understand him” and brought him for a psychiatric examination to help “decide what was the best course to take.” Dr. Richards “gave his case very much consideration and talked with him at some length.” She discerned that “the best adjustment he has thus far was that of working last summer as a messenger boy. With this job went the satisfaction of earning money and spending a certain amount of it as he pleased.” She recommended his stopping school and starting a “permanent industrial adjustment,” but then added that “he seems to have some inclination at present to take to the sea and I would encourage this desire as a very laudable outlet for his adventurous spirit...”.

Perhaps not surprisingly given the open-ended quality of the recommendation, the social worker and his family decided instead to commit him again to the Maryland Training School for Boys for three years.

In a different case, Richards took a decidedly negative stance towards a thirteen year-old boy David who was failing out of a private school designed for boys of limited means but of good character.⁶⁴ David had been orphaned after his mother died and his father deserted him. After six months at the new school, the headmaster complained that he was failing and could no longer stay at the school.

Dr. Richards found that his IQ was actually above average and ascribed his failure to his “poor habit equipment.” She furthermore remarked that he was “thoroughly spoiled so that at the present time he is impudent and definitely lazy.” She recommended that he be sent to the country to work on a farm and “as soon as he is [old enough] to secure a permit I would urge that industrial adjustment be undertaken.”

David agreed with this recommendation, stating that he did not like the school and preferred to farm work rather than commitment to Maryland Training School.

⁶⁴ FCS case 18.

Unfortunately, the social worker contacted his uncle who was “extremely busy” and did not have time to deal with the difficulties of his nephew. The uncle strongly recommended commitment to the Training School where he ultimately was sent.

In both cases, the psychiatric assessment attempted to give an individualized recommendation based upon the clinician’s opinion of salient “life facts.” The psychobiological approach proved to be difficult to implement under these circumstances of limited options and the need for expediency.

Conclusion

When Meyer addressed the National Conference of Charities and Corrections in 1925, ten years after his address above, his tone was wary and reactionary as he “became very conscious of a profound change that has taken place – we might almost say a temporary revolt against organization of the type I looked forward to and an emphatic assertion of individualism.”⁶⁵ He viewed the current “mood” of individualism as something new and possibly dangerous, leading to lawlessness, if not steered correctly. He recognized that some of these changes were brought about by modern psychiatry and pedagogy, with “more and more emphasis on the inner needs of the individual.”

His hopes for a cohesive community as the foundation for mental hygiene floundered in post-war America, with its increasing consumerism and developing youth culture. He asked the audience of the Progressive Education Association in 1928:

[W]hy there is such a zest for saving the child from becoming just a plain human being, such as most of us are, subject alike to the laws of nature and the opportunities of growth and to occasional blunders. It looks almost as if we were playing ourselves up as the sole originators and creators of nature, not content with finding our place as part of nature.⁶⁶

The idea of a bounded, hierarchical world seemed increasingly out of touch.

Meyer tried to reduce the inherent tension between social cohesion and individual needs through optimizing the fit of individuals into society. Attending to individuals had the untoward consequence of trying to grade and remove specific children in large systems such as schools and social agencies, although this was contrary to Meyer’s philosophy. Also, the impetus in psychobiology to attend to an individual’s total situation fell short of

⁶⁵ Adolf Meyer, “Individualism and the organization of neuropsychiatric work in a community,” in Eunice Winters (ed), *The Collected Papers of Adolf Meyer Vol IV*, (Baltimore: The Johns Hopkins Press, 1952) p. 257.

⁶⁶ Adolf Meyer, “Freedom and Discipline” in Eunice Winters (ed), *The Collected Papers of Adolf Meyer Vol IV*, (Baltimore: The Johns Hopkins Press, 1952), p. 416.

generating a close-knit community, but attending to the individual's relation to his or her nuclear family would become increasingly salient in child psychiatry from the 1930s onward.

CHAPTER 3

Training Social Workers at Johns Hopkins, 1919-1929

Before the Phipps Clinic officially opened, Meyer addressed the members of the Federated Charities of Baltimore at their annual meeting in 1910. Meyer sought to enlist the collaboration of social workers in helping to care for patients after discharge from the psychiatric hospital. The Phipps Clinic requested the “heartly collaboration” of social workers to provide a careful study of the patient’s home environment in order to “reach him through an improvement of the methods of living of the whole family.” Physicians were “naturally...in the center of the work,” but “friends or helpers” or “visiting nurses and social workers” had the important task of making sure “that his advice is actually carried out.” He entrusted those on the periphery with a therapeutic role: “It is easy to take medicine. To change one’s habits is much more difficult and needing capable and judicious help.”⁶⁷

Meyer’s speech reveals tensions that would become clear to psychiatrists and social workers in the next two decades. In 1910, he could comfortably equate “friends or helpers” with “visiting nurses and social workers.” From his medical authority in the bastion of the hospital, he could graciously bestow a therapeutic role to these women in the community. His confidence rested upon the particular division of labor and society of the Victorian era. Women could take on public duties as natural extensions of their responsibilities in the private domain without jeopardizing men’s authority. However, as medical practitioners began to emphasize preventive measures to counter disease at the turn of the century, they sought to influence activities in the domestic domain. Thus, the activity of these social reformers loosened the gendered division of public and private spheres.

After World War I, several universities developed courses to train professional social workers, which further problematized the ideology of separate spheres. Lasting only a decade, the course in Social Economics at Johns Hopkins spanned a tumultuous period as female social workers sought to define a profession. By the end of the 1920s, many social workers had a significantly different relation to psychiatrists, their clients, and the state than their predecessors. They considered themselves no longer simply friends of

⁶⁷ Federated Charities (Baltimore, Md.), *Annual report of the Federated Charities (incorporated 1910) for the year ending*. (Baltimore, Md: Central Offices, Charities Building, 1910), p. 36. The COS underwent several name changes during the period of this chapter. Charity Organization Society, COS (1881-1910), Federated Charities, FC (1910-1919), Family Welfare Association, FWA (1919-1942), Family and Children’s Society, FCS (1943-1985).

clients or helpers of psychiatrists but paid professionals with a unique skill. Instead of social investigators, they began to consider themselves as therapists.

While female reformers of the late nineteenth century sought the power of the state to implement child welfare reforms, the majority of graduates of training courses such as the Hopkins program sought employment in private social service agencies. Social work in the public social sector was generally considered routine and substandard.⁶⁸ The private charities and philanthropies offered women more freedom and autonomy in their work. They experimented with psychiatric approaches as a means of improving upon their skills as case workers. However, these gains came at the cost of limited public authority and low wages.

Some commentators have lamented the psychiatric influence on social work as a misguided focus on individual case work rather than wider community concerns.⁶⁹ Historian Roy Lubove attributed the narrowing of scope to the process of professionalization in an increasingly bureaucratic society. After Abraham Flexner infamously announced at the National Conference of Charities and Correction in 1915 that social work was not a profession, social workers scrambled to define their professional skill. Psychiatry, and especially psychoanalysis, provided social workers with a more “scientific” and “hence more professional” approach.⁷⁰ However, social workers treaded dangerously upon psychiatric terrain, leaving them vulnerable to exposure as trespassers and novices because of their weaker professional status.⁷¹

Yet what needs to be reassessed is social workers’ contribution to psychiatric knowledge, especially in child psychiatry. Social workers of the 1920s chartered new terrain by adapting psychoanalytic ideas to work with children and families. With more autonomy in domains related to women and children, they adapted psychoanalytic concepts to

⁶⁸ Edward Devine describes the majority of workers in the public sector as having “so little general education, and so little special training, that their presence can be accounted for only by the absence of effective competition or by very low standards in their employers.” In Edward Devine, Mary Van Kleeck, and Florence Woolston, *Positions in social work* (New York city: The New York school of philanthropy, 1916), 7.

⁶⁹ See Frank Bruno, “Twenty-Five Years of Schools of Social Work,” *Social Service Review* 18, No. 2 (Jun., 1944): 152-164 and Sydnor Walker, *Social work and the training of social workers* (Chapel Hill: The University of North Carolina press, 1928).

⁷⁰ Roy Lubove, *The professional altruist; the emergence of social work as a career, 1880-1930* (Cambridge: Harvard University Press, 1965), 220.

⁷¹ See Lubove op. cit.; Elizabeth Lunbeck, *The psychiatric persuasion: knowledge, gender, and power in modern America* (Princeton, N.J.: Princeton University Press, 1994); Margo Horn, *Before it's too late: the child guidance movement in the United States, 1922-1945* (Philadelphia: Temple University Press, 1989); and Kathleen W. Jones, *Taming the troublesome child: American families, child guidance, and the limits of psychiatric authority* (Cambridge, Mass: Harvard University Press, 1999).

approach social problems in an epistemologically new way that used both empathy and objectivity. Through the act of imagining another's experience, empathy brought forth another stream of data that could then be analyzed. This combination helped workers to comprehend the seemingly irrational behavior of children who could not as readily articulate their concerns as adults.

Despite the advances in the field of social work in the 1920s, the course at Hopkins failed to find an intellectual base. The Political Economy Department housed the Course largely out of historical reasons. Faculty offered basic courses in social legislation and statistics, which offered limited utility to students who spent most of their time doing case work in social agencies. On the other hand, the courses in psychiatry given by Meyer's staff provided little inspiration. His psychiatric approach did not change significantly during his tenure at Hopkins, from 1909 until his retirement in 1941.⁷² Thus, the courses of the 1920s deviated little from Meyer's speech to the local charities in 1910, which consigned social workers to the role of assistants.⁷³

This chapter is divided into four sections. The first sets out the male precedent in the History and Politics Seminary at Hopkins in the late 19th century. Young men became leaders in civic affairs including the Charity Organization Society. The second section contrasts the comparatively limited options for women in charity work and the push to establish professional schools for social work in the early 20th century. The third describes the establishment and evolution of the Course in Social Economics with an increasing emphasis on psychiatry throughout the 1920s. The final section contrasts the stagnation of the Hopkins course with other schools that embraced psychoanalysis. Looking at the developments at other institutions, I seek to bring into relief the particularities of the development of child psychiatry at Johns Hopkins. What emerges is

⁷² According to Andrew Scull and Jay Schulkin, "Meyer's original contributions to neurology and neuroanatomy virtually ceased once he arrived in Baltimore. His psychiatric papers from his three decades at Hopkins were programmatic rather than substantive, and they were written in a notoriously dense and impenetrable prose." They cite Thomas Turner's "generally hagiographic" account of Hopkins as a "damning assessment": "Meyer seems to have done very little research in the accepted sense after coming to Hopkins' and pronounces himself unable to discern 'any direct contribution to knowledge in the field.'" Andrew Scull and Jay Schulkin, "Psychobiology, Psychiatry, and Psychoanalysis: The Intersecting Careers of Adolf Meyer, Phyllis Greenacre, and Curt Richter," *Medical History* 53, no. 1(2009): 11. Cited Thomas B Turner, *Heritage of excellence: the Johns Hopkins medical institutions, 1914-1947* (Baltimore: Johns Hopkins University Press, 1974) 441-4.

⁷³ Sydnor Walker's appraisal of schools of social work in 1929 found that other schools suffered similar problems: "The courses now operating have too often been set up in a rather haphazard way to meet the demands, only half-comprehended, of local social organizations or of students. The curriculum resulting may be made a part of the Sociology or Economics Department, and may not have the whole-hearted backing of any member of the faculty...." in Walker, *Social work*, 160.

a story that gives female social workers a much larger contribution to the development of the medical subspecialty of child psychiatry.

Historical Precedents

When the Baltimore Alliance of Charitable and Social Agencies approached Johns Hopkins rather than the all-women Goucher College for a course to train social workers in 1918, members were looking back with nostalgia to a period of intense collaboration in the late nineteenth century. Daniel C. Gilman (1831-1908), the first president of Johns Hopkins, initiated the formation of the Baltimore Charity Organization Society (COS) in 1881, serving as president of the organization from 1891-1902.⁷⁴ The COS quickly became the largest and most dynamic charity in Baltimore, recruiting a number of volunteer visitors from the student body and staffing the various managing boards with faculty and local elites. By the 1910s, however, the landscape of charity had changed. With an emphasis on efficiency, local private charities such as the Baltimore COS became part of larger financial organizations such as the Baltimore Alliance in order to centralize fund-raising efforts. Trained staff, generally women, increasingly took over the work of volunteers.

During the period of early enthusiasm, faculty and graduate students of the Hopkins Seminary of History and Politics, at the time an all-male gathering, participated in the COS at various levels. The Seminary, a bi-weekly evening meeting to discuss research and contemporary events fostered a spirit of public interest.⁷⁵ Most participants pursued careers in academia or government and generally supported progressive causes although there was a spectrum of opinions. Some, including economists Richard Ely, John Commons, and Henry C. Adams, endorsed socialist politics, from which they backed away when such views threatened their academic careers in the 1890s.⁷⁶ Others had successful careers in government, including future president Woodrow Wilson and the Willoughby brothers who held government posts in China and Puerto Rico as the United States expanded its interests abroad.

⁷⁴ After Gilman retired from Hopkins, the next president of the University, Ira Remsen, also became the COS president in 1902.

⁷⁵ The minutes of the Seminary are published in Gettleman, Marvin E. *The Johns Hopkins University Seminary of History and Politics: the records of an American educational institution, 1877-1912 : in five volumes*. (New York: Garland, 1990).

⁷⁶ Mary Furner details the academic freedom cases of the 1890s in her book *Advocacy & objectivity: a crisis in the professionalization of American social science, 1865-1905* (Lexington: The University Press of Kentucky, 1975). Dorothy Ross charts the move from socialism to liberalism by these academics, in response to their job insecurity. See Dorothy Ross, "Socialism and American Liberalism: Academic Social Thought in the 1880s," *Perspectives in American History*, XI (1977-1978): 7-79.

Historian Herbert Adams (1850-1901) led the Seminary for nearly twenty years beginning in 1882 and expressed a degree of ambivalence towards various social reform activities, often in gendered terms. On several occasions he lauded Arnold Toynbee's work in East London and the continuing efforts at Toynbee Hall, but at other times he derided settlements as "fashionable charity... given to 'slumming.'" ⁷⁷ Similarly, Adams endorsed activities modeled after England's University Extension efforts, and lectured at Chautauqua in New York, an adult summer education program, in the late 1880s. But on another occasion, he read a letter from the late English historian Edward A. Freeman that "seemed to regard work done for 'Lads' as wasted. The University men should spend his time writing." ⁷⁸

Adams offered fatherly advice to his young male students before the school year adjourned: "...Professor Adams warmly commended [University Extension] as a means of uplifting the masses. A University man could do nothing better in the summer [than educating others] for it is only through higher education that our citizens can appreciate a just conception of civic duty.... However, he warned them against carrying out the latter injunction to the extent of forming entangling matrimonial alliances. Summer, said he, is an especially deceptive and dangerous season for the contraction of such [entangling matrimonial] alliances for there the feminine parties to the agreement have us completely at their mercy. Wait and turn the cold white light of winter on the female specimens." ⁷⁹

The Baltimore COS, modeled after existing organizations in London, Buffalo, and New York, ascribed to the faith that charity should be based upon science rather than sentiment. Instead of indiscriminate almsgiving, including books and clothing, with its inherent danger of pauperizing or degrading the poor, members of the COS believed they could alleviate, if not eradicate, poverty through investigating each case of need. Their motto, "Not alms, but a friend," attested to the ideology that the poor required individualized moral guidance, and the belief that friendship rather than radical reform could alleviate class conflict.

Historians, and some contemporaries like Jane Addams, have pointed out the contradictions of the COS faith that poverty could be alleviated through a combination of "scientific" investigation of each case and personal friendship between economic classes. ⁸⁰ Historian Roy Lubove referred to the COS as "an instrument of urban social control for the conservative [Protestant American] middle class." ⁸¹ At the time, however,

⁷⁷ March 20, 1891 Gettleman, *The Johns Hopkins University Seminary*, Volume 2, 189.

⁷⁸ May 20, 1892, Gettleman, *The Johns Hopkins University Seminary*, Volume 2, 879.

⁷⁹ May 21, 1897 Gettleman, *The Johns Hopkins University Seminary*, Volume 4, 342.

⁸⁰ Michael Katz called the COS "hopelessly anachronistic," and "fail[ing] on every major dimension." Michael Katz, *In the shadow of the poorhouse: a social history of welfare in America*, (New York: Basic Books, 1986), 67, 80.

⁸¹ Lubove, *Professional Altruist*, 5, 16.

many university men like Daniel Gilman believed that the COS was at the vanguard for solving social problems. It also provided a politically safe means for involving students in social issues. Gilman and graduate Amos Warner (1861-1900) offered a course in 1892 on Social Science to introduce the public to the “New Charity” of the COS. The lectures emphasized the scientific approach of the COS, based upon the observation and arrangement of facts with potential to discover “lessons useful for mankind.”⁸²

Faculty encouraged students to participate as volunteer friendly visitors as a means to “take object lessons in social pathology.”⁸³ Under the auspices of the COS, students visited various public and private charitable institutions such as orphan asylums, hospitals, jails, and reformatories.⁸⁴ One Hopkins graduate used visits to these institutions as the basis for his report on the “Charitable Institutions of Maryland” for the Chicago World Fair in 1893.⁸⁵ Students undertook research projects on local conditions of unemployment and poverty. In one example, a graduate conducted interviews with homeless men for two nights at the privately run shelter of the COS. Although he found that most were middle-aged, American-born, “more or less addicted to drink,” he suggested “remedies for the ‘Tramp Trouble’” which reflected values shared by members of the Seminary and COS more than logical conclusions from his observations: “stricter immigration laws, encouragement of economic stability, arbitration of labor troubles, abolition of ‘artificial’ work and indiscriminate charity, and regulation of boarding and lodging houses.”⁸⁶ Object lessons bolstered these young men’s ambitious conclusions and more ambitious career aspirations.

A striking number of prominent leaders of the newly developing field of social work came out of the Johns Hopkins and Baltimore COS environment. Amos Warner worked as the COS General Secretary between 1887-1889 while obtaining his doctorate in economics at Hopkins. He later became the first Superintendent of Public Charities of the District of Columbia before teaching economics at Stanford. He wrote his widely influential treatise *American Charities: A Study in Philanthropy and Economics* (1894) based on his experience in administering private and public charities, underscoring his belief in organized charity and an enlightened public as the rational means to alleviate poverty.

Jeffrey Brackett (1860-1949) and John M. Glenn (1858-1950) also had influential careers in social work. After graduate work in history at Hopkins, Brackett worked as a district manager of the COS and served on the newly formed Board of Supervisors of Charities

⁸² “Johns Hopkins University” *Lend a Hand*, 4:3 (1889), 234.

⁸³ March 16, 1893 Gettleman, *The Johns Hopkins University Seminary*, Volume 3, p. 66.

⁸⁴ *Ibid.*

⁸⁵ David I. Green in *Annual report of the president of the Johns Hopkins University for 1892-93* (Baltimore: Johns Hopkins Press), 56.

⁸⁶ May 5, 1889 Gettleman, *The Johns Hopkins University Seminary*, Volume 2, 473.

in Baltimore, overlooking public relief. Brackett taught courses in philanthropy at JHU until he founded and directed the country's first full-time school of social work in Boston through Simmons College and Harvard in 1904.⁸⁷ After Glenn briefly attended graduate studies at Hopkins, he studied and practiced law before devoting himself to the Baltimore COS full-time. He served as the first director of the Russell Sage Foundation from 1907-1931, exerting influence on the field of social work and social welfare.⁸⁸

The Questionable Status of Social Work

While the Seminary expected young men to take leadership positions, contemporaries at Goucher College, Baltimore's women's college, might expect a life in social work with "no immediate and brilliant results, but many burdens and small praise,"⁸⁹ as Mary Richmond addressed students in 1896. Richmond (1861-1928) took over the position of General Secretary of the COS after Amos Warner in 1891 and worked with Brackett and Glenn. Although she, too, became a national figure in social work and perhaps more profoundly influenced the field with the publication of *Social Diagnosis* (1917), a textbook for case workers, her background differed significantly from her male colleagues.

After losing both parents to tuberculosis, Richmond grew up with her aunt and grandmother in Baltimore. Money was tight as the family relied on the income from a boarding house.⁹⁰ A promising student, Richmond graduated from high school but did not attend college. She worked in various secretarial jobs before obtaining a paid position as bookkeeper at the COS. She availed herself of the tutelage of John Glenn, John M. Glenn's uncle, a wealthy businessman who helped reinvigorate the COS in the mid 1880s. Glenn, also a mentor to Warner and Brackett, supported Richmond's promotion to General Secretary, a prestigious post formerly held by Warner. Richmond proved quite capable as an organizer and devoted much of her efforts to standardizing the work of the organization. She had a penchant for creating forms and protocols, but she was also an avid student and teacher. She intended first book, *Friendly Visiting Among the Poor* (1899), as a handbook for friendly visitors but it became a standard text for social workers.⁹¹

⁸⁷ Gettleman, *The Johns Hopkins University Seminary*, Volume 1, 39.

⁸⁸ This period funded extensive surveys of working class conditions in cities, contributing to legislation.

⁸⁹ Mary Richmond, "Criticism and Reform in Charity", in Mary Richmond et al., *The long view; papers and addresses by Mary E. Richmond* (New York: Russell Sage Foundation, 1930), 43-55.

⁹⁰ Elizabeth Agnew, *From charity to social work: Mary E. Richmond and the creation of an American profession*. (Urbana [Ill.]: University of Illinois Press, 2004), 17-26.

⁹¹ Alice Channing, "The Early Years of a Pioneer School," *Social Service Review* 28, No. 4, (1954), 436.

When Richmond addressed the students in the Social Science Club at Goucher College in the 1890s, she anticipated many of the problems paid social workers of the next generation would face. She described the gendered division of labor in charity organizations as “artificial”, with men dominating the official and impersonal positions and women tending to the “private and more personal side of the work.”⁹² At the same time, she was conservative in approach, disliking the “fanfare” of socialism and social settlements and remaining indifferent to the suffrage movement. She encouraged women to continue with the plodding, patient work of “making crooked paths straight” which would bring its own “modest rewards.”⁹³

Richmond’s self-avowed “depressingly low-keyed” speech to the Goucher students raised concerns about attracting young, educated people to organized charity work.⁹⁴ College settlements were intellectually vibrant institutions, especially for college women. The following year, Richmond made one of the first public calls for a professional school in “applied philanthropy” at the National Conference of Charities and Correction (NCCC) in 1897.⁹⁵ A school would help to raise standards for charity work, and the demand for highly trained workers would allow the graduates to earn a living.

Although Boston and New York developed full-time courses in 1904, Baltimore charities did not push the local universities for a training school until after the war. Instead, volunteers or agency workers could attend public lectures or courses given through the universities and various charity agencies. Porter Lee of the New York School of Philanthropy dubbed the a la carte offerings of various opportunities the “Baltimore Plan” for social work training. Lee warned about the risks of superficiality without an established school. The development of solutions and techniques required “clear thinking” and the study of methods.⁹⁶

While workers in the field of philanthropy recognized the importance of a professional training school, this was far from evident to the outside observer. In an infamous speech in 1915 at the NCCC, Abraham Flexner voiced his opinion that social work was not a profession. Social work did not have its own area of expertise; rather, it served as a mediating function amongst various other domains such as medicine, law, and

⁹² Richmond, *Long View*, 53.

⁹³ Richmond, *Long View*, 55. Muriel Pumphrey, “*Mary Richmond and the rise of professional social work in Baltimore the foundations of a creative career*” PhD diss., Columbia University, 1956, 358.

⁹⁴ Richmond, *Long View*, 54.

⁹⁵ Mary Richmond, “The Need of a Training School in Applied Philanthropy” in *Long View*, 99-104.

⁹⁶ Porter Lee, “The Baltimore Plan for Training in Social Work”, *The Survey* (December 26, 1914), 335-6.

education.⁹⁷ Flexner gave the following example: “The social worker takes hold of a case, that of a disintegrating family, a wrecked individual, or an unsocialized industry. Having localized his problem, having decided on its particular nature, is he not usually driven to invoke the specialized agency, professional or other, best equipped to handle it? There is illness to be dealt with – the doctor is needed; ignorance requires the school; poverty calls for the legislator, organized charity, and so on.”⁹⁸

Flexner also questioned whether social work had skills that could be taught: “Well-informed, well-balanced, tactful, judicious, sympathetic, resourceful people are needed, rather than any definite kind or kinds of technical skill.”⁹⁹ Furthermore, the nominal salaries and use of volunteers to perform the job also precluded professional status: “Well trained men and women cannot, as a rule, be attracted to a vocation that does not promise a living wage in return for competent service.”¹⁰⁰ Flexner turned the COS philosophy against itself through its insistence on friendship as the panacea for social problems.

Flexner’s criticisms cut to the historical core of charity in social work. Charity was based upon spiritual, humanitarian sentiment not on learned, scientific technique. However, to those who developed careers through the COS, such as many leaders of the field including Mary Richmond, Edward Devine, and Jeffrey Brackett, charity could, and should, be based upon skillful application of rational principles. The COS based its scientific aspirations upon the study of each case in its particularity. In the publication of *Social Diagnosis* in 1917, Richmond gave the field of social work a defining text of the scientific method of case work.

Social diagnosis rested upon a series of steps. First, a collection of social evidence through interview with the client; contacts with family members; and testimonials from social relations outside the family including employers, neighbors, clergy, and social agencies; then the social worker then made a social diagnosis by “carefully weighing” all evidence to derive at an “exact definition” about the client’s “situation and personality.”¹⁰¹ Richmond granted that a non-specialist could possibly carry out some of

⁹⁷ Abraham Flexner, “Is Social Work a Profession?” *National Conference of Charities and Correction* (1915), 581. Flexner’s six criteria for professions: “Professions involve essentially intellectual operations with large individual responsibility; they derive their raw material from science and learning; this material they work up to a practical and definite end; they possess an educationally communicable technique; they tend to self-organization; they are becoming increasingly altruistic in motivation.”

⁹⁸ *Ibid.*, 585.

⁹⁹ *Ibid.*, 587.

¹⁰⁰ *Ibid.*, 588.

¹⁰¹ Mary Richmond, *Social diagnosis* (New York: Russell Sage Foundation, 1917), 357.

the work of a social worker, but the combination of skills set the social worker apart, which “no untrained person, however intelligent, would have achieved.”¹⁰²

In addressing the NCCC, shortly after the publication of *Social Diagnosis* in 1917, Richmond disagreed with Flexner’s analysis:

But as we listened to Mr. Flexner we were more or less aware that quietly and behind his back, apparently, there was developing a skill quite different in method and in aim from the work that he described.... [T]he distinguishing marks of their work were, first, skill in discovering the social relationships by which a given personality had been shaped; second, ability to get at the central core of difficulty in these relationships; and third, power to utilize the direct action of mind upon mind in their adjustment.¹⁰³

This definition of the aims of social work would soon lead to confrontations with psychiatrists. But in 1917, Richmond, who had been working on *Social Diagnosis* for several years, did not see a clash of interests.

She believed that the older professions such as medicine and law had new demands for “social evidence” produced by case workers:

Social evidence may be defined as consisting of any and all facts as to personal or family history which, taken together, indicate the nature of a given client’s social difficulties and the means to their solution. Such facts...will influence...the diagnosis of physical and mental disorders, will reveal unrecognized sources of disease, will change court procedure with reference to certain groups of defendants, and will modify methods in the school class room.¹⁰⁴

For Richmond, social workers were neither assistants nor competitors but colleagues and consultants.

The Course in Social Economics

The First World War helped to provide the necessary public support for trained social workers. The National Committee for Mental Hygiene (NCMH) and the Red Cross organized training courses for social workers to meet the needs of families of servicemen while away and upon their return. The NCMH held a summer course in 1918 at Smith College in conjunction with the Boston Psychopathic Hospital to train social workers in rudimentary psychopathology in order to better handle the needs of soldiers returning

¹⁰² Mary Richmond, *What is social case work? An introductory description* (New York: Russell Sage foundation, 1922),102.

¹⁰³ *Ibid.*, 399.

¹⁰⁴ Mary Richmond, *Social Diagnosis*, 43.

with war neuroses. This course trained seventy women and was the first formal attempt to teach the specialized branch of psychiatric social work.¹⁰⁵

The American Red Cross began an extensive effort to train volunteers in 1917 through the creation of Home Service Institutes associated with universities. The Institutes offered six to twelve week courses in the rudiments of social work. Mary Richmond, then working at the Russell Sage Foundation, wrote the training manual for these Institutes. Among other duties, volunteers investigated families of service men requesting the help, usually monetary aid, of the Red Cross. Richmond outlined a detailed set of questions about the home environment, the education and health of the children, and household finances.¹⁰⁶

Goucher College and Johns Hopkins jointly hosted the Baltimore Home Service Institute. Theo Jacobs (b. circa 1880 – N.D.) and Mary Goodwillie (1870-1949) of the Family Welfare Association directed the course. Jacobs later headed the Hopkins course on Social Economics. Both Jacobs and Goodwillie were part of Baltimore's social elite and thus shared the background of the generation of politically active Arundell Club women at the turn of the century.¹⁰⁷ Jacobs graduated from Goucher College in 1901 and worked with the FWA, eventually appointed as acting general secretary in 1917. Goodwillie extolled the virtues of volunteer work in addresses to the National Conference of Social Work in 1915 and 1917. According to an article in the *Baltimore Sun* cheerfully entitled, "The Baltimore Home Service Section of the Red Cross has Done Much Good during the War," a large number of the Red Cross Home Service volunteers were of similar social standing: "these delicately-raised, faultlessly groomed women from the best families in Baltimore."¹⁰⁸

Despite the enthusiasm of volunteer efforts, some social work professionals found the work substandard. The flooding of the field with minimally trained recruits concerned leaders who sought to raise standards of the profession. Stuart A. Queen, sociologist associated with the Potomac Division of the Red Cross, criticized the superficial quality of the Institutes: "Some of the 'graduates,' by reason of native ability and previous experience, had done splendid work. But others have not only failed to do good work;

¹⁰⁵ Mary Jarrett, "Psychiatric Social Work: An Emergency Course in a New Branch of Social Work," *Mental Hygiene*, Vol 2 (1918), 593.

¹⁰⁶ The American Red Cross, *Manual of Home Service*, 2nd ed (1917), 40.

¹⁰⁷ Listed in Baltimore's Social Register, *Baltimore Society Visiting List "Blue Book", 1921* (Baltimore, MD: The Norman, Remington Co., 1920), which listed approximately 1 percent of the city's population per James Crooks, *Politics & progress; the rise of urban progressivism in Baltimore, 1895 to 1911* (Baton Rouge: Louisiana State University Press, 1968), 196.

¹⁰⁸ Gertrude Leimbach, "The Baltimore Home Service Section of the Red Cross has done much good during the war", *Baltimore Sun* (May 4, 1919), 12.

they have done actual injury to the communities in which they have been employed.”¹⁰⁹ Local charities also worried about the continued use of Red Cross services in peacetime. Although many charities supported the Red Cross efforts by loaning their staff during the war, they feared the effects of “top down”, large-scale bureaucracies on their work.¹¹⁰

The Baltimore Home Service Institute discontinued its training after Johns Hopkins started a full-time course for social workers in 1919. In conjunction with the Baltimore Alliance of Charities, the Department of Political Economy supervised the two-year course in Social Economics.¹¹¹ Over the next ten years, 42 women received Master’s degrees in Political Economy and 276 others registered for courses without enrolling as full-time students.¹¹² The Family Welfare Agency and the Henry Watson Children’s Aid Society paid for the tuition of ten students annually and provided them with a small salary. These students were expected to work for two years with the agency after graduating.

The cachet of Johns Hopkins as a graduate-level, scientific institution likely influenced the decision to establish a professional course there as opposed to Goucher College. The two institutions rhetorically approached social work in widely different ways. While the Hopkins course emphasized objective laboratory methods for professional advancement, Goucher College stressed the powers of empathic understanding for good citizenship.

An early announcement of the Hopkins course echoed the History and Politics Seminary’s approach to social agencies as sites for scientific object lessons: “The plan of the Courses is to train case workers and to equip persons to fill a variety of positions...by dividing attention between theoretical and practical instruction. The work will be made scientific through close coordination of class-room with field experience. The field work will be given through facilities offered by the Alliance.”¹¹³

¹⁰⁹ Stuart A. Queen, “Training for Home Service,” *City and State: a Maryland journal of civic and social progress*, (October 1919), 9-10.

¹¹⁰ Richmond, *Long View*, 419.

¹¹¹ The use of the term “social economics” instead of “social work” may have seemed anachronistic to contemporaries. In the late nineteenth century, Franklin Sanborn of the American Social Science Association referred to “social economics” as “the feminine gender of Political Economy, and so, very receptive of particulars, but little capable of general and aggregate matters...” as cited in Nancy Folbre, “The ‘Sphere of Women,’” in Helene Silverberg, *Gender and American social science: the formative years* (Princeton, N.J.: Princeton University Press, 1998), 43.

¹¹² John French, *A history of the university founded by Johns Hopkins* (Baltimore: Johns Hopkins Press, 1946), 237-239.

¹¹³ “University Courses in Social Economics,” *City and State: a Maryland journal of civic and social progress*, (October 1919), 11.

This contrasted with the aims of the undergraduate “Social Science Laboratory” at Goucher College in 1916, which stressed the empathic connection with the poor as a means to “bring about the true democracy”:

Social observation, however, is different from other kinds of observation. We can observe objects from the outside adequately, but we have to observe people from the inside. That is, the largest part of people is something one cannot see with objective observation. It is the motive forces in people that are important; and these consist of emotions, hopes, fears, desires. . . . The observer must himself pass through, as nearly as possible, the experience of those he is studying, and observe his own emotions, hopes, fears, etc., in those experiences. Under certain circumstances he may then impute these emotions and feelings to the persons he is studying. The social observer and expert is the one who has had the common experience of many elements in society. He is just the opposite form the well-to-do person who goes slumming. He is the true democrat, having passed through the experiences of the many.¹¹⁴

Many students of the Hopkins course had been undergraduates at Goucher and likely pursued a career in social work because of the attraction of empathic principles. Historian Regina Morantz-Sanchez hypothesized that the decline of female medical students in the early 20th century could be related to the rise in the new helping professions such as social work. As medicine increasingly valued laboratory work in hospital settings over the intimacy of home calls, women found the profession less compelling.¹¹⁵

The course suffered Flexner’s criticism that social workers provided a mediating function between other disciplines, rather than a field unto itself. Thus, faculty from various fields gave rudimentary lectures, without necessary consideration of how this tied into an emerging profession of social work.

Unlike the thoughtful consideration of methods for social work, Jacob Hollander (1871-1940), the chair of Political Economy, gave little formal attention to its scope and methods although he supported the course. His background reflected the male province of statesmanship and academia. He received his PhD in economics at Hopkins in 1894 and participated in the Seminary of History and Politics under Herbert Adams. Like others in his cohort, his training led to high-level government work and a sense of civic duty. Appointed Treasurer of Puerto Rico, he aided US interests in the Caribbean.¹¹⁶ He served on boards of local charities, including the Family Welfare Association.

¹¹⁴ Clarence Blachey, “Social Science Laboratory at Goucher,” *The Town: a civic journal*. Baltimore, Md: Women's Civic League (Nov. 25, 1916), 6.

¹¹⁵ Regina Morantz-Sanchez, *Sympathy and science: women physicians in American medicine* (New York: Oxford University Press, 1987), 262-263.

¹¹⁶ Gettleman, *The Johns Hopkins University Seminary*, Volume 1, 56.

As common among his mentors and peers, Hollander gave lectures to the public, including a series on “Practical Political Economy” to the Arundell Club women in 1895.¹¹⁷ This was likely a satisfying experience as these women requested these lectures to foster their political activism in passing child welfare legislation. Hollander’s political economy course for social workers intended to “give [them] training in the principles of the science. Especial attention has been paid to the subject of distribution.”¹¹⁸ Hollander, who recently wrote *The Abolition of Poverty* (1915) which argued for minimum wage legislation, likely envisioned a group of leisured but politically engaged women similar to the Arundell Club twenty years earlier.

Although women with college degrees still constituted an elite group, they came from socially different backgrounds than the Arundell Club women. Of those from Baltimore, none of the students who completed the full course were from families listed in Social Register. After graduation, most women worked for several years in various social agencies, as caseworkers rather than administrators. All five women who received Master’s degrees in the first class of 1921 were still working at least six years out from graduation. Two continued to work for the children’s agency that sponsored their education, whereas the other three worked in various agencies throughout the country.¹¹⁹ These women fit Daniel Walkowitz’s study of social workers who had professional aspirations of the New Woman of the 1920s but lacked the salaries to support the idealized lifestyle of a fashionable and sophisticated single woman.¹²⁰

Hollander relegated his teaching duties to his former student, Broadus Mitchell, after the first year. Mitchell (1892-1988) taught a course on social reform that reviewed “the principal proposals for alteration of the existing social structure...to give students some comprehension of the economic organization in which their work must be done.”¹²¹ Mitchell had interests in labor organization and women’s education. In the 1920s he taught at the Summer School for Women Workers at Bryn Mawr College, a course encouraging women’s activity in trade unions.¹²² However, two years later, Mitchell’s

¹¹⁷ Arundell Club (Baltimore, Md.), *The annals of the Arundell Club of Baltimore, 1894-1925. Compiled mainly from the Reports of the Presidents, with a Sketch of the Woman's Literary Club from which it came.* (Baltimore: Norman, Remington, 1926), 52.

¹¹⁸ The Ferdinand Hamburger Archives of The Johns Hopkins University (FHA), Record Group Number 04.140, Department of Political Economy, RG 04.140, Series 4, Box 3, Folder 5 Curricular Materials, 1921-1924: “Report on Courses in Social Economics.”

¹¹⁹ FHA, Record Group Number 04.140, Department of Political Economy, RG 04.140, Series 4, Box 3, Folder 7, “Graduates in Social Economics 1921-1927.”

¹²⁰ Daniel J. Walkowitz, “The Making of a Feminine Professional Identity: Social Workers in the 1920s,” *The American Historical Review* 95, No. 4 (Oct., 1990), 1051-1075.

¹²¹ FHA, Record Group Number 04.140, Department of Political Economy, RG 04.140, Series 4, Box 3, Folder 7, “Graduates in Social Economics 1921-1927.”

¹²² He also ran for Governor of Maryland, representing the Socialist Party, with Elisabeth Gilman, the daughter of the late president of Hopkins Daniel C. Gilman, in the 1930s. Oral

course became an elective rather than a requirement. Mitchell seems to have lost interest as his course description did not change after the first few years.

On the other hand, Theo Jacobs, the course director with an ambiguous title of “Associate in Social Economics,” busily continued to revise the course curriculum throughout. Like others in her generation, she learned case work on the job rather than a formal training institution. Unlike course leaders of other schools such as Sophonisba Breckenridge and Edith Abbott of the Chicago School of Civics and Philanthropy who had PhDs in economics or Porter Lee of the New York School of Social Work who actively published and lectured, Jacobs had comparatively minor academic credentials. In addition to her gender, this comparative academic deficit severely restricted any influence within her own department.

Although Jacobs acted as the main coordinator of the course, she was not on the planning committee until 1923. She wrote Hollander with proposals to improve the course, although it is not apparent that her suggestions were implemented such as hiring more faculty. The majority of the instructors were local community experts that received a nominal honorarium. More fundamentally, she questioned social workers’ place within a political economy department. The University should grant degrees that “recognize social work as a profession.” She continued:

A degree in Political Economy is misleading. Political Economy, though necessary to the social worker, should not be overstressed to the exclusion of other sciences. Social workers, in adjusting satisfactorily the individual to society, must base their efforts not only on the knowledge of the processes by which men make their living, but on the significance of heredity, environment, character basis, the place of laws and government action in social control, etc.¹²³

Although political economists might write about the abolition of poverty at an abstract level, social workers confronted the immediate needs of the poor. An understanding of the industrial revolution and English Poor Laws, as Mitchell taught, might be interesting but not necessarily relevant to their concerns.

Theo Jacobs taught the principles of case work, which students then practiced at social agencies. Students spent twenty-four hours a week at a social agency. During the first four years, the course was based upon the approach outlined in Mary Richmond’s *Social Diagnosis*. The course description of “Social Case Work” stressed the “conditions

History Interview with Broadus Mitchell, August 14 and 15, 1977. Interview B-0024. Southern Oral History Program Collection (#4007) <http://docsouth.unc.edu/sohp/B-0024/menu.html>.

¹²³ FHA, Record Group Number 04.140, Department of Political Economy, RG 04.140, Series 4, Box 3, Folder 8, Jacobs to Hollander, Jan 29, 1923.

surrounding dependency, ways and means of adjusting dependent families to society through right contacts, development of character and enlargement of opportunities.”¹²⁴

During their field work experience in the social agency, students were expected to implement case work principles of investigation, diagnosis, and treatment.¹²⁵ At first, a student might begin with an established case before progressing to the point where she could investigate a new case. Richmond placed much importance on the first interview with a new client because it set the tone and expectations of future work for the client and also secured clues for whom the case worker should next approach for testimonial evidence. A social worker’s skill could be measured by the finesse in which she conducted the first interview.

The “psychology of the first interview” was based upon “winning the client’s confidence” in order to “make truth telling easy.” In order to secure the confidence, the social workers should simply give each client a “fair and patient hearing” and “establish a sympathetic understanding.”¹²⁶ In *Social Diagnosis*, Richmond offered tips such as “Worker can inspire confidence in [client] by her manner, which should always be cheerful and at ease” and “Worker helps [client] to concentrate his attention upon this ‘study’ by the businesslike way of writing down his answer to questions, or the narrative he gives unassisted... This rule is broken only when in a more confidential part of the story [client] needs the help of an encouraging look, or undivided attention from worker.”¹²⁷

Another important aspect of case work was record keeping. Supervisors encouraged students to write “in narrative form colored by descriptions which leave vivid pictures in the reader’s mind.”¹²⁸ The importance placed on detail served the social work’s aspiration for a scientific method by providing more data, which supported the inductive process. Also, these records constituted a main source of instruction for students. A contemporary account of social work instruction described an empathic process, which was facilitated through these detailed accounts:

A common method is for the instructor to read [the case record], paragraph by paragraph, in the classroom for the purpose of enabling the students to reconstruct in imagination the

¹²⁴ *Courses in Social Economics Offered by Johns Hopkins University, 1920-21*, (Baltimore: The Johns Hopkins Press, 1920).

¹²⁵ Family and Children's Society Records Ms. 360, Special Collections, Milton S. Eisenhower Library, The Johns Hopkins University, , Ser 1.1, Box 3, Folder 26, “Field Work of Student Social Workers with the Family Welfare Association”, (Dec 5, 1921), 2.

¹²⁶ Ibid.

¹²⁷ Richmond, *Social Diagnosis*, 457-458.

¹²⁸ Family and Children's Society Records Ms. 360, Special Collections, Milton S. Eisenhower Library, The Johns Hopkins University, Ser 1.1, Box 3, Folder 26, “Field Work of Student Social Workers with the Family Welfare Association”, (Dec 5, 1921), 4.

actual situation faced by the worker who handled the case and then decide between the alternative courses of action that present themselves at critical points of the record. By thus living through, as it were, the experience of the case worker and step by step working out the proper procedure to be followed, the student not only becomes familiar with the technique of case work, but obtains a real knowledge of the nature of social problems and the social forces in the community that may be utilized in working out their solution.¹²⁹

Similar to learning from case reports in medical journals, social workers adapted the method for pedagogy. Not only did this educate students about social problems, it also exercised empathic skills required in case work.

In 1923 Jacobs revised her course on case work, emphasizing the psychological aspect which had become increasingly common in social work. Mary Jarrett, a psychiatric social worker and instructor at the Smith College Course, argued that half of the cases in *Social Diagnosis* actually suffered from psychiatric problems. Social workers should learn to apply “simpler rules of mental hygiene, to promote the mental vigor and mental development of individuals who do not require the care of a physician but are not as competent as they might be. Wrong habits of thought, badly trained emotions and instincts that may never cause a condition warranting medical attention, may interfere seriously with the happiness and usefulness of an individual.”¹³⁰

Jacobs also enlisted psychiatrists Adolf Meyer and his colleague and Hopkins graduate, Esther Richards (1885-1956) to teach courses beginning in 1923. Meyer taught introductory courses on psychopathological types for two years, likely similar to lectures he gave at the Smith College Course in 1918. Richards taught psychiatric aspects of case management and mental hygiene in childhood, and gave practical instruction at the Phipps dispensary. Although some colleagues considered her cold and unfriendly,¹³¹

¹²⁹ Steiner, Jesse Steiner, *Education for social work* (Chicago, Ill: University of Chicago Press, 1921), 53-54.

¹³⁰ Mary Jarrett, Psychiatric Thread Running Through All of Case Work, *Proceedings of the National Conference for Social Work* (1919), 591.

¹³¹ In Andrew Scull’s interview with former Meyer student, Phyllis Greenacre, reported being frustrated by Meyer’s promoting “Richards and [Ruth] Fairbank as ‘second rate people’ advancing ‘at the expense of first rate people’ (among whom she clearly numbered herself). Esther Richards, in particular, was ‘much disliked, very cold, often cruel in front of patients, much disliked by the staff’, someone afflicted with ‘scoliosis, a kind of hunchback’, with a personality to match.” Scull and Schulkin, “Psychobiology, Psychiatry, and Psychoanalysis,” 17. Another former trained of Meyer, Theodore Lidz described Richards as “unempathic” in her handling of patients: “For instance: you get a girl, a little feeble-minded, illegitimate pregnancy, ‘poor stuff’ - send her to the reform school. No real feeling. Rapid disposition, and to me very little empathy for the patient. I could never understand how Meyer wanted her to be in charge of the outpatient clinic. She was one of the first students, I think. She was a nice person in her way.

Richards actively participated in teaching mental hygiene principles to nurses, social workers, and the community. She wrote on extensively on childhood behavioral problems through her experience as the director of the outpatient dispensary of the Phipps Clinic. Richards graduated from Wellesley before coming to Hopkins for medical school. Like many women doctors in her generation, she dedicated herself to her work, eschewing marriage and family.¹³²

Like several other students of Meyer, Richards doggedly championed the psychobiological approach and had little patience for psychoanalysis, which was becoming increasingly popular in the 1920s. Within the paradigm of Richmond's case work, psychiatrists like Meyer and Richards believed social workers had an important contribution to mental hygiene as intermediaries between physicians and patients. In addressing the Johns Hopkins Hospital Social Service Staff in 1922, Richards recounted the importance of social workers for physicians:

As is my custom I turned to one of our social workers, after going over a case and said, 'Before a physician can come to any conclusion in regard to the diagnosis and disposal of this patient he must have a home visit to find out something about the setting in which the psychopathological process has developed. One would like to know how this patient behaves at home, how she eats and sleeps, what the story of the family is toward her, and how much truth there is in her story.'¹³³

Richards gave more credit than Meyer to social workers' skills. They contributed necessary parts of the diagnostic process, not just as friends who could help the patient after discharge from the hospital.

Richards also lauded social workers' "quiet accumulation of facts" upon which scientifically based social and medical diagnoses could be made: "Social case work is right in its insistence on a thorough and systematic study of individual differences in concrete situations of industrial unrest and maladjustment, domestic relations, chronic dependence, delinquency and all other ills embodying poor social health. Call it technique, if you will. The point is to make sure that our enthusiastic zeal always has a solid substratum of method and experience."¹³⁴

Despite the Meyer-Richmond equipoise of the domains of psychiatry and social work, social workers increasingly felt dissatisfied with the quality of their skills and depth of

But an unempathic kind of person. Otto Marx, "Adolf Meyer and psychiatric training at the Phipps Clinic: an interview with Theodore Lidz." *History of Psychiatry*, 4, no.14 (1993), 263.

¹³² Morantz-Sanchez, *Sympathy and Science*, 312-350.

¹³³ Esther Richards, "Defining the Function of the Hospital Social Worker," *Hospital Social Service*, 4 (1922), 173.

¹³⁴ Esther Richards, *Behaviour aspects of child conduct* (New York: The Macmillan company, 1932), 96.

their knowledge. The inductive process left social workers and psychiatrists without a sense of direction in terms of diagnosis or treatment. The lack of a coherent theory in the face of an inordinate amount of facts paradoxically led to a reliance on standardized assessments and recommendations. One social worker criticized the “stereotyped prescriptions, such as employment for men, recreation for children standardized by scout and settlement movements, et cetera, and health examinations and treatment for all.”¹³⁵

Psychoanalysis Elsewhere

The influence of psychoanalytic thought on social work in the 1920s provided workers with a stimulating model of personality development and treatment possibilities. Social workers adapted psychoanalysis to their own needs in working with clients with limited means and/or time. Frank Bruno, a prominent social worker, retrospectively described the embrace of psychoanalysis in the 1920s: “Almost immediately [after *Social Diagnosis*], Freudian concepts and methods were made available to social workers, and they proved almost as if created for the purpose of providing them with a means of realizing the diagnostic and treatment challenges facing them. Social workers adopted the methodology, and they adapted it more whole heartedly than doctors for whom it was designed.”¹³⁶

Because most psychiatrists pre-WWII worked in hospitals and adhered to Meyer’s psychobiological approach,¹³⁷ private agencies fostered greater freedom to explore psychoanalytic theories. The Commonwealth Fund-sponsored Bureau for Child Guidance, connected with the New York School of Social Work, was one of the largest clinical training centers for social workers in the 1920s. Psychiatrist Marion Kenworthy and social worker Porter Lee adopted a psychoanalytic model as the scientific basis of child guidance.

Students were taught an “ego-libido” theory of development, which posited that all behavior had a conscious or unconscious purpose. Children’s behavior could be comprehended as a means to satisfy an underlying need, either in the realm of love, or libido, or self-protection, or ego. The following example demonstrates the detailed level at which social workers were encouraged to analyze behaviors:

[T]he fact that Billy brought two dollars to his teacher for Red Cross Relief, and Johns twenty-five cents has no meaning as an isolated circumstance. When associated with

¹³⁵ Virginia Robinson, *A changing psychology in social case work* (Chapel Hill, N. C.: Univ. of North Carolina Press, 1930), 49.

¹³⁶ Frank Bruno, “Twenty-Five Years of Schools of Social Work” *Social Service Review*, 18, No. 2 (Jun., 1944), 162.

¹³⁷ Abraham Myerson, “Attitude of Neurologists, Psychiatrists and Psychologists Towards Psychoanalysis,” *American Journal of Psychiatry*, 96 No. 3 (1939), 623-641.

Johns' stealing five dollars from home later on that same day and offering three to a now suspicious teacher, we become aware that Billy's display of wealth was extremely unsatisfying to John; that John resented anyone's being more favored in the teacher's eyes than he; that the reason for this resentment was John's insecurity with his mother at home so that he had to obtain most of his satisfactions from a mother-substitute person in the classroom....¹³⁸

Given the precision in which a situation could be understood, psychoanalysis provided an intellectual framework while providing a means for empathizing with troubled children. Social workers also met with parents to uncover attitudes towards their children, which often arose from their own childhood experiences. Understanding parental attitudes then gave insight into the child's experiences and thus a clearer appreciation for the motivations behind a child's behavior.

In child guidance clinics, social workers were often given significant freedom to experiment with techniques, partly because the knowledge base was rapidly evolving. One social worker at the Los Angeles clinic recalled her experience in the mid 1920s:

...I remember tackling [an early case] with fear and bewilderment, although I was supposed to know something about mental mechanisms and parental training. My treatment approach called for various devices including specific directions, authoritative lectures...and other didactic means of 'telling them what's what.'...I had definite, though very ambiguously defined goals to which I hoped to 'adjust' the 'maladjusted'. I set out to 'direct' but soon found myself involved in a 'relationship.' Intuitively I groped my way...to arouse the parents' love and interest in their son.¹³⁹

She stumbled upon the use of transference after finding that habit training or other appeals to reason failed. A few years later, the clinic gave up the extensive social investigations in order to encourage clients to come to their own understandings of the problem and to encourage the development of a "dynamic relationship" between the parent and social worker.¹⁴⁰ The veracity of a client's statements was less important than the underlying meaning of how the client perceived the world.

Psychoanalysis also gave social workers confidence that they could handle children's behavior problems as well as doctors. Jessie Taft (1882-1960), who earned a doctorate in psychology from Chicago, deftly demystified the authority of psychiatrists and argued that social workers could become mental hygienists. Taft taught social workers at the University of Pennsylvania from 1919 onwards. After graduation from Chicago in 1913,

¹³⁸ Porter Lee and Marion Kenworthy, *Mental hygiene and social work* (New York: The Commonwealth fund, Division of publications, 1929), 67.

¹³⁹ Esther Heath, *The approach to the parent: a study in social treatment* (New York: Commonwealth Fund, 1933),viii.

¹⁴⁰ Esther Heath, *The approach to the parent*, x.

Taft pursued her interests in mental hygiene by working at the Bedford Hills Reformatory for Women and the Children's Aid Society of Pennsylvania. Her work with foster children made clear to her that social workers constantly used the skills of mental hygiene: "Here we see the case worker, using her knowledge of the family romance and the dependency complex in an objective way to bring about a vital adjustment in a family situation quite independent of the psychiatric clinic."¹⁴¹

Taft rejected the ostensibly objective and rational approach of Meyer and Richmond:

A good many people, caseworkers, teachers, and even some psychiatrists dislike very much the thought of an emotional relationship to the client, student, or patient. ... People who have this strong aversion to emotional responses in themselves or their clients like to believe that treatment – successful readjustment of families and individuals - comes from practical use of resources and the education of the individual concerned through ideas and rational appeals. ... [T]he basis of all casework therapy is primarily emotional, not rational or intellectual. ... The emotional going over of the client to the caseworker breaks down old fears and inhibitions and provides a safe medium in which the growth of new thoughts, feelings, and habits become possible.¹⁴²

Instead, she embraced the emotional basis of transference, which gave caseworkers "her most valuable tool." The analysis of the transference constituted a "conscious, skillful, and impersonal" process.¹⁴³

Taft argued that the structure of the office gave the psychiatric interview its therapeutic importance rather than any specialized skill or "magic." Indeed, Taft found little written on psychiatric treatment: "No one who was using the office contact as his medium of treatment seemed to be very clear as to just what were the factors in the psychiatric interview which produced therapeutic results; and, as far as I know, there has never been any attempt to establish a clear-cut theory or technique based on conscious knowledge of the relation of the process to therapy or casework."¹⁴⁴ She posited that the office provided a safe and limited space where the child, "freed from morality or social obligation," might have a cathartic emotional experience. The value of the office interview "is not a rehearsal of misdeeds or a recounting of old loves or fears, it is rather an immediate feelings experience produced by the temporary security which the relation

¹⁴¹ Jessie Taft, "Mental Hygiene and Social Work," in Frankwood Williams et al., *Social Aspects of Mental Hygiene* (New Haven, Yale University Press, 1925), 144.

¹⁴² Jessie Taft, "The Use of Transfer Within the Limits of the Office Interview" (1924), in Virginia Robinson, *Jessie Taft: Therapist and Social Work Educator* (Philadelphia, University of Pennsylvania Press, 1962) 108.

¹⁴³ Ibid.

¹⁴⁴ Jessie Taft, "The Function of the Mental Hygienist in a Children's Agency," (1927) in Virginia Robinson, *Jessie Taft: Therapist and Social Work Educator* (Philadelphia, University of Pennsylvania Press, 1962), 112.

to the mental hygienist in the role of understanding parent affords.”¹⁴⁵ Little, Taft believed, stood in the way of social workers’ taking on this role.

Return to Baltimore

Despite Theo Jacobs’ best efforts, the training at Hopkins paled in comparison to institutions with vibrant mental hygiene programs such as the New York School, University of Pennsylvania, Smith College, and Simmons in Boston. Paul Beisser, in 1925 the new head of the HWCAS and recent graduate of the New York School, ended the relationship with Johns Hopkins by sending the student-case workers to the New York School instead. This move had large consequences as it reduced the number of scholarship students for the program by half, crippling the income. Furthermore, Beisser announced plans to hire an in-house psychiatrist because the routine psychiatric examinations at the Phipps Dispensary, under Esther Richards, no longer met the agency’s needs: “With the increasing emphasis on specialized boarding home service, with the gradual change in our work, with higher standards of case work, it becomes clearly evident that our need extends beyond the routine examination.”¹⁴⁶

Although Richards would likely refute any insinuation that her work was routine, the psychobiologic approach ultimately relied on the formula balancing endowment and environment, with emphasis on finding the appropriate level of vocational training. In 1932, Richards addressed the National Conference of Social Work on the “Practical Objectives of Hospital Social Service.” She had sharp words for social workers who wasted their time, brazenly stepping upon clients’ intimate matters that even physicians “learned to go carefully about, feeling his way as angels fear to tread”: “Yet I have waded through pages of material in hospital social records that seemed to me not only quite irrelevant to the social issue, but plain bad taste in reproducing. It does not seem to me to be the business of a social worker...to acquaint clients with the mysteries of an Oedipus complex that we suspect they are suffering from.”¹⁴⁷ In the case of an adolescent girl with gonorrhea, Richards encouraged workers to focus on the girl’s limited intellectual abilities, which caused her to turn away from schoolwork to “the unwholesome stimulations in search of pleasure and satisfaction. Adjusting this girl vocationally is the logical objective of social case work’s job.”¹⁴⁸ By 1932, this approach appeared old-fashioned.

Theo Jacobs, herself, felt dissatisfied with her level of understanding psychiatry, and wrote a resignation letter to Hollander in 1927 explaining that she was “anxious to devote

¹⁴⁵ Taft, “The Function of the Mental Hygienist,” 115.

¹⁴⁶ Henry Watson Children’s Aid Society, *Annual Report for 1925* (Baltimore), 12.

¹⁴⁷ Esther Richards, “Practical Objectives of Hospital Social Service,” *Hospital Social Service*, 27 No. 2 (1933), 132.

¹⁴⁸ *Ibid.*, p. 128.

the major part of my time next year to gaining a clearer understanding of the principles of psychology and psychiatry.”¹⁴⁹

On the other hand, Hollander submitted a grant to the Laura Spelman Rockefeller Fund for the creation of an independent school of Social Economics at Hopkins in 1926. Hollander relied on the reputation of Hopkins’ excellence in graduate training and the rhetoric of science, breezily writing about the University’s concern with the “discovery of new knowledge,” and that the “study of social economics has now reached the stage where it needs the inspiration which comes and can come only from the closest association with those bodies of investigators who have developed most fully the spirit of scientific inquiry.”¹⁵⁰

John M. Glenn, who was then at the Russell Sage Foundation, acted as an intermediary between the Beardsley Rumml of the Rockefeller Fund and Hollander. Glenn reported that it was unlikely to receive funding in the near future, but encouraged Hollander to “define the functions of a School of Social Research much more definitely and concretely... before we can hope to get money to establish such a school.”¹⁵¹ Hollander, who had nominal involvement with the Course on Social Economics, was finally awoken to the fact that Hopkins was actually behind the ball.

Conclusion

The field of social work in the 1920s was enmeshed within a changing complex of gender and its relation to the ordering of society. Women reformers of the previous generation could become active participants in the public sphere through strategically focusing on domestic matters involving women and children. Social workers of the 1920s were career women who sought a satisfying professional life. They also gravitated towards female-dominated fields such as child welfare, which granted them more autonomy. Unlike professional women before them, these young women found a field in which they did not have to reject feminine qualities such as empathy and intuition. These qualities strengthened their work in child welfare agencies and guidance clinics because women could operationalize these qualities through a rigorous analysis of their effects. Psychoanalysis proved a worthy ally but brought social workers into conflict with hospital-based psychiatrists who could dismiss their efforts as unprofessional. However, social workers were not so easily deterred.

¹⁴⁹ FHA, Record Group Number 04.140, Department of Political Economy, RG 04.140, Series 5, Box 2, Folder 15, Faculty Appointments, leaves of absence, 1922-1943, Letter from Jacobs to Hollander, Feb 19, 1927.

¹⁵⁰ FHA, Record Group Number 04.140, Department of Political Economy, RG 04.140, Series 4, Box 3, Folder 12, Letter from Weeks to Hollander 16, August 1926, 5.

¹⁵¹ FHA, Record Group Number 04.140, Department of Political Economy, RG 04.140, Series 4, Box 3, Folder 12, Glenn to Hollander Jan 10, 1927.

Despite the weaknesses of the Hopkins course, social workers in the 1920s felt a thrill from their growing profession. A former student social worker in Baltimore described the 1920s as an “exhilarating experience”:

One felt one’s self coming full awake and growing.... One found in his chosen profession of social work that which helped life become whole...Creativity was limited only by one’s ability to grow. In this fact lay priceless satisfaction... So much needed to be learned, thought through, absorbed. An expression picked up at one seminar, ‘the need of getting it into one’s muscles,’ bespoke concern to make the new knowledge [of psychiatry] one’s own...Thinking deeply about practice was a characteristic of the ‘20s and ‘30s.¹⁵²

The closing of the school did not diminish their enthusiasm for learning. The FWA simply sent their students to the New York School and Smith College for training.

The enthusiasm for case work carried through the 1930s. The growing amount of relief work during the early 1930s frustrated the staff of the Family Welfare Association. Despite the efforts to educate social workers in political economy, the gendered division of labor was sustained by social workers’ interest in case work. In the annual report of 1930, the director of the FWA wrote:

Family social work has little if anything to contribute toward the discovery of the causes and remedies of unemployment. But it can and must testify to the relative amount existing, to the price in human suffering and to the direct and indirect costs which communities have to pay. Social workers must continue to paint the picture of the family destroyed until men understand the terrific suffering and until their emotions drive their brains to work out a solution.¹⁵³

However, with the creation of the Baltimore Emergency Relief Committee in 1934, a federally funded program, case workers enthusiastically transferred the majority of their relief cases and returned to their passion of social case work. They saw unemployment as something beyond their capacity to handle, instead, believing that this was the responsibility of others.

However, in the Phipps Clinic, social workers continued to have a limited role, undertaking extensive social investigations. Social workers outside the hospital, in the less hierarchical environment of child welfare agencies or child guidance clinics, had more opportunities for independent work as therapists. Although social workers amassed

¹⁵² Family and Children's Society Records Ms. 360, Special Collections, Milton S. Eisenhower Library, The Johns Hopkins University, Series I, Subseries I, Box 2, Grace Sperow, “Part IV: The Family Welfare Association,” 9-15.

¹⁵³ Family Welfare Association of Baltimore, *Annual Report for 1930*, 9.

a good amount of technique in working with children and families, the first text book on child psychiatry by Leo Kanner in 1935, gave one scant paragraph to them:

We cannot close the chapter on specific therapeutic aids without a brief reference to the assistance of a competent social worker who can do a great deal helping the family to carry out the physicians' recommendations.... One must be careful not to select the type of worker, fortunately diminishing in number, who goes beyond the physician's arrangements and feels called upon to lecture to the parents on the castration and Oedipus complexes and on the significance of their offspring's high or low IQ, or who feels that her duty is performed if she brings in a detailed description of the pattern on the living room carpet....¹⁵⁴

Social workers had little claim over a discipline that they helped create. During the tightening of ranks in the medical profession in the 1930s, social workers were given less of a role. However, their contributions would work its way into child psychiatry in the 1940s when psychoanalysis predominated psychiatric thought.

¹⁵⁴ Leo Kanner, *Child psychiatry* (Springfield, Ill: C. C. Thomas, 1935), 135.

CHAPTER 4

Treating the “Whole Child”: Pediatrics, Psychiatry, and Philanthropy

Child psychiatrist Leo Kanner began his book for the popular press, *In Defense of Mothers* (1941), with the following “Open Letter to Contemporary Mothers”:

First of all, allow me to extend to you the sympathy of one to whom thousands of you have come with various worries, anxieties and bafflements. ... There is no raid shelter from the verbal bombs that rain on the contemporary parents. At every turn they run against weird words and phrases which are apt to confuse and scare them no end: Oedipus complex, inferiority complex, maternal rejection, sibling rivalry, conditioned reflex, schizoid personality, repression, regression, aggression, blah-blah, blah-blah, and more blah-blah.... Let us, contemporary mothers, together regain that common sense which is yours...¹⁵⁵

The “common sense” which Kanner invoked has a double meaning of both something that is culturally shared as self-evident as well as being a key phrase of the psychiatric approach of his mentor, Adolf Meyer. The culture of mothers that Kanner addresses is an American middle-class consumer of the interwar period, which he characterizes in his last chapter, “A Portrait of a Good Mother.” A “good and competent mother... keeps herself informed about the contemporary advances and trends in child psychology. But she does not swallow everything she hears and reads.... She selects her informers with at least the same discrimination as that with which she selects her groceries, her chinaware and her hairdresser.”¹⁵⁶

The concerns of this mother center on the home, what the members consume and how they present themselves. By the interwar period, children’s behavior problems were increasingly linked to emotional difficulties within the home rather than resulting from inborn deficiencies or urban chaos. By grouping the services of child experts with other household goods, Kanner underscores this anxiety of children’s behavior as public displays of private problems. A good mother will choose her advisors wisely, and during this period, the medical profession was vying to be her top choice.

By the time Kanner was writing in 1941, he had held his position as a psychiatrist in a pediatric hospital at Johns Hopkins for over a decade. Although psychiatrists had worked with children since the 1920s in child guidance clinics, physicians did not necessarily hold authority over children’s behavioral problems. This began to change in the 1930s as

¹⁵⁵ Leo Kanner, *In Defense of Mothers* (Springfield, IL: Charles C. Thomas, 1941), p. 1-6.

¹⁵⁶ *Ibid.*, p. 166.

a result of large-scale philanthropic investment in medicine and middle-class demand of professional services for the health of their children.

In this chapter, I focus on the negotiations of psychiatrists and pediatricians with philanthropic organizations to further their own professional goals. I examine the development and workings of the pediatric-psychiatric clinic at Johns Hopkins and the career of Leo Kanner, considered today as a founding figure in child psychiatry. I argue that child psychiatry as a discipline developed initially as a by-product of the professional interests of psychiatrists and pediatricians to capitalize on the funding possibilities made available through philanthropic interest in children's mental health, rather than any design to create a new domain of expertise and knowledge. I also examine the practices of Kanner's clinic in relation to pediatricians, which begins to shed light on the demand for these services, which will be explored further in the next chapter.

Negotiations with Philanthropy

Mental Hygiene and Child Guidance

In 1927, Abraham Flexner, the Director of the Studies and Medical Education Division of the Rockefeller Foundation, wrote a letter to Adolf Meyer, asking him to clarify what exactly was mental hygiene, and how did it relate to the fields of psychiatry and neurology. Up until that point, the main source of funding for mental hygiene activities came from the Commonwealth Fund, a philanthropy founded in 1918 based on the fortune of Stephen Harkness' investments in Rockefeller's Standard Oil.¹⁵⁷ Meyer, who had helped the activist Clifford Beers found the National Committee for Mental Hygiene (NCMH) in 1909, had become disenchanted with the direction of the work, especially the focus on children.

Although Meyer supported psychiatric work with children, such as the Locust Point school survey as described in chapter three, he was less than enthusiastic about the Commonwealth Fund's child guidance clinics that were established in the 1920s in conjunction with the NCMH. Although initially conceived as a means to prevent juvenile delinquency, the clinics expanded their purview to treating mild behavioral or emotional problems of children. This change was also consistent with the preventive work of the NCMH that emphasized mental health rather than mental illness. The clinics were not necessarily tied to hospitals or a university, and the staff consisted of a three-fold team of

¹⁵⁷ *A part of the Rockefeller Foundation, the Laura Spelman Rockefeller Memorial Fund, was the lead sponsor for academic psychology departments that studied normal child development such as the Iowa Child Welfare Station and the longitudinal studies at University of California at Berkeley from the 1920s.*

psychiatrist, psychologist, and psychiatric social worker, referred to as “the distinctive child guidance pattern”.¹⁵⁸

Meyer criticized the field of mental hygiene as “over-advertized” and lacking a scientific basis. He scorned the post-war leadership of the NCMH, which “is at present in the hands of a group strongly inclined to exploit child guidance... often on but little psychiatric and mainly psychoanalytic training, with a strong bias to draw in lay persons.”¹⁵⁹ By the 1920s, Meyer had become wary of psychoanalysis because he believed it to be an overly systematized way of approaching mental illness, with too heavy reliance on theory instead of observable facts. By contrast, psychoanalytic approaches had become popular with child guidance workers, especially social workers and some of the influential psychiatrists such as David Levy, head of the training center of the Institute of Child Guidance in New York. Meyer believed that child guidance depended too heavily on the use of psychoanalysis to understand the patient, the family, and relevant social factors.¹⁶⁰

Moreover, Meyer was frustrated that the popularity of child guidance clinics left little money for clinical and basic research in psychopathology, such as was undertaken at academic and state hospitals. In comparison to the Commonwealth Fund’s annual budget for mental hygiene and child guidance of over \$400,000, the Phipps Clinic could only allot \$500 a year to teaching mental hygiene.¹⁶¹ Finances were a large concern for Meyer since the opening of the Johns Hopkins Phipps Psychiatric Clinic in 1913. His speech at the celebratory ceremony of the 24 years of the Phipps Clinic in 1937 included a detailed recollection of his funding worries. Funds for research generally came out of Meyer’s consultation fees before philanthropic grants were accessible.¹⁶²

In crafting his reply to Flexner, Meyer pushed his agenda of obtaining funding for the Phipps Clinic by defining mental hygiene along the lines of his theory of psychobiology and then outlining institutional domains beyond the hospital in which psychiatric work could take place:

¹⁵⁸ Commonwealth Fund Annual Report, 1931 (New York: Harkness House), p. 32. The three-pronged approach endeavored to provide a complete evaluation with the psychiatrist primarily dealing with the patient, a.k.a., the child; the psychologist administering testing; and the social worker dealing with issues in the environment of the child such as the family or the school.

¹⁵⁹ Meyer to Abraham Flexner April 20 1927, III/276/7, The Adolf Meyer Papers, The Alan Mason Chesney Medical Archives (AMCMA), The Johns Hopkins Medical Institutions.

¹⁶⁰ Adolf Meyer, “Organization of community facilities” (1930), in Eunice Winters (ed.), *The Collected Papers of Adolf Meyer Vol IV*, (Baltimore: The Johns Hopkins Press, 1952) p. 272.

¹⁶¹ Meyer to Abraham Flexner April 20 1927, III/276/7, The Adolf Meyer Papers.

¹⁶² Adolf Meyer, “Retrospect and Prospect” (1938), in Eunice Winters (ed.), *The Collected Papers of Adolf Meyer Vol II*, (Baltimore: The Johns Hopkins Press, 1952) p. 220-224.

Mental hygiene should not be announced unless it can rest on a basis of research in 1. Psychobiology – with research in personality-study in the various periods of life from infancy to advanced age, and with special attention to the needs and emergencies out of which disorders of ‘health, happiness and efficiency’ can develop. 2. The field of pre-school and school hygiene... 3. Factory and industrial hygiene... 4. Court work...¹⁶³

Meyer’s conception of mental hygiene remained consistent from his earlier espousals of preventive psychiatric work in the community during the opening of the Phipps Clinic in 1913. In an address to the First International Congress of Mental Hygiene in 1930, Meyer said he had “always stood firmly for leadership by hospitals serving definite districts...and maintaining at the same time a close contact with the community. It will never do to focus too exclusively on the child at the expense of interest in the psychiatry and hygiene of the adult....”¹⁶⁴ For Meyer, mental hygiene consisted of extending his psychobiological approach to other institutions in the community, not a reworking of a psychiatric approach.¹⁶⁵

Mental Hygiene and Training Psychiatrists

Meyer’s discontent of the Commonwealth Fund activities in child guidance in the 1920s troubled the Fund leaders. The 1930 annual report of the Fund echoed Meyer’s criticisms of the isolation of the guidance clinics and lack of research:

After this decade of rapid growth, the clinics face two barriers to further progress. One is the failure of psychiatry as a specialized field of medicine to keep pace with the enormous interest in its findings by carrying forward basic research into the origins of personality disorders and the nature and variations of normal development. Broadly speaking, the clinics lack the stimulation and the guidance which they would derive from a continuous inflow of fresh concepts, currently tested hypotheses, and new techniques from the institutions best fitted for research into such matters. ...The second barrier... is the undersupply of competent psychiatrists.¹⁶⁶

Given these concerns, the Commonwealth Fund worked more closely with medical schools by sponsoring training fellowships in psychiatry and supporting Meyer’s efforts to improve standards of psychiatric training. Beginning in 1928, the Phipps Clinic, along with the Boston Psychopathic Hospital, the University of Colorado, and the Institute for Child Guidance in New York, received funding for training fellowships. The Phipps Clinic received support through the 1940s and furthered Meyer’s influence on the field.

¹⁶³ Ibid. , p. 5-6.

¹⁶⁴ Adolf Meyer, “Organization of community facilities” (1930), p. 274.

¹⁶⁵ Adolf Meyer, “The psychiatric clinic, its aims” (1913) in Eunice Winters (ed.), *The Collected Papers of Adolf Meyer Vol II*, (Baltimore: The Johns Hopkins Press, 1952) p. 204).

¹⁶⁶ Commonwealth Fund Annual Report, 1930 (New York: Harkness House), p. 49.

By 1937, eighty-three of Meyer's former students held teaching positions, representing twelve percent of all teachers of psychiatry in the US.¹⁶⁷

The Fund tried to exert its influence through the selection of fellows, preferring American-born, Protestant men. Women and Jewish applicants were routinely discriminated against in the Fund's effort to bolster the status of the field of child psychiatry they helped create.¹⁶⁸ In a letter from the Fund Director Barry Smith to Adolf Meyer, Smith asked whether Meyer would "find available among American medical graduates, first class candidates for these fellowships. I know that a good many of the men who have been at Phipps with you, have come from abroad, and I judge that is partly because it has been difficult to secure American students without having fairly generous fellowships to attract them."¹⁶⁹ Meyer eventually selected four men and one woman.

Leo Kanner (1894-1981) was among this first group of fellows. Like the others, Kanner was in his mid-30s and had a few years' experience working in a state psychiatric hospital. Unlike the others, he worked previously as an internist in Berlin before immigrating to the US because of better job prospects given the anti-Semitism and economic instability in Germany in the 1920s. Through a friend, he worked for five years at a state hospital in South Dakota before applying for the Commonwealth Fellowship at Hopkins. When Meyer submitted his list of new fellows to Smith, he reported that he had accepted Kanner only on a one-year conditional basis. Unlike the factual background accounts of the other fellows, Meyer felt the need to bolster his choice of Kanner by adding that he "shows a great eagerness and determination to avail himself of further training."¹⁷⁰ Kanner would be the only Jewish fellow for the first ten years of the fellowship program.¹⁷¹

The support of training fellowships ultimately led to questions of what psychiatrists should know. Meyer exerted a large influence in steering the field towards his theory of psychobiology. Franklin Ebaugh, the director of Colorado Psychopathic Hospital, was a loyal student of Meyer and incorporated much of Meyer's approach in his teaching materials of the Fund fellows at his institution. In 1930, The Commonwealth Fund, through the NCMH Division on Psychiatric Education, sponsored Ebaugh and Australian psychiatrist Ralph Noble to survey the teaching of

¹⁶⁷ Franklin Ebaugh, "Adolf Meyer, The Teacher" *Archives of Neurology and Psychiatry*, 37, 4 (1937), p. 736.

¹⁶⁸ See Margo Horn, *Before It's Too Late: The Child Guidance Movement in the United States, 1922-1945* (Philadelphia: Temple University Press, 1988), p. 119-131.

¹⁶⁹ Smith to Meyer Mar. 9, 1928, III/265/8, Meyer Papers, AMCMA.

¹⁷⁰ Meyer to Smith, Oct. 31, 1928, III/265/11, Meyer Papers, AMCMA.

¹⁷¹ Horn, *Before It's Too Late*, p. 127, cites a 1938 memo from one of the administrators of the fund noting that one of a total 56 fellows was Jewish.

psychiatry in both post-graduate programs and medical schools as well as a series of conferences throughout the 1930s.¹⁷²

Noble's report, published in 1933, framed the problem of mental hygiene along the lines of Meyer's argument to Flexner six years earlier:

...the stimulus for study of the personality came mostly from non-medical circles concerned in large part with immediate social problems. Hence, much of the modern interest in the social behavior of the individual is not deeply rooted on scientific principles....Continuance of indiscriminate propaganda and of treatment for mental ailments by poorly qualified persons will not improve the situation. It can best be met by acknowledging the importance of psychiatry in medical education and the necessity of adhering to basic principles in this field.¹⁷³

Both Noble and Ebaugh's report, published in 1942, gave centrality to Meyer's psychobiology as the most relevant and scientific approach to psychiatric problems. Beneath the lofty but vague aims of studying the individual as an integrated whole, psychobiology presented an attitude of "open-mindedness and breadth of view in examining, sifting, and synthesizing the data accessible through many different approaches to the study of man."¹⁷⁴ The openness and lack of theorizing, on the one hand, tended to leave American psychiatrists "without any clear theoretical orientation or therapeutic approach."¹⁷⁵ On the other hand, psychobiology allowed psychiatry to be more accessible to other branches of medicine, which helped to legitimize the discipline and transform other fields such as pediatrics.

Psychiatry and Pediatrics: The White House Conference of 1930

Meyer was not alone in his misgivings of the child guidance clinics. Pediatricians also bristled with the encroachment of this new group of child experts. During the 1920s, federally funded infant welfare stations helped to create the demand for routine, preventive medical exams of children. In the early 1930s, pediatricians actively worked

¹⁷² Although the Fund did not directly support the creation of a specialty board, Ebaugh and Noble's research aided the efforts, which came to fruition in 1934 after three years of disagreements between the professional organizations of psychiatrists, neurologists, and the American Medical Association. See Horn, *Before It's Too Late*, 107.

¹⁷³ Noble, *Psychiatry in Medical Education* (1933), p. 9-13 in Gerald N. Grob, Ralph A. Noble, and Franklin G. Ebaugh, *Psychiatry and medical education: two studies* (New York: Arno Press, 1980).

¹⁷⁴ Franklin Ebaugh, *Psychiatry in medical education*, (1942), in Grob et al., *Psychiatry and medical education: two studies*, p. 38.

¹⁷⁵ Horn, *Before It's Too Late*, p. 108.

at organizing their specialty in order to capitalize on the market of middle-class patients as their role of “family advisor.”¹⁷⁶

In the 1930 White House Conference on Child Health and Protection, a group of pediatricians, psychiatrists, and psychologists met to discuss the topic: “Psychology and Psychiatry in Pediatrics: The Problem.” This subcommittee was one of nearly twenty specialized meetings that comprised the Medical Service section. The Conference was a “landmark event” for raising awareness of children’s mental health as well as galvanizing the field of pediatrics.¹⁷⁷ Bronson Crothers, a pediatrician specializing in neurological issues at Boston Children’s Hospital, chaired the meeting. The subcommittee was composed of six psychiatrists and one psychologist. The psychiatrists included Adolf Meyer and Esther Richards from the Phipps Clinic and David Levy, head of the Commonwealth Fund’s Institute for Child Guidance in New York.¹⁷⁸

Given the preponderance of physicians on the subcommittee, the agenda was geared to establish the dominance of medical professionals in mental hygiene and child guidance. The summary report announced, “There seems to be no doubt that every child should be under medical observation.”¹⁷⁹ As part of this goal of preventive medicine, physicians “could occupy a position of dignity and power in any program for adequate supervision of so-called mental hygiene in childhood.”¹⁸⁰

However, the members also realized that other fields such as psychology and social work had become heavily invested and sent questionnaires to gather insight into their conception of the field. Not surprisingly, the answers supported the particular field’s contribution and, perhaps even less surprisingly, they were placed in the appendix of the report.

Crothers’ report chided the child guidance clinics for assuming authority in this field: “...there are a great many people who are in a tremendous hurry to get immediate results. These propagandists believe that methods are available which should be put into

¹⁷⁶ Halpern, Sydney A. *American pediatrics: the social dynamics of professionalism, 1880-1980* (Berkeley: University of California Press, 1988), p. 98-109.

¹⁷⁷ Julia Grant, *Raising baby by the book: the education of American mothers* (New Haven: Yale University Press, 1998), p. 165.

¹⁷⁸ The committee also included Douglas Thom, who started the first habit clinic for children’s problems through the Boston Psychopathic Hospital; James Plant of the publically funded Juvenile Clinic in New Jersey; and Edward Strecker of Jefferson Medical College and author of one the standard textbooks of psychiatry at the time. John Anderson of the Institute of Child Welfare at the University of Minnesota represented psychologists.

¹⁷⁹ White House conference on child health and protection, Bronson Crothers and Philip Van Ingen, *Psychology and psychiatry in pediatrics: the problem; report of the Subcommittee on psychology and psychiatry* (New York: The Century co., 1932), p. 20.

¹⁸⁰ *Ibid.*, p. 61.

widespread use without delay. Some of them are willing to apply the term ‘classical’ to forms of organizations which they believe are of permanent value.... Statements of this type suggest that leadership is established and that methods of approach are standardized.”¹⁸¹

The subcommittee also partly blamed pediatricians and general practitioners for their seeming lack of interest in mental hygiene: “...they have not been particularly involved in the preliminary investigations of the new field and are caught almost unawares by a growing public interest in the promise of the new medical approach.”¹⁸² Furthermore, pediatricians could simply not afford to remain aloof to emotional problems of childhood because it “may lead to transfer of this field to formal organizations or to individuals without medical experience. Such a solution will inevitably diminish both the prestige of the private practitioner of medicine and the interest of his job.”¹⁸³

The solution proposed by the subcommittee was beneficial to both psychiatrists and pediatricians. This consisted of improving general physicians and pediatricians’ knowledge of personality and emotion through better instruction of psychiatry in medical schools, thus bringing psychiatry closer to medicine. In an interesting comparison, Crothers wrote that psychiatrists should be consulted as specialists in difficult cases “just as the technical resources needed for urological study should be those of the urologists.”¹⁸⁴ This relation to general medicine would begin to remedy the low status and isolation of psychiatry, which was “in closer contact with teachers and social workers” than the medical profession.¹⁸⁵

The Commonwealth Fund also took notice. The annual report of 1932 noted at the end of the section on mental hygiene that “current medical journals give evidence that relations between what is called medicine and what is called psychiatry are being explored from a good many approaches.... There is growing recognition of the fact that what is commonly called the art of medicine may well be fortified by what we begin to know scientifically about human behavior.” Although still a strong supporter of the training of social workers and psychologists, “the Fund has taken steps to stimulate the study of some of its aspects in the belief that the future of mental hygiene, which is so obviously related to education and social work, is not less intimately bound up with the future of medical practice.”¹⁸⁶

A Pediatric Psychiatric Clinic at the Harriet Lane Home

¹⁸¹ Ibid., p. 17.

¹⁸² Ibid., p. 13.

¹⁸³ Ibid., p. 43.

¹⁸⁴ Ibid., p. 43.

¹⁸⁵ Ibid., p. 13.

¹⁸⁶ Commonwealth Fund Annual Report, 1932 (New York: Harkness House), p. 51

Before the 1930 White House Conference, the Commonwealth Fund took little interest in funding ventures between pediatricians and psychiatrists. In 1927, Edwards Park (1878-1969), chief of the Johns Hopkins' pediatric hospital, the Harriet Lane Home, approached Meyer about placing a psychiatrist in the outpatient dispensary. Park assumed leadership of the pediatric department after the death of his mentor and colleague, John Howland (1873-1926), the head of the Harriet Lane Home since its opening in 1913. Park anticipated many of the concerns raised in the 1930 Conference. He believed that minor behavioral disorders in children were common but not well attended. Only children with obvious psychiatric disturbances such as delinquency or hysteria were referred to the Phipps Clinic. Psychiatrists, thus, had little contact with "the stream of children of ordinary daily life... Yet among these children are the cases of the greatest interest and importance to the psychiatrist and to the community because of the simple nature or short duration of the disorder which permits its understanding or perhaps its easy correction."¹⁸⁷ Additionally, Park wanted the educational opportunity this posed for his staff in handling mild behavior disorders. Park was enthusiastic and wrote Barry Smith, "the step will be the first of its kind, so far as I am aware, in this country or in Europe and should be of great value..."¹⁸⁸

Smith did not see the distinction between the type of work the Phipps Clinic offered in its dispensary and that of Park's proposal. He wrote Meyer that he was "not so much interested... We are already making such considerable appropriations for clinics dealing with behavior problems in children..."¹⁸⁹ Meyer, too, showed less interest in having a psychiatrist in the dispensary, which had similarities to a child guidance clinic, and more interest in having a psychiatric ward for children. Park sensed that Meyer was somewhat of a reluctant partner in this venture, as he later wrote Kanner in 1958, "I had discussed repeatedly with Dr. Meyer the advisability of establishing such a clinic, but the instigating force was Stewart P[aton]. I think that it was Dr. P[aton]'s influence which stirred Dr. Meyer and caused him and, at his invitation, me to apply to the Rockefeller Foundation for the necessary funds."¹⁹⁰ Stewart Paton was a physician, formerly at Johns Hopkins, who was active in the mental hygiene movement and lobbied Henry Phipps to fund the psychiatric clinic at Hopkins. Ultimately, the Fund did not support the venture.

In the meantime, Park and Meyer obtained support for the psychiatric clinic through a grant from the Josiah Macy, Jr. Foundation in 1930 and then continuous support from the Rockefeller Foundation from 1934 onwards. Meyer chose Leo Kanner, who had completed three years of the Commonwealth Fund training fellowship at the Phipps, to run the clinic. Kanner was an unlikely candidate for the position because of his

¹⁸⁷ Park to Smith Jan. 9, 1928, Park Papers, AMCMA.

¹⁸⁸ Park to Smith Dec. 30, 1927, Park Papers, AMCMA.

¹⁸⁹ Smith to Meyer, Jan. 11, 1928, Park Papers, AMCMA.

¹⁹⁰ Park to Leo Kanner, Jan 22, 1958, Park Papers, ACMCA.

background. Not only had the Commonwealth Fund limited the number of Jewish and foreign recipients, but Park, too, had also written Smith earlier that Meyer had “many foreign physicians in his department, some of who[m] were not adapted to children’s work.”¹⁹¹

Kanner also faced a difficult job in being a psychiatrist in an environment that could be hostile. The rabble-rousing pediatrician, Joseph Brenneman from Chicago, wrote an article entitled “The Menace of Psychiatry” in 1930, which decried the popularity of psychiatry among his clientele and its inaccessibility to ordinary pediatricians.¹⁹² Park also recognized that pediatricians often have a “warped opinion of child psychiatry.” In a letter to Allan Gregg of the Rockefeller Foundation, Park described the problem in the following way:

They feel that the pediatrician knows far more about the child than the psychiatrist and with a very little training can do better work than the psychiatrist himself. Part of the feeling of pediatricians against child psychiatrists is due to an apprehension that the child psychiatrist is encroaching on their field. Another part is due to bad experiences with the psychiatrists of the Freudian school, who have attempted to explain behavior disturbances on grounds intolerable to common sense.¹⁹³

Meyer’s distrust of psychoanalysis was passed on to many of his students, which proved helpful in Kanner’s new position.

Meyer’s Emissary to Pediatrics

Pediatricians largely viewed behavioral problems as a matter of an inherited nervous disposition and faulty training. The tenth edition of the popular pediatric textbook, *Holt’s Diseases of Infancy and Childhood* (1933), espoused many of the same principles of the first edition in 1897 in regards to handling children’s disagreeable behaviors. Emmett Holt, Sr., a pediatrician at the Babies Hospital in New York, wrote the original text, which was one of the first comprehensive texts on pediatrics. He enlisted his former student John Howland of Hopkins for help with editions from 1911 to stay abreast of the developments in the new field. The Hopkins pediatric staff continued to have an influence after the passing of Howland in 1926, when the editorship was passed onto Edwards Park and then to Holt’s son, Emmet Holt, Jr., of the Harriet Lane Home. Kanner gave comments to the section on “Functional Nervous Disorders” of the 1933 version, but much of the prior versions remained intact.

¹⁹¹ Memorandum from Haupt to Smith, Feb 24, 1928, Commonwealth Fund Files, Series 18.1, Box 167, Folder 1552, Rockefeller Archive Center (RAC).

¹⁹² Joseph Brenneman, “The Menace of Psychiatry,” *Am. J. Dis. Child.*, 42: 376-402.

¹⁹³ Park to Gregg, March 2, 1934, Rockefeller Foundation, Record Group 1.1, Series 200, Box 93 Folder 1116, RAC.

The section, “Behavior Problems,” consists of one entry entitled “The Neuropathic Child.” Irritability, even in infancy, was often a sign of this inherited constitution. A list of related symptoms are included: poor sleep, malnutrition, vomiting, bed-wetting, rapid pulse. These children are “apt to be bright, often precocious, but they usually show a great lack of concentration. . . . Emotionally, they are sensitive and mercurial. . . . Many are affectionate and attractive, but they are usually self-willed and often tyrannize over the household.” When these traits appeared later in childhood, they might be a combination of inheritance and environment, especially “association with a nervous adult” and a “faulty mode of living” including late hours, inadequate sleep, and consuming tea, coffee, and cigarettes.¹⁹⁴

Treatment consisted of the “wise management of daily life,” especially by someone who does not “spoil or indulge” and uses “gentle but firm control.” In the 1933 edition, Kanner added, “psychoanalysis has its enthusiastic advocates for childhood as well as adult problems, notably Anna Freud, but we are inclined to doubt that its possibilities are other than very limited. Like other cults, when used inadvisedly it may do harm.” He further conceded the limitations of the research behind treating behavior disorders in children, commenting, “On the whole it must be admitted that our approach to these behavior problems is still largely intuitive.”¹⁹⁵

Behavioral problems, according to Holt’s text, were evidence of an inherited “neuropathic” disposition, exacerbated by poor training, and could be associated with other somatic symptoms. Thus, the pediatrician’s approach would be to recognize this constellation of symptoms, diagnose the child as “neuropathic,” and give standard recommendations about proper habits of living.

Although habit training comprised a large part of Meyer’s treatment recommendations, his approach to the patient differed radically. In what Meyer called the “genetic-dynamic” approach, behavior was the result of a person’s cumulative reaction to his environment over the course of one’s life. Behavior such as temper tantrums was not inherited. Instead, the child’s behavior revealed a reaction of displeasure to a potential variety of situations including thwarted desires, a strategy to prevent punishment, physical discomfort as in sickness, or copying a parent.¹⁹⁶ The goal of the psychiatrist was to construct a meaningful narrative that explained the patient’s behavior.

Techniques and Practices

¹⁹⁴ Emmett L. Holt, Jr. and Rustin McIntosh, *Diseases of infancy and childhood, for the use of students and practitioners of medicine* (New York: Appleton-Century, 1933), p. 761.

¹⁹⁵ *Ibid.*, p. 763.

¹⁹⁶ Leo Kanner, *Child psychiatry*. (Springfield, Ill: C.C. Thomas, 1935), p.276-9.

The step of constructing a narrative based on the details of a patient's life was what Meyer called, "critical common sense." This was the basis of psychobiology, and he likened it to a natural scientific approach. As his former student Ebaugh outlined in a discussion with pediatricians in 1936, the method consisted of finding "1. the conditions that gave rise to the complaint, 2. the predisposing factors, 3. their working or course, 4. their results, and 5. the modifiability of the whole."¹⁹⁷

The technique consisted of a taking an extensive history of the patient's life with the orientation of determining why the problems were happening now in the context of the patient's "total personality" and environment. Kanner called this a "biographical analysis of all events which seem to have mattered in the patient's life."¹⁹⁸ In practice, this consisted of largely prosaic questions about the child's relatives' health and education, the family's living situation, age when the child began walking and talking, dates of illnesses, habits of eating and sleeping, personality traits such as aggressiveness or shyness, types of recreation, and school progress. The mother generally provided this information while the child played in a different room. Then, the psychiatrist met with the child for intelligence testing and tried to ascertain the child's perspective of the present situation.

The psychiatrist should then be able to formulate a "diagnostic synthesis," consisting of a re-stating of the complaint in the context of the pertinent data obtained from the interview. Kanner gave the following as examples in his textbook *Child Psychiatry* (1935):

Lifelong feeding problem and frequent diurnal enuresis in a healthy six year old boy of high average intelligence, youngest in a family of four, badly spoiled by an invalid father and a hypochondriacal mother.

A physically and mentally healthy, well adjusted seven-year-old boy, handicapped by a moody, emotionally unstable mother who has branded him as a 'feeding problem' and changes schools, doctors, and 'diets' almost every week.¹⁹⁹

These examples demonstrate the culturally saturated "common sense" that Meyer advocated as an objective means to evaluate patients and formulate their treatment. It was common sense that women tended to be emotionally unstable and men were ineffective or absent parents. Yet in working with patients' narratives as a means towards self-understanding and helping them overcome their current problems, using a common logic, or common sense, was necessary. Psychiatric evaluation could reveal causality from everyday life that, upon becoming known to the patient, provided a means for

¹⁹⁷ American Academy of Pediatrics, "Round Table Discussion on Childhood Psychiatry", *J. Pediatrics*, 1936 p. 552.

¹⁹⁸ Kanner, *Child Psychiatry*, p. 113.

¹⁹⁹ *Ibid.*, p. 115.

amelioration. Thus, while common sense was predicated on a shared worldview, psychiatrists like Meyer sought to influence the content.

Discussing the diagnostic synthesis with the parent required tactfulness and plain language and avoiding “berating the parents, even if they seem to deserve it.”²⁰⁰ Kanner recommended using phrases to bring the discussion into the shared realm of common sense: “‘You have said yourself that...’, ‘Your own observations have led you to believe that...’”. The physician would then elaborate from these parental concerns to explain the situation as “intelligently, convincingly, and concretely” as possible in order to gain the parents’ cooperation.²⁰¹

The treatment principle of psychobiology consisted of adjusting the child to the “reasonable demands of a suitable environment.” Especially in the first years of the clinic, treatment emphasized changes in the environment of the child, especially the methods of parenting. The actual recommendations were often similar to the behavioral and educational advice given by pediatricians: proper physical hygiene, regular habits, frank discussion with the child, recreation and socialization with peers, and correcting any “faulty” notions of a “superstitious...or pseudo-scientific” nature.²⁰²

Two small but significant practices also helped to inculcate the psychobiological approach in pediatric practice. Kanner used the referral slip for a psychiatric consultation as an educational device. Instead of relying on a diagnostic category such as “neuropathic child, please evaluate,” Kanner requested that pediatricians describe the actual problems and any factors that might be contributory. Comparing a referral slip from 1931 with one from 1938 reveals a change in the pediatrician’s approach to behavioral problems. Both cases concern five-year old children.

1931: “Child has severe temper tantrums and upon such occasions throws everything in sight. Home situation poor for such a child. Does spoiled child reaction explain all in such an environment?”²⁰³

1938: “A fairly intelligent child with an uncooperative mother. The child takes hours to eat because ‘my mouth is small and won’t take large bites’ and ‘mamma feeds me large spoonfuls to choke me.’ Has been a feeding problem with vomiting since six months of age. Mother just won’t follow the instructions to take plate away after 20 minutes and still coaxes the child to eat.”²⁰⁴

²⁰⁰ Ibid., p. 24.

²⁰¹ Ibid., p. 126-8.

²⁰² Ibid., p. 125-8.

²⁰³ Case 9576. Identifying characteristics have been changed for all cases, including case numbers, for patients’ privacy. Researchers with permission to use the records may consult the Alan Chesney Medical Archives, Johns Hopkins University, for the original numbers.

²⁰⁴ Case 4492.

In the first case, the pediatrician recognized that environmental factors were likely contributing to the child's behavior but then tried to diagnose the problem as a standard type of reaction. The second case gives a sense of the feeding difficulty as a reaction of this particular child to her mother and the methods that have yet to work in this situation.

Secondly, Kanner continued Meyer's practice of typing his notes.²⁰⁵ Stenographers were not an insignificant part of the operation at roughly twenty percent of the total operating costs.²⁰⁶ The legibility gave the psychiatric consultation a sense of transparency to the pediatricians, whose own notes were handwritten. All of the relevant facts of the history were easily accessible and orderly: Complaint, Family History, Personal History, Physical Status, Mental Status, and Summary and Disposition. In reality, the summary statement often gave more prominence to the psychiatrist's impressions rather than a deduction from the extensive collection of facts. For example, this summary statement is typical of the earlier reports: "Very spoiled child, hyperactive, restless, eager to attract attention" despite the lack of recorded evidence of the patient's spoiling.²⁰⁷ Later reports were longer and recorded more subjective evidence from the patient. Nevertheless, the typed report provided a clear, organized collection of details and gave the impression of an objective and reasoned assessment.

The Psychiatric Approach in Practice

This section uses a case to show the differences in approach between pediatrics and psychiatry, and also how pediatricians used the services of psychiatrists.

The first case returns to the five-year old girl mentioned above who believed her mother was trying to choke her.²⁰⁸ Her parents brought her to the Harriet Lane Clinic for vomiting her food soon after eating, which had been a chronic pattern since birth. The pediatrician noted the child's temper tantrum during the examination which was otherwise normal. She/he considered the issue as a behavior problem and advised the mother to be indifferent about the child's behavior. Laboratory tests revealed no evidence of diabetes, kidney disease, or tuberculosis. The mother brought the child back

²⁰⁵ Working in state hospitals with a tradition of classification, Meyer sought to instill his approach through concrete practices. For example, he encouraged the use of stenographers to type psychiatric case records. Handwritten notes could be quick but careless, often relying on diagnostic terminology rather than the facts of the particular case. Producing typewritten notes encouraged the physician to formulate the case through the evidence provided in the patient's story. As Meyer explained in his annual report of Superintendents of New York State hospitals in 1904: "My first aim was to cultivate habits of work and thought which would tear us away from the old traditions into actuality. ... The interest must be extended so that the facts established furnish material for progressive activity." (Meyer, *Collected Papers*, Vol 2, p. 121).

²⁰⁶ "For Study and Teaching in Field of Child Psychiatry," Sept 1, 1934 to Aug 31, 1935, Rockefeller Foundation, RG 1.1, Series 200A, Box 93, Folder 1116.

²⁰⁷ Case 8230.

²⁰⁸ Case 4492.

for two check-ups over the following weeks and indicated that the child's eating had improved but she still made life difficult for the parents by dawdling during her meals. The mother was given further instructions about taking the food away after twenty minutes and not coaxing the child to eat. A month later, during another check-up, the mother reported that the child vomited when she tried to carry through the instructions. The pediatrician referred the case to Kanner's clinic out of frustration that the mother was not following instructions.

The psychiatrist working in Kanner's clinic recorded an extensive history of the problem. A story unfolded of multiple illnesses, the parents' concern about her poor health, and the multiple interventions to cure her poor eating including removing her tonsils and administering a medication for a year for possible intestinal problems. Her eating patterns led to fighting between the parents. The psychiatrist also elicited a history that the child was an unwanted pregnancy because of the financial strain, the father had a "nervous breakdown" when he was a teenager although the mother knew little about the episode, and the father felt mother was not disciplining the child but felt unable to do this himself because of his own poor nerves. The family also felt squeezed financially on the father's income as a truck driver. They lived in an apartment with no modern conveniences such as an indoor plumbing.

The child was interviewed by a different psychiatrist who specialized in play-therapy. She re-enacted the interactions between herself and her mother. The mother doll threatened to whip the child doll, and the child vomited to prevent punishment. The psychiatrist noted that the child realized that she pretended to be sick as a strategy.

All these factors went into the summary statement of the report to support the main conclusion that the child was spoiled. Similar to the pediatrician, the psychiatrist recommended approaching the child's eating more casually and taking the food away after a certain amount of time. Parents were also advised to let the child fight some of her own battles with the other children in the neighborhood. A star chart was also given to the child for eating without problems.

The family returned a week later for a return visit and expressed their continued concern about the patient's eating problems although they were trying to ignore it. The psychiatrist reassured the father about the psychological basis for the vomiting and the child's good physical health. He remained somewhat skeptical, stating, "I stuck three years to one doctor and he promised a lot but didn't produce a thing. But I'll play ball. She's had this a long time and is no thinner than I was so you may be right." Meanwhile the child proudly showed her star chart with only eight episodes of vomiting after the 21 meals for the week.

The family followed monthly with the psychiatrist for six more sessions, with an overall improvement in the child's eating. The psychiatrist linked the improvement to the

parents' attitude of handling the child more casually. This began a virtuous cycle in the family's overall happiness. The parents could have more of their own life as they no longer went to bed with her at 7:30, finding that she could fall asleep without them. They were able to see the child's occasional mischief as "amusing" rather than worrisome. Overall, the family seemed "happier and more composed." In the final session, the mother acknowledged that the child may have been "just putting on the pain."

Not all cases showed improvement and many parents did not follow up regularly, if at all. The difference between pediatricians and psychiatrists in this example is based upon the approach as well as the time spent. Collecting an extensive history was time-consuming, and pediatricians often found it impossible with their schedule. On the other hand, there is also a qualitative difference in the searching for reasons as to why the child is behaving in a particular manner. Psychiatrists dug deeper and also covered much more terrain in their questioning, including the family's reaction to the various childhood illnesses and the effect of the patient's behavior on the family. Although the pediatrician's advice was not significantly different from that of the psychiatrists, the family had a different relation to someone who saw their problem as unique and within the context of their other concerns. This family experienced improved relations and happiness, despite little evidence that the economic situation improved during the course of treatment. Parents were willing to spend money to pay physicians for the welfare of their children. In this case, the parents also valued the money and time spent towards improving relations in the home.

Conclusion

In his conversation with Allan Gregg of the Rockefeller Foundation in 1934, Park was enthusiastic about Kanner's clinic: "For the first time [the pediatric interns] are leaving their term of service with an idea of the child as a whole and a feeling of obligation to the child as a personality."²⁰⁹ This broader armamentarium for pediatricians also bolstered their position as a family advisor. Park also noted that the role of the pediatrician had changed and broadened: "I was rather slow, perhaps, in grasping the idea...that the pediatrician was really responsible for the child from the standpoint of behavior...I had never quite conceived of that as my duty before. I thought it was the duty of the teachers or of the parents or the priest."²¹⁰

The Commonwealth Fund began to fund similar projects like Kanner's clinic from the mid 1930s, as part of an effort to "broaden the concept of health to include the non-

²⁰⁹ "From Allan Gregg's Diary, Mar. 1, 1934, Baltimore," Rockefeller Foundation, RG 1.1, Series 200, Box 93, Folder 1116.

²¹⁰ Edwards Park, draft of "Methods, Results and Opportunities of Four-Year's Liason between Pediatrics and Psychiatry," (1935), p. 16, in Meyer papers, II/353, AMCMA.

physical.”²¹¹ This impulse would be more elegantly named “comprehensive medicine” in the 1940s. With the growing trend towards specialization in medicine from the 1930s onward, the ability to provide medical care that treated the patient as a whole person became an attractive, and perhaps necessary, skill. The Commonwealth Fund sponsored efforts to teach psychiatric techniques to pediatricians and eventually to physicians working with adults.

Psychiatry, in particular, was placed in an awkward situation with the Fund’s interest to increase psychiatric education in other fields starting with social work, to pediatrics, and later to general medicine. Psychiatry became boiled down to an “attitude” of patience, curiosity, respect for the patient.²¹² Ostensibly, this could be attained by anyone.

In the 1947 meeting hosted by the Commonwealth Fund on “Pediatrics and the Emotional Needs of the Child,” pediatricians, psychiatrists, and social workers converged to discuss the progress of those programs funded for psychiatric work in pediatrics. One participant asked if physicians actually should treat emotional problems in children when less expensively trained personnel such as social workers could accomplish the same end.²¹³

Although Adolf Meyer advocated back in 1917 to the American Medical Association that psychiatrists had left the asylum to find his calling in “treating the patient as a person,” he left psychiatrists with little special technique when this type of approach became common sense among medical practitioners.²¹⁴ Ironically for Meyer, psychiatrists turned to psychoanalysis, especially after the Second World War, as a means to differentiate themselves.

²¹¹ Commonwealth Fund Annual Report, 1935 (New York: Harkness House), p. 35.

²¹² American Academy of Pediatrics, “Round Table Discussion on Childhood Psychiatry,” *J. Pediatrics*, 1936, p. 557.

²¹³ Helen Leland Witmer, *Pediatrics and the emotional needs of the child* (New York: Commonwealth Fund, 1948), p. 51.

²¹⁴ Adolf Meyer, “Progress in Teaching Psychiatry”, *JAMA*, 1917, LXIX, No 11, p. 861.

CHAPTER 5

Leo Kanner's Clinic, 1931-1945: Developing a Specialty

Leo Kanner began his work in the psychiatric liaison clinic at the Harriet Lane Home in the midst of a controversial time in the approach to behavioral problems in children. Pediatricians, who had worked hard to establish their niche of preventive care for children, felt behind and beleaguered in this domain. In 1928, when Edwards Park began to lobby for a psychiatrist to be placed in the dispensary of the Harriet Lane Home, the pediatric hospital of Johns Hopkins, he sought to educate pediatricians to handle everyday, minor behavioral problems. Leo Kanner, whom Adolf Meyer selected to run the clinic, considered one his entrusted objectives to “teach pediatricians how to handle the rank and file of children’s personality disorders, which they usually *would not* and, if properly trained, *should not* refer to a psychiatrist.”²¹⁵ (Italics mine).

Park hoped the educational benefits of a psychiatric liaison clinic would cement pediatricians’ role of family advisor, a position Park and his pediatric mentors worked hard to obtain, and thus corral the expanding market for child behavioral experts.²¹⁶ In his preface of Kanner’s 1935 textbook on child psychiatry, Park encouraged his pediatric colleagues that childhood behavioral disorders were “within the grasp of the pediatrically trained mind”: “As compared to those of the adult, however, they are generally simple. The brevity of experience, the ignorance of life, the simplicity of thought tend to make the personality difficulties of children, particularly of young children, readily ascertainable and explicable.”²¹⁷

Instead of decreasing, however, the rate of pediatrician’s referral of behavioral problems to Kanner’s clinic rose, from 65% to as much as 90% during the first fifteen years of the clinic.²¹⁸ Rather than obviating its services, the psychiatric clinic both expanded its purview and deepened its niche as a specialty. Kanner imagined that child psychiatry would “cease to be the object of the psychiatrist alone” and “become one of a number of branches of the science of pediatrics.”²¹⁹ This did not occur, however, and I argue in this

²¹⁵ Leo Kanner, *Child Psychiatry* (Springfield, IL: Charles Thomas, 1948), p. 28.

²¹⁶ For pediatrician as “family advisor” see Sydney Halpern, *American pediatrics: the social dynamics of professionalism, 1880-1980* (Berkeley: University of California Press, 1988), pp.106-7.

²¹⁷ Leo Kanner, *Child Psychiatry* (Springfield, IL: Charles Thomas, 1935), p. viii.

²¹⁸ From my sample of case records: 1931-1945. Percentage referrals of “behavior problems” from pediatricians to Kanner’s clinic 1931-1935: 64% (n=67); 1936-1940: 90% (n=50); 1941-1945: 80% (n=41).

²¹⁹ Kanner, *Child Psychiatry* (1935), p. xvii.

chapter that two factors led to the solidification of child psychiatry as a subspecialty of psychiatry, as opposed to dissolving within pediatrics. These factors are the evolution of technique and a growing middle-class demand. I examine these changes within the first fifteen years of Kanner's clinic, from 1931-1945, after which child psychiatry was clearly differentiated from pediatrics.

Park's opinion that children were simpler organisms became increasingly problematic and outdated. Commonwealth Fund-sponsored child guidance clinics of the 1920s encountered intractable cases and experimented with new approaches, including addressing emotional problems of the parents. The armamentarium of treatment changed from relatively simple advice on habit training, easily accessible to pediatricians, to techniques based on unearthing and transforming emotional problems of children and their parents.

Concurrently, the clientele of Kanner's clinic also changed over this period of time, with an increasing usage of the clinic of middle-class parents who were vigilant of their children's development. Specialty clinics within an academic hospital offered "intellectual prestige and public confidence" and attracted paying patients.²²⁰ The pediatric psychiatric clinic was modeled off of the existing specialty clinics such as cardiology and endocrinology at the Harriet Lane Home. In my sample, these patients came for consultation rather than treatment. Thus, although techniques evolved over time, the middle class rarely came for treatment as much as for an opinion.

Overview

My data from eighty-six case records of Kanner's clinic reveal that significant heterogeneity of technique and social composition existed in the clinic despite the trends of increasing psychodynamic influences and middle-class patronage.²²¹ This is different from other historians' observations in child guidance clinics in which the prevailing practice was psychodynamic therapy with middle-class children.²²² I argue that this

²²⁰ Charles Rosenberg, *The care of strangers: the rise of America's hospital system* (New York: Basic Books, 1987), pp. 172-74.

²²¹ Edwards Park kept an index of cases by diagnosis which is at the Alan Chesney Medical Archives, Johns Hopkins University. Under the heading, "Behavior Disturbance," there are roughly 5,000 cases from 1931-1950. This comprises the largest group of psychiatric cases at the Harriet Lane Home. I randomly selected nearly 200 cases over the course of twenty years. Of this, only 86 cases were evaluated in Kanner's clinic from 1931-1945. The remaining included those who came only for a physical examination from the Phipps Psychiatric Clinic (n=29) and were thus not seen by Kanner; those not referred to Kanner's clinic (n=40); those referred to Kanner's clinic but did not come to the appointment (n=30); and the small sample from 1946-1950 that were evaluated by Kanner but I did not include in these statistics (n=8).

²²² Margo Horn, *Before It's Too Late* and Kathleen Jones, *Taming the Troublesome Child*.

heterogeneity was professionally beneficial for psychiatry to flourish in a medical center that accepted a variety of cases. It suggests a degree of flexibility to meet the demands of staff and patients and widened the applicability of psychiatric knowledge.

The sample reveals the development of distinct patterns of use, roughly falling along class lines. The middle class tended to come from further distances for a consultation with Kanner, rarely using the clinic for treatment. The poor and working class had higher rates of engagement with treatment, more reliably returning for appointments. These patients provided the bulk of training opportunities for young doctors rotating through Kanner's clinic.

Middle-class families generally brought their children when problems were in an early stage. Difficulties with schoolwork, unhappiness, not getting along with others were common complaints. Familial discontent centered on skirmishes about the confines of gender roles in marriage. By comparison, working-class children were more often referred from school rather than brought in preemptively by parents. Truancy and other delinquent behavior led many working class boys to the clinic. The unhappiness in marriage expressed by working-class mothers was of a different nature altogether than middle-class counterparts, often involving an alcoholic and violent spouse. For families of the poor, parents risked having a child taken away if the staff felt the home conditions were unsuitable. Dealing with the variety of problems precluded the use of any one approach.

However, there were changes in approach, the dominant paradigm of habit training gave way to a model loosely based on psychoanalytic principles focusing on parental attitudes toward the child. This is clearly demonstrated in the shifting etiology from the "spoiled child" to an "overprotective mother" by the mid-1930s. Mothers were not blamed for their ignorance in proper technique as much as their emotional immaturity. The clinic began to incorporate a variety of techniques including play therapy with children and more intensive therapy with parents. The use of specialized techniques to treat everyday problems such as temper tantrums further distinguished psychiatrists from pediatricians as having a special skill set.

Changing Demographics

Over the time period of 1931-1945, the demographics of families coming to Kanner's clinic shifted. The largest degree of change occurred during the first ten years of the clinic, from predominantly poor and working class to middle and working class. In this section, I will outline the changes, illustrate differences with select case studies, and hypothesize why these changes occurred.

The largest changes came from the rise of the middle class and a decrease in the poor. The middle class increased from 14% to 37% of Kanner's clinic population.²²³ Middle class families were predominantly native-born white. Of the 24 middle class families, there was one African American family and three families with one immigrant parent (Germany, Russia, Rumania). Only one family had more than three children, and the majority had two or fewer children. There was a fifteen percent separation or divorce rate, although these occurred in parents' prior marriages as opposed to imminent marital discord.

By comparison, the percentage of poor families decreased from 32% to 11%, with a total of 15 families. African Americans comprised nearly twenty percent of this group, which was consistent with the general population of Baltimore. Unlike other classes, there were no immigrants in this sample.²²⁴ Native-born whites comprised the remaining eighty percent. The poor had much higher levels of separation and divorce, affecting more than half of the families. This group also had the largest family size, with nearly forty percent having more than three children.

By contrast, the working class consistently comprised a little over half of the patient population during this period with 47 families. One quarter of these families were immigrant families from a variety of places, including Poland, Russia, Bohemia, and Italy. This was higher than the immigrant population of Baltimore, which was less than ten percent. African American families made up ten percent of this patient group, which was lower than the general population.²²⁵ The majority of working class families had three or fewer children. There were similar rates of separation or divorce to the middle class, although half of these occurred during the family's contact with the clinic. See Chart I and Table I below.

The lower rate of African-Americans than within general population is both surprising and not. African-Americans lived closer to the hospital than other groups because of race-based zoning laws, and thus we might expect a higher proportion. However, schools

²²³ I generally followed criteria used by Horn: Middle/educated class: businessmen, shopkeepers, salesmen, professionals, and parents referred to as well-educated; Working class: service occupations, factory work, and skilled labor; poor: receiving social welfare assistance or described as financially marginal. Horn, *Before It's Too Late*, p. 179.

²²⁴ US Census figures for Baltimore from Historical Census Browser. Retrieved 11/30/2011, from the University of Virginia, Geospatial and Statistical Data Center: <http://mapserver.lib.virginia.edu/collections/>

(1920) Total: 733,826; Immigrants 84,000; African Americans 108,000.

(1930) Total: 804,874; Immigrants 73,000; African Americans 142,000.

(1940) Total: 859,100; Immigrants 60,969; African Americans 165, 843.

(1950) Total: 949,708; Immigrants 51,000; African Americans 225,000.

²²⁵ Ibid.

tended to be the largest source of referral for all patients, and African-American schools were underfunded with limited resources to even handle attendance problems.



Chart 1: Kanner's Clinic Patient Economic Background

	% African American	% Immigrant	% Separation or Divorce	% Families > 3 children	Number Families
Poor	19%	0	56%	38%	15
Working	9%	25%	16%	20%	47
Middle	4%	13%	15%	4%	24

Table 1: Demographics of families of Kanner's clinic patients, 1931-1945

Middle Class

Reasons for bringing children to the clinic also differed with socioeconomic background. The most common concern of middle class parents centered around education. Unlike other groups, these parents brought their children in prior to any gross difficulty that would result in a school referral. Difficulty in the first few grades of school upset parents who wanted to correct any problems early on. Although there was a range of parental toleration of children's performance, most expected their children to excel in school. One mother brought her seven year-old-daughter because she was not in the highest group in the second grade, whereas she had been the previous year. The teacher expressed her surprise to the social worker of the clinic that there were any difficulties

with this child.²²⁶ Another seven year-old boy was brought in because he was on the verge of failing first grade, which the mother found embarrassing especially because of her active participation in the Parent Teacher Association. The teacher thought he lacked motivation and thought he was smarter than everyone else.²²⁷

Having a disagreeable attitude also concerned parents. The parents of a six-year-old boy complained that he had “a superiority complex” and played unfairly with his baby brother. He bossed his playmates around and dawdled over his meals, demanding that his father read to him while he eats.²²⁸ An eleven-year-old boy was brought in because his parents thought he was unhappy and fought with his younger siblings, creating a tense environment at home although he excelled at school.²²⁹

Unhappiness in the home, especially between parents, often magnified behavior problems in children, both in reality and perception. In middle-class families, discontent with gender roles in marriage was voiced during the interviews with psychiatrists and social workers. Fathers commonly blamed mothers for a child’s problems. This was especially true if the mother had a part-time job or other activities outside of the home such as volunteer work. One mother hid her son’s poor report card from the father because she was afraid he would blame her. Some middle-class mothers complained of feeling bored or undervalued in their lives. Some felt resentful that their husbands were not more ambitious. Husbands generally left the disciplining to their wives, preferring to be able to “pal around” with their kids after work. This created further resentment on the mother’s part, with more friction in the mother-child relationship.

As a detailed example of a middle-class family, I return to the mother who brought her daughter to Kanner’s clinic because she was not in the highest group in second grade.²³⁰ This family of four lived in the suburbs in the 1930s, with father steadily employed as an auditor. The mother expressed several frustrations about her child, the older of two girls. Not only was she now in the middle group rather than the highest, she continued to show poor habits such as not putting her toys or clothes away. She was not as social or attractive as her younger sister. The father often became impatient with the children for making too much noise or messing up his clothes when he played with them. The father also criticized the mother about her housekeeping, with the result that the mother spent much time cleaning. Through further contacts, the social worker described the house as “spotlessly clean as usual” with a kitchen that was “a model of perfection, with a recent

²²⁶ Case 1258. Identifying characteristics have been changed for all cases, including case numbers, for patients’ privacy. Researchers with permission to use the records may consult the Alan Chesney Medical Archives, Johns Hopkins University, for the original numbers.

²²⁷ Case 2256.

²²⁸ Case 1759

²²⁹ Case 2948

²³⁰ Case 2381

model porcelain sink, electric refrigerator, electric mixer.” The mother described weekends as a “nightmare” because the father refused to help her with the tasks of getting the children ready for church, and they fight because they are always five minutes late. Instead, the father enjoyed cleaning the car or puttering around the house.

When told that her child was normal at the end of the first interview, the mother “seemed dissatisfied” and said that she “needed help herself perhaps as much if not more than the child.” Although the father refused to come to the clinic, he allowed the social worker to visit even though “it was obvious that he was not very much interested.” However, he participated in the discussion. During this meeting, the mother voiced some of her frustrations. Although the father was “inclined to treat them as very minor matters and hardly worth discussing,” the mother “felt strongly enough about them so that tears came in her eyes while they were discussed.” In this case, the mother brought the child to the clinic out an underlying sense of unhappiness in the home. However, it would be unlikely that the mother would have come to a psychiatric clinic to discuss her unhappiness. Instead, the child’s slip in class rank gave the mother a socially acceptable reason to seek help, even if largely for her own mental health.

Working Class

Among the working class, failure in school also was a leading cause for parents to bring their child to the clinic. Unlike the middle class, however, most children were referred from the school, sometimes without the mother’s awareness of any problem. As a result, children with school difficulties often came when they were older, with an average age of nine years old, rather than seven for middle class kids. One mother of a thirteen year-old-boy was defensive and angry with the teacher for referring her child to the clinic. The teacher asked to have his hearing checked because he was inattentive and likely would fail sixth grade. The mother believed that the teacher treated her son unfairly.²³¹ Another parent brought her eleven year-old-boy after the school referred him because he was failing a few subjects. Father tried to help the boy with his lessons in the evenings but had little patience. His father had ambitions for the child and would not allow the boy to quit school.²³²

Delinquent behavior such as truancy or stealing was also a common reason for working-class boys to come to the clinic. The school was one of the regulating institutions in the community, referring children for truancy or poor behavior within school. Some children with poor behavior were mandated to come for regular sessions to the clinic in order to attend school. The clinic also received some referrals from the juvenile court. One mother referred her own eight year-old-son to the juvenile court because he was staying

²³¹ Case 1604

²³² Case 1611

out all night, watching movies. She hoped that the court would be able to at least keep him out of trouble until school started.²³³

Like the middle class, working class parents also brought in their children for concerns that they were not happy or getting along with others. One immigrant mother wrote letters to the psychiatrist about her thirteen year-old-son because she had difficulty conveying her concern during the interview. She wrote, "...it seems to me, the more I try to convey to others what is wrong with [her son], the more I feel that I am just trying to complain about my own child...It seems to me he is just a 'bunch of tangled nerves,' needing someone to unravel them...It seems such a shame to have all of this contention, because deep down there somewhere within him he has a lot of the best..."²³⁴ This mother feared that her son's complaining attitude and fearfulness was hampering him from getting along in school and with peers.

Unlike unhappy marriages in the middle class, working class mothers more often revealed domestic lives that were unraveling through chronic money concerns, alcoholism, and violence. Many of the working class were on relief for some part of the Depression. A misbehaving child could suffer severe punishment in these circumstances of duress. Mothers in these situations usually were not as interested in working on the marriage as figuring out a way to temporarily relieve the stress of a misbehaving child.

As an example of a working class family in the early 1940s, a mother brought her five year-old-boy to the clinic because he fought with other children in school, was "wild" and broke things at home, and had temper tantrums.²³⁵ The family lived close to the hospital with two other children. The father worked as a policeman while mother ran a small confectionary store. The parents punished him severely because of his behaviors. The mother said, "I have beaten him so that I was ashamed of myself afterwards...I just don't know what to do with him. A lot is really not the child's fault. He has seen too much of the wrong things."

The mother then revealed that her husband was an alcoholic who had been brutal to her and the children, threatening them with a knife and a gun. She had left him twice before and felt certain that she would leave him again. She had been very depressed in the past and felt that she might need her own treatment. Although she did not explicitly say that she wanted to send her child away, she raised the point that he behaved very well at her sister's home last summer and wanted to go back. Ultimately, the clinic helped to orchestrate the child's returning to the aunt's for a few months. However, both parents came to several appointments in which the clinic tried to help repair the relationship, although the mother had little interest in staying. In this case, the mother brought the

²³³ Case 2195

²³⁴ Case 1601

²³⁵ Case 1336

child because of behavioral problems that she had no ability to handle at that time. She hoped the clinic would help her in her desperation to relieve some of the stress of the chaotic household.

The Poor

Like the other classes, the poor brought their children for a variety of reasons. The situations in which the children were brought to the clinic were often precarious and sometimes resulted in a referral to foster care. For example, a mother brought her seven year-old-boy after referral from the school because he was restless and performed poorly. Although the mother tried to help the child with his lessons in the evening, her ability to help the situation was limited given the severe poverty of the family and the father's mental illness. Soon after the evaluation, the father tried to throw one of the children out of the window, which led to his commitment to a psychiatric hospital. Kanner recommended foster care for the children, but the mother refused and managed to keep the social agencies at a distance.²³⁶

Several mothers were divorced and raising their children on their own. After her second divorce, another mother asked the psychiatrist to sign the papers to send her son to a training school. She felt incapable of raising him alone, especially with his poor behavior in school.²³⁷ Another mother, who had separated from her alcoholic husband, brought her four year-old-daughter to the clinic for temper tantrums. The mother revealed that she was contemplating suicide and considered "taking her two children with her." Foster care was recommended while the mother was committed to a psychiatric hospital, but the grandmother preferred to keep the children.²³⁸

As an example of a poor family in the 1930s, an eleven year-old girl was brought to the hospital because of abdominal pain. She came from a large, poor rural family with a bad reputation in the community because the family had trouble with the law. The medical team believed the pain to be psychogenic, and a psychiatrist from Kanner's clinic found the child to be unhappy in her surroundings. The social worker and psychiatrist, in conversation with the reverend who brought the child to the hospital, felt the child should not return home because "...this child is decidedly of better stuff than her immediate family, and that, if possible, she should be removed from the home." The psychiatric clinic facilitated the plan for the child to live with the reverend and his wife. Two years later, however, the parents demanded that their daughter be returned. The psychiatrist was contacted to testify on behalf of the child's interests. The reverend feared that if she returned home, "the little social prestige which they have been able to build up for her in

²³⁶ Case 1089

²³⁷ Case 1001

²³⁸ Case 1217

the community will be lost.” The parents ultimately lost custody of the child.²³⁹ In dealing with unstable families, child psychiatrists were called to make judgments based on the best interest of the child, as opposed to the child within a larger family group.

“Crisis” of the Family

In order to account for the changes of clientele in my sample, I follow the lead of historians who have examined the “crisis” of the middle class family in the 1920s. As historian Paula Fass explains in *The Damned and the Beautiful* (1977), the middle class family experienced two shifts, beginning in the nineteenth century and effective by the 1920s. First, there was a change in the internal order of the family, whereby middle-class families became more “democratic”, less hierarchical, and more “affectionate” resulting from smaller size and less strained by production or economic concerns. Secondly, the family lost its social function as a means of mediating individuals in regards to other institutions such as work, church, or school as society became more bureaucratized, rational, and impersonal. Family experts including sociologists, social workers, and psychiatrists, in the 1920s were self-conscious of the family’s loss of social function and insisted the family had the important functions of child-nurture and attending to emotional needs of family members. Thus, the new social function of the family was to create psychologically adjusted members of society.²⁴⁰

Thus, although the benefits of an emotionally satisfying family unit were potentially tremendous, the difficulty in reaching this ideal created dissatisfaction. As sociologist Ernest Groves in *American Marriage* (1928) wrote about modern culture and modern marriage: “In so far as marriage brings the end or even the decline of the romantic sentiment or the intellectual growth of either member of the partnership, it becomes inherently destructive to personality, and in a proportion of such cases brings about an inevitable disappointment.”²⁴¹

Family experts, such as those in child guidance clinics, sought to help families through these disappointments and stresses in raising children. Porter Lee and Marion Kenworthy, of the Commonwealth Fund’s Institute for Child Guidance in New York, outlined their agenda in 1929:

Every human being has an urge towards the kind of happiness which comes when those interests in which he has a stake are satisfying to him. In none of life’s interests have parents any greater stake than in their children. Parents seem destined never to be

²³⁹ Case 2969

²⁴⁰ Paula S. Fass, *The damned and the beautiful: American youth in the 1920's* (New York: Oxford University Press, 1977), pp. 53-118.

²⁴¹ Ernest Rutherford Groves and William Fielding Ogburn, *American marriage and family relationships* (New York: H. Holt and Company, 1928), p.99.

without some measure of anxiety over children, but when children are more prolific of anxiety than of satisfaction, the load upon the parents becomes heavy. We stress this point because we believe that from no point of view can the contribution of child guidance be given a higher rating than from the point of view of the relief which it has given to overburdened parents.²⁴²

Thus, the promise of happiness and satisfaction brought many middle-class families to the clinic. Unlike parents of working-class or poor families, concerns about happiness could be central to the middle-class.

In the oft-cited sociological study of a small American city in the Midwest, *Middletown* (1929), Helen and Robert Lynd find differences between working- and middle-class families with regards to childrearing. Working class mothers regarded “strict obedience” and “loyalty to the church” as most important values to teach children, as compared to the stress on “independence” and “frankness” amongst business class mothers.²⁴³ These values of the middle class support the development of a more democratic quality to family life, as the Lynds observed.

The decreasing number of poor families referred to Kanner’s clinic may reflect the increasingly use of psychiatric techniques in social work in general, and thus the poor requiring psychiatric assistance may have received this through the social agencies instead of referring to the Harriet Lane Home for an evaluation.

As another possibility, the poor may not have been referred to the psychiatric clinic as often because of the stressors of the Depression and war. According to Linda Gordon in *Heroes of their Own Lives* (1988), these two crises led to increase emphasis among caseworkers on poverty and relief, tending to hide family violence. She writes, “The crisis sensibility promoted a view of family unity as essential to survival...many caseworkers operated as if naming and discussing family conflict, let alone violence, was encouraging it.”²⁴⁴

Whatever the reasons behind these demographic changes, psychiatrists in Kanner’s clinic encountered more middle class families with different types of concerns by the mid 1930s. They began to experiment with different techniques in order to meet this demand.

Changes in Treatment

²⁴² Lee, Porter R., *Mental hygiene and social work* (New York: The Commonwealth fund, Division of publications, 1929), pp. 8-9.

²⁴³ Robert Staughton Lynd and Helen Merrell Lynd, *Middletown, a study in contemporary American culture* (New York: Harcourt, Brace and Company, 1929), p.144.

²⁴⁴ Linda Gordon, *Heroes of their own lives: the politics and history of family violence : Boston, 1880-1960* (New York, N.Y., U.S.A.: Viking., 1988), p. 158.

When Kanner wrote his textbook *Child Psychiatry* in 1935, he had had less than five years' experience of working with children. His text was a clear application of Adolf Meyer's psychobiology to children and was the first textbook of Meyer's teachings, as well as the first textbook of child psychiatry in English.²⁴⁵ Psychobiology had been the dominant approach in American psychiatry since the 1910s. Meyer became trenchantly opposed to psychoanalysis as its popularity rose in the 1920s, and this distrust is reflected in Kanner's book. However, by second edition in 1948, Kanner gives psychoanalysis more weight and measure. John Whitehorn, who assumed the chair of psychiatry at Hopkins after Meyer's retirement in 1941, described the second edition as a "wholly new work, reflecting, directly, [Kanner's] own more fully matured perspective."²⁴⁶ Kanner's change of opinion reflects both efforts to meet the changing needs of the patients and an evolution of his development as independent from Meyer.

Parental Attitudes

In the second edition, Kanner embraced two advances from child guidance clinics and based upon psychoanalytic concepts: the central role the parent-child relationship and the use of transference in therapy. In the first edition, Kanner places the family as one among other "environmental factors," on par with the neighborhood and the school. Parents should provide an environment that allows the child to grow into a healthy adult. This includes providing the basic needs of protection, food, clothing, and education as well as allowing the child to develop responsibilities. He cites domestic frictions and paternal alcoholism as common environmental factors leading to behavioral problems. Parents of problem children required education in providing a beneficial environment, which generally consisted of proper means of habit training.²⁴⁷

By comparison, the later edition stressed parental attitudes rather than methods. Kanner wrote, "It is quite conceivable that future textbooks of child psychiatry will be organized on the basis of parental attitudes and their effects on children....Much of the phenomenology of behavior disorders and personality deviations can be linked directly with motivations resulting from parents' attitudes toward their children."²⁴⁸ Providing a

²⁴⁵ Meyer never wrote his own textbook, relying instead on his students to put his method into print. Kanner's was the first, followed by Wendell Muncie, *Psychobiology and Psychiatry a textbook of normal and abnormal human behavior*. (St. Louis: C.V. Mosby Co., 1939) and Esther Richards, *Introduction to Psychobiology and Psychiatry, a textbook for nurses* (St. Louis: The C.V. Mosby Co, 1941).

²⁴⁶ Kanner, *Child Psychiatry*, (1948), p. vii.

²⁴⁷ Kanner, *Child Psychiatry*, (1935), pp. 86-98 and 126-128.

²⁴⁸ Kanner, *Child Psychiatry*, (1948), p. 117.

safe environment no longer sufficed, instead the parents should provide children with emotional security, “rest[ing] on three pillars of affection, approval, and consistency.”²⁴⁹

Kanner cast aside earlier efforts to advise patients as “naïve” and “ineffectual.”²⁵⁰ Instead, parents needed to understand the emotions behind their own attitudes towards their children. Parents should be given an opportunity to “express, recognize, and eventually modify their attitudes.”²⁵¹ David Levy, a psychiatrist at the Institute for Child Guidance in New York, worked with Smith College social work students to develop and refine the approach of working with parents, usually mothers, calling it “attitude therapy.” Levy was the first to clearly enunciate what child guidance practitioners perceived as over-solicitous or maladaptive behavior in mothers. Levy introduced the terms “maternal overprotection” and its opposite, “maternal rejection,” throughout a series of articles in the 1930s.²⁵² Attitude therapy was designed to correct these pathogenic mindsets.

Levy and associates attributed emotional problems within the mother as the cause of these malignant attitudes. These problems included her own unhappy childhood, a dissatisfying marriage, and thwarted ambitions. Kanner understood these discontents as signs of emotional immaturity. Kanner applauded increased opportunities for women to fulfill their ambitions beyond the home, but this was only to be a temporary phase, before motherhood. He wrote, “stable” mothers enjoyed working before a child as the job “had given them an opportunity for personal enrichment, the satisfaction of having had a fling at life before their domestication...”; however, “they new experience of motherhood is enjoyed because the mother obtains a richer biological and psychologic gratification from it than she has obtained from her job, because she wants a child or children from the man whom she loves.”²⁵³

Kanner’s description of “stable” mothers mainly concerned middle-class women where working was an option rather than a financial necessity. However, the notion of an overprotective or rejecting mother could apply to any class of patient and was applied liberally, often without clear indication. In the case of the immigrant mother who wrote letters to the clinic, the psychiatrist described her as expressing “hostile feelings toward [the child] and attempt[ing] to cover those up with pseudo interest in him.” One African-American working-class mother in the 1940s brought her son to the clinic because he was running away from home and she feared for his safety. The clinic described her as

²⁴⁹ Ibid., p.78.

²⁵⁰ Ibid., p. 253.

²⁵¹ Ibid., p. 118.

²⁵² David Levy, “Maternal Overprotection and Rejection”, *Archives of Neurology and Psychiatry* 25 (1931): 886-889. H.L. Witmer et al, “Studies in maternal over-protection and rejection”, *Smith College Studies Social Work*, 2 (1932):181-282.

²⁵³ Kanner, *Child Psychiatry*, (1948), p. 128.

“rejecting” and creating a “drab, nagging, punitive background” from which the child rationally sought to escape. The psychiatrist recommended that the child return to the clinic “as a pleasant escape into a relationship with a warm, accepting person.”²⁵⁴

Although mothers may not have agreed with the damning terms or their conservative underpinnings, many welcomed the opportunity to talk about the unhappiness in their own lives. I return to the suburban family in the 1930s as an example of the middle-class demand.²⁵⁵ However, this case is also unusual because of the duration of treatment and the social worker’s visit to the home for sessions. Although the social worker undertakes most of the therapy in this case, psychiatrists also conducted treatment with parents, unlike the strict division of labor in child guidance clinics.²⁵⁶

After the mother brought the child into the clinic because of school concerns, the social worker visited the mother at home seven times over the course of three years. Mother and child returned to the clinic once at the end to meet with Kanner. The social worker recorded her observations of the mother on her arrival during visits: “She seemed very anxious to talk about her problems but she was very critical”, and “The worker found the mother hurrying through her housework to get out for an appointment in town. However, she had many things she wanted to talk about.” The mother seemed to have little opportunity to talk with others. In describing conversation at the dinner table, the mother said that the father and children want to tell of the incidents of their day, but “nobody wanted to hear about what she did, but she does not mind this.”

The social worker worked with many registers, including educating the parent and offering more insightful comments. She did not challenge the mother’s repetition on multiple occasions that “she and her husband are really very happy together.” For example, the mother asked if the parent’s primary concern was to study their children’s faults and try to correct them. The social worker disagreed and spoke of the “necessity for encouraging the child’s virtues.” The social worker noted, “The conception of a positive rather than a negative approach to the child’s problems seems very difficult for the mother to grasp.”

The social worker then wondered if “the mother’s great concern over the patient’s minor faults could be a reflection of the father’s disapproval of the child.” This led to the mother’s becoming “very emotional” over her husband’s need for orderliness and

²⁵⁴ Case 2406

²⁵⁵ Case 2381

²⁵⁶ In child guidance clinics, the social worker worked with the parents, generally the mother. The psychiatrist continued to work with the child patient, but the importance of such work began to decline relative to work with the parent. As a training site, the division of labor in Kanner’s clinic was not as distinct. Psychiatrists sometimes worked both with children and parents, the latter under the social worker’s guidance. At other times, the social workers played a larger role.

neatness. Over time, the mother became more accepting of her daughter who was getting along better at home and school. However, she expressed resignation that “her husband has not changed his attitude at all, and still feels too superior to come to the clinic, or accept advice.”

The clinic did not attempt to directly challenge the tensions in the marriage, but it gave a venue for the mother to express dissatisfaction although it was quickly muted. For most middle-class parents, however, the opportunity to talk may have proved cathartic but also destabilizing. Most did not return after their first visit, even when the next appointments were scheduled. During the first appointment with the psychiatrist, the father of a six-year-old boy was asked to describe his own upbringing which led to memories of not having enough food, being raised by his grandmother, and working at a young age. He lived in fear that this would happen to his own family. The parents were “very appreciative” after the first visit but did not return.²⁵⁷ In another middle-class family, Kanner describes that they came to some realization about their own “perfectionistic” attitudes to the child: “As they were given the opportunity to tell their story, they began to realize more and more their contribution to the picture. The father, especially, made a complete turn-about and began to speak of his faults.”²⁵⁸ This family, similarly, did not return.

Additionally, the demographic shifts in the clinic described earlier had geographical consequences, which, in turn, may have affected patterns of use of the clinic. After World War I, Baltimore expanded its city limits through annexation and developers produced a suburban landscape of single-family homes, aimed at the middle-class market.²⁵⁹ In mapping the residences, I found that this expansion is largely corroborated in my sample. Four of five of middle class families lived more than four miles away, with one of three coming from Washington DC or out of state. Thus, the increase in the middle class also meant that they traveled from farther away to come to the clinic.

Therefore, two patterns of use emerged in the clinic, based largely on class. Whereas the middle-class used the clinic for a consultation only, the working and poor more often returned for treatment. Given the distance to the clinic, the middle-class may have sought treatment elsewhere or the visit alone may have met their needs.

Inner Life of the Child

Treatment of the child also changed during this period, from an appeal to his rationality to one of emotional transformation. In Kanner’s 1935 text, he psychoanalysis as fanciful

²⁵⁷ Case 2244

²⁵⁸ Case 1306

²⁵⁹ Olson, Sherry H. Olson, *Baltimore, the building of an American city* (Baltimore: Johns Hopkins University Press, 1980), p.325

as opposed to the “sober” work of psychobiology: “For our own purposes and for anyone trained to deal soberly with the concrete facts, it seems sufficient to know that the patient listens to us attentively, understand what we have to say to him, is capable of accepting facts which have been furnished by himself, by his parents, and by an objective examination, and is willing to participate in an arrangement which promises to relieve him of his difficulties.”²⁶⁰

By contrast in the second edition, Kanner applauded the psychoanalytic principle of transference as “one of the crucial therapeutic insights of our time”:

The basic factor in psychotherapy is not primarily the choice of a certain ‘method’, ‘approach’, or ‘school.’ The therapist himself is the principal therapeutic agent. ...[T]he relationship is conceived as an immediate experience. The therapist begins where the patient is and seeks to help him draw on his own capacities toward a more creative acceptance and use of the self he has. ...The child, as he plays, discovers his strength, is a winner in his struggle for identity, ‘releases’ his hostilities, frees himself of his anxieties, and learns what to do with his new freedom.²⁶¹

The change from educating the child to a dynamic experience between child and physician reflects a shifting emphasis towards a child’s inner life rather than outward behaviors.

Kanner’s clinic experimented with play therapy in a small percentage of patients. European psychoanalysts, especially Hermine Hug-Hellmuth and Melanie Klein, initiated play therapy as a means to observe the unconscious of children. The use of play therapy in Kanner’s clinic reflects a remarkable degree of separation from the reign of psychobiological methods. However, the mainstay of treatment remained behavioral methods such as star charts.

Initially, the use of play techniques in this clinic largely worked on the level of conscious thought. In the following case, a nine-year-old working class boy of immigrant parents was referred from the school because of disruptive behavior including fighting and stealing in the late 1930s. The boy came several times, bringing in a star chart to record days when he did not fight at school. The use of dolls to facilitate conversation had similarities to the older didactic approach. In one session, the boy used a doll to talk about fighting:

Child doll: He gets into fights but runs away because he’s scared they beat him. He cries. He’s afraid his clothes might be torn. Then his father or mother would beat him. It’s worse when they beat him, they use a strap. At night he’s scared somebody might come in and kidnap him.

²⁶⁰ Kanner, *Child Psychiatry* (1935), p. 122.

²⁶¹ Kanner, *Child Psychiatry* (1948), pp. 243-44.

Doctor doll: Who is scaring him?
Child doll: The dark.

Doctor doll: What are the ideas?
Child doll: Imagination.

Doctor doll: Who is scaring?
Child doll: His self.

Doctor doll: What have you learned?
Child doll: I'm scaring myself. I've got to try not to be scared of the dark or of being beat up.

Through the course of the treatment, the sessions had a similar interrogatory quality. However, the use of dolls helped the child to express himself as well as gave him a sense that what he had to say was important. The child's behavior improved for short periods of time, followed by a relapse. The child enjoyed coming to the clinic, but the mother requested these visits be limited to once per month, especially given the obvious lack of benefit.

In a case from the late 1940s, the technique had become more sophisticated, with more emphasis on emotional experience. A mother brought her six-year-old boy to the clinic because could not handle his temper tantrums.²⁶² She also expressed her thoughts of leaving her husband. While the mother met with the social worker over the next several weeks, the psychiatrist met with the child. The records of the sessions reveal the psychiatrist's thoughts on the relationship with the child.

During a typical session, the boy spent much time "laughing, screaming and yelling very playfully." After he smashed one of the toys, the psychiatrist was careful to not show disapproval. He noted that the "play at the clinic is entirely different from his usual activity at home where he is sullen, quiet, and apparently being crushed by the adults around him..." At one point, the boy began to jump off the table onto the psychiatrist "in a friendly way" several times. The psychiatrist noted that "this was the closet physical contact and any indication of affection that had been overtly exhibited" and attributed this to a "positive attachment" developing between the patient and doctor.

Like the child in the previous case, improvement was often followed by relapse of poor behavior. Despite lack of clear efficacy of the treatment in regards to his behavior, the psychiatrist felt that the child had made progress in being able to form a relationship with another person. This progress was intangible and difficult to measure. At the same time, the technique depended upon equally intangible qualities of the psychiatrist. A

²⁶² Case 1610

pediatrician with little time to devote to individual patients could not easily acquire the skills.

Conclusion

Although Kanner's clinic began as an attempt to teach pediatricians to handle everyday behavior problems of children, the demands for specialized treatment precluded pediatrician's mastery of this domain. Kanner described the difficulties of his objective: "Young pediatricians are in a dilemma. Modern parents expect them to be familiar with present-day methods of dealing with problems of behavior, at least with the 'everyday problems of the everyday child.' Some medical schools have not taught them the necessary skills. Yet the demand for psychiatric insights is growing rapidly."²⁶³ Instead of becoming a part of pediatrics, child psychiatry became more closely associated with psychiatry, especially as parents became patients.

Instead of taking sides in the turf war amongst various disciplines over the domain of children's behavioral problems, Kanner focused on meeting the needs of the staff through seeing all patients referred to him. At the same time, an increasingly middle-class clientele, coming from farther away, brought their children for an evaluation of behavioral problems and demanded expertise. The increase in the percentage of middle-class families rose as a result of difficulties in domestic life and the promise of improvement, even happiness, through family experts. The change in technique to treat the parents as well as the children also helped to meet this demand.

The working class continued to account for the majority of cases. These families had ambitions for their children but had fewer time and resources to monitor their development. Thus, some children had more entrenched behavior problems. Because they generally lived closer to the clinic and sometimes were mandated by the school, working-class and poor children more often used the clinic for treatment in addition to an evaluation. The problems of working-class and poor children may have been less suitable for newer techniques such as play therapy because there often was a myriad of other concerns for the family. However, these children seemed to enjoy coming to the clinic, even though the results were often intangible.

By the time Kanner identified autism as a specific syndrome in 1943, important shifts had already occurred. Well-connected middle class families were seeking expertise at academic hospitals, mother blaming was a dominant framework for understanding behavioral problems, and Kanner's clinic was not selective of types of patients. Psychiatrists, pediatricians, and social workers fostered these conditions well before Kanner saw his first autistic patient.

²⁶³ Kanner, *Child Psychiatry* (1948), 247.

Epilogue

The identification of autism depended upon a host of historically specific institutional, social, and intellectual factors. Kanner identified eleven cases of autism over the course of six years, from 1938 to 1943. I was able to view the case records of three of the eleven patients that Kanner detailed in his presentation of a condition that “differs so markedly and uniquely from anything reported so far.”²⁶⁴ I will give here a few preliminary observations of the factors that created the conditions for Kanner’s contribution.

First, Kanner’s location in an elite pediatric hospital was important for accessing a network of pediatricians across the country. Two of three cases came from referrals of pediatricians at other elite medical centers who had professional connections to Edwards Park or Leo Kanner. Before Kanner published his case series, it appears likely that he spread word of his initial observations to pediatricians to facilitate referrals of similar cases. Pediatricians wrote him in advance with detailed descriptions to determine whether Kanner would be interested in seeing the particular patient. Edwards Park and Harriet Guild, Director of the Harriet Lane Dispensary, also referred cases to Kanner if the patient demonstrated certain symptoms that Kanner had found remarkable such as pronoun reversal, “you” for “I,” for example.

Secondly, the socioeconomic position of patients’ families also facilitated Kanner’s identification. All three patients and their parents traveled from out of state to come to Johns Hopkins, which would have been difficult on limited means. These parents sought out multiple experts, including other prominent child psychiatrists. Kanner tended to conflate the high education level of the parents with factors contributing to the syndrome, rather than recognizing the necessary socioeconomic conditions which enabled parents to seek out his expertise. Thus, Kanner noted at the end of his 1943 paper that the parents were not “really warmhearted” because they were “strongly preoccupied with abstractions of a scientific, literary, or artistic nature.... Even some of the happiest marriages are rather cold and formal affairs.... The question arises whether or to what extent this fact has contributed to the condition of the children.”²⁶⁵

Finally, Kanner’s identification of autism required his separation from Meyer’s strict teachings. Meyer eschewed nosology, or the classification of disease, because he believed the concept of disease entities was misleadingly reductive. Perhaps it is no coincidence that Kanner published his paper after Meyer retired. Kanner’s ability to see a pattern as unique syndrome also required his intellectual separation from Meyer who instead saw each case as a unique manifestation of a life history. Kanner’s position

²⁶⁴ Leo Kanner “Autistic disturbances of affective contact,” *Nervous Child*, 2, (1943) p. 217.

²⁶⁵ *Ibid.*, p. 250.

within a pediatric hospital that pioneered discoveries in endocrinology and cardiology likely contributed to his openness to nosology as well as providing an impetus to write his textbook on child psychiatry. Although the first edition of the textbook in 1935 was a bald application of Meyer's psychobiology to childhood, it is remarkable this was the first exposition of Meyer's ideas in textbook form. In attempting to bridge the separation of pediatrics and psychiatry, a specialized form of psychiatry arose instead.

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