The child guidance field is a relative latecomer to the residential or inpatient treatment of disturbed children. This is an unfortunate paradox, because it appears to offer generally effective machinery for diagnosis and treatment for many of the problems now being referred to inpatient units. However, any effort to transplant this machinery in vivo, like a skin graft, without appropriate modification is predestined to fail. It is my purpose to discuss some of the lessons learned from the application of child guidance concepts and practices to inpatient treatment.

During the second quarter of this century, many residents in general psychiatry were not likely to meet their patients until after hospital admission. Residents in child psychiatry were likely not to see patients any more if they referred them for hospitalization because little or no training experience was provided in inpatient units. These blind spots proved to be quite costly as adult psychiatry remained too institution-centered and child psychiatry did not assume its full responsibility in developing adequate hospital facilities. It was, for example, uncommon for an inpatient unit to evolve from an existing child guidance clinic, although many early contributions were made by child psychiatrists.

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During the period of greatest confusion and divergence in the field, child psychiatrists in clinics tended to remain isolated from the problem and to focus their attention on the everyday effort of developing services for the less disturbed child who could still get along in the community. Indeed, an examination of the origins of units which have existed for any length of time reveals that most evolved expediently from (1) institutions for the retarded, (2) publicly owned adult psychiatric facilities or (3) social welfare programs which had either a "dependency-replacement" or a "correctional-rehabilitation" approach. This means that, for a long time, many residential units were pragmatic outgrowths of facilities designed to do one job but then somewhat reluctantly confronted with doing another. Faced with this transition into "treatment" units for disturbed children, they sometimes tended to cling to the comfort of doctrines and techniques gained through several decades of experience in other clinical frames of reference.

Perhaps for this reason, more than any other, the field of inpatient treatment of children has been characterized by a great deal of chauvinism. Depending upon the ideological origins of the institution evaluating him, the child might be viewed as a genetic "bad seed," a behavior disorder, the product of a disrupted dependency situation, or simply a miniature adult patient.

The efforts of Robinson (1947, 1949) were especially important in describing the indications for institutionalizing a child and in clarifying the role of resident child care staff. Bender's (1947) long experience with childhood schizophrenia made available detailed descriptions of the developmental processes of these children. Szurek's (1947, 1952) early attention to intrastaff dynamics and treatment of parents and Krug's (1952) interpolations of treatment principles into residential work were all significant keystones on which later developments depended. It should be noted, however, that even these early papers postdate World War Two.¹

In their growing need for help, most residential units turned to

¹It is perhaps significant that no definitive text has yet been written on inpatient treatment of children by a child psychiatrist. Most books which have achieved prominence have been authored by leaders in psychology, special education, or social casework (Aichorn, 1955; Alt, 1960; Bettelheim, 1950; Redl and Wineman, 1957). These writers probably have been strongly influenced by child psychiatrists under whom they had some training or with whom they were associated.
prominent child analysts as consultants. Thus, during the 1930’s and 1940’s there was an intense exposure of residential staff personnel to psychoanalytic concepts of child development and treatment. The conceptual models of management in some units became fusions of behaviorism and intrapsychic phenomenology. Although this made for growing pains in the field of inpatient care,\(^2\) it was nevertheless an important step in the right direction. Psychoanalytic theory provided the basis for viewing the child’s behavior as symptomatic of inner conflict related to parental forces.

It is not difficult to guess what might have happened during those early developmental phases had not psychoanalytic thinking been available. Many units would have foundered in their confusion and very possibly would not have been able to arrive at a rational basis for further operation in the field.

**The Child Guidance Influence**

Once sufficient advances had been made in formulating an organized body of knowledge which would make the child’s disturbance understandable, inpatient units were ready for the next step in maturation, that is, the incorporation of orthopsychiatric team concepts of function. However, the child guidance clinic which was to bring this influence into inpatient practice primarily could not do so until it reached real maturity as a model of collaborative machinery for diagnosing and treating family dysfunction and childhood disturbance. This, in essence, represents the fundamental contribution of the child guidance clinic to inpatient treatment. It is a major one which, with appropriate modification, often spells the difference between success and failure in treatment (Kaufman, 1961).

The use of casework services in intake (supported by the other collaborative professions) to assess (1) the nature of parental motivation in seeking help, and (2) the resources available in the family for participating in the treatment of the child, is a hallmark of orthopsychiatric practice. Realistic application of this know-how to inpatient work results in better matching of service to need, a state of affairs for

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\(^2\) One illustration of this is that for some time there was greater separation between “professional” and “nonprofessional” personnel on the basis of facile use by the former of a new kind of language which carried with it membership in a select group and certain magical but often unspecified powers.
which children’s units have not been famous in the past (Cohen, 1962). The introduction of child guidance principles into intake procedures in residential units has resulted in broader diagnostic formulations which encompass not only the nature of the child’s illness and the state of his development, but the role that illness and development have played in the family economy. This means that no child is accepted for treatment without due consideration being given to the question of his potential reintegration into the emotional life of the family (Cohen, 1962).

To personnel whose experience is exclusively in a child guidance clinic setting, the following examples may seem quite elementary. To inpatient personnel who may have seen several large, stagnant, deteriorating populations of disturbed children, it holds the key to effective practice (Maxwell, 1950). It is not enough to say, “This is a psychotic child. We will treat him. His parents are disturbed too. Therefore, we will also treat them so that someday he may return home.” In the child guidance clinic, we have learned how these two helping processes are so interdependent that separation of them, whether in attitude or in practice, means that the principle driving force of each is lost. The drive for reintegrating the family as an autonomous unit is a prime factor in making therapy possible. The recognition of these resources within the family, when planning for the child who requires hospitalization, has become an accepted part of institutional practice.

In connection with this, it must be kept in mind that the most crucial difference between clinic and inpatient treatment is that the latter introduces a more powerful level of intervention into the destructive family process. This intervention is represented by the child’s hospitalization itself. As far as treatment is concerned, the significance of this event of separation is that the care of the child is no longer in parental hands. It is for this reason, primarily, that major modifications in child guidance practice are necessary.

Like the clinic, the children’s psychiatric hospital must also find a role in treatment which is supportive of parental function, and which carefully avoids supplanting the parents’ basic tie to the child. To achieve this while actually carrying responsibility for daily care is difficult. To do it without an intensive examination of parental motivation may be therapeutically suicidal. Many (perhaps, most) parents
of children who are ill enough to warrant psychiatric hospitalization have had such an un.rewarding experience in caring for them that they carry powerful though unconscious rejecting attitudes toward the very child for whom they overtly seek treatment (Cohen, Charny, and Lembke, 1961). Under these conditions, placement of the child in the hospital may be sensed by both child and parents as a final acting out of the rejection long feared and defended against. Unqualified acceptance of a child for treatment without identification and working through of the destructive elements of parental motivation may be experienced by the family as professional alignment with their own destructive wishes. Treatment is difficult, if not impossible under these circumstances.

**Operational Significance**

Perhaps we can understand better what modifications are necessary in conventional clinic management by looking at the usual reasons for referral to an inpatient unit. Almost without exception, the children seen in the hospital with which I am connected have had at least one previous trial at outpatient therapy. Some have had as many as three or four. In fact, about 80 per cent of our referrals originate in one of the local child guidance clinics.

Reduced to the most basic determinants, these cases come to us for one or more of three interrelated reasons: (1) The family interaction has proven to be the result of a network of interlocking, mutually supportive defenses in which the child’s illness plays a crucial role. The maintenance of family equilibrium is dependent upon the child’s symptom picture so that as long as the child is continuously available to the family, the emotional economy of the group is best served by resisting or sabotaging change in the “patient” (Bateson, 1956; Rinsley, 1961; Vogel and Bell, 1960). (2) The child’s developmental level and ambivalent expression of dependency is such that no family, even a healthy one, should now be expected to care for him. It is considered best to fractionate his care between several professional people who do not carry a personal stake in his growth. The inpatient unit provides a setting where the child can be buffered from stresses with which his ego cannot cope, and where he can be provided with relationships and experiences designed to organize, broaden, and diversify his ego re-
sources. (3) The child’s behavior is such that he can no longer be (a) served by conventional professional resources (e.g. pediatrician, school), (b) tolerated by the community, and (c) contained by existing controls.

Converted into operational terms, this means that the inpatient program must be structured to deal with (1) parental resistances and acting out which sometimes reach heroic proportions; (2) subsequent decompensation of family defenses and states of marked dysequilibrium in the family; (3) bizarre, primitive, and dysocial behavior in the child which may be largely autistic in nature or may appear as destructive and self-destructive characterological defenses; (4) serious learning disorders in the child accompanied by poorly differentiated use of objects and defects in the child’s capacity for communication; (5) somatic components operating either causally (e.g., the so-called “subclinical organicity” [Smolen and Rosner, 1961]), or as a part of the child’s defensive structure (e.g., asthma, eczema [Sutton, 1958]). In many children, especially those with developmental distortions dating from infancy, one is confronted with varying degrees of growth failure also (Fried and Mayer, 1948).

Adaptations in Practice

In view of these factors, we can deduce what some of the necessary adaptations in clinic practice might be. The conventional orthopsychiatric team must be expanded from three to about seven professional disciplines. The additions are special education, psychiatric child care, pediatrics, and nursing. If staffing ratios are adequate and the problems of integration and collaboration are resolved, the full impact of the child’s distorted demands for care can be borne without having to be submerged in a program of structured activities.

Through this approach, the child’s dependency conflict can be exposed and he can be helped to resolve it experientially as his developing ego makes available more effective anxiety-bearing machinery. His growth failure can be studied continuously and a global approach for its management devised and implemented. Housekeeping, maintenance and administrative personnel must be included in this plan because of their intimate and continuous involvement with both children and parents.

Techniques for maintaining therapeutic control of parent-child con-
tact are necessary. In our setting, there is contact on the average of once a week. Early in treatment, there is almost always a professional person present, so that the interaction can be used both for continuing diagnosis and treatment. In many cases, we actually do family psychotherapy with this being the only contact between child and family for many months (Charny, 1962). It is not until we feel a definite shift in the destructive cycle that we permit uncontrolled contacts, and even these are preceded and followed by casework interviews (Lembke, 1960).

Our experience has indicated that the treatment process is accelerated by the use of a staff person to mediate interaction between parents and child, to act preventively when the old destructive patterns begin to appear, and to be available to the rest of the staff as a resource in the continuous process of evaluating the role of the child's illness in the family. We have found that both parents and child accept the use of staff in this way with a real sense of security. It is quite common for parents to ask the caseworker to be present and for children to ask a child care worker to be present during visits. Half facetiously, we have compared the use of the professional person during these contacts with the behavior of Harlow's (1960) monkeys who are observed to dash back and forth between the "terrycloth mother" (staff person) and the anxiety-producing, perplexing, uncertain stress in the field (child or parent). When we begin to gain conviction that the child's symptoms are no longer playing a critical role in the family's emotional constellation, we encourage much free, unsupervised experience with the child not only during hospital visits, but during increasingly long stays at home.

There needs to be modification in the practice of psychotherapy and in the role of the therapist himself. Questions which he is accustomed to redirect to parents in a clinic are now matters of professional responsibility, as the therapist becomes collaborator and consultant to those caring for the child (Cecil and Cohen, 1962; Hirschberg and Mandelbaum, 1957; Krug, 1952). Because of his knowledge about human communication and psychological growth processes, he becomes intimately involved with the child's educational program. The child's over-all physical status and intercurrent illnesses are also matters compelling his attention and participation. He can no longer say, "This child cannot use therapy." It is up to him to design a set of environmental conditions which will facilitate and energize therapy. He can
elect to do family psychotherapy. He can isolate the child from all non-cruel sensory stimulation and from social contacts in order to enforce regression which will allow for infantile expressions of dependency on the therapist. We have used this latter technique with some success both with severe character disorders and borderline psychotic states. The rationale and description of this isolation and sensory deprivation procedure have been described in previous papers (Charny, 1961; Cohen, 1963). In essence, the therapist becomes the universal joint around which treatment turns, so that there is no aspect of the child’s existence in which he does not carry a legitimate professional stake.

One needs to remember also that, in contrast to clinic practice where a one-to-one relationship exists between patient and therapist, in an inpatient unit the child’s treatment must be carried out in an encapsulated subculture. This human milieu is formed not only by the child’s helpers, but by a score or more of other severely disturbed patients who can influence his development to no small degree. It is therefore vitally important to assess the nature of group interaction on a continuous basis and to develop the know-how to use this interaction purposefully in treatment (Goldfarb and Radin, 1961; Goodrich, 1960; Rausch, Dittman, and Taylor, 1959; Robinson, 1951). Acting-out children are especially resourceful in using peer group gratifications in order to bolster their denial of dependency.

Many modifications must be made in the nonhuman aspects of the treatment program. These need not be catalogued here. Many of them are quite obvious, but it is as easy for an inpatient unit to fail because the physical structure does not support the treatment process as for any other reason. Generally, the site and physical plant must be adapted to needs of staff and children so that interaction can be as spontaneous or as controlled as indicated, so that needs for privacy of all are respected, and so that the roots of the hospital and the children can be maintained in the community without becoming a public nuisance.

**Summary**

In summary, the children’s inpatient unit of today owes a debt to the child guidance movement because of the lessons to be learned in understanding and dealing with family dynamics by the use of the orthopsychiatric team, in working in intake with parental motivation in seeking help for the child, and the interrelated nature of the helping
processes of parents and child. An inpatient unit which does not incorporate these concepts into practice is not a modification of child guidance practice. In the author’s opinion, many inpatient units are not. They are modifications of some other child care model as indicated at the beginning of this paper.

A truly mature children’s unit should find ways to use the experience of training schools, social case and group work programs, adult psychiatric centers, and pediatric hospitals; it must, if it is to be effective. It is the writer’s conviction that this considerable repertoire of skills should be built on a foundation of child guidance concepts.

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