

A COMPARISON OF THE PSYCHIATRIC
AND THE SOCIOLOGICAL APPROACH TO
THE STUDY OF PROBLEM CHILDREN

by

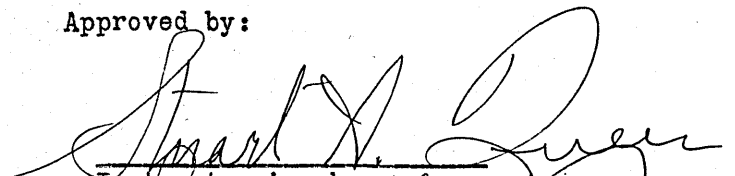
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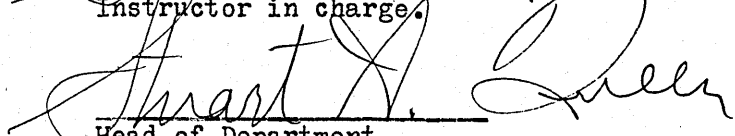
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VARYING APPROACHES TO SOCIAL WORK

Social work has a long history, yet it is a new profession. In its early beginnings we find social work expressed in the mutual aid of the medieval groups and the ecclesiastical charities, with emphasis upon the theological and moralistic function of almsgiving; followed by the humanitarianism and public relief systems of the nineteenth century. With the Protestant Revolt and the rise of Nationalism the shift was away from the ecclesiastical, with its emphasis upon the theological and ethical to the state and political economy, although there was, at that time, no science called political economy. From the middle class humanitarians of the nineteenth century social work received financial backing for making experiments; from the development of the English Poor Laws social work inherited the idea of national responsibility for the problems of poverty and the notion that charity, as such, would never solve them. When social science began to appear and first to have an influence on social work, the shift was from the philosophical and ethical to the economic. This was the first real move of social work in the direction of the so-called scientific approach to a study of the problems of a people in trouble.

Following this emphasis upon the economic approach to the

study of people in trouble early in the twentieth century as shift in emphasis was made to the biological, the physical and medical approach. This emphasis inferred that it was because of broken health, or accident that people were in trouble. About 1907, emphasis was shifted to the psychological and the psychometric tests. Extremists who followed this influence felt sure that if an Intelligence Quotient could be obtained for all the clients of the social agencies they would have the solution of their problems. With the World War, the emphasis was shifted to the psychiatric and the interpretation of human ills in terms of the emotions, and at the present time we are under the influence of this wave. Appearing on the horizon is another influence, the sociological, with emphasis upon the group and social inter-relationships as a means of studying the problems of people in trouble.

At the present time there is a tendency on the part of the social worker to use the contributions from all these fields and to co-ordinate them, using what can be used and applied from each in the study of the problems, and in working out a plan for treatment.

Let us consider what is implied in each of these approaches, to the study of people in trouble that we may have a better understanding of the field of material available to the

social worker, as well as the influences that have their bearing upon the development of social work and social work procedure.

ECONOMIC APPROACH

People with whom the social worker has come in contact throughout the centuries have usually been in serious economic difficulty. A shortage of money and the things that money will buy has been one of the factors that has attracted attention and continues to be the center of attention, down into the twentieth century. The principal variation has been in the shift of emphasis, first from the ecclesiastical and moralistic to the economic and recently to the sociological.

During the nineteenth century there were two economic interpretations of poverty and its cause, first was that of the philanthropist who thought that because people were poor they needed help. These same people might be feeble minded, or sick, but the reason they were objects of charity was because they were "poor", not because they were feeble minded or sick. The second interpretation of poverty and its causes comes from the socialist group who said that because people are poor is the reason they are delinquents, criminals, or feeble minded. One socialist's explanation of poverty is that¹ "labor is paid for, but not paid." The consumer pays enough for the product to remunerate the laborer, but the capitalist retains all except what will barely suffice to keep the laborer alive.

1. Warner--American Charities, p. 34.

In the writings of certain economists it has been a fundamental thought that poverty exists mainly, if not entirely, because population tends to increase faster than the food supply.

"Poverty is bound up with the economic life and it is impossible to select any one feature of the present industrial system as responsible. The Malthusian seizes upon the redundant population; the communist upon private property; the socialist upon property and means of production; the single tax payer upon property in land; the cooperator upon competition; the anarchist upon government, et cetera. The causes of poverty are as complex as the causes of civilization, and the growth of wealth."¹

Poverty is a relative term involving many variable factors, and is said to exist when there is inability to maintain existence at all, or to keep up to the standard of living of one's own group.

Warner² states that "three tolerably distinct methods have been employed by those students of social sciences who have sought to ascertain the causes of poverty. They are first, those deductive or philosophical thinkers who have sought to deduce causes tending to poverty, as a systematic writer on

1. Warner--American Charities, Ch. 2.

2. Warner, Queen, Harper--American Charities, Ch. 3.

pathology seeks to set forth the inherent characteristics of the bodily organism which tend to make disease likely or inevitable. Second, there are those who study classes not yet pauperized to determine by induction what forces are tending to crowd individuals downward across the pauper line. Third, there are those who make an inductive study of concrete masses of pauperism, usually separating the mass into its individual units, seeking to ascertain in a large number of particular cases what causes have operated to bring about destitution."

The economist not only studies poverty and its causes, as he approaches the study of people in trouble, but he studies the whole economic system of supply, distribution, and consumption.

For the practical purposes of the social worker the economic aspect is a factor that has to be considered along with the biological, psychological, psychiatric and sociological in dealing with people in trouble.

BIOLOGICAL APPROACH

The immediate significance of biology for the social worker lies in the fact that people with whom he deals usually have, or have had physical troubles--sickness, accident or irregular development.

There have been a number of theories advanced, and experiments performed in the field of biology to show the influences of the biological factors upon the individual's behavior and reactions in the group. Among these theorists are some extremists like Dunham¹ who says that if we care for the physical all the other problems will be solved.

"As a clinical concept, conduct may be defined as the degree of harmony attained by the individual in the social organization of biological mechanisms concerned with fundamental needs. Intimately associated with this function are the organic system. - - - So long as the physico-chemical equilibrium between nerves, glands, and muscle cells, and their surroundings is maintained a balanced social relation exists, antagonisms are neutralized and inertia prevails."

Another student in the field of biological study in its

1. Dunham--"An Approach To Social Medicine"; Queen--"What Is Social Pathology. Unpub.

relation to human behavior is Lawrence K. Frank,¹ who presents the theory that personality development is the outcome of the individual learning how to manage his physiological tensions, under the tutelage of parents and other adults who present him with various tensional problems, in their effort to mold his behavior into socially sanctioned patterns.

Perhaps the most popular and widely known theory at the present time is the theory advancing the important part played by the endocrine glands upon the physical and mental development of the individual, as well as the influence upon personality and behavior. Much time and attention has been given to the study of the glandular systems, especially of those humans indicating mental deficiency or deviation, personality deviations and change, abnormal physical development, or behavior problems. There is a great deal of literature in this field, perhaps the best known is a book by Berman called "Glands Regulating Personality".

Among others in this field we have Bolk,² who says that the endocrine glands are, so to say, the sense organs of the autonomic system, sensitive only to chemical stimuli, as the organs of the cerebro-medullary system are to the physical stimuli. And Hammett, who presents the theory that

1. Frank, Lawrence K.,--"The Management of Tensions", Amer. Jr. Sociology, Vol. 33:705-736.

2. Thomas,--"The Child In America".

temperaments are based on bodily conditions, that the difference in temperaments seems to be associated with the manner in which the respective individuals handle their intermediary metabolism.

Also Kretschmer who relates causation of insanity to the endocrine inadequacies and peculiarities and not to brain disorders.

Among other biological experiments and research attempting to find a solution to individual behavior in terms of biochemistry, bodily changes, and reactions are those made by Rich¹ at the Institute For Juvenile Research in Chicago. He made tests for hydrogen-ion concentration of the saliva, acidity of the urine, alkali reserve of the blood, creatinine content of the blood and excretion in the urine. The subjects were rated on good naturedness, aggressiveness, and emotional excitability. His results show that the least excitable individuals tend to have the most acid saliva and also the most acid urine. He states that it would seem that there is a definite, though low, negative correlation between body acidity and emotional activity.

The experiments and literature in the field of biology indicate that the biologist is attempting to understand and interpret the behavior of individuals in terms of bodily

1. Thomas--"The Child In America", Chapter 11.

mechanisms, bio-chemistry, and bodily changes and the reaction that takes place within the organism.

Thomas¹ says that, "while the organism lives in the inner environment, its behavior takes place and is provoked and conditioned by the outer environment; given the most perfect glandular and nervous system conceivable there is trouble ahead for the organism if it is not integrated with the outer world and, in human society its fellows by a system of learning and habit formation."

1. Thomas--"The Child In America", Chapter 11.

PSYCHOMETRIC APPROACH

In the second decade of this Century, great emphasis was placed upon the psycho-metric tests and low I.Q. as a cause for people being in trouble. Mental tests were held to be diagnostic of mental ability and mental ability was assumed to be highly correlated with behavior, and the ability of the individual to adjust to society.

Soon after the concept of the Intelligence Quotient was evolved, the claim was made that low intelligence was the determining factor in misconduct and delinquency. From results of tests given it was assumed that all delinquents were feeble minded and that all feeble minded were potential criminals. Following this assumption the results of tests given the drafted army, at the time of the World War, almost half the adult population were mentally defective and "potential criminals".

Further testing and work done with delinquents and with school children make it obvious that the I.Q. is not an explanation of delinquency nor of behavior in general. It is not reasonable to assume that the inferior intelligence was the determining factor in all cases of feeble minded offenders, since so many feeble minded persons with an I.Q. equally low are leading regular lives.

More recently the results of the intelligence test have been recognized as a factor to be considered in the study of behavior problems in children, but it is rarely, if ever, by itself a causal explanation of any particular type of behavior. Behavior problems and delinquency occur in all levels of intelligence, but the maladjustment of the feeble minded and the dull normal lead to delinquency in a larger proportion than among those who are the so-called normal.

The social worker working with school children recognizes the I.Q. as one of the diagnostic agents. It serves as a guide post in working with those children who do not get along in the ordinary regime of the school; those who can get along and make a better adjustment in a "special" or "opportunity" room with a specialized type of instruction and training.

At the time of the introduction of intelligence testing there was not an adequate realization of the fact that the whole organism participates in thinking and in behavior.

Since the World War the emphasis has shifted to the consideration of the whole organism in analyzing its behavior. Following closely upon the psycho-metric influence came the psychiatric, under which we are still working.

PSYCHIATRIC APPROACH

Prior to the World War the psychiatrist had a limited field and was seldom heard of outside of institutions for the insane, or as an "alienist" who appeared in court hearings where there was a question of sanity on the part of a person on trial or a person to be committed to an institution for the insane. His work was largely with the individual after there had been a complete mental break down, although he was doing some preventive work and making statistical studies.

With the World War psychiatry stepped into the lime light and up to the present time has held the center of the stage. Recently there have been indications that psychiatry is beginning to be pushed aside, a bit, by sociology, a new comer in the field of the study of human beings and their inter-relationships, and the forecast is that in the rather near future sociology will have the center of the stage.

At the present time the psychiatrist is concerned with the study of the individual as a whole, with special attention to his inter-acting relationships with his environmental background, when, as formerly, he emphasized the inherited patterns in his explanation of the reasons for deviations from the normal in the mental and emotional levels of the individual's experiences.

As contrasted with the economist who stresses poverty, the biologist who stresses the physical health, and the psychometrist who stresses intelligence, the psychiatrist stresses the emotional development of the personality. This newer influence, or emphasis of psychiatry, which involves a study of the growth processes of personality and the treatment of personality disorders, is concerned with the whole individual, the whole mind, and the whole body. It is believed that an unhealthy organ produces its emotional response on the whole system and that the mind is influenced thereby.

A number of theories have been developed in the psychoanalytic school, among the best known of which are; Freud's theory of "conflicts and repressions", Alfred Adler's theory of "inferiority complexes" and "organic inferiority". He associates physical inferiority with psychopathic traits and compensatory strivings and delinquency. Then there is Jung's theory of the "collective unconscious", the "Oedipus" and "Electra" complexes, and the "superiority complex" or ambition; and Rand's theory of the "birth trauma" and the desire for regression to the womb.

Around these theories have been built up so-called schools of psychiatry; the "Behavioristic School" which emphasizes the early "conditioning" of conduct which takes place in the

lives of all children. The "Adlerian School" which attempts to analyze behavior in terms of "feeling of inferiority" and "compensations" made thru "recognition and response," especially the attempts at "compensation thru boastfulness". This school also presents the theory of the "family constellation" and the effects upon the individual resulting from his place therein. The "Freudian School" speaks in terms of "identification", "projection", "transference", "repression and conflicts", "sublimation", "regression", "perfectionists", "wish fulfillment and flight from reality", "rationalization and defense reactions", and the "ego-libido satisfactions". The "Jung School" seeks to analyze human behavior in terms of "introvert" and "extrovert" types.¹

Many of the present-day practicing psychiatrists, while fundamentally following one school are using as their basis for the understanding of human behavior parts of the theories from all the material in the theoretical field.

Thomas says that "stated very generally, from the standpoint of causation, the present psychiatric view is that mental disturbance represents a failure of the organism to adapt to the conditions of life and of the society in which it lives, that this failure involves the functioning of the organism as

1. Healy--Bronner,--"Reconstructing Behavior In Youth", Ch. 10.

a whole, and that no adequate "specificity" can be indicated"¹

Based on the theory that all behavior is purposive, the psychiatrist seeks to find the cause behind the behavior. The "problem" or behavior expressed is usually merely symptomatic of a deeper underlying problem of emotional and personality maladjustment frequently of long duration. To locate the cause requires an intensive and detailed analysis of the individual that goes back far into the early life of the individual with special attention to his inter-acting relationships within his environmental background. It is necessary to study in addition to his life history, all aspects of his social environment and to note his reactions to this environment. A physical examination alone will not reveal the causes behind the symptoms of maladjustment; nor will an I.Q. alone, nor will a knowledge of his endocrine disorder give a solution to the problem apart from a study of his social environment.

The distinctive technique used by the psychiatrist in his study of a human being is his exploratory interview in which he seeks to find how the individual feels about his experiences. The psychiatrist's theory is that it is not what you experience but how you feel about it that is of importance.

Preceding this exploratory interview the psychiatrist has

1. Thomas--"The Child In America", Ch. 10.

familiarized himself with the patient's social history, physical examinations, and psychiatric tests. The psychiatrist is concerned with the environmental elements in the patient's life, his family setting, hereditary problems, and so on. He is also concerned with the personalities of the patient's ancestors, and the emotional relationships that existed. Recognizing that mental disturbances are not hereditary and inevitable but are not due to conditions of life and training, it is easily conceivable that in some cases the occurrence of mental disturbance, if treated in time, may be prevented. Following the theory that the personality of the individual is developed and grows through experience, and that each new experience is interpreted in terms of past experiences, it is often possible to find a clue to the causes of a behavior problem through the study of a life history. No experience can come to any individual, at any time, which does not leave some emotional tone, either satisfactory or unsatisfactory, or with a positive or negative value.

Psychopathology as related to the study of behavior problems began to be formulated in two research approaches, first, a study of the incidence of psychopathic traits in the general population and in institutions, particularly in prisons and penitentiaries, and second, in the development of child guid-

ance clinics. The first Child Guidance Clinics were Juvenile Court Clinics. The Child Welfare Clinics were developed later where problem children from the home, school, or other sources might be taken for study. Some of these were financed by private foundations, others by city or state.

¹The contributions of the Child Guidance Clinics from the standpoint of problem children have been two, first, it helps in the understanding of the emotional factors that underlie conduct and second, it adds to the stock of methods for handling children in order to prevent their becoming problems.

In addition to these two contributions the Child Guidance Clinic has given the psychiatrist a growing appreciation that his field is not an isolated one of disease exclusively, and an appreciation of the close relationship and influence of the environing social situation upon the development of the individual. The Child Guidance Clinic has turned the focus of attention from the adult to the child and stressed the study of beginning symptoms as a means of preventing emotional and personality unadjustment.

"If we take a longitudinal as well as a cross-sectional view of the advance in our understanding of childhood problems it might be said that the progress which marks the last decade of our growth has been dependent upon our capacity to integrate the

J. Lee and Kenworthy--"Mental Hygiene and Social Work", Published by The Commonwealth Fund, 1929.

contributions coming from the fields of social psychiatry, psychology, sociology, physiology, biology, hygiene, and chemistry. - - - - To facilitate the study of cause and effect relationships in the child's and adult's experience and to make use of the contributions from all these fields, the four-fold study plan was developed. This four-fold plan in psychiatric practice consists of a social, psychological, physical, and psychiatric investigation of the individual and his growth and environmental experiences."¹

In practice the psychiatrist assumes a dual role. He makes a distinctive contribution in his study of the individual and his emotional responses, yet in the Clinic he acts as the coordinator, in that he assembles the contributions from the other fields, and uses these contributions in his interpretation of the problem, and in the formulation of a diagnosis and plan for treatment. It is possible that any one of the persons contributing to the study of the problem, the social worker, the physician, or the psychologist might act as the co-ordinator, but usually this duty devolves upon the psychiatrist because of his wider and more varied training and experience and greater prestige. The psychiatrist is a physician and has knowledge and appreciation of the field of biology, psychology and social work. However in some clinics the physician and in others the psychologist co-ordinates and interprets the material contributed. There are some psychiatrists, practicing outside a clinic who resent the inference

that the social worker or psychologist might have anything to
1. Lee and Kenworthy--"Mental Hygiene and Social Work, p. 23.
Published by The Commonwealth Fund, 1929.

contribute that he could use in his study and treatment. These latter are few as more and more the psychiatrist is turning his attention toward the Clinic and the methods of study used there. It is no longer uncommon to find a psychiatrist in private practice employing a social worker to help him with his study and especially with his treatment.

SOCIOLOGICAL APPROACH

While it has always been very obvious that people in trouble frequently had broken health, and sometimes abnormal minds, and usually had flat pocket books, there has been some recognition of the fact that these people had difficulty in getting along with other people. It is comparatively recent that social workers have been treating their clients in an objective manner and on a scientific sociological basis. It has been customary to take a subjective approach in considering vice, crime, and character defects treating them on a moralistic basis.

Of more recent date the social worker has been giving attention to the neighborhood and the various groupings of the clients who come to them. In other words, the sociological approach through the group study to the problem of the client is being employed. Social workers are beginning to talk about and in terms of sociology--though it is not long since the word was not even a part of their vocabulary.

In social work individuals are engaged in the practical tasks of alleviating distress, and mediating personal adjustments between individuals and the social order.

The sociologist, in making a study of people in trouble uses the group approach, whereas the psychiatrist uses the in-

dividual approach, as a means of analyzing human behavior. The sociologist begins with this question:¹ "What situations provide what experiences leading to what behavior?"

It is the task of sociology and the sociologist to define the processes of human inter-action, and describe the sequence of steps in the development and formulation of human personality and culture. He does not isolate the individual from the group and its social setting for study as a self contained unit, rather he emphasizes the importance of the social role of the individual and his status in the group or groups of which he is a member in determining his personality. The procedure is to study the social situations and the inter-relations between individuals and their joint behavior. The sociologist studies the various forms of causal relationships between the activities of individuals that are always occurring in the home, school, neighborhood, and wherever human beings meet. In fact the sociologist studies the contacts of the individual in all situations of life and measures the influence upon his behavior. In order to understand behavior manifestations it is necessary to study a large series of individuals in a great variety of situations comparatively. For his purpose of study the sociologist uses the life records of individuals in the group, prepared in detail and as objectively as

1. Queen--"What Is Social Pathology?"--Unpub. MSS

possible. His technique also includes interviewing the members of the group individually, and observing their behavior.

Like the psychiatrist the sociologist assumes a dual role, in that he makes a direct contribution to the study of people in trouble, and in that he is often the co-ordinator of the materials contributed from the fields of economics, biology, psychology, and psychiatry. He does not use biological data, as such, but deals with the disturbance of human relationships which are sometimes associated with specific physical conditions. The same thing is true of economic data. The sociologist is not concerned with industry and employment, or income and outgo, as such, but he is interested in the ways in which these involve human relations and ways in which humans influence each other. Likewise psychological data, as such, are not included in the sociologist's study, but he is interested in the disturbance of human relationships sometimes associated with specific mental conditions.

The psychiatrist endeavors to find the inner causes behind individual behavior patterns; the sociologist endeavors to find the outer factors underlying and determining the behavior of groups and their members. Both are making attempts to understand the world we live in.

It is of interest to note the rise and decline of the influence of each of the preceding fields, the economic with its emphasis upon poverty, the biological with its stressing of the physical, (called by some the tonsil and adenoid era), the psycho-metric with its attention to the intelligence quotient, the psychiatric with its emphasis upon the emotions, and now the sociological with its emphasis upon the group and social relationships. Each in its turn has sought to analyze the behavior of people. Social work has been influenced by each in its turn. At present the tendency is for social work and social workers to use the contributions from each of these fields in the study and understanding of those human beings who are in trouble. The social worker considers both the functioning of the human organism and the social environment in his approach to a problem. It is necessary to consider total situations involving the human organism and its environment. It is not possible to isolate the individual from the group or to study the group and ignore the individual.

For the practical purposes of the social worker all these fields tend to converge. Psychiatry and Sociology tend to converge in that both emphasize the inter-relations of personality and social situations. Their principal difference is that one starts with the individual, the other with the group.

Another trend that is of interest to students in both fields is that it is a frequent happening for a psychiatrist to appear on a sociological program and for a sociologist to appear on a psychiatric program. In 1916, the National Conference of Social Work established a Division on Mental Hygiene and in 1927, the American Sociological Society created a Section on Sociology and Social Work. These two events show the tendency of sociology and psychiatry to converge in social work. Recently numerous magazine articles have appeared on Psychiatry and Social Work and on Sociology and Social Work.

A number of sociological studies have been made which are furnishing data for social workers, for example studies on family organization or disorganization, ecological studies and the light these throw on family and neighborhood life. Also studies of varied types of humans such as the hobo, the gypsy, and the rooming house dweller.

The sociological emphasis upon culture is significant for the social worker. One of the reasons for the failure of social work with the immigrant group is due to the social work group not understanding what is meant by culture, and how important it is to the understanding of any group of humans. "The Polish Peasant" by Thomas and Znaniecki is of great value to social work because it shows how to study a culture.

While we have the psychiatrist with his approach through the individual, and the sociologist with his approach through the group study, both are seeking to understand human behavior. For the practical purposes of the social worker they tend to converge though each makes a distinctive contribution.

The social workers of today, utilize the concepts, the techniques, and the findings of all the sciences and the professions in working out their problems. They realize that the difficulties presented by their clients involve, the economic, or the industrial system; biology, or heredity and the physical condition of the body; psychology, or the levels of intelligence; psychiatry, or the emotions; and sociology, or the inter-relationships within a group.

II. PROCEDURE IN A PARTICULAR PROBLEM

As a social worker dealing with problem children, in a public school system, and having had training in both psychiatry and sociology, I have been interested in the differences and likenesses of these two approaches and procedures in the study of unadjusted human beings.

After a general reading in the field, and the discussion of the problem in a general way with various people, I have selected a number of case records of problem children. These records were made in a child guidance clinic with which I was connected at one time, however I am not responsible for all of the work done on these cases. These cases were selected for analysis to show the differences and the likeness of the psychiatric and the sociological approaches, because of familiarity with the type of case and the fact that these records are relatively full and offered possibilities of a dual analysis. For the purpose of this study all identifying data in these records have been changed.

The form of psychiatric analysis is that used by Dr. Marian E. Kenworthy, New York School of Social Work, New York City; whereas the form of sociological analysis is that used by Dr. Stuart A. Queen of the University of Kansas.

For the purpose of this presentation, I am giving first,

the detailed history on three cases (other cases used are summaries), which includes a statement of the problem presented by the particular child, family history, both paternal and maternal, the home, fraternity, and a detailed account of the patient including the developmental history, medical history, conduct, school history, and the psychological test results.. Second, the psychiatric analysis with a brief diagnostic summary, and third the sociological analysis with a brief diagnostic summary.

In the "Ego-Libido" analysis (psychiatric) we assume the theory that all behavior is purposive. In terms of this purpose, if this behavior is an urge or desire to love and be loved, to retain the dependency relation of the love life, then it is Libidinal. If this behavior is a reaching out, a growing toward freedom, an "expression of the self", away from the love satisfactions in others, then it is Ego. In terms of the Means through which the purpose is attained the behavior is satisfying to the individual, and it is positive, or it is unsatisfying to the individual and negative. In terms of the end achieved through this behavior it is either socially desirable and it is called constructive or it is socially undesirable and is called destructive. Following this outline, the problem is analyzed in terms of the Libido, constructive,

positive and negative; Libido destructive, positive and negative; and Ego, constructive, positive and negative; Ego destructive, positive and negative.

LIBIDO

EGO

| Constructive | | Destructive | | Constructive | | Destructive | |
|--------------|----------|-------------|----------|--------------|----------|-------------|----------|
| Positive | Negative | Positive | Negative | Positive | Negative | Positive | Negative |
| | | | | | | | |

For the sociological analysis we have used three divisions or parts in the outline, first Concrete Situations or Events that have occurred in the life of the individual and have had influence upon his behavior; second Social Relationships which have followed or been connected with the first part; and third, the Probable Mental Reactions to these social relationships that have developed out of the social situations or events.

| Concrete Situations or Events | Social Relationships | Probable Mental Reactions |
|-------------------------------|----------------------|---------------------------|
| | | |

Following are five cases which have been analyzed according to the above outlines, the psychiatric and the sociological.

CASES

CASE OF--Harry Norton

STATEMENT OF PROBLEM--

Mrs. Norton refers her son Harry. He stammers, is very nervous and timid. Mrs. Norton knows of no physical illness to account for this.

FAMILY HISTORY:

Paternal: The paternal grand mother was born in Virginia 78 years ago. She and the paternal grand father came north to visit the son (patient's father) before his marriage. When he married he begged them to remain, because of his wife's delicate health. The grand mother is now inclined to question the wisdom of granting his request. She helped to care for the babies as they came and did all the house keeping until two years ago when her health failed. She appears to be an easy-going, gentle woman, rather religiously inclined. Says she was always ready and willing to relinquish the control of the household, and repeatedly asked the daughter-in-law (patient's mother) to assume the head of the household but she refused to do so.

Father: The patient's father was the only son. He is 45 years old. For 20 years he has been a signal inspector on a subway and does night work. He tells with some satisfaction that removal of dead bodies from the tracks is part of his work and scoffs at his wife's shrinking and excitement at such things. (It was not learned if father recounts these incidents to patient) In his youth the father was quite a ball player, and wants to make ball players of his boys. He wants them to have a college education, which he did not have, and he regards this as necessary to success in any line. He is a big, ruddy-faced man, down right in speech and manner; less refined than his wife though of apparently good intelligence. He drops readily into a bantering, teasing tone of resistance and attack, and gives the impression of being out of place in the midst of his rather sensitive family.

The father attributes Harry's stammering to the fact that he was compelled in school to use his right hand,

when he is naturally left-handed. He believes that he will out grow it and for the present the only way to deal with it is to stop the boy when he commences to stammer, quiet him down and then make him say what he wants to say very slowly.

Maternal:

Mother: Patient's mother, 44 years old, born in Washington, believes she inherited her nervous tendencies from her father. She is the fourth in a family of six, three boys older and two sisters younger. She says she was the only frail child in the family. She was thin and anemic from birth, and her mother lived in constant fear of her developing tuberculosis. Accordingly she was much petted and watched over. As the first girl she was her father's favorite. She says she would have been spoiled, if it hadn't been for the fact that she wouldn't take spoiling. Her home life in her family was a happy one, the children were "ruled by love", there was no nagging or scolding.

She had a "nervous breakdown" toward the close of her second year in high school, which necessitated her leaving school and going to the country for a time. She had always had an excellent record at school. After leaving school she studied voice. She was allowed social activities and had many friends. She was never interested in housekeeping and wasn't expected to take any share in it. She remained at home with her parents until their deaths which took place a short time apart, three years before her marriage. She was "very close to her mother" and felt that when she died "there was nothing left to live for."

Since her mother-in-law's strength began to fail, she has taken over the housekeeping without difficulty in spite of her lack of preparation for house work. The fact that her husband works nights and the children have different school hours keeps her almost constantly in the kitchen. She finds this fatiguing but is not worried by it.

She states that she was warned not to marry because of her poor health, however since her marriage at the age of 30, her health has been slightly better. She has been constantly under the care of physicians who have not been able to help her and have found nothing

organically wrong. She is thin and frail, but the weariness and weakness of which she speaks do not show in the expression of her face. She has a nervous depreciatory laugh.

She impresses one as a sensitive, refined, serious woman of good intelligence, and high ideals. She would like to have the boys become professional men, but they are to be free to follow their own bent. She is particularly eager to have one of them become a doctor. She wants them to go to college. The father leaves all the management of the children to her; she says no strong punishments are ever necessary.

MARITAL RELATIONS:

There is some evidence of temperamental friction between the parents. Also some disagreement in regard to the handling of the children. The father maintains that the mother is too easy with them, and does too much for them; remarking that she herself would have profited by sterner measures in her childhood. Their family disagreements are never aired before the children, and the mother is the final authority with the children.

HOME:

The home atmosphere is one of quiet control and order. The boys sleep together in their own room in a large double bed.

There was a strong attachment between the paternal grand father who lived in the home, and Meade, who was his favorite; he took little notice of Harry. The grand mother has shown no favoritism.

FRATERNITY:

1. Meade: Born March, 28, 1917. The mother was in poor health during pregnancy. He was a "blue baby" born 3 weeks before full term. Instrumental birth, breast fed for six weeks, no thumb sucking nor nail biting. Has had measles, whooping cough, chicken pox, influenza, and recurrent attacks of rheumatism. At age of 9 years, had a light attack of chorea, from which he recovered in 3 weeks. Restless sleeper. Is nervous, fidgety, and over-active.

He is in the second term at Junior High School-- in the rapid class. Has an excellent school record. Is popular with both teachers and students. He frequently holds such positions as class president, monitor, proctor, etc. His teachers describe him as a good-looking, likeable, smart boy. He is fond of reading "anything from fairy tales to Shakespeare"; and always wants other boys with him even when reading.

2. Harry--patient: Born January 21, 1930; weight 10½ pounds; normal birth, full term, 3 hours labor. Breast fed 11 months. Hard to wean, "went to sleep on a bottle till 4 years old". Dentition at 7 or 8 months, walked at 16 or 18 months. Enuresis ceased before 1 year old. Talked at about 1 year. Thumb sucking and nail biting.

When Harry was about 1½ years old the mother who was suffering from nephritis went to another city for treatment. She took the children with her and placed them in charge of a negro nurse maid. When Harry first saw the nurse he screamed with fear and he never did like her. With the advent of the move to the other city and the colored nurse, Harry's effort at speech entirely ceased and he did not commence again until he was 3 years old.

Mrs. Norton told the psychiatrist that when Harry was 2½ years old he fell into a bonfire while out in the country for a visit. It was necessary for the doctor to dress the burn on his hand three times. In addition to the burn on the hand, his hair was singed. Mrs. Norton says, "He suffered dreadfully", "I think there was quite a fright, and a great deal of suffering for a couple of days."

Harry was an exceptionally good baby, who almost never cried, while never seriously sick, always had a tendency toward constipation. He had whooping cough at 6 years, chicken pox at 7 years, and measles and German measles after he started to school.

He was left handed from birth.

There was some hang-over of baby talk when he entered school; after about three weeks in school he began to stammer. For a period of two months, two years ago, when in 3 A, and with a teacher whom he liked, he showed a very marked improvement. The day before promotion the stammering grew worse again.

About three weeks after he entered first grade he began having night terrors. These lasted over a period

of two years, occurring only five or six times in all. When these occurred, he would lie tense, with eyes staring, his body dripping with perspiration and shaking all over. During these spells he would be counting or reading to himself. Sleep now is quiet and undisturbed.

At 5½ years, after he was vaccinated he had his first fainting spell. This lasted about two minutes. When he was in 1 B grade at school he fainted after a fire drill, while standing in line with the other children in the school yard. This time he was said to have remained unconscious for almost half an hour. At a later time he had a long scratch on his arm, three times he knocked this and loosened the scab and fainted each time. The mother thinks the injury was not severe enough to have been painful. His present physical condition is good.

APPETITE:

His appetite is good, habits of eating are regular and he has no food fads.

SEX:

He has had no sex information from his parents. No sex habits have been noted by the parents.

OTHER HABITS:

He is very slow in dressing and constantly has to be prodded by his mother. She brushes his hair, ties his tie, and polishes his shoes. She bathes Harry and inspects Meade to see that he bathes himself properly.

Harry sometimes plays on the streets for a while after school, but always gets in an hour of violin practice.

SCHOOL:

Harry entered kindergarten at 5½ years, with considerable reluctance. His mother urged him to try it for one day, and if he did not like it he need not return. He did like it and continued to go.

He has progressed till now in 5 A, the slow division, there has been no repetition of grades. He attends a school in a Jewish neighborhood, and at times has been the only Gentile child in the class.

He was fond of the first grade teacher, and took her candy. She called him her "candy kid". She was

the one who urged him to write with his right hand. He does so, but writes slowly and very poorly. It was while in this grade that the stammering and night terrors developed.

He was also fond of the 3 A teacher and in her class the stammering improved, and ceased for about two months. She paid no attention to him for a time after he entered her room, then gradually she began to use him for errands, while he was gaining a feeling of security. He was always awkward and stumbling in his movements, and slow but accurate in his mental processes. In his compositions he frequently referred to his mother, but never to his father.

COMPANIONSHIP
and
RECREATION:

Harry does not seem to resent being unfavorably compared with his brother Meade by his school teachers or others. He is less inclined to seek companionship than Meade. He likes to play ball, which he does only fairly well. He is not at all interested in reading but does like music and enjoys his violin lessons.

CONDUCT:

He displays exemplary conduct both at home and school. The mother says he is overly conscientious and is easily controlled by religious appeal. He is slow in all his movements and given to day dreaming. The mother thinks the content of these day dreams is mostly base ball. He is not cowardly but fights only when he has to. The mother considers him timid, the father does not. He is afraid of the dark, as is his brother. He is afraid of mice and the sight of blood. He is very close with his money, usually saves his whole allowance of 50 cents a week. He is willing to lend his toys, but wants other children to be very careful of them. He is self-conscious and shy, yet is confiding and trusting with his family and his teachers. The mother describes him as "quaint and old-fashioned in his speech and manner."

PSYCHOLOGICAL:

When talking with the examiner he did not stammer, but when the testing started he began to stammer. On his first test--Binet-Simon, his I.Q. was 119. A supplementary test raised his I.Q. to 121.

When the psychologist told Mrs. Norton he was going to talk with Harry she said, "Do you think he will be able to answer your questions without my being present?" "I thought he might have some difficulty if he were alone."

DIAGNOSTIC SUMMARY:

The primary problem is that of an unhealthy mother-son attachment, in which speech has been the regressive mechanism unconsciously selected by the patient.

He begins to speak at about 1 year of age; at a year and a half of age, he goes to another city with his mother and brother leaving his father. His over-solicitous mother is ill, and has to turn him over, in part, to the care of a colored nurse maid. Rebellious at being robbed of his mother, he tries to restore the former relationship to become again mother's baby, by ceasing all efforts at speech, until he is 3 years old. There is still some hang over of baby talk when he enters school. School experience brings again the desire to be protected; to return to babyhood. His ego will not let him return all the way to a cessation of speech--and disturbed speech is the way therefore, in which he now secures the mother's attention.

Probably the fact that he is the youngest child, is the reason speech was selected as a medium. The apparently high degree of correlation between stammering and a change from left handedness to right handedness must also be taken into consideration.

The primary mechanism utilized then is a protective infantile one, calculated to keep him a dependent individual. It is carried over to the school situation, his occasional school failures probably having for him a positive value in so far as they tend to keep him dependent. His timidity, and stinginess (in that it probably has his mother's approval) are also a part of the picture.

In analyzing the child's experience in terms of the

constructive elements in his love life (libido) and his drive for achievement (ego) it was found that the factors in the case grouped themselves mainly under the head of "positive destructive libidinal" and "negative destructive ego", that is, the greater number of elements in his emotional experiences have tended to tie him closely to his mother and his ego experiences have been so negative in character as to drive him back to her when circumstances should have separated him from her.

The patient may feel some jealousy of the older brother, who is given particular consideration by the mother on the grounds of poor physical health, and nervousness, and with whom he is unfavorably compared at school. Also the favoritism shown by the paternal grand father for this older brother as long as he was in the home. The value which the grand mother places upon the patient's abilities and personality traits probably help to offset this.

The role which the father plays in the boy's life is not clear, but appears to be fairly negative. His belief that Harry will outgrow his stammering may have a positive ego value for the boy.

The use of a religious appeal to a boy of Harry's make-up is potentially dangerous in so far as it tends to create a feeling of guilt and emphasize his dependency.

PSYCHIATRIC ANALYSIS

Ego-Libido Analysis of Harry

LIBIDO--POSITIVE--CONSTRUCTIVE:

1. Pregnancy full term, normal birth
2. Has a good and comfortable home
3. Fond of his first grade and 3 A teachers
4. Stammering ceased for two months with 3 A teacher
5. 3 A teacher gave Harry errands to perform.

LIBIDO--NEGATIVE--CONSTRUCTIVE

(None noted)

LIBIDO--POSITIVE--DESTRUCTIVE:

1. Mother's poor health and neurotic make-up
2. Breast fed for 11 months
3. Difficulty in weaning--used bottle at bed time till 4 years old.
4. Cessation of talking from 1½ years till 3 years of age
5. Stammering began after 3 weeks of school
6. Hang-over of baby talk in first grade of school
7. Constipation and headaches
8. Fright in connection with burn at 2½ years
9. Measles--whooping cough--chicken pox
10. Fright terrors for 2 years after entering school
11. Fainting attacks from 5½ years on, in connection with vaccination, fire drill at school, scratch on arm.
12. Slow undressing and dressing; has to be prodded and helped by mother.
13. Overly-conscientious--self conscious--shy
14. Day dreams
15. Easily controlled by religious appeal on part of mother
16. Fears--dark, mice, and sight of blood.
17. "Old-fashioned ways"
18. Mother overly solicitious, over patient
19. Mother's attitude regarding saving
20. No sex instruction from parents

LIBIDO--NEGATIVE--DESTRUCTIVE:

1. With his ill mother in another city 1½ years
2. Separated from father 1½ years
3. Fear of negro nurse maid
4. Split of parental opinion regarding rearing of children
5. Family privileges given to older brother
6. Paternal grandfather's preference for older brother
7. Youngest child in the family

EGO--POSITIVE--CONSTRUCTIVE:

1. Kindergarten at 5½ years
2. School progress fair
3. Enuresis ceased at 1 year
4. Started speech at 1 year
5. Normal physical development
6. Good intelligence (I.Q. 121)

7. Errand boy for teacher
8. Good progress with violin
9. Grand mother's value of boy's assets

EGO--POSITIVE--DESTRUCTIVE:

1. Father's belief that the stammering is dependent on his left handedness
2. Day dreams
3. Stinginess

EGO--NEGATIVE--DESTRUCTIVE:

1. Frequent falls as a baby
2. Stammering began 3 weeks after entering school
3. Left handed--forced to use right hand in school
4. Writes slowly and poorly
5. At times the only gentile child in the class
6. Teacher's derogatory comparison of Harry with his older brother.
7. No clubs--few close friends
8. Plays ball only fairly well
9. Not interested in reading
10. Slow in work at school--in slow division
11. Poor psychomotor control--awkward and clumsy
12. Brother's success in school
13. Shares bed with older brother

DIAGNOSIS:

An unhealthy mother--son dependency, the primary mechanism the boy is using is an infantile protective mechanism, carried over secondarily into the school setting; his school failures having the same protective value for him, in as much as they make him a dependent person

SOCIOLOGICAL ANALYSIS

| Concrete Situations and Events | Social Relationships | Probable Mental Reactions |
|--|---|--|
| <p>1. Paternal grand parents live in the home. Pat, g. f. favors older brother.</p> | <p>Lack of attention from g. f. Insecurity</p> | <p>Jealousy of brother</p> |
| <p>2. Father shifts all responsibility of children to mother, criticizes her for leniency.</p> | <p>Marital conflict Dependency on mother, lack of attention from father. Lack of status with father</p> | <p>Feeling of insecurity Feeling of dependency on mother</p> |
| <p>3. Mother--poor health and of neurotic make-up; over solicitous of children. Goes to another city for treatment. Away from father 1½ years.</p> | <p>Dependency on mother Insecurity Subordination Deprived of father</p> | <p>Feeling of physical inferiority; increasing dependency on mother Loss of father--insecurity</p> |
| <p>4. Children in care of colored nurse during mother's illness away from home. Talking ceases, no further attempt till 3 yr. old</p> | <p>Deprived of mother's attention Insecurity Isolation</p> | <p>Fear at separation from both parents; feeling of insecurity Infantile regression as means of holding mother's attention</p> |
| <p>5. Older brother has poor health; mother gives him much attention</p> | <p>Conflict with brother</p> | <p>Jealousy, Resentment Antagonistic, Bitter</p> |
| <p>6. Older brother does very well in school, in slow division; left-handed writes poorly and slowly</p> | <p>Conflict with brother, with school, Insecurity; lack of status; few friends</p> | <p>Discouragement; humiliation; Feelings of inferiority, Insecurity, Jealousy; Resentment, antagonistic; Self-conscious--withdrawn</p> |
| <p>7. Entered school at 5½ yr. Nite terror and stammering develop; at times only gentile in class</p> | <p>Temporary loss of status, Insecurity; Isolation; few friends</p> | <p>Fear of new situation Feeling of inferiority Timid, shy, withdrawn</p> |
| <p>8. 3A teacher uses him as errand boy; stammering ceases for two months</p> | <p>Temporary security, status, and recognition</p> | <p>Feeling of superiority, Status</p> |

SOCIAL DIAGNOSIS:

We have here a small lad who received very little attention from the father and too much attention from a neurotic, over-solicitous mother. He has had to give way to an older brother who has poor health and was favored by the paternal grand father and the mother. When there was temporary deprivation of the mother the lad's feeling of insecurity increased and this insecurity was carried over into his school situation. As the feeling of insecurity and inferiority increased his dependency and attachment to the mother increased.

CASE OF: Jack Hooper

STATEMENT OF PROBLEM:

Jack was referred primarily as a school behavior problem; he was also difficult to control at home because of his temper out-bursts and the friction with his older brother, John.

FAMILY HISTORY:

Paternal: The paternal grand father, Thomas Hooper, age 67, was born in Austria. He is now living in a small eastern city, earning a bare living as a laborer.

Paternal grand mother was born in Austria. She died there of tuberculosis, at age of 43.

Father: Henry Hooper, was born in Austria in 1887, the last of 10 children. He died of tuberculosis 2/22/24. He was reared in a small village adjoining the one in which Mrs. Hooper lived. He attended the Catholic School, the only one which the village afforded, but became so lawless that he was expelled. His father then put him in the Protestant school which Mrs. Hooper attended, also the only one in that village. At the age of 11 he was again dismissed because he would obey none of the rules, and he never returned to school. He was high-tempered "just like his father". His mother had no control over him and there were constant quarrels between him and his father. Mrs. Hooper knew Mr. Hooper (patient's father) slightly at this time and she said he was always in trouble, but he seemed very fond of his mother who was with him a great deal.

When 20, Mr. Hooper came to the United States, settling down in Elmdale, Nebraska, where he worked as a laborer in the cement works. While here he renewed his acquaintance with Mrs. Hooper, who had also come to the United States and was living with a sister in Elmdale. Two years later they were married.

Before coming to Omaha, they lived several years in Copley, Nebraska, where Mr. Hooper did cement work and had other laboring jobs. During this time he became increasingly irregular in his support of the family and Mrs. Hooper was compelled to work to support the children. Mr. Hooper drank more and more heavily and went with other

women, at times being away from his family a week or more.

When the family came to Omaha they had many financial difficulties because of Mr. Hooper's irregular employment and his illnesses. Because of a fracture of his leg he was unable to work, according to Mrs. Hooper, for over a year, during which time Mrs. Hooper worked by the day and did janitress work at night to support the family. Mr. Hooper finally got work in a restaurant where he remained for several years but two years before his death he became too ill to work and again Mrs. Hooper supported the family, waiting upon her husband at the same time. During this period the family welfare society was twice called in for assistance.

Maternal: Maternal grandfather George Mohr, age 78, was born in Austria, and is still living there. He was born out of wedlock, the only child of a woman who served in a semi-religious capacity in a Catholic Convent. It has been said that a priest was his father but this was never known. As far as Mrs. Hooper knows, he had an uneventful childhood, receiving the small amount of schooling possible there, and working on farms of the community. About the time of his marriage he became a porter on a large estate, and held this position over 25 years. It was a position of trust and responsibility and Mrs. Hooper referred to it with some pride. A comfortable cottage was furnished for him and his family, as well as all the milk, butter, and eggs that he needed. The estate is now in the hands of a nephew of the former owner. He allows the old couple to continue to live in a small cottage on the estate, tho her father is too old to work

Maternal grandmother, 55 years old, was born in Austria, and is still living with her husband in the cottage on the estate. She came of a healthy peasant stock. Two sisters and a brother are living in the same community, all in straitened circumstances but as well off as others of their class.

AUNTS AND UNCLES:

Aunt, Mrs. Anna Geneo, 40, is the oldest of the family. Since coming to Omaha a year or so ago she and her family live next door to Mrs. Hooper, when Mrs. Geneo does the janitress work. She has 5 children. Her husband is a laborer, but his earnings are irregular and small, making it necessary for her to work to supplement his income.

Her oldest child, a boy of 16, finished elementary school, and has gone to work. According to Mrs. Hooper he had a very bad influence on Jack (patient) but now that he is working nights and sleeping during the day, the contact is broken.

The two families have had the usual contacts of near neighbors, though both women are too busy to do much visiting. The children do not play together to Mrs. Hooper's knowledge, except as they congregate in the street with other children.

Aunt, Mrs. Mary Moltz, lives in the East. Her husband is in poor health, being very thin and coughing constantly (probably T. B.). They have had 13 children, only 5 of whom lived. Mrs. Hooper does not know the causes of their deaths. Mrs. Moltz works to support the family.

Uncle, Frank Mohr, 27, is married and has one child. He lives near his parents in Austria and helps with their support. He works as a farm laborer on small pay.

Uncle, Jim Mohr lives in the East. Is married and has one child. Is a cement worker.

Aunt, Hannah Make, unmarried, is 19. She lives with her older sister, Mrs. Geneo. Has been looking for work as it is necessary for her to be self-supporting.

Mrs. Hooper says all her brothers and sisters work hard, earning barely enough to support themselves and their families.

Mother: Minnie, age 34, was born in Austria. She is a small wiry looking woman, who speaks rather broken English with a rapid flow of words. Even when scrubbing the halls, she is neatly dressed, and gives the appearance of unusual cleanliness.

Mrs. Hooper was the second of six children. She said her childhood was a very happy one. Her home was comfortable, and the atmosphere congenial, with little friction. Her parents seemed very happy together. The children were given the utmost freedom on the estate and were devoted to the owners. Mrs. Hooper spoke with particular fondness of her father, with whom she went many times when he drove the members of his employee's family to and from their destinations.

Mrs. Hooper had excellent health in her girlhood. Following her marriage, she continued to work while having children, and the strain proved too great. While carrying her first child she sat long hours in a cigar factory. The child died at birth, and for a year following Mrs. Hooper was in very poor health. In later years, as a result of over-work and contact with her husband's active lung condition, she developed a suspicious pulmonary condition. She was examined at that time; fortunately this condition has not progressed and recent examinations show no activity.

Since her husband's death, Mrs. Hooper has been adequately supported by the family welfare society without being in any way pauperized. For eight years she has held her present position of janitress.

Mrs. Hooper will soon have her second naturalization papers, after which she will receive a mother's pension.

MARITAL RELATIONS:

Mrs. Hooper said she was very happy during the first year of her married life. Mr. Hooper was a devoted husband, and seemed interested only in her and his home. Though he had fairly steady work his earnings were not large, and she continued working. He did not object when she became pregnant, and seemed to want children.

For a year following her first confinement she was in poor health, and during this time Mr. Hooper began to lose interest in her. He went out more frequently at night, and she finally realized that he was going with other women. He began to come home drunk, and when under the influence of liquor was extremely surly, often hitting or beating her. He failed to bring her money and the family often went hungry. The children feared him when drunk, and crept away when he arrived home in this condition. When Mr. Hooper recovered from his sprees, he became penitent and sorry for what he had done, and for several days would treat his family with every consideration.

Mrs. Hooper never, at any time, thought of separation. She said, "I always liked him--even when he drank. He liked the children, and it made him mad if I did not keep their clothes mended, and the house clean, and he expected me to take good care of his clothes."

HOME:

The Hoopers live in a crowded district of cheap and fairly good apartment houses. The streets throng with children during play hours. Little foodshops abound, and the vegetable and fruit stands line the curbs.

The Hooper family live in a four-room apartment on the ground floor in the rear. It is well lighted with four large windows. Mrs. Hooper keeps the place extremely clean, and though the furniture is not attractive there is a comfortable homey look. She makes every effort to keep congenial pleasant surroundings for the children and succeeds fairly well, except for the friction between the two boys. They all study around the dining room table at night, including Mrs. Hooper who has been attending an English class.

RELIGION:

The family all attend St. Catherine's Church regularly, and all the children go to Sunday School. They seem to enjoy it and expect to go.

Mr. Hooper had nothing to do with the Church (though reared a Catholic) and disapproved of the children attending. There were frequent quarrels, especially when Mr. Hooper was home ill. He said he would rather have the children spend their church donations and go to a movie.

FRATERNITY:

1. Theresa: Died soon after birth. Diagnosis malnutrition.

2. John: 13. He was born at term and normal delivery. His development was retarded, but he was a generally healthy baby and child. At present he is in excellent health, though undersized and with sallow complexion.

John has made normal progress in school. He has a cheerful happy disposition, making friends easily and fitting well into his home and school environments. He is devoted to his mother and as the oldest son has perhaps come to take first place with her, though Mrs. Hooper shows great impartiality in her relations toward all her children. Her expression lights up, however when she speaks of John, and she compares him with Jack to the latter's discredit.

John comes home after school to see if he can help his mother clean the halls, run errands, etc. He is al-

ways thinking of ways to help her and is content to remain at home if she wants him to do anything, although he enjoys going out to play.

He rather good-naturedly provokes Jack until the latter loses his temper, which is easily roused, and a row results. The feeling has become so tense, especially on Jack's part that they cannot be sent to school together, and have difficulty studying in the same room at night. Mrs. Hooper handles the situation by telling John to leave Jack alone, for he knows Jack cannot stand teasing. The two boys keep away from each other's "crowds" and except at home, have little to do with each other. They sleep together, however, but apparently have no difficulty in the matter.

3. Frank, age 12. Normal birth, but from birth was under size and frail. He was examined and found to have Pulmonary T.B., second stage. He was sent to a Sanitarium, where he now is. He has greatly improved but may stay another year; he has been there two years now.

Mrs. Hooper said her husband was exceedingly fond of Frank and clearly showed his preference. Because of his frailty, Mrs. Hooper also gave him much attention.

4. Joseph, 10 years of age, patient.

5. Mary, 6 years. Was full term baby; breast fed about a year, normal development. She is a small child for her age and peaked looking. Is shy and of quiet disposition, but inclined to be friendly. She has always been easy to control. Mary likes school, is regular and has good reports. In April she was placed in a Preventorium.

DEVELOPMENTAL HISTORY:

Jack, age 10 years. He had a normal birth at nine months and normal development. About one year ago he was operated upon because of acute appendicitis at P-- hospital. He was sent to M--- Convalescent Home for after-care, but ran away returning home. He told his mother that he went for a walk with some other boys and got lost, finally arriving home. Three months after the appendectomy he had a tonsillectomy. Physical examination reveals him to be somewhat under sized and under nourished, and about

nine pounds underweight. Poorly developed musculature, paleness of skin, carious teeth, also were noted.

SEX LIFE:

Jack has received no sex information at home, but his mother feels that he is beginning to show an unhealthy interest in girls, and she is doubly apprehensive as "he is just like his father." He insists upon going with an older crowd, rather than playing with those his own age, and Mrs. Hooper fears that he is given bad sex information through this source and is led on to do things not just right.

HABITS:

Jack has not shown any unusual habit tendencies. He has a good appetite, and sleeps well. Aside from nail biting there is no history of nervous habits, food fads, etc.

SCHOOL HISTORY:

Jack entered school at 6, remaining in one elementary school four years. He repeated 2A and 3B in that school. These repetitions were because of poor conduct primarily, though his marks were poor as result of conduct. The principal said that from the time he entered school he was a "general nuisance". He became more and more disobedient, and inclined to fight with other children and began at an early age to use bad language. He was generally good in his work but slow. Every effort was made by his teachers "to straighten him out", but the more personal attention they gave him, the worse he acted. It was finally decided that a transfer to another school might improve his behavior, and this transfer was made in April.

This school accepted him unwillingly, and this attitude has been felt by the child. His conduct improved some during the remainder of the term and he was passed into 4B but with deficiencies in reading and spelling. During the Fall term following, he was absent more than half the time, because of the two operations, but in spite of this he was again passed into 4A, with deficiencies in spelling and Arithmetic.

His present teacher (4A) says that "he does not pay attention to his work, leaves the room without permission, and flies into a rage when told to do anything". He is so surly that the children are afraid of him and have nothing to do with him. He is extremely restless, and has little power to concentrate. His written work varies according to his mood. At times he follows directions accurately, but if irritated by anything, he makes deliberate mistakes. He is failing in all his work and cannot be passed in June.

The above information was given by the principal. She is unwilling to have Jack continue in school as he upsets the morale of the whole class. She considers a correctional institution the only solution, and if no other arrangements can be made, she will have to recommend him for the correctional public school. It would be better if he were taken entirely out of the home, however, because (according to this principal) his mother uses such poor judgement in trying to control him, being too lenient at times and again "beating him too severely". (Mrs. Hooper states that the principal advised her to be more strict with Jack and whip him whenever he misbehaves, and she refused to consider the advice. She says that she does not whip him at all, and finds him reasonable and responsive when she has him alone.)

PSYCHOLOGICAL EXAMINATION:

At time of psychological examination, Jack's chronological age was 10 years, 9 months; mental age 9 years, 3 months, I.Q. 86. He showed very good apperceptions, average motor control, good reading comprehension, average arithmetic, and poor spelling. Language difficulties were marked and he showed considerable feeling about the bi-lingual situation in his home. He related in detail the fact that his father had insisted upon German being spoken in the home, that even now they speak German together at home and that John "nags" Jack about his preference for English.

RECREATION AND COMPANIONSHIP:

Jack does some reading at home, at times becomes deeply engrossed in some magazine or boy's book which he has picked up. He usually prefers, however, to "run the

streets", being very active and restless. He is heedless about the house, showing much less thought or affection toward his mother than John does. He usually wants to be let alone, and allowed to go out. If Mrs. Hooper lets him out in the evening, however, he is gone beyond recall, and she cannot count upon his returning at a reasonable hour. She compares him unfavorably with John, who can always be depended upon to behave himself and stay near home. (Another social worker states that the worker at a Settlement House reported that John and his cousin have been making Jack steal sacks of coal and gas pipe, which they sell. They threaten to "beat him up" if he tells on them or refuses to follow their orders.) Jack is now attending a "gym" class twice a week from five to six at the Settlement House, which is the only planned recreation he has.

CONDUCT:

As a baby, Jack was stronger and better developed than any of the other children. At the time of his birth John was 3 and Frank a frail, sickly baby of twenty-one months. Mrs. Hooper admits that much of her attention was given to Frank and that very early, Jack resented this fact, crying loudly whenever she held Frank or paid attention to him. Jack was weaned at eleven months, but was nineteen months old before he gave up the bottle. Mrs. Hooper allowed him to have it when going to sleep as it was so difficult to get him quiet without it.

When Mary was born two and a half years later, this jealousy was extended to her. Many times Jack pulled her off the bed and onto the floor, or turned over the buggy when she was in it. From the time he could crawl, he was "just like a fly", into everything, on the go every minute, and picking on the other children. As soon as he could toddle out doors he began quarreling with other children. Mrs. Hooper was constantly hearing complaints regarding him from their parents.

As Mary grew older Jack changed his attitude toward her and now he shows no jealousy. If he is given any candy or other present, he always brings it home to divide with her. She seems fond of him although she finds John easier to get along with.

Jack is still jealous of his brothers, however, and often says to his mother, "You care more for them than

you do for me." The children were all very much afraid of their father, and obeyed him without question. He was usually drunk, however, and they always avoided him at such times, he had little share in their up-bringing.

According to Mrs. Hooper, Jack cried a great deal following the death of his father and was very despondent for some time. Once when he seemed so distressed she asked him what was the matter and he finally admitted that he was afraid that he would be put in a home, now that his father was dead. At one time when John was complaining about his father's treatment of the family before his death, Jack retorted, "Well, he was ours anyway, if he wasn't any good."

Mrs. Hooper says Jack still has temper outbursts, when he "gets white in the face, looks mad, hollers and curses." These outbursts last only a few minutes, after which he says he is sorry and does as he is told. If alone with his mother he seldom has such outbursts, but they are frequent when John is around.

At times Jack shows great affection for his mother, putting his arms around her, telling her he wants to be good, etc. Or again he will compliment her on the breakfast or supper she has prepared. Sometimes after he has been to mass on confession he feels repentant, and tells his mother he is really going to be good.

Jack feels that his teacher does not like him and "has it in for him" and so "picks on him" unfairly.

Mrs. Hooper would like to have Jack go to a boy's school, where he would be under the influence and direction of a man, and where he could get some manual training. "He is always going around with a hammer in his hand, pounding or fixing things."

Jack talks freely with psychiatrist about his dislike for school, his difficulty with English and Geography and his inability to get on with his teacher, who, he relates, has to call in other teachers to help her manage the boys. He says he is fond of his brother John but complains with a good deal of feeling that John "never wants to chop wood", always wants new clothes and gives his old clothes to Jack, always wants to have a good time.

PSYCHIATRIC ANALYSIS

Ego-Libido Analysis of Jack

LIBIDO--POSITIVE--CONSTRUCTIVE:

1. Mother's love for father
2. Homey atmosphere in family apartment
3. The children's share in the mother's responsibilities
4. A few companions interested in church

LIBIDO--NEGATIVE--CONSTRUCTIVE:

(None noted)

LIBIDO--POSITIVE--DESTRUCTIVE:

1. Prolonged bottle feeding
2. Nailbiting
3. Fewer temper outbursts when alone with mother
4. Disobedience and over-demonstrativeness

LIBIDO--NEGATIVE--DESTRUCTIVE:

1. Father's alcoholism
2. Father's infidelity
3. Father's desertion
4. Father's high temper
5. Father's irregular presence in the home
6. Father's inconsistent treatment of the family
7. Father's unpleasant attitude toward mother
8. Father's insistence that German be spoken in the home
9. Father's attitude toward the Catholic Church
10. Fear on part of the children when the father was drunk
11. Father's death from tuberculosis
12. Mother is out of the home much of the time.
13. Mother's attention occupied with hard work
14. Mother wants patient sent away to school
15. Mother beats patient
16. Mother considers patient undependable
17. Mother compares patient unfavorably with brother John
18. John has an enviable position with the mother as the oldest son
19. John teases patient, and the boys do not get along
20. Frank was the father's favorite and received much attention from the mother because of his illness

21. Patient has few companions
22. Patient's school teachers are antagonistic toward him

EGO--POSITIVE--CONSTRUCTIVE:

1. Mother's desire to learn English and become naturalized
2. Family's adequate support through family welfare society
3. Jack's normal development
4. Good apperception
5. Average motor coordination
6. Ability with concrete material

EGO--POSITIVE--DESTRUCTIVE:

1. Teacher has to call in other teachers to help control him
2. Resentment of attention given Frank by mother
3. Jealousy of siblings
4. Quarreling with other children, especially John
5. Fits of temper and disobedience
6. Bad conduct in school
7. Surliness, stubbornness, restlessness
8. Staying out late at night
9. Sometimes unaffectionate with his mother

EGO--NEGATIVE--DESTRUCTIVE:

1. The father's share in the family relationships and his behavior
2. Mother identifies patient with the father
3. Poverty, and the need for assistance from relief agencies
4. The mother's hard work as a janitress
5. Conflict over German and English spoken in the home
6. Mother voices her irritation at patient
7. Mother's unfavorable comparisons of patient with John
8. Patient's conflict with John
9. Mary's and John's satisfactory school standing as compared with patient's poor progress.
10. Demotions for poor conduct
11. Change of schools
12. The fact that the teachers do not want him in school
13. He has a "disciplinarian" for a teacher
14. He is at further disadvantage because of his language handicap
15. Physical underdevelopment

DIAGNOSIS:

In Jack we see a boy compensating on a destructive ego level for libidinal deprivation. The primary mechanism the boy is using is a protective mechanism, carried over secondarily into the school setting.

SOCIOLOGICAL ANALYSIS OF JACK

| Concrete Situations and Events | Social Relationships | Probable Mental Reactions |
|---|--|---|
| <p>1. Unstable father--drink, infidelity, desertion, temper, irregular presence in the home, inconsistent treatment of family, unpleasant toward mother</p> | <p>Friction between parents; children avoid father; insecurity. Lack of attention (status) for boy</p> | <p>Fear of father; loss of respect; feeling of insecurity; protective attitude toward father when others criticize the father</p> |
| <p>2. Father's insistence that German be spoken in the home.</p> | <p>Language handicap in school. Isolation, few companions or friends</p> | <p>Embarrassment; discouragement; feeling of inferiority</p> |
| <p>3. Mother sends children to Catholic Church and Sunday School in face of father's opposition</p> | <p>Conflict between parents</p> | <p>Mental conflict--environmental pressure; various religious teachings and influence</p> |
| <p>4. Death of father. Assistance from Family Welfare Society. Employment of mother</p> | <p>Removal of tension in family. Dependency. Partial deprivation of parental oversight</p> | <p>Feeling of insecurity; feeling of inferiority; Humiliation, resentment</p> |
| <p>5. Mother attends English Classes at night school</p> | | <p>Embarrassment</p> |
| <p>6. Mother's favoritism toward other children in family</p> | <p>Subordination Conflict with siblings</p> | <p>Bitter; resentful; antagonistic; combative</p> |
| <p>7. Quarrelling with siblings and neighbor children; temper spells; staying out late at night Disobedience</p> | <p>Conflict with mother; conflict with neighbors Insecurity; lack of status</p> | <p>Jealous; Vindictive; Intermittent affection for mother; surly; stubborn; restless</p> |
| <p>8. Teachers "pick on" boy; change of schools; disobedience; quarrelling; poor school progress</p> | <p>Conflict with teachers; conflict with school mates; Resistance against total social environment; insecurity; lack of status</p> | <p>Feeling of insecurity; antagonistic; combative; resentment--vindictive; Feeling of inferiority; humiliation; discouraged</p> |

SOCIAL DIAGNOSIS:

We have a small boy who has never received much recognition, and whose general situation has always been insecure. He was first ignored, then subordinated, both at home and school. There was marital conflict in the home and presently the boy himself was in conflict with his whole social environment.

CASE OF--Roy Garvin

STATEMENT OF PROBLEM:

Roy is failing in his school work; is careless and forgetful. "He seems just like a helpless baby."

FAMILY HISTORY:

The paternal family is of Sicilian stock. There were several children in the family. Mrs. Garvin denies any knowledge about her husband's people. She knew only two of his sisters who are in this country. According to her report, one of them was a nervous, quarrelsome woman always trying to pick trouble between her brother and his wife. Mr. Garvin was deeply attached to this sister; Mrs. Garvin states that she believes the family to have been a strong healthy one--the members she knew were so.

Father: The patient's father died four years ago of tuberculosis. Two years previous to his death, he had been obliged to give up his business as a barber. He was about 34 at the time of his death. Mrs. Garvin considered him inferior because of his nationality and because she felt that his family stock was not as good as hers; but she thought him a very fine man in spite of this. She expatiates at great length on what a good husband he was, how he protected her from all worry and hard contact with the world.

This tale of felicity may be considerably exaggerated but Mrs. Patterson, a teacher at the Junior High School, who has known Mrs. Garvin ever since the children started to school, states that before her husband died Mrs. Garvin was a very happy, carefree woman, apparently living in very comfortable circumstances, and very devoted to her husband. Mr. Garvin had a kindly affectionate disposition, never lost his temper or became "riled" over things. He was very fond of the children and helped them a great deal; the daughter was his favorite, but he always treated Roy as his baby. He was very successful in business and was able to maintain his family in comfort.

Maternal: The maternal grand father, aged 76, is still living, well and strong. He has a very strong will and a violent temper. He brought his children up very strictly and ruled them by fear.

The maternal grand mother died 27 years ago of heart trouble. Previously she had been a strong, healthy woman. She had ten children, the mother of Roy being her youngest. In disposition she was much more calm and even than her husband.

Mother: Aged 34, is a very obese woman of the self diagnosed nervous type. She is strongly egotistic, delighting in enlarging upon her ills and misfortunes and in describing what kind of a woman she is. With much satisfaction she talks of her faults, of her stubbornness and distrust of the world, and with less satisfaction of her truthfulness and strict principles. She moans continually about the place in which she has to live, four dark, vermin infested rooms in a cellar, but makes no attempt to improve their condition of filth and untidiness. She gets her satisfactions from pretensions of former gentility--of the 14-room house, servants, and general comfort she used to enjoy. She is of Scotch descent, being born in Scotland and claims that her grand mother bears the title of "Lady". Her speech and manners and certain demands for politeness on the part of her children, show that she has known better things, but she often lapses into crude speech and her ideas are cheap and lacking in refinement.

Emotionally she is very unstable. She weeps at the slightest provocation but shortly recovers herself and is smiling again. In the same way her anger flares up but soon dissipates into a state of fairly good humor. By her own statement she is very shifting in her reactions--one minute she likes a person, the next minute she hates them. Her conduct is characterized by great impulsiveness. She claims that she is in a constant state of nervous tension, that she has tremors, dizzy spells, and many somatic complaints. She had three of her nervous attacks in the workers presence. When these occur she stops talking suddenly, draws in her breath in long gasps, throws her body and particularly her head backwards as though fainting and then breaks into violent sobbing. These attacks last about two minutes, and bear strong evidence of being voluntarily produced. She seems to have found her nervousness a means of put-

ting herself across and capitalizes it as such. There seems to be an undoubted state of nervousness and emotional upset but she enhances it.

In keeping with her egotistic make-up is her resistance to advice or to interference in her affairs. She has been found most difficult to deal with by the teachers at the school, refusing her cooperation entirely and taking an antagonistic defensive attitude. Her ideas of her own ability and intelligence lead her to consider any offers of assistance, other than material, most insulting. She flies into a rage when her desires are thwarted. She is very boastful of her power at cowering people. She is constantly boasting of her great will power which will enable her to undergo and accomplish anything, and sees no discrepancy between this statement and the wretched situation in which she is now.

She wants Roy transferred to another school, but admits it would do no good for her to go down to the school and fuss about it as the teachers pay no attention to her, yet in the next breath, she states, "The mother of the child rules---they could never do anything with Roy against my wishes, Whatever I want done with him, my will accomplishes".

Her resentment of interference is mingled with strong ideas of persecution. She feels intermittently that all her worries and hence her nervousness would end if people would stop "pestering" her. Sometimes she refers specifically to people, such as the visiting teacher, and the social worker who come in and try to tell her how to manage her children, as the authors of the pestering, but generally she uses the indefinite "they" and will not explain how she is so deeply harassed. She feels that in some mysterious way all these people who are "pestering" her are set upon her by her sister-in-law, for whom she has great hatred. As stated before, this woman was Mr. Garvin's favorite sister and she caused considerable difficulty in their home during Mr. Garvin's life. At his death this sister-in-law secured his money. She had been made trustee by Mr. Garvin's wish. Mrs. Garvin was only able after a long struggle to obtain the money. As the children's God mother, this sister-in-law attempted to assume charge of them because she considered Mrs. Garvin as unable to care for them properly. Mrs. Garvin is un-

der constant apprehension as to vague persons who may come prowling down into her cellar and try to injure her. She extends her ideas to the children, feeling that their teachers pick on them and when any difficulty arises, it is merely the teacher's persecuting the children.

She shows considerable lack of consistency and rationality of which she appears entirely unconscious. At one time she said, that the doctor had told her that her trouble was sciatic rheumatism, but that she knew it was influenza--a little later, in the same interview she stated that the doctor tried to make her believe that she had "Flu" but it was really nervous prostration. She made much of the fact she could never have a minute's peace away from the children, later--that she often felt an impulse to walk out and leave them, and she would not care if she did.

She asserts an intense devotion for the children, and she apparently has in so far as her shallow egotistic temperament allows. However it manifests itself in selfish ways, and is in no wise an enlightened love. The two oldest children are in need of tonsilectomies, but she will not allow them to be performed because it would frighten her too much and be too much of a nerve strain for her. She will not discipline the children in any way or force them to do things which she knows are best for them, partly through laziness and inertia and partly because she feels that she is thus asserting her independence. She states that she seems more like a sister than a mother to her children, and that frequently they all scrap like a pack of children.

Physically, she is in a very poor condition, as mentioned before. Her obesity makes it difficult for her to be on her feet a great deal and do the scrub work by which she earns her living. This condition is complicated by flat feet, a defect for which she is unwilling to receive treatment. She has some kidney trouble but makes no attempt to have a proper diet. She complains of pains all over her body and difficulty in getting her breath. She has been to a doctor for this, but failed to take any of the medicine given her or return for further observation and treatment. She says that doctors can do nothing for her.

She has had no miscarriages or still births.
Has never used alcohol or drugs.

HOME:

The family has lived in the present locality in a large city for ten or twelve years, though during the husband's life time they occupied a much better house. The neighborhood is a fairly good residential one, closely bordering on a commercial district. There are "bed" streets scattered about them. There are practically no recreational facilities. There is a Y.M.C.A. within available distance and some of the churches have considerable social activity, circulating libraries, etc. There are two parks each about six blocks away. The four-room basement flat is ill-lighted, poorly ventilated and extremely dirty and untidy. The place is filled with vermin, and rats and mice, the latter coming about even in the day time. Three rooms only are used. There are very poor toilet facilities. There is absolutely no attempt to make things comfortable and home-like, or even keep things in order. Mrs. Garvin apologizes for the condition and bemoans it but makes no attempt at remedy. John shares a dark, windowless inner room with his brother.

The economic condition of the family is rather precarious. They receive a pension from the child welfare department of \$37.00 per month. The daughter who is working makes \$12 per week and the mother from \$15 to \$18 when she works. The rent is \$15 per month, and the gas which they have to burn all the time, generally comes to about \$7 per month. The children are well-dressed and none of the family look under-nourished.

The atmosphere of the home is one of stress and strain. The mother is constantly complaining and ranting at something or other. The mother frequently quarrels with the children, and they are always scrapping and fussing because one is getting more than the other, or is being picked on; apparently every one gets on every one's else nerves. The mother feels that the daughter should assume a greater share in the house work, whereas the girl feels that the mother should have things ready for her when she comes home at night.

Underneath all the fussing, there seems to be real affection. The mother and daughter are fairly companionable and frequently go out together, chiefly to the movies. The boys do not take much interest in shows but are intensely fond of reading.

FRATERNITY:

1. Marie, age 16, is now working. She is not strong, physically. Her tonsils are in such a bad state of infection that they have brought her whole system down to a very rundown condition. Both she and the mother refuse to have a tonsillectomy performed.

2. Alexander, age 14, is a quiet docile boy, rather shy and self-conscious. He is in 8th grade in school, and doing poor work. Conduct is unsatisfactory, as he is constantly talking and failing to pay attention.

3. Roy, age 12.

DEVELOPMENTAL HISTORY:

Weight at birth, 10½ pounds. Pregnancy and birth normal. Breast fed. Dentition and walking normal, talking somewhat early. Enuresis stopped at age of 3.

HEALTH HISTORY:

No serious illnesses. He has a curious fluttering movement of the hands, and his eyelids twitch and blink. He gets to bed very late but sleeps well. He is very fussy about his food and will touch nothing which is the least bit slimy. The meals are rather erratic as the mother frequently is not there to get them and when she is she lets the children get the food for themselves.

SCHOOL HISTORY:

Roy entered school in the first grade at the age of 5. From first grade through fifth grade his record was "B" and "B+". He was in a rapid advancement class through 6th and 7th grades, completing these two grades in 1½ years. He excelled in oral work. He occasionally caused trouble because of over activity and a lively temper, but was not a conduct problem. There was no difficulty about forgetfulness there. He was very well liked by the boys and was made an officer in some of their student organizations.

In his present school (Junior High) he has never done satisfactory work; his summarized record is "D".

conduct "B". His teachers consider him a bright boy, but he will not do his home work, and in school his activity and effort seem to produce nothing. He is eager and interested; he appears to attend, but never gets anywhere. He is very careless and forgetful, constantly losing his work, forgetting where he is supposed to go at a certain hour. He seems just like "a helpless baby", very spoiled. He has no initiative, and does not seem capable of work unless he has some one to follow right after him and tell him what to do. He does his best in mathematics which he likes. He brings his home work for this.

Attendance is regular; never truants.

At home he appears to be fond of his teachers and of school. He seems much younger than most of the boys in the school; in a class of about 135, there are only seven his age or younger.

RECREATION AND COMPANIONSHIP:

Roy is especially fond of reading and spends most of his time in the house at that occupation. He does not seem to care to play with other boys. In elementary school he showed enthusiasm for the signal drill, gymnasium work, and basket ball. In elementary school, he manifested great hero worship for some of the older boys.

He does not get on particularly well with his brother and does not pal around with him much.

SPECIAL CHARACTERISTICS:

Roy has a very impulsive, excitable nature. He is rather shy at first, but the shyness soon thaws and he becomes friendly and expansive. He is so eager to talk to people about the things he sees and thinks about that he cannot talk fast enough. He is loving and affectionate. He is rather jealous of his mother and sister. He never shows sullenness; when he is reprimanded he never answers in a resentful manner, but appears astonished and surprised that anyone should find anything wrong with him. He does not hold a grudge. He does not appear easily discouraged, because he does not appear conscious of failure. He appears to be one of the herd rather than a leader. His

strong social interests would indicate that there were other motives rather than lack of interest which keep him by himself a good deal.

He is frank and confiding. He seems rather intimidated by the mother. She constantly fusses and nags at him.

RELIGION:

The family have no stable religious connections. The father was originally a Catholic but gave up his religion when he became a Mason and was unwilling for his family to attend. Now the children are going intermittently to the Dutch Reformed Presbyterian Church.

PSYCHOLOGICAL:

When Roy entered the Junior High School he was given psychometric tests which showed an I.Q. of 142. Later tests confirmed this rating which places him in the very superior group.

PSYCHIATRIC ANALYSIS

Ego-Libido Analysis of Roy

LIBIDO--CONSTRUCTIVE--POSITIVE:

1. There seems to be real affection among members of the family.
2. Father was fond of children
3. Boy is loving and affectionate
4. Has strong social interests

LIBIDO--CONSTRUCTIVE--NEGATIVE:

(None noted)

LIBIDO--DESTRUCTIVE--POSITIVE:

1. Father considered Roy his baby
2. Seems like a helpless baby; no initiative
3. Is not capable of working by himself
4. Does not seem to care to be with other boys out doors
5. Mother constantly nags and fusses at him

LIBIDO--DESTRUCTIVE--NEGATIVE:

1. Home in a basement; vary dirty
2. Boy shares dark, windowless room with his brother
3. Children constantly scrap
4. Mother constantly complaining
5. Father died of tuberculosis after long illness, 4 years ago
6. Meals erratic
7. Mother nervous--infantile
8. Boy seems much younger than most boys in his school
9. Boy does not get on with older brother
10. Boy is jealous of mother and sister
11. Brother intimidated by mother
12. Mother too much interested in her own concerns to be interested in boy
13. Father originally a Catholic, joins Masons
14. Boy changed school 4 times in 3B

EGO--CONSTRUCTIVE--POSITIVE:

1. Normal development; good physical development
2. Appetite good; sleeps well
3. Entered school at age of 5
4. Work and conduct "B" and "B+"
5. Rapid advancement class 6th and 7th grades; completed in 1½ years
6. Excelled in oral work
7. Very well liked by boys in Elementary school; was made officer in some student organizations
8. Considered bright by all his teachers
9. Does best work in Mathematics which he likes
10. Attendance regular at school
11. Appears fond of school and likes his teachers
12. I.Q. 142. Has a broad fund of general information
13. Especially fond of reading
14. In elementary school was enthusiastic about signal drill, gym work, and basket ball.
15. Upon acquaintance becomes friendly and talkative; eager to talk about things he has seen and read
16. Strong social interests
17. Frank and confiding; does not hold grudges

EGO--CONSTRUCTIVE--NEGATIVE:

(None noted)

EGO--DESTRUCTIVE--POSITIVE:

1. Enuresis up to 3 years
2. Fluttering movement of hands; eyelids twitch and blink
3. Very fussy about food
4. Careless and forgetful; constantly losing books
5. Incapable of work unless some one works with him; no initiative
6. Results not commensurate with his ability
7. Spends most of time in house reading; does not seem to care about play with other boys
8. Impulsive, excitable
9. Does not appear conscious of failure
10. Easily discouraged

EGO--DESTRUCTIVE--NEGATIVE:

1. Has not done satisfactory school work since entering Junior High School
2. Seems much younger than most boys in his class
3. Does not get on well with brother
4. No special companion; thinks no one likes him
5. Rather intimidated by mother

PSYCHIATRIC DIAGNOSIS:

Roy is a lad with many things to build upon. He has no security in the school nor the home since his father's death and as a result shows a tendency to withdraw and spend his time dreaming or reading. The primary mechanism used seems to be a protective ego to make up for feelings of insecurity.

| Concrete Situations and Events | Social Relationships | Probable Mental Reactions |
|--|---|---|
| <p>1. Death of father following illness of 4 years--tuberculosis. Boy was father's favorite</p> | <p>Loss of attention Loss of security Loss of status</p> | <p>Feeling of insecurity Grief</p> |
| <p>2. Change in home conditions Now lives in basement flat--dark and dirty; meals irregular; mother works</p> | <p>Insecurity Further loss of status; deprivation of mother</p> | <p>Feelings of inferiority, embarrassment, humiliation, resentment. Jealous</p> |
| <p>3. Mother neurotic--complaining, nagging and scolding</p> | <p>No security Lack of attention Conflict with mother</p> | <p>Feeling of insecurity</p> |
| <p>4. Doesn't get on with brother</p> | <p>Conflict with brother</p> | <p>Antagonism--combative</p> |
| <p>5. Poor school progress Previously very satisfactory progress. Teacher considers him bright; has superior intelligence. Doesn't do work; no initiative. One of the youngest in his class. No friends; thinks others do not like him. Stays in house and reads</p> | <p>Conflict with school Insecurity Lack of status</p> <p>Isolation--no friends or chums</p> | <p>Feelings of insecurity Feelings of inferiority Discouraged--Embarrassed; shy, self-conscious Infantile Withdrawn</p> |

SOCIAL DIAGNOSIS:

We have here a boy whose security and status in the home was withdrawn with the death of the father. He carries this over into the school where he fails and tends to withdraw himself from group relationships so far as possible.

CASE OF: Frances Freeman

STATEMENT OF PROBLEM:

Frances, a girl of 13 years has been failing in her school work, and truanting from school. She is careless about her personal appearance. Unconfiding, sullen, and weeps frequently.

FAMILY HISTORY:

Paternal: The father, Morris Freeman, was born in Russia. He came to the United States at the age of 20, and died at the age of 40, following a serious illness of seven months; malignant tumor of the spinal column. He was the second of ten children and was especially fond of his mother. He had unusual business ability, and was more successful than other members of his family. In the United States he worked up a trade buying and selling fine leathers for upholstery.

Mr. Freeman met Mrs. Freeman, at her sister's home, the day she arrived from Russia at the age of 15. He decided at once that he wanted to marry her and finally did so six years later. They have always lived in comfortable apartments ranging from \$80 to \$150 a month rental. During Mr. Freeman's illness no expense was spared. The best specialists were called in and at his death their entire savings were gone. Mrs. Freeman had only his life insurance amounting to \$2000.

Mr. Freeman did not want children, but after they came was fond of them, always placing them second to Mrs. Freeman. He assumed almost entire care of the children, relieving his wife of every responsibility. He bought all their clothes (also Mrs. Freeman's) and directed their training.

Maternal: Maternal grand mother lived in the home for 9 years, following death of grand father. She was a semi-invalid for 15 years.

Mother: Mrs. Freeman, age 35, was born in Russia, the fourth of five girls and her father's favorite. She came to the United States at the age of 15, and married Mr. Freeman at the age of 21. She never learned to write but can read anything.

Within three weeks after her husband's death she began a beauty course in the Marinella School at a cost of \$300. She had to take oral examinations, (because she cannot write) and passed with almost "letter perfect". During the summer she established a beauty parlor of her own. Her equipment cost \$2000. She succeeded so well that she cleared \$1000 by the end of the season. She is now establishing herself in a well-equipped shop of two rooms, behind which is her apartment of three rooms. Her prices are high and she is going to cater to the wealthy patrons.

Mrs. Freeman is a rather fine appearing woman, slightly over medium build. She speaks English somewhat brokenly and in rapid excitable tones. She has always been in good health, but now feels she is on the verge of a "nervous breakdown". She has lost between thirty and forty pounds since her husband's death, is sleepless at night, and subject to depression. She says that she has been tempted more than once to end her life. According to a friend (Mrs. S.) and Frances' teacher, Mrs. Freeman is domineering, selfish, and so self-centered that she has little affection for any one else and no insight into the needs of her children. She complains of the burden the children are to her since her husband's death. She pays little attention to them and tells them that they should realize what suffering she is going through and try to make it easier for her.

MARITAL RELATIONS:

Mrs. Freeman said she never had a word of misunderstanding with her husband during their married life. She was content to have few interests outside her husband and her home and she had practically no responsibilities.

HOME:

Patient seems to have had a normal home life until the death of her father when she was 12 years old. Since the death of the father, the mother has been so wrapped up in her own experiences that she has paid little real attention to the children so that there is no longer a congenial atmosphere. Frances sleeps with her mother in a double bed.

RELIGION:

During Mr. Freeman's life the family observed certain of the Jewish ceremonies for special occasions, but they did not go regularly to the synagogue. Mrs. Freeman never goes to service now, although she still observes many of the Jewish customs in the home.

FRATERNITY:

1. Frances, 12 years old, patient.
2. Joseph, 9 years old. Normal development. Now in 4B at school; has always had excellent marks in school. He always behaved well and was never the slightest trouble till after his father's death. For several months he has been taking money from the mother's purse.
3. Cecile, 5 years old; normal development. Seems devoted to Frances who is irritable with her.

DEVELOPMENTAL HISTORY:

Frances, born 2-18-17. Instrumental birth. When six months old the parents went to Russia for a visit; they remained about one year.

The first tooth erupted when Frances was about eight or ten months old, and was accompanied by a severe convulsion. There were similar attacks until Frances was four, occurring every time a tooth came through.

At $4\frac{1}{2}$ years, she had a severe attack of the measles followed by ear trouble. At $5\frac{1}{2}$ she had chicken pox with high fever and was out of school three months. Some months later she had a severe case of whooping cough. When 8 years old she became ill and ran a temperature for six weeks (probably typhoid fever). Since this illness she has been well. Her teacher feels that Frances is not in good physical condition at present. She cries upon the least provocation, and it is felt that this is only in part due to her sense of failure and emotional upset, and partly due to overwork at home. Last winter Frances typed all her mother's notes for her course in beauty work and did much of the house work and cleaning. (This last statement is contradicted by Mrs. S., a friend of Mrs. Freeman's who

said Frances never did any house work and should long ago been taught and expected to do some.)

Frances was easily weaned, no feeding difficulties. Enuresis ceased by end of first year. Walked at 14 or 15 months. Talked at 18 months, and plainly by 2 years. (Has a light lisp, talks in a childish immature way) Developed habit of thumb-sucking but the habit was easily broken--no other habits. Appetite good. Sleeps well, though she talks in her sleep.

Lately Frances has become careless in her personal habits. Looks untidy most of the time.

SEX LIFE:

Frances first menstruated at eleven. She has been given no sex information by parents and has never asked any questions.

SCHOOL HISTORY:

Entered kindergarten when 5 years old. Was in kindergarten a whole year. She received "A" in conduct and "B" in work until she reached 2A when she received "C" in her work and conditions in reading and spelling. During one semester in second grade she was transferred to four different schools. She continued to get "A", "B+" and "B" in conduct and work until 6B when she received "C" in both. Mrs. Freeman said this was because the teacher took a dislike to Frances.

During her father's illness Frances stayed with a maternal aunt in another city where she attended the 7th grade. She had some tutoring during the summer, having been in school only part of the year. In December she was admitted to the present school and was placed in 8B on trial. She has done very poor work from the beginning though taking the commercial course which is easier than the academic. She is now in 9A. She failed 2 subjects and is trying to make them up and remain in 9A. She cried hysterically when told of her failures and said her mother must not know.

At home she tells her mother she has no studying to do and is getting along very well. Recently she has lost all interest in trying to keep up and remained away from school $2\frac{1}{2}$ days one week and 3 days the next week. She has not played truant for the last week or

two, but has been coming home from one-half to one hour late with various good excuses.

In the opinion of the teachers and principal, Frances is of limited mental capacity, and has already gone beyond her limit. When it was suggested to Mrs. Freeman that Frances might be trained by her to do beauty work, Mrs. Freeman strongly disapproved and said Frances was only a hindrance when around.

When scolded at school Frances is meek and unresponsive. She does not seem timid or self-conscious. She shows no particular interest in any boys, but is chumming with one girl who is decidedly "boy-crazy".

RECREATION AND COMPANIONSHIP:

A year before his death, Mr. Freeman had Frances begin piano lessons. She did not practice very willingly at first, but is now eager to begin lessons again. She is not at all interested in reading or sewing, and has few friends. Since her father's death, Frances has become silent and moody. She is now going with a school mate who dresses flashily.

A series of dances are being held at school on Friday afternoons, and Frances seems deeply interested in them. She plans what she will wear on those days and looks forward to them.

CONDUCT:

During her father's life Frances was a quiet, well-behaved child, offering no conduct problems either at home or school. When her failure in school became serious, she began to truant, and to show a change of attitude at home. Frances was always unconfiding, but she has become more so, and is easily irritated. She is lazy and unwilling to help her mother in any way. If her mother does not give her what she wants, she is resentful and thinks her mother selfish and stingy.

SPECIAL BEHAVIOR REACTIONS:

Frances has always been quiet and reserved, and this reserve has become extreme so that she will not confide in any one. She becomes sullen if her mother scolds her, and weeps frequently. She is irritable toward Joseph and changeable toward Cecile, snapping at

her and the next minute kissing her.

Mrs. Freeman has to speak to Frances sharply and often several times before she will mind her. Frances never dares to answer back when scolded, but her extreme unresponsiveness is baffling. Occasionally she will start to scrap with Joseph.

The only apparent constructive interests at present are her desire for piano lessons and her interest in school dances. She has spoken to her mother a time or two about quitting school and trying to find some work, but is vague about what she wants to do and receives no help from her mother.

PSYCHOLOGICAL:

Examination results show Frances to be dull normal in intelligence. She is slow but her motor coordination is accurate. She is placed far above her ability in school.

PSYCHIATRIC ANALYSIS

Ego-Libido Analysis of Frances

LIBIDO--CONSTRUCTIVE--POSITIVE:

1. Father had unusual business ability and was very successful
2. Father had very good health until about seven months prior to death.
3. Father lavished attention on patient's mother
4. Mr. Freeman took great pride in his wife
5. The family life was almost ideal during Mr. Freeman's life
6. Father had an even temperament, was never cross or irritable
7. Father showed no favoritism among his children
8. Following the father's death, the mother took a Marinello Beauty course and opened a shop, which was successful.

CONSTRUCTIVE--NEGATIVE:

(None noted)

LIBIDO--DESTRUCTIVE--POSITIVE:

1. Mr. Freeman handled all the buying for the mother and the children (He planned the meals and ordered the groceries)
2. The father was so devoted to the mother that he resented the coming of the children, although later he was devoted to them.
3. The father assumed almost entire care of children, relieving the mother of responsibility
4. The father lavished the family with presents
5. The children were always second to his wife
6. Mother was her father's favorite. She received the adulation of her parents and friends.
7. Cecile is devoted to Frances who is quite irritable toward her
8. Several severe illnesses
9. Convulsions with teething up to four years of age
10. Cries upon least provocation

11. Cries hysterically when school failures are mentioned and says her mother must not know of it
12. Truanted from school
13. Comes home late from school with various excuses
14. Teachers consider Frances of limited mental capacity and that she has gone far beyond her limit
15. Chummy with a girl who is "boy crazy" while she herself apparently is not interested in boys.
16. Easily irritated
17. Lazy and unwilling to help her mother
18. Is resentful if her mother does not give her what she wants, and thinks her mother selfish and stingy
19. Sullen after mother scolds her and weeps frequently
20. Irritable toward Joseph; changeable towards Cecile
21. More fond of father than of her mother

LIBIDO--DESTRUCTIVE---NEGATIVE:

1. Father died a year ago after a serious illness of seven months
2. Maternal grand-mother a semi-invalid for 15 years before her death, lived for about 9 years with patient's family
3. Patient's mother and her family are selfish and self-centered
4. Patient's mother is domineering, and so self-centered that she has little affection for anyone else.
5. The mother has no insight into the needs of her children
6. Mrs. Freeman feels her children are a burden to her
7. Since the father's death there is no longer a congenial home atmosphere
8. Frances sleeps with the mother
9. For several months, Joseph has been taking money from his mother's purse

EGO--CONSTRUCTIVE--POSITIVE:

1. Patient eager to start music lessons again
2. Easily weaned
3. Enuresis ceased at end of first year
4. Walked at 14 or 15 months
5. Talked at 18 months
6. Good appetite; sleeps well
7. Entered kindergarten at age of 5

8. Frances looks forward to school dances on Friday after noons and plans what she will wear
9. No conduct problem during father's life either at home or school
10. Motor coordination good
11. Friendly

EGO--CONSTRUCTIVE--NEGATIVE:

(none noted)

EGO--DESTRUCTIVE--POSITIVE:

1. Frances is not interested in reading or sewing
2. Several severe illnesses--convulsions with teething up to 4 years of age
3. Cries upon least provocation
4. Untidy in appearance
5. Truanted from school
6. Doesn't do home work.
7. Meek and unresponsive when scolded
8. Plenty of excuses to give for cutting classes
9. Inattentive in class
10. Indifferent to class mates
11. Has few friends
12. Always unconfiding and growing more and more so
13. Is easily irritated
14. Lazy and unwilling to help mother
15. Doubt average intelligence
16. Always quiet and reserved, but reserve has become extreme
17. Becomes sullen if mother scolds and weeps frequently
18. Rather shy
19. Lisps, talks in childish immature way

EGO--DESTRUCTIVE--NEGATIVE:

1. Instrumental birth
2. Poor school marks

DIAGNOSIS:

Frances misses her father and the security she had in him. She is unable to find any security in her self-centered, infantile mother, nor does she find it in her

school or the school work. She is expressing her insecurity through the medium of easy crying and provocation, her irritable manner, truanting from school, refusal to do home work, untidy appearance, and the lisp and immature childish way of talking--all a positive destructive ego value because all are attention-getting mechanisms. The primary mechanism used is a protective one, protecting the ego to make up for her feeling of insecurity since the removal of her father.

SOCIOLOGICAL ANALYSIS

| Concrete Situations and Events | Social Relationships | Probable Mental Reactions |
|--|--|--|
| <p>1. Father assumes most of the responsibility for care of children; relieves the mother of responsibility Congenial family</p> | <p>No conflicts Status Attention from both parents</p> | <p>Feelings of security in father</p> |
| <p>2. Death of father following seven month's illness</p> | <p>Loss of attention from father and mother; loss of status</p> | <p>Feelings of insecurity</p> |
| <p>3. Mother absorbed in own loss and herself; mother goes into business Considers children a burden</p> | <p>Deprived of mother Conflict with mother, siblings; insecurity; resistance against changed home situation; Loss of status; subordination</p> | <p>Feeling of insecurity Jealous, antagonistic Resentful, bitter, withdrawn; feelings of inferiority; sullen</p> |
| <p>4. Failure in school; truancy; dull normal intelligence; late getting home from school; refuses to do home work; Lazy and unwilling to help mother. Irritable toward sibs; weeps frequently. Unconfiding quiet, reserved; few interests; lisps, childish talk; untidy</p> | <p>Conflict with school, mother, sibs; insecurity. Isolation--few friends or interests; lack of status; insecurity</p> | <p>Feelings of inferiority and insecurity; jealous, resentful, bitter, sullen, shy, reserved, timid; Discouragement, humiliation, embarrassment. Feelings of inferiority and insecurity</p> |

SOCIAL DIAGNOSIS:

The father's death destroyed a happy home situation, leaving the girl without security, affection, or attention, since her mother's attention was also withdrawn. This sudden change completely disrupted the girl's life organization. Her low intelligence was a further handicap to successful readjustment. Hence it was natural for this general disorganization to be carried from the home to the school.

CASE OF: Bill Carter

STATEMENT OF PROBLEM:

Bill has been stealing, truanting from school, and doing very unsatisfactory school work. He is unresponsive to appeals of any kind.

FAMILY HISTORY:

Paternal: The paternal grand father was one of a family of 16 children. He was born in the United States; died at the age of 49--paralysis.

The paternal grand mother re-married and is living with the youngest of her 14 children.

Father: Samuel, age 41 years, was born in the East. He finished 5th grade in school. At present he is employed as a head mechanic for the American Railway Express. He works nights from 12 to 8 A.M. His earnings average \$50 per week.

He is very much interested in his children and cares a great deal for them. He says he was "nearly crazy" when Bill got into trouble. He went to see the boy's teacher, the minister, and finally took Bill to a doctor for a general examination to see if there was anything "wrong" with him. He doesn't like the school because most of the children are foreigners and he doesn't like to have his children associate with foreigners.

Maternal: Maternal grand father, born in United States; died at age of 61.

Maternal grand mother, age 65, is living with some of her unmarried children.

Mother: Anna, age 40, finished 8th grade in school. She has been married to Mr. Carter for 15 years.

She is a slovenly, pleasant faced woman, of extremely easy going habits. Is lazy, sleeps late, and does as little work as possible. Seems to be fond of the children and they are very fond of her. She allows them to do as they please, and they go dirty and unkept.

Very recently there has been a change in Mrs. Carter's appearance; she has cut her hair, and is using rouge and lip stick. With all this she has assumed a "kittenish air". The neighbors suspect Mrs. Carter of having a "gentleman

friend". At one time Mrs. Carter was away for a week and the neighbors suspect she was away with her "friend".

MARITAL RELATIONSHIP:

The parents seem to have affection for each other, and consult one another on matters concerning the children. Mr. Carter has higher standards, and his wife's slovenly housekeeping annoys him at times.

RELIGION:

Father Roman Catholic, seldom attends church. Mother and children attend Episcopal Church.

HOME:

The family live on the first floor of a cheap tenement. They have four rooms. All these rooms have outside windows. The house is very dirty and untidy.

Bill sleeps with a brother in a double bed which almost fills the small bed-room.

FRATERNITY:

1. Samuel, age 16. When about 3 or 4 years old he fell from the curb onto a piece of glass and it caused the loss of his left eye. He has an artificial eye and wears glasses. He is his mother's favorite and sleeps with her.

He has never done any stealing or been a conduct problem in school, but for past year has not shown any progress. Results of a mental test show an I.Q. of 101. He has repeated 6B and 6A grades.

He belongs to Boy Scouts and a boy's club at the Episcopal Church. Is a choir boy at the Church.

2. Bill, patient, 14 years.

3. Harold, age 12. He was kicked by a horse two years ago, and injured back of his ear. Three weeks ago he was operated on for mastoid.

4. Richard, age 5; is in kindergarten

-5. Marguerite, age 4

6. Mary, age 2

DEVELOPMENTAL HISTORY:

Bill, age 14. Normal development, walked at about 9 months. Talked early and had first tooth before 7 months old. Enuresis till 7 years old and still has occasional trouble. Health history is good. When 4 or 5 years old he was run into by an auto and had a concussion of the knee. Knee is stiff. Is a restless sleeper, talks in his sleep.

SCHOOL HISTORY:

Entered school at age of 5 years. Had 3 school changes in first 2 grades. Repeated 4B and 4A. Conduct in lower grades "A"; now is "C" and "B". I.Q. on a Haggerty test is 104.

Last year gave much annoyance in school by untidiness, eating crackers in school, tardiness, poor work, indolence, and indifference. He does work "just good enough to win promotion."

CONDUCT:

Bill was reported to the school office for stealing a toy, and also for taking his teacher's desk keys. A few months later he and some boys from the Parochial School went into the Church basement and stole a quantity of yellow candles. He brought these to school and was distributing them among his friends when the teacher caught him. Later he was reported for writing "nasty notes".

RECREATION AND COMPANIONSHIP:

Bill plays on the streets with other children from after school till 5 o'clock when he has to go into the house. He goes to bed at 7. He is very much interested in reading. On Wednesday afternoons he goes to the Church to play for an hour or so under supervision. The father is very generous and the children have many toys and games. Bill is very popular with the children and likes to play with them. He helps his mother a great deal around the house. When his mother doesn't get up in the morning, Bill cooks the breakfast. He usually washes the dishes at night and gets in the wood.

PSYCHIATRIC ANALYSIS

Ego-Libido Analysis of Bill

LIBIDO--CONSTRUCTIVE--POSITIVE:

1. Parents fond of children
2. Father generous in buying toys and games
3. Parents appear to have a healthy attitude toward Bill

LIBIDO--CONSTRUCTIVE--NEGATIVE:

(None noted)

LIBIDO--DESTRUCTIVE--POSITIVE:

1. Sam is mother's favorite and sleeps with her
2. Mother demonstrates her affection for Sam
3. Mother inclined to be unstable, frivolous, recently changed manner of dress; suspected "gentleman friend"
4. Enuresis till 7 years old and about once a week at present time.
5. Knocked down by auto when 4 or 5 years of age. Concussion of knee
6. Untidy
7. Talks in sleep; nervous
8. Father greatly disturbed over Bill's behavior

LIBIDO--DESTRUCTIVE--NEGATIVE:

1. Father works at night; sleeps in daytime

EGO--CONSTRUCTIVE--POSITIVE:

1. I.Q. 104; good intelligence
2. Developmental history normal
3. Breast fed
4. Interested in reading
5. Popular with other children; likes to be with them
6. Helps mother around the house
7. Good natured boy

EGO--CONSTRUCTIVE--NEGATIVE:

(None noted)

EGO--DESTRUCTIVE--POSITIVE:

1. Dishonest--steals--is "sneaking"
2. Fails to respond to appeal of any kind
3. Father is antagonistic toward the school
4. Impatient, impulsive, easily discouraged
5. Frequently tardy to school
6. Poor school work. Does just enough to get promoted
7. Indolent, indifferent
8. Writes "nasty" notes
9. Requires much urging in school; not very cooperative;
wastes time
10. Truant
11. Hates school and teachers

EGO--DESTRUCTIVE--NEGATIVE:

1. Feels inferior
2. Nervous--restless
3. 3 school transfers
4. Repeated 4B and 4A
5. Undersized
6. Lacks confidence; feels he will fail anyway

PSYCHIATRIC DIAGNOSIS:

We have a small boy (undersize for age), handicapped with a stiff knee, with a feeling of inferiority. He is jealous of his brother and is compensating for these feelings by making use of a regressive infantile mechanism, primarily on the libidinal side in order to continue his dependency. His secondary mechanism is a protective one on the ego side.

| Concrete Situations and events | Social Relationships | Probable Mental Reactions |
|--|--|--|
| <p>1. Run into by an auto when 4 or 5 years old. Concussion of knee--stiff knee. Undersized boy. Made over by playmates</p> | <p>Recognition (status) Insecurity</p> | <p>Feelings of inferiority Antagonistic Resentful; bitter</p> |
| <p>2. Mother's favoritism for older brother, who sleeps with her. Attempts to win mother's favor by helping her around the house</p> | <p>Conflict with brother; lack of status</p> | <p>Jealous; attempted compensation; feeling of insecurity, inferiority; bitter--resentful</p> |
| <p>3. Mother frivolous--probably going out with "gentleman friend"; neighbors talk</p> | <p>Lack of status</p> | <p>Feeling of inferiority</p> |
| <p>4. Father interested but not assuming active role. Works at night; sleeps in day time</p> | <p>Lack of status, security, and attention</p> | <p>Feeling of inferiority Feeling of insecurity</p> |
| <p>5. Poor school success. Just manages to pass. Repeated 4B and 4A. Reads library books. Hates school and teachers</p> | <p>Conflict with school. Insecurity; lack of status</p> | <p>Embarrassment; humiliation; discouragement; compensation; feeling of inferiority and insecurity</p> |
| <p>6. Stealing and dishonesty at school. Stole candles from Catholic Church; truancy; tardiness</p> | <p>Conflict with environment, school, home, Church; insecurity; lack of status</p> | <p>Combative; resentment; bitter; feelings of insecurity and inferiority; compensation</p> |
| <p>7. Popular with other children. Is well-liked, tho he bosses the gang</p> | <p>Status in juvenile group</p> | <p>Feeling of security and superiority</p> |

SOCIAL DIAGNOSIS:

We have here a boy who does not get the attention he craves from his father, who is too busy, or from his mother who gives her attention to her own affairs and an older brother. This boy has neither status nor security at home or school, although in his play group he does have status.

IV. CONCLUSIONS

In the analysis of the preceding cases we have followed first the psychiatric outline for analysis, with its individual approach, and second the sociological with its group approach. It has been our purpose to determine, if possible, the differences and the likenesses in these two approaches and methods of analyzing human behavior problems.

Their likeness lies particularly in their interest. Both the psychiatrist and the sociologist are interested in the human being, and his inter-relationships. While the psychiatrist emphasizes the emotional development and the personality of the individual in relation to his behavior, the sociologist emphasizes the adjustment of the same individual in his relation to other individuals and to his group.

In each of these fields there has developed a more or less distinctive characteristic lingo or terminology. The psychiatrist talks mainly about mental mechanisms and uses such terminology as "conflicts and repressions", "inferiority" and "superiority complexes", "Oedipus and Electra complexes", "infantile regressions", "compensation", "identification", "projection", "transference", "sublimation",

"wish fulfillments", "flight from reality", "rationalisation", "ego-libido satisfactions", "introvert" and "extrovert". Whereas the sociologist talks mainly of processes of interaction, in terms of "isolation", "contact", "communication", "competition and conflict", "accomodation", "super-ordination", "subordination", "cooperation", "avoidance", "assimilation", and "social control".

The main difference in these two approaches, appears to be in their emphasis; the psychiatric upon the individual and his related environment; the sociological upon the individual's total social environmental situation in its relation to him. While it is obvious that both the psychiatrist and the sociologist start from a situation of concrete events, it is from this point that there is a divergence in method and process. The psychiatrist makes inference about the emotional life of the individual, while from the same objective data, the sociologist makes inference about the social relationships and group life.

For treatment purposes it is necessary to take into account both types of inference and view the maladjusted person with reference to both his inner mental life and the outer social environment. For scientific purposes we may

take the detail apart in so far as it seems practical.

This is what the sociologist, as a scientist does.

Another type of difference lies in the distinction between the two fields. Psychiatry, while built upon society as a background, is an art and the psychiatrist is a practitioner, whereas sociology is a science, and the sociologist is a scientist and research worker. The psychiatrist attempts to regulate individual behavior and self-control, whereas the sociologist is interested in manipulation of group behavior and social control. At present the psychiatrist is primarily the practitioner whereas the sociologist is the scientist in the field of research.

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