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THE PSYCHIATRIC CLINIC IN THE TREATMENT OF CONDUCT DISORDERS OF CHILDREN AND THE PREVENTION OF JU- VENILE DELINQUENCY¹

VICTOR V. ANDERSON²

INTRODUCTION

A noticeable swing of the pendulum is taking place in the application of psychiatry to social problems. The early phases of interest centered around the recognition of the insane and the feeble-minded, and, until recently, the conception of psychiatry's position in delinquency was limited to the classification of the mentally handicapped.

For a period of years, most of the contributions in this field called attention to the striking frequency of mental disease and feeble-mindedness among the inmates of penal and correctional institutions and offenders coming before the courts. These studies, though radical and extreme and based upon superficial data, certainly served to call attention to the fact that insane and feeble-minded persons, whether found in 75 per cent or in 10 per cent of the population of institutions or in the "run of the mine" of the courts, were being bandied about from place to place, and were spending the greater part of their lives in and out of prisons, jails, and almshouses.

The great pity of it all was that whatever chance of recovery or social adjustment there may have been in any of these cases was usually lost sight of until dementia in the mentally sick and character deterioration in the mentally defective had become so marked and fixed as to render remedial work hopeless.

But it began to be appreciated that psychiatry could aid institutions and courts in determining the presence of insane and feeble-minded persons, and this sort of service began to be supplied. It was seen that the psychiatric classification of the inmates of penal and correctional institutions, and of individuals passing through courts, rendered a very practical as well as humane service to the public.

Boston, Chicago, Philadelphia, and other cities began to develop psychiatric clinics for their municipal courts. Certain state prisons and reformatory institutions secured the services of psychiatrists as

¹Read before the New York Psychiatric Society, June, 1923.

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permanent members of their staffs. And so it was, so far as delinquency was concerned, for a period of several years psychiatrists concerned themselves mainly with the issues involved in classifying and tagging the mentally handicapped.

More conservative and careful studies brought out the fact that mental disease and mental defect are less frequent among delinquents than had at first been thought, but that many other conditions, both constitutional and environmental, are to be reckoned with as determining factors in delinquency—conditions that affect the physical health and the emotional life which form the very basis of character and act as the driving forces in behavior.

Recent studies made by the National Committee for Mental Hygiene in connection with juvenile courts and delinquent institutions have brought to light information of the utmost importance. These investigations and the splendid work done by others are changing our whole conception of the role of psychiatry in the field of delinquency.

A recent mental-hygiene survey in Cincinnati, in which each juvenile delinquent received a careful physical, psychiatric, psychological, and social diagnosis, is significant in its bearings upon this question. In a study of the "run of the mine" of the juvenile court of that city, we found that feeble-mindedness was present in only 8 per cent of the cases; 63 per cent of the children had an intelligence quotient above 80. We did not feel that inferior intelligence had a very important part to play in the delinquent conduct of these children.

As pointed out in the report of this Cincinnati survey, a very great variety of individual and environmental factors entered into the career of each child. Serious mental conflicts, mental maladjustments, emotional complexes, unhealthy mental imagery, various physical disorders, bad home influences, were constant factors. Sixty per cent of these children had parents who had already been problems to the various social organizations of Cincinnati, in some instances a great many times. Seventy per cent came from homes in which parental conditions and parental control received the very lowest possible ratings; desertion on the part of the father or mother, bad moral influences exercised by one or both parents, total lack of proper supervision of the child, were marked in these cases. Of the girl delinquents who passed through this court, 90 per cent came from such homes. We were impressed by the fact that the most important influences in the lives of these children were not to be found in the material conditions of the home—its sanitation, and so forth—but in the personalities with which the children daily came in contact, in the moral, intellectual, and re-

ligious atmosphere of the home, in character training, parental control, and supervision. These factors, we believe, have much to do with the formation of character and the development of personality, and here is the crux of the problem so far as the delinquent child is concerned. Eighty-four per cent of these juvenile-court children showed character defects and serious personality difficulties of such a nature as undoubtedly to constitute important factors in their delinquent behavior. We may regard these personality handicaps as the covert mechanisms that, under certain stimuli, issue later into overt behavior.

The great importance of physical health as a factor in the careers of delinquent children was evident from the frequency with which physical disorders were found. Eighty per cent of the Cincinnati cases suffered from physical disease, physical defect, or physical ill health. It is interesting to note that 14 per cent were suffering from heart conditions. Endocrine disorders, kidney conditions, and other important physical disturbances were not uncommonly found. The relation of these findings to the mental health and adjustment of the individual needs no discussion. Physical health and mental health are two aspects of the same thing—the expression of a well-adjusted human machine. It is our opinion that the basis and foundation of personality are in the physical organism and that mental balance and mental health are not possible in the absence of physical health.

If there is anything to be said in regard to the recent developments of psychiatry in delinquency it is this: psychiatry is not interested merely in the determination of feeble-mindedness, insanity, and epilepsy among delinquents, and is not concerned merely with the classification of individuals—with pigeonholing them and giving them Latin designations. Treatment and ultimately prevention have ever been the aims of scientific medicine; these seem now to be the dominant aims in the field of psychiatry. We have left behind us the period when we were satisfied with merely calling an individual something—with simply diagnosing him and then leaving him to his fate.

The contribution of psychiatry is to the study of the individual as a whole, in order to determine all of those factors, intrinsic as well as extrinsic, that influence his life behavior, and to map out, in the light of a psychiatric understanding of his case, a well-rounded plan of treatment. Psychiatry has an interest and is seriously concerned in the study and treatment of delinquent behavior as such, without any reference to whether disease or defect is an explanation of that behavior.

I think the mere fact that this branch of medicine has only recently come from the state hospital and has brought along with it the

state hospital's conception of the limitations of psychiatry has had much to do with its point of view in attacking delinquency, and necessarily has greatly limited the scope of its service.

But mental disease and mental defect are only some phases of the various problems with which this branch of medicine is concerned. Psychiatry devotes itself to the study and treatment of human behavior, particularly that form of human behavior that is now, or may later become, inimical to the welfare of the individual and society. The only difference between the psychiatrist and any other physician is that the former concerns himself with the whole individual, as an integrated organism—not so much with the heart, or lungs, or skin, or gastro-intestinal tract, or the nervous system itself, but with these organs as a whole, as an integrated piece of machinery adjusting itself to its environment and expressing itself in behavior.

The psychiatrist approaches the problem of conduct with the idea of finding out and seeking to correct the various causes of maladjustment. These may be purely psychic, or they may be largely an expression of physical ill health—of fatigue, nutritional disturbances, metabolic changes, or disorders of the ductless glands—or they may be environmental in origin.

It is not our opinion that what we speak of as character is an inherited, fixed, permanent, and unmodifiable entity, but that it is the product of the life experience of the human organism, and is subject to change, modification, and treatment. Character is something that is largely molded by the environment and may be affected for good or for ill.

Psychiatry, then, is not a narrow specialty dealing solely with the care and treatment of the insane and feeble-minded; it is an intensely human branch of medicine concerned with the affairs of everyday life, and it bids fair to play no unimportant part in the solution of human welfare problems. Though in the past the contribution of psychiatry has been largely in the fields of mental disease and mental defect, there is now a rapidly growing interest in the application of its knowledge to other conditions—to the subject of delinquency and dependency as such, to industrial, educational, and other welfare problems.

Already a fund of information is at hand, from contributions made by psychiatry and psychology, that justifies us in believing that the causes of failure in individuals can often be ascertained by the application of scientific methods of inquiry; and that, through competent psychiatric, psychological, and social diagnoses, factors that tend to

produce delinquent careers can be discovered early, and sound and constructive methods or treatment and prevention applied.

We need not recite here facts that have already been presented over and over again, with regard to the striking frequency, cost, and menace of the crime problem. Of the most profound significance in the entire situation is the fact that the great majority of all criminal careers begin in childhood. Dr. Thomas W. Salmon has well said: "We think of the greatest woes of childhood as destitution and disease, but delinquency, of a degree requiring the attention of courts and officers of the peace, shadows the lives of more children than do some of the most prevalent and serious diseases, and the danger of entering upon criminal careers is a more threatening one than is hunger or bodily neglect. If this great burden that rests now upon childhood and youth and later will be borne by society in general can be even partly lifted, the task is one of the most pressing duties of the day."

Nowhere have we sought to apply on a large scale to the prevention of delinquency in children those same scientific methods that have been so successful in dealing with other human problems. Nevertheless, a considerable body of knowledge is at hand that makes it possible to explain and, in a measure, modify the anti-social conduct of delinquent children.

In order that the benefit to be derived from the application of the new methods of approach to the problem of delinquency may be made available to juvenile courts, public schools, and other agencies in the United States, the Commonwealth Fund of New York City has undertaken a five-year program in the prevention of delinquency. This program is probably the most noteworthy undertaking that has ever been entered upon in the way of striking at the roots of crime and juvenile delinquency. It provides for a joint campaign on the part of four national organizations, each with a specific task. These agencies are the New York School of Social Work, the National Committee for Mental Hygiene, the Public Education Association, and the Joint Committee on Methods of Preventing Delinquency.

To quote from Mr. Barry C. Smith, the author of this program, who is general director of the Commonwealth Fund: "Only very recently has there come to be some conception that early study of the individual who is out of adjustment, scientific diagnosis of his social difficulty, may make possible a considerable degree of prevention; that carefully differentiated treatment—physical, mental, and social—based on such diagnosis, may produce results quite as salutary as may be found in the physician's practice, may even direct many a young

offender on the pathway toward good citizenship instead of toward the life of the 'repeater.' To the Commonwealth Fund it has appeared that for the child who is tending toward delinquency, who fails to 'get along' in his school, home, or neighborhood environment, who is troublesome or 'different' or 'maladjusted,' who comes for the first time before the juvenile court—for him the greatest single need is that he be accurately and adequately understood; that his problems, difficulties, and motives be appreciated—in short, that the decision as to what is the best thing to do for him be based on a thoroughgoing knowledge. Therefore, the Fund has chosen to concentrate its efforts in the following directions:

"1. To develop the psychiatric study of difficult, pre-delinquent, and delinquent children in the schools and the juvenile courts, and to develop sound methods of treatment based on such study.

"2. To develop the work of the visiting teacher whereby the invaluable early contacts which our school systems make possible with every child may be utilized for the understanding and development of the child.

"3. To provide courses of training along sound lines for those qualified and desiring to work in this field.

"4. To extend by various education efforts the knowledge and use of these methods."

That phase of the program known as Section II provides for the creation of a new division within the National Committee for Mental Hygiene. This division is known as the Division on the Prevention of Delinquency and is charged with the responsibility of demonstrating, through the medium of three clinics, the value of psychiatric service in the study and treatment of conduct disorders in children. Two of these clinics are traveling clinics and move from city to city giving demonstrations. These demonstrations are free and are available to any city in the United States.

These clinics are staffed by psychiatrists, psychologists, psychiatric social workers, clinic managers, and stenographers, and will remain from six to twelve months in each city for a demonstration of the methods and technique employed in studying and adjusting delinquent and pre-delinquent children. Such clinics will concern themselves with stimulating social agencies, courts, schools, and institutions to carry out the most modern and effective means of treatment.

Naturally, the selection of cities for demonstrations will depend largely upon the interest manifested in establishing permanent clinics. The selection will also be largely determined by the degree of develop-

ment already attained in the matter of understanding modern methods of child welfare work. A successful demonstration naturally will depend upon existing facilities, such as a well-equipped probation department, good medical clinics and hospitals, well-organized agencies for dealing with childhood problems, progressive school systems, organizations of Boy and Girl Scouts, Big Brothers, and such other resources as would make possible an effective campaign in the prevention of delinquency. The degree of development and the use that can be made of such agencies will measure the amount of treatment that can be accomplished.

Following upon the announcement of this service, requests for demonstrations were made by a great many cities throughout the country. These requests came mainly from public officials and social agencies.

St. Louis was selected for the first demonstration, and by April, 1922, a clinic had been opened in that city. Commodious quarters, conveniently located, consisting of a series of attractive, well-equipped offices, were provided for us by the city in the Municipal Courts Building.

Splendid co-operation was shown by the hospital division of the department of public welfare, the department of health, the probation department of the juvenile court, the medical department of the public schools, Washington University, the Missouri School of Social Economy, and other bodies and agencies in the city. Various laboratory tests, such as blood Wassermann, basal metabolism, X-ray, and the like, were made at no cost to the clinic staff. Two physicians for physical examinations were furnished by the medical department of the public schools. The part-time services of local psychiatrists and neurologists were given to the clinic. Students in psychology and in social work were taken on from Washington University and the Missouri School of Social Economy for purposes of training. (As a result of this, both institutions decided to give credit toward degrees to future students taking practical work in the permanent clinic, and at the present writing both have students under training in the St. Louis clinic.) Two probation officers were attached to the clinic by the probation department of the juvenile court. One social worker from the Board of Children's Guardians and others from various bodies in the city were placed for training purposes. All work was done under supervision by the clinic director and by the head of the appropriate clinic department. Conferences were held on specific questions as occasion demanded and staff conferences came regularly.

Each volunteer social worker received an outline of the points to be covered in the investigation and reports were read and corrected by the chief psychiatric social worker before they were incorporated in the clinic record. The training in case-record making was planned to develop ability to select significant facts, to arrange and present information in orderly fashion, and to describe accurately and concretely. In actual contacts with parents and children, the aim of training was to make the volunteer increasingly alert to detect signs of trouble in the mental life of his client and increasingly perceptive of the subtle values of personality interplay in the home and school environment of the child.

Physicians, psychologists, and psychiatrists had the opportunity of observing approved methods of examination and treatment and of discussing diagnoses and recommendations. Each gained also by contact with the other types of clinic workers. The value of the social-service investigations to the physician, the futility of attempting to grade a child psychologically without knowledge of medical and psychiatric conditions, the influence of the mental attitude of the patient upon his health, these were among the points on which a definite educational campaign was waged. Particular attention was given to the technique of handling children as distinguished from adults.

The case conferences conducted by the demonstration clinic were of three sorts—those for the staff only, those to which volunteers were admitted, and those held when agencies were in doubt as to the best means of effecting some change in a child or his environment and wanted a consultation. A fourth type of case conference has now been developed in the Dallas and Norfolk demonstrations (which are being conducted by this division), at which typical cases are presented for general discussion and to which any responsible adult may be admitted, particularly teachers, medical men, probation officers, and social workers.

The value of a case conference from the educational standpoint depends upon the skill with which the discussion is directed. In competent hands every significant point in the case can be impressed upon the mind of the new worker, not only with reference to its direct practical bearing upon the special situation under consideration, but as illustrative of the underlying principles of psychiatric social work. New sources of information can be opened up, new methods of obtaining results can be explained.

The placing of probation officers and social workers in the clinic for a period of training is strongly recommended. In cities where

there is a university, the great opportunities offered to medical students, psychological students, and students in sociology, in securing practical work in social psychiatry, clinical psychology, and social case-work, are obvious. University authorities should need no urging to utilize these resources.

While the demonstration emphasized the great importance of well-rounded clinical studies in the adjustment of delinquent children passing through the juvenile court, the clinic itself was open to and daily served many other agencies in the city, notably the Board of Children's Guardians, the Children's Aid Society, the Provident Association, Big Brothers' Organization, and the Bellefontaine Farms for Delinquent Boys. But most of all did it welcome parents who, frequently of their own accord, brought their children for study and advice.

METHODS EMPLOYED

Each case received an initial study covering from two to five days. (This does not mean that the entire clinic group was employed from two to five days on one case, for different examiners were responsible for different cases.) A very complete physical (including the various special laboratory tests), neurological, psychiatric, psychological, educational, and social study was made of each child. The social investigation made by the psychiatric clinic differs from that usually made by probation officers or other social case-workers chiefly in the special emphasis that it lays upon facts related to the physical and mental development of the child, his family, his immediate ancestry, and the mental attitude of the individuals who make up the little world that surrounds the child. It seeks to record the interplay of personalities and to find there, as well as in the concrete evidences of care or neglect that the home affords, the causes of maladjustment or unhappiness.

When all the facts were in, a conference was held by the various clinic workers concerned in the study—the psychiatrist, the physician who made the physical examination, the psychologist, and the psychiatric social worker. At this conference, the entire case was discussed and a summary report of all the findings, together with recommendations, was prepared. This report was given to the court, the probation officer, the social worker, or other person who referred the child for study. Each report included suggestions for treatment along the following main lines: medical, psychiatric, educational, and social. A monthly follow-up form was used by the clinic in which the clinic, through the services of one of its psychiatric social workers, endeavored to find out how well those who referred the children for study

were carrying out the recommendations for treatment. Considerable thought was given by this follow-up worker to the matter of tactfully stimulating and inspiring others to do better social work. This question of treatment is one to which we have given much concern and upon which we have laid much stress, not that the clinic alone and of itself can ever effectively work out and administer treatment, but that, through its understanding insight into the disabilities and assets of the child and his environment, a constructive and effective method of treatment may be evolved by the clinic and employed by the agency that referred the child.

This question of therapeutics has been the great shortcoming, as we see it, in clinical work of this sort throughout the country. In visits to out-patient departments of hospitals and to other clinics, we have been struck with the lack of follow-up work—the failure to check up the results of recommendations. Many valuable experiments in studying the causes of delinquency have failed to obtain satisfactory practical results because the diagnostic study was never fairly tested out in adequate medical, psychiatric, and social treatment. Above all, there has been no social case-work that has compared with the diagnostic end of the study, that has carried into the daily treatment of the case the psychiatric and psychological understanding of the individual. This divorce of clinical diagnosis from case treatment has been the great stumbling block in the way of practical results in dealing with delinquents. We know of several juvenile courts in this country where reasonably good clinical diagnoses are being made, but there is a gap that amounts to complete separation between this fundamental phase of the work and the treatment of the children that is being carried out by the probation officers. If such methods were employed in dealing with sick people, it would be a calamity. It is no less a calamity as far as the delinquent child is concerned. Certainly, such unintelligent separation of diagnosis and treatment need never occur if a close relationship is continually maintained between clinic workers and those who are conducting the social treatment of the child. Frequent consultation, continual checking up of the therapeutic methods employed, and further studies of the child are essential if successful results in treatment and prevention are to be accomplished.

As time progressed in the St. Louis demonstration, it became evident that different types of clinic service were needed in different situations and that in comparatively few instances did the clinic need to assume the entire responsibility for treatment.

The committee on clinic methods of the Commonwealth Fund pro-

gram has worked out a classification of types of service rendered which has been adopted by all the clinics operating under this program. It is reproduced here as giving a good idea of the St. Louis situation:

1. Consultation Service. If the clinic's contacts with the child cease after its recommendations are transmitted to the proper authorities or to the agency or individual referring the child, the clinic is giving a consultation service rather than treatment.
2. Follow-up Service. If the clinic through its own employees informs itself from time to time of the progress of a child thus cared for by another agency, but gives no further advice to the agency, it is establishing a follow-up service in the interests of its own records. It is realized that incidentally the knowledge that the clinic continues its interest in the child may stimulate the co-operating agency to better work.
3. Advisory Service. If, in addition to informing itself as to the progress of a child, the clinic either volunteers advice or gives advice on request as to further treatment of the child without bringing the child again before the clinic, it may be said to furnish advisory service.
4. Co-operative Treatment. The service rendered when a child for whom a co-operating agency assumes full responsibility is brought by that agency to the clinic for psychiatric or other treatment following the diagnosis may be called co-operative treatment.
5. Clinic Treatment. The service rendered when the clinic assumes full responsibility for putting into effect its own recommendations in the case of any child may be called clinic treatment.

GENERALIZATIONS FROM STATISTICAL MATERIAL GATHERED

CLINIC CASES

Approximately 300 children were given intensive clinical study during the period of our demonstration. Of the 300 cases, we had completed work on 250 up to the date of gathering this statistical material in shape, and at present all of the material on these cases is available in our records for a well-rounded statistical study. Some of the most outstanding facts we are giving in the present report, and we are planning a more complete study later on.

Of the 250 children studied, 186, or 74.4 per cent, were boys, and 64, or 25.6 per cent, were girls. Two hundred and twenty-three, or 89.2 per cent, were white, and 27, or 10.8 per cent, were black. It will be seen that the percentage of negro children in our clinic cases is approximately the same as the percentage of negroes in the general population of St. Louis as given in the 1920 census, in which 9 per cent of the population were negroes.

A larger percentage of native-born children of native-born parents were referred to the clinic than the population of St. Louis would warrant, 59.6 per cent of the clinic cases being native-born whites of native-born parents, while the 1920 census of St. Louis showed that 46.5 per cent of the general population were native-born whites with native-born parents. A smaller percentage of the clinic cases were foreign-born children than the population would warrant, 4 per cent of the clinic cases being foreign born, while 13.4 per cent of the general population were foreign born.

The ages of the children varied from three to over twenty years, the median age falling at fourteen years—at the very portal of adolescence, the period of stress and strain when the human machine is undergoing powerful changes, when the mental life and the personality of the child are shaping themselves for adjustment to the great problems of life. It is at this period of life that conduct disorders manifest themselves in socially unacceptable and delinquent behavior that later on, if unchecked, develops into what we call a criminal career.

Developmental History

The important thing to bear in mind in the study of these children is that in no instance did their difficulties develop all of a sudden and out of a clear sky. Our investigations of their early childhood and infancy disclosed many important facts that serve to throw light upon their behavior later. Approximately 43 per cent had suffered from severe illnesses or prolonged ill health throughout infancy and childhood. Ten and one-half per cent have had severe injuries, particularly to their heads; approximately 32 per cent had for years suffered from enuresis; 20 per cent had exhibited throughout childhood periodic attacks of temper and had suffered from night terrors; 26 per cent were acknowledged masturbators; 28 per cent were confirmed smokers; the great majority had been retarded in school throughout their school careers. In short, a study of their lives showed that a very large number of these children had for a period of several years presented some sort of problem, either in physical health, personality and character make-up, school retardation, or behavior.

Two and four-tenths per cent had never gone to school; 80, or 32 per cent, had left school and were out in the community either in industry or at home; 19, or 7.6 per cent, were in special classes for subnormals; and 145, or 58 per cent, were in the regular grades.

Behavior

An analysis of behavior histories showed that 154 children were charged with stealing (ranging all the way from simple thefts in the home to the stealing of automobiles); 25 children were charged with burglary; 79 with truancy; 82 with frequent running away from home; 66 with sex delinquencies; 98 with being unmanageable and staying out late at night; 16 with fighting and other conduct disorders. Seventy-four per cent were actual court cases, being referred to the clinic by either the judge or a probation officer. Twenty-six per cent were not charged with any offense and were not under arrest. Nevertheless, the great majority had histories of marked behavior difficulties and conduct disorders.

It is a significant fact that 43 per cent had been in court more than once and were considered "repeaters." We cannot stress too strongly the serious implication of this finding. Every one of these children needs the most careful, thoroughgoing, well-rounded, far-reaching study of his problems, inasmuch as it is from this group that our serious criminals will be drawn. Approximately 30 per cent of the cases had received commitment to public institutions prior to study in the clinic. A good many of this latter group had served repeated sentences at Bellefontaine Farms, and had proven to be most difficult problems, failing to respond to any of the usual measures employed by the court through its probation staff. It is an interesting fact that about two-thirds of the children charged with delinquencies were arrested for the first time before the age of fourteen.

Physical and Mental Findings

The material gathered in the physical and mental examinations is very extensive and does not lend itself well to statistical presentation. What we are recording here gives but a very limited picture of the data our case studies contain. It must be remembered that many children presented a great variety of physical conditions; in fact, no child could be tagged with any one defect or disorder. The same can be said as to mental classification. We appreciate fully how impossible it is to include, under one artificial classification scheme, all the wealth of valuable information gathered by the psychiatrists and psychologists in analyzing and searching the mental life of these children. However, what we are presenting gives, we believe, an idea of the frequency of certain well-known conditions that seriously handicap children in their efforts to adjust themselves and that prevent them from developing

those elements of body and mind that are the basis for normal socialized adult life.

Approximately 87 per cent of these children showed some evidence of physical disease, physical defect, or physical disorder of such a nature as to require medical treatment. It is not without significance that more than one-fourth of the children showed marked nutritional disturbances, while 23 per cent gave evidence of faulty physical development. It is also interesting that nearly 20 per cent suffered from disorders of the ductless glands. The effect of the disturbances of these organs on physical and mental growth and on good health of mind and body needs no detailed discussion here. Suffice it that more and more stress is being laid by the medical profession on the importance of these organs in maintaining a proper balance in the human economy.

For many years the public has been informed, through the repeated campaigns of public health officials, as to the serious effects of defects and disorders of vision and hearing, of diseased tonsils and bad teeth. Twenty-nine and six-tenths per cent of these children were suffering from defects of vision; 3.6 per cent from defects of hearing; 10.4 per cent from nasal obstructions; 24 per cent from diseased tonsils; 38.4 per cent from bad teeth. The influence these conditions have had upon the health of the child is obvious and needs no detailed discussion.

Twenty-eight of our cases showed spinal curvature; 2 children were suffering from active tuberculosis; in 3 cases tuberculosis was definitely suspected though not positively diagnosed, while 10 other children were considered pre-tubercular types; 4 children were suffering from kidney disease; 21 from venereal disease; 22 from heart conditions. Many other conditions were found, such as anæmia, 4 cases; organic brain disease, 1 case; chorea, 1 case; trachoma, 2 cases; eczema, 1 case; varicocele, 1 case, etc.³

³Most of the physical examinations were conducted by Dr. P. J. McAuliffe, a member of the medical staff of the public school system of St. Louis. His splendid work deserves special attention.

The following tests are routine on all cases:

1. Stanford Revision of the Binet-Simon Intelligence Tests.
2. National Intelligence Tests (additional for court cases).
3. Healy Pictorial Completion Test II.
4. Healy-Bronner Learning Tests.
5. Tapping Test for Psychomotor Control.
6. Stenquist Mechanical Tests (Series I, II and III).
7. Porteus Maze Tests.
8. Healy Construction Puzzles.
9. Seguin Form Board (for young children).
10. Monroe Silent Reading Tests.
11. Curtis Arithmetic Tests.
12. Trabue Language Completion Tests.

The psychological examination is designed to secure the following on all cases studied by the clinic:

1. A determination of mental development.
2. A measurement of educational progress.
3. Information as to special abilities and disabilities.

These data are secured by the application of objective measurements. The mental development and abilities of the individual child are measured in relationship to the same abilities of other children of the same age. From the results of examinations made on large numbers of children of various ages, races, and nationalities, it is possible to ascertain with a high degree of reliability the mental endowment and educational progress of any individual child. Accordingly we say that a child possesses the mental age of 10 years, by which we mean that he is able to respond accurately to certain questions and problems that most ten-year-old children answer correctly and that he is unable to perform the mental operations of eleven-year-old children.

This measurement of the mental development of the individual child is an important aid both in the understanding of his past behavior and in the effective application of social treatment in the future. A fifteen-year-old boy who measures at 10 years in mental development cannot be expected to conduct himself at his life-age level. The girl who possesses the physical development of an adult and the mentality of a child of nine will generally carry on her social relationships at a nine-year-old level. Even in such small inequalities as one or two years' mental retardation, there may be evidences of social maladjustment arising from feelings of inferiority and discouragement.

Forty-seven per cent of the clinic cases rate as average in general intelligence (so-called normal intelligence) and 4 per cent are superior. These statistics agree with other studies made throughout the country with regard to the relationship of delinquency to mental deficiency. The old theory that most cases of delinquency can be explained on the basis of mental deficiency is not substantiated. Though subnormal mental development is to be found in any group of behavior-problem cases, the large percentage of cases grade as average or better in native mental endowments. The origin of delinquency is far too complex a problem to be explained purely on the ground of defective mental development. Degree of intelligence is only one of the many important factors to be considered in the study of the individual delinquent.

The problem of school adjustment is closely associated with the study of mental development. According to the 1920 census report,

the average age of first-grade pupils is seven years, of second-grade pupils eight years, of third grade nine years, etc. On the theory that an advance of one grade in school is normally made every year, a study of school placement was made in relation to the chronological ages of the 164 children who were still attending school. The findings of this study were as follows:

- 5.4 per cent were in grades one year above their life ages.
- 10.1 per cent were in grades corresponding to their life ages.
- 19.0 per cent were in grades one year below their life ages.
- 21.4 per cent were in grades two years below their life ages.
- 19.6 per cent were in grades three years below their life ages.
- 6.5 per cent were in grades four years below their life ages.
- 2.4 per cent were in grades five years below their life ages.
- 1.8 per cent were in grades six years below their life ages.
- 13.8 per cent were in ungraded rooms.

School retardation is found, according to the above, in 85 per cent of these cases; in 30 per cent there is a retardation of three years or more; and 14 per cent are in rooms for ungraded and subnormal children. This high percentage of retardation is particularly significant from a behavior standpoint. Obviously the great majority of children who are being referred to the clinic as conduct problems have not made satisfactory educational adjustments in school requirements. The effect of being classified with younger children and the lack of interest in regular school work undoubtedly have an important bearing on conduct.

A further study was made of the relation of school-grade classification to mental ability. It has been found that most children in the first grade possess a mental age of seven years; second-grade pupils have a mental age of eight; third-grade children are nine years old mentally, etc. Any considerable variation from these norms is likely to be associated with conduct difficulties. The child whose mental capacities and interests are not adequately utilized becomes restless and troublesome, and the child whose school work is beyond his mental ability becomes discouraged and indolent.

In the cases of the 145 children who were in the regular grades, the discrepancies of school classification with reference to mental ability were as follows:

- Three cases (2.1 per cent) were classified four grades above their general mental ability.
- Six cases (4.1 per cent) were classified three grades above their general mental ability.
- Twelve cases (8.3 per cent) were classified two grades above their general mental ability.

Thirty-three cases (22.8 per cent) were classified one grade above their general mental ability.

Forty cases (27.6 per cent) were classified correctly according to their mental ability.

Thirty cases (20.7 per cent) were classified one grade below their general mental ability.

Eleven cases (7.6 per cent) were classified two grades below their general mental ability.

Six cases (4.1 per cent) were classified three grades below their general mental ability.

Three cases (2.1 per cent) were classified four grades below their general mental ability.

One case (0.7 per cent) was classified five grades below his general mental ability.

In general, a variation of one grade from the general mental ability may be considered to fall within the normal range of variation. Of the above cases, 71 per cent are so classified. On the other hand, 14.5 per cent of the children are classified from two to four grades above their mental ability, and 14.5 per cent from two to five grades below their mental level.

Of the 250 cases studied by the clinic, 80 cases had left school. Approximately 70 per cent of these children left school between the ages of thirteen and fifteen. There was only one individual, an adult, who left school under thirteen years of age. The school-grade attainment of these cases is as follows:

Number	Grade Attained Upon Leaving School
4.....	Ungraded
4.....	Second grade
4.....	Third grade
5.....	Fourth grade
11.....	Fifth grade
19.....	Sixth grade
14.....	Seventh grade
18.....	Eighth grade
1.....	First year of high school

A large majority of these children had attained the fifth grade. From a study of the mental ability of these 80 individuals who had left school, it is estimated that 40 per cent might have attained higher classifications than those that they had reached upon leaving school.

The investigation into special abilities and disabilities was made by the use of standardized measurements. The accomplishments in various school subjects are determined and studied in relation to mental development and school classification. It is possible to say thereby

that a child reads with the comprehension generally required of fourth-grade pupils, that he is able to solve arithmetical problems with the facility of a child in the third grade, or that he spells, writes, and does language work at the level generally found in the fifth grade. Such determinations are of particular value in the school adjustment of the child. In several instances special disabilities in arithmetic were found to be so marked in contrast to general mental level as to constitute an important cause for continued truancy from school. Special disabilities in some one of the various school subjects were found in 18 per cent of the cases that were attending school at the time of the examination.

A study of mechanical aptitude was made in the cases of 168 boys. It was discovered that 74, or 44 per cent, had a mechanical ability that was beyond their general mental levels. Such mechanical aptitude is of particular value in the adjustment of the individual who is deficient in the general requirements of intelligence. Of such abnormal boys studied by the clinic, 30 were found to have special mechanical aptitudes that warranted training for mechanical occupations.

The bearings of this entire discussion upon the question of the need for a more intelligent and adjustable educational system are quite obvious. Often the methods we are employing in the school room, unintelligent applications of narrow academic standards, are contributing to delinquency.

The object of the psychiatric examination is to summarize all the facts obtained in the social investigation, the medical examination, and the psychological and educational studies with regard to their bearing upon the personality of the individual child. The psychiatric study discloses the presence or absence of various mental abnormalities. It outlines and organizes in a systematic way all the presenting symptoms for the purpose of getting at the underlying causes of the behavior disorder. It discovers pathological personalities. It excavates for mental conflicts. It analyzes the mental content. In short, it seeks to get a picture of the child as a whole, of the child as a living and adjusting personality, and groups the entire study of the case in such a fashion as to map out a scheme of treatment.

The psychiatric study of these children brought out a great variety of mental conditions, mental disease, psychoneurosis, psychopathic personality, epilepsy, endocrine disturbance, mental conflict, feeble-mindedness, and many and various forms of mental maladjustment which undoubtedly were fundamental factors in their delinquent behavior.

Eight and four-tenths per cent of the 250 examined were feeble-minded; 10 per cent were cases of border-line mental defect; 26 per

cent were classified as subnormal in intelligence; 0.4 per cent were suffering from neurosyphilis; 24.8 per cent were cases of psychopathic personality; 17.2 per cent showed a psychoneurosis; 1.2 per cent mental disease; 1.6 per cent epilepsy. Nearly 20 per cent showed endocrine imbalance. No one of the above diagnoses represents the only mental classification given. There was naturally much overlapping; for instance, a child with subnormal intelligence was found to have a psychopathic personality, or a child with epilepsy was found to be also a mental defective; a child classified as suffering from mental disease may have neurosyphilis, or a child with an endocrine disorder may be also feeble-minded. Quite a number of the children showed no definite mental abnormality. Nine per cent were considered free from such conditions, while 25 per cent showed nothing further than a mild personality disorder.

In short, 66 per cent of the 250 cases were given by the psychiatrist certain well-defined psychiatric classifications. It will be noted that feeble-mindedness is not as frequent as many persons have led us to believe. Psychopathic personality was three times as frequent as mental defect.

Let us stress again our belief that the mere calling of a child a defective or a psychopath goes a very little way toward helping to adjust him to the conditions of life. His mental defect or his psychopathic personality may be only one of the many factors involved in his case and not always the most important one at that. The prime object of the study of the child should be to aid those charged with his guidance to a better understanding of the child himself and of his needs; above all, to map out, in the light of a well-rounded study of his condition, a comprehensive plan of treatment.

Family

The family stock from which these individuals came was one of the important fields of our investigation. The social investigation of a case was made by some member of the clinic's social service department and covered a period of from three to five days. It included a very careful analysis of the child's heredity, his home, the personalities in the home, the neighborhood, and the child's associates, as well as an intensive study of the developmental history of the child himself.

Mental disease, mental defect, and epilepsy were found in 22 per cent of the families of the 250 children, while delinquency was found in other members of the family in the cases of 46.4 per cent of these children. It is a significant fact that approximately every fifth child

came from a family that showed defective stock, while almost every other child came from a family in which there were other members with delinquent tendencies.

Certainly, of as much importance in the life of the child as his natural heredity is his social heredity. While the germ plasm furnishes the native material, the environment molds it into its permanent shape and brings out or represses those elements in the child's constitution that mean success or failure in life. The daily contacts with the personalities in the home, the religious, intellectual, and moral atmosphere, the relations of the parents with each other and with the children, the understanding or lack of understanding of child life, the degree of supervision and control exercised, the economic status of the home—all these bear very strongly on the careers of us all and have everything to do with the formation of characters in childhood.

The homes of 76 per cent of the children examined were rated as distinctly unfavorable, possessing factors that were inimical to the healthy, moral, and mental development of the child. The importance of this cannot be stressed too strongly, inasmuch as the very foundations of future success in the prevention of juvenile delinquency must be laid in constructive social work in the homes of delinquent children. Fortunately many of the conditions found were modifiable. It should be remembered that all of these children, particularly all of the juvenile court children, were serious problem cases. This may account in a measure for the high percentage of cases in which home conditions were bad.

Approximately 33 per cent of the children came from homes where there was actual dependency, while in 25 per cent of the homes there was real poverty. It is a significant fact that the mother of almost every third child was working away from home, leaving no one there to care for the children. This means lack of supervision and control for the child, absence of ordinary home life and proper training.

Speaking of the supervision and control received by the child, our records on these 250 cases show statements which indicate that in 83 per cent of the cases there was little or no supervision and control. This lack of teaching, training, guidance, and discipline, which are essential to the development of a properly adjusted character and personality, has been regarded by all students of juvenile delinquency as one of the important factors in the development of behavior difficulties in children.

As to environment, 71.6 per cent of these children have lived from early childhood in their parental homes, 4.8 per cent in foster homes,

and 1.6 per cent in institutions; 9.2 per cent have lived part of the time in their parental homes and part of the time in institutions; 5.6 per cent part of the time in their parental homes and part of the time in foster homes; and 5.2 per cent part of the time in foster homes and part of the time in institutions.

The influence of neighborhood conditions must have been important in a large proportion of these cases, for our records show that 48 per cent came from low-grade neighborhoods, rated from a social, educational, moral, and recreational point of view.

Sixty-one per cent had been associated with gangs or groups of other delinquent persons, who were considered by probation officers and social workers to have exerted important influences upon the careers of these delinquent children.

Treatment

Medical treatment was conducted in the majority of cases through the various medical clinics in St. Louis, splendid co-operation being shown in this particular. The educational recommendations were carried out through the public school system; the psychiatric recommendations by means of frequent interviews on the part of the child and parents or guardians with the chief psychiatrist of the clinic. Much thought was given to the social recommendations, and it was our object here, through our own staff of nine psychiatric social workers, to stimulate and inspire the agencies that referred cases to carry into their daily social case treatment what the clinic regarded as a real psychiatric and psychological understanding of the child. This, it seems to us, is one of the greatest values of the clinic to probation officers and social workers, in that it enables them to adapt their social treatment to the personal needs of the individual child. Splendid and intelligent co-operation was given by probation officers and social workers from the Board of Children's Guardians and other agencies.

In order to meet the recreational and special educational needs of the children, every possible resource in the community was brought into play—Boy Scouts, community centers, special speech-correction classes, Big Brothers, trade schools, and the like. If the proper resources were not available, the need was discussed with people who could be expected to start a movement whereby the deficiency might be supplied.

All the agencies in St. Louis were most co-operative in this follow-up work. Many of the workers fell into the habit of coming to the clinic often for informal talks about treatment details in certain

cases. For instance: "Tommy bunked out again last night, and his foster mother is terribly concerned. What do you think we'd better do? Shall I bring him in for another talk with the doctor? That last talk really impressed Tommy, you know." So Tommy's case is thoroughly discussed, the foster-home situation is reviewed to date, and plans are laid accordingly. Again, "At last I've got Edna interested in trying to learn something, but now she's determined to be a stenographer. Do you think she's got brains enough?" Vocational possibilities for Edna are considered in the light of clinic findings, and it is decided to try to divert her ambitions from stenography to dressmaking or millinery.

The joint co-operation of community and clinic in the follow-up work, therefore, was of great mutual benefit; it directed the community toward a more comprehensive type of case adjustment and brought both to the clinic and the agencies a clearer realization of community needs.

The extent of follow-up work on each case varied from one report during the demonstration to weekly, and at times daily, reports.

The following is a list of the agencies that handled clinic cases and in conjunction with which follow-up was done: Probation Department, Juvenile Court; Missouri Home-Finding Society; Children's Aid Society; Board of Children's Guardians; Big Brothers' Organization; Big Sisters' Organization; Bellefontaine Farms; State Reformatory for Boys; State Reformatory for Girls; Christian Orphans' Home; City Sanitarium; Convent of the Good Shepherd; and Epworth School for Girls.

The records kept in the social service department of the clinic included an adjustment chart which listed, month by month, the actual adjustments effected in the case in the four spheres in which the clinic recommendations were made—physical, psychiatric and psychological, educational, and social. This chart enabled anyone to see at a glance what had been done and what still remained to be done in putting into effect the clinic recommendations.

A brief analysis of the treatment results of the first 200 cases studied by the clinic gives the following figures:

	First 100	Second 100
A. Making definite progress.....	58	39
B. Cases upon which recommendations have not yet been thoroughly carried out, or have been too lately carried out to be of value..	31	58
C. Results unknown, families moved away, etc...	5	0
D.. Response unsatisfactory	6	3
	<u>100</u>	<u>100</u>

Class "A" represents those children who are reported by the worker or relative in charge to be actually showing marked changes in behavior—temper tantrums are fewer and milder, truancy is ceasing, more responsible attitude is being shown, etc. Class "D" represents those whose behavior and attitude show little or no improvement. Five of these are institution cases (by clinic recommendation) and four are probation cases upon which earnest and intelligent work was done, but with little actual result in terms of improved behavior or attitude. In the second hundred, the decrease in Class "A" and the increase in Class "B" are due largely, of course, to the shorter period of treatment received by the later group of cases.

In considering the above figures, one point must be clearly kept in mind—the adjustment of a child who for years has been subjected to bad environmental influences, who for years has been developing abnormal trends and unhealthy mental attitudes, cannot be accomplished within four or five months. Only the merest beginning in reconstructing a personality can be made in that time. The greatest qualification one can bring to the study of such problems is a freedom from the ever-present desire to prove pet theories—a mental attitude so unprejudiced by special lines of thought that one is not anxious to formulate a panacea for the treatment of all criminals, but is willing to apply time, patience, science, and common-sense understanding to each individual case.

SUMMARY

CLINIC CASES

Of a group of 300 cases, statistical material gathered from a study of 250 records has been recorded.

Seventy-four and four-tenths of the children were boys and 25.6 per cent were girls.

Eighty-nine and two-tenths per cent were white and 10.8 per cent were colored.

Fifty-nine and six-tenths per cent were native-born whites of native-born parents.

The ages varied from three to over twenty years, the median age falling at fourteen years.

In the great majority of the children, the developmental histories disclosed important facts, relating to physical health, personality make-up, and school adjustments, that threw light on their later behavior,

Fifty-eight per cent of the children were in the ordinary grades in the public schools; 7.6 per cent were in classes for subnormals; 34.4 per cent were not attending school.

Fifty per cent (every other child) had been in court more than once and were considered "repeaters."

Approximately 30 per cent had already received commitment to public institutions prior to study in the clinic; many had served repeated sentences at delinquency institutions.⁴

Approximately 87 per cent of the children gave some evidence of physical disease, physical defect, or physical disorder of such nature as to require medical treatment.

School retardation was found in 85 per cent of the cases; in 30 per cent there was a retardation of three years or more.

Quite a discrepancy was found in the relationship of school grade to general mental ability. Fourteen and five-tenths per cent of the children were found to be classified from two to four grades above their mental ability and 14.5 per cent from two to five grades below their mental level. A study of the child's abilities and disabilities in various school subjects was made. Certain striking disabilities were found in marked contrast to general mental level, so much so as to constitute an important cause of continued truancy from school. Eighteen per cent of the children who were attending school were found to show certain special disabilities in school work.

A study of the mechanical abilities of the boys showed that 44 per cent had a specialized mechanical ability that was quite beyond their general mental levels. Of the children classified as subnormal, 30 cases were found to have such special mechanical aptitudes as would warrant training for mechanical occupations.

Psychiatric examination disclosed the fact that 66 per cent of the children could be classified under well-defined psychiatric terminology. More than 8 per cent were found to be feeble-minded. Other conditions found were psychopathic personality, psychoneuroses, mild personality disorders, and so forth.

The social investigations disclosed the presence of mental disease, mental defect, or epilepsy in 22 per cent of the families of these 250 children, while delinquency in other members of the family was found in 46.4 per cent of the cases.

⁴At the beginning of the demonstration, we found that a very large number of very difficult cases had been held pending the arrival of the clinic in order that a diagnosis might be made of their mental condition. This explains why a large number of the clinic cases, particularly at the first part of our work, were institutional cases.

The homes of 76 per cent of the children were rated as distinctly unfavorable, containing factors that were inimical to the healthy moral and mental development of the child. A lack of supervision and home control of such a degree as to be considered a factor in the delinquent behavior of the child was found in 83 per cent of the cases.

Forty-eight per cent of the children came from low-grade neighborhoods.

Sixty-one per cent had been associated with gangs or groups of other delinquent persons.

CONCLUSIONS

More than one-half of the children that pass through the juvenile court show physical and mental disabilities that are fundamental factors in their delinquent conduct. The disposition of their cases without an adequate knowledge of the social implications of these conditions merely invites failure, so far as the adjustment of the child is concerned. Certainly, intelligent treatment without such knowledge is impossible. While a certain percentage of the children present serious problems, the great majority of them are not to be thought of in terms of the usual medical classifications, but rather as examples of childhood difficulties that have their origin in the home, the school, or other situations in which parents, brothers and sisters, teachers, and play-mates have an important part.

In the particular conduct of the child we will find the role his personality plays in adjusting itself to life situations. This view of behavior as a personality reaction, an effort of the child to adjust himself to his environment, by no means excludes full consideration of the values to be attached to serious constitutional conditions both inherited and acquired. The importance, however, of feeble-mindedness and grossly abnormal mental conditions is not such as we were led to believe from earlier investigations.

Real progress will be made through a better understanding of the child's personality, and the influences from within and without that mold it and make it what it is.

As we pointed out in the introduction to this report, psychiatry is not concerned merely with the problems of mental disease and feeble-mindedness; in conjunction with clinical psychology and social casework, it has a most practical contribution to make to the understanding and management of human behavior in health as well as in disease. Workers in the field of delinquency are now convinced that the greatest

progress in the future will come through the utilization of these sciences in dealing with the individual delinquent.

So there has come to be a growing demand for psychiatric clinics to serve juvenile courts and other agencies that handle delinquent and pre-delinquent children. It is being recognized that these clinics should be a fundamental part of the court's machinery for the investigation and adjustment of problem children.

The financing, however, of such facilities is the usual difficulty. Juvenile courts in general are so inadequately financed as to make satisfactory constructive social work in the prevention of delinquency out of the question. The addition of a budget of from \$15,000 to \$25,000 a year to provide for a clinic is consequently an utter impossibility, so far as the great majority of the courts are concerned. However, our studies have shown that practically all of the delinquent children that pass through the juvenile courts are also problems to the public schools from an educational or behavior point of view and have been so in many cases for a period of years. Also, many of the children, as well as their families, have been dealt with unsuccessfully by the social agencies of the community. It is therefore clear to us that effective preventive work means the application of more scientific measures in understanding and solving the problems of these children before they get into court, while they are in the school and at home. Consequently, we would recommend for small cities a community child-guidance clinic to serve not only juvenile courts, but public schools, social agencies, and parents. Almost any city of 50,000 or more will be able to finance the minimum personnel required for such a clinic. Certainly the returns from such an investment will more than justify the expense involved.

The clinic personnel should be composed of a psychiatrist, a psychologist, at least two psychiatric social workers, a clinic secretary, and clerical service. The psychiatrist should be the director of the clinic. The usual formal training in clinical psychiatry received by a state hospital physician does not equip him to understand and treat conduct disorders in children. The breadth of training and experience upon the part of the director in the application of psychiatry to the study of human behavior will determine the quality of work done and the results accomplished. Certainly something more than the mere appropriation of from \$15,000 to \$25,000 a year is needed to build up a psychiatric clinic in a community. The methods and technique to be employed by such clinics have everything to do with their success or failure. The question of treatment is one about which but little is

known and yet the methods to be employed are the most fundamental problems that face a clinic. We cannot stress too strongly our belief that superficially trained and inexperienced personnel are not only worthless, but are likely to do real damage.

In choosing a location for a psychiatric clinic accessibility and adequate floor space are considerations of first importance. The headquarters should be centrally enough located so that the clinic can be easily reached by street car from any part of town. This will greatly facilitate regular attendance by children and parents at psychiatric interviews and will be of convenience to social workers and others who meet to consult the clinic staff frequently.

Yet, unless absolutely necessary, the clinic should not be in the juvenile court building itself—at least not in any criminal court building. Even the provision of a separate entrance, which goes a long way toward eliminating some of the undesirable contacts almost certain to take place without it, does not remove the unpleasant associations of such a location. The clinic desires to help pre-court as well as court cases; it wants parents to feel free to bring troublesome children for examination to the psychiatrist just as they would take sick children to the doctor; it wishes to avoid anything like the atmosphere of a courtroom or a correctional institution.

Ideally the clinic offices should be sunny, well-ventilated, and attractive. They need not be elaborately or expensively furnished and the private offices need not be large, but absolute quiet and privacy are essential at least for the physical examiner, the psychologist, and the psychiatrist, and are desirable for the whole staff. At least five private offices and one waiting room must be provided.

The actual equipment in the way of laboratory tests is exceedingly small. The great majority of the medical tests should be made by hospitals and medical clinics. The very closest co-operation should be maintained with the medical men and hospitals of the city, and consultants from the medical profession should be attached to the clinic (volunteer aid).

This must be borne in mind: the clinic, alone and of itself, can accomplish little in the prevention of juvenile delinquency. Success in the way of well-rounded treatment of the entire situation and of all the issues in a given case will depend upon the existence of well-organized and progressive social, medical, and educational forces in the community, the extent of co-operation, and the degree to which these forces may be made available in carrying out under the guidance of the clinic the adjustments recommended.

The placing of probation officers and social workers in the clinic for a period of training is strongly recommended. In cities where there is a university, the great opportunities offered to medical students, psychological students, and students in sociology in securing practical work in social psychiatry, clinical psychology, and social case-work are obvious. University authorities should need no urging to utilize these resources.

ILLUSTRATIVE CASES

CASE I

Gabriel, white boy, thirteen years old; American, born of American-born parents.

Introductory Statement

This boy was brought to the clinic by a probation officer of the juvenile court. He had been suspended from school for continued fighting with other children and for improper conduct toward one of the little girls in school. He would, when passing her, lift up her dress and make indecent remarks and proposals. This boy had also run away from home at times, remaining away for several days. During these periods he would bum with other boys in the block. He invariably got into mischief—"swiping" things, clogging up chimneys in houses under construction, stealing vegetables and fruit from neighbors, and, in general, making himself a source of considerable annoyance to the neighborhood. A proper understanding of his personality difficulties, together with constructive contacts with his parents and school, has cleared up much of the situation.

Family Background

Paternal Antecedents: So far as we could ascertain, there was on the father's side no history of mental disease, mental defect, delinquency, or the like. The paternal grandfather, born in England, was an expert weaver. There are two uncles in St. Louis, living and well. The oldest is a prominent business man of that city. Gabriel's father has been excessively alcoholic, is subject to violent outbursts of temper, and at times is very abusive. He is an expert mechanic, and occupies a very important position with a large business concern in St. Louis. He is very difficult to deal with, is stern and strict, and shows little understanding of children.

Maternal Antecedents: The mother's people are of Scotch descent. Her family history, so far as we were able to ascertain, is in general

negative. She is indolent, loose morally, and has neglected her home and her children. The father separated from her when Gabriel was an infant. She became involved in questionable conduct with another man, and the father secured a divorce.

Brothers and Sisters: There are four children living, of whom Gabriel is the youngest. Two children died in infancy, and there was one miscarriage. A sister is reported to be mentally defective. She ran away and married when she was twenty. Her present location is unknown. Another sister, nineteen, is living in a convent. Another, eighteen, is attending business college; she lives with an aunt, and is getting along very well, never having been a problem.

Home Conditions

As has been said, the parents separated when Gabriel was an infant, and were later divorced. Gabriel was then boarded in a good home until he was four years old. At that time the father remarried and took Gabriel with him. Discord followed, and the stepmother later left home. In 1913, the father bought a new home and tried keeping house, with the oldest daughter in charge. At that time the house was very filthy, and Gabriel's condition in school was such that he had to be excluded by the school authorities. The children were reported to the juvenile court as neglected, and in 1917 Gabriel was given into the custody of the Children's Aid Society for placement. He then lived in an orphanage until June, 1921. At this time the father remarried for the third time, and Gabriel was returned home under court supervision.

The home at present is a neat, six-room cottage, with a pleasant lawn and garden. The father owns the home and the family is in comfortable circumstances. The stepmother, a woman of very nice appearance, is fond of Gabriel. Both parents are overly strict with the child, having little understanding of his difficulties, and do not allow him much freedom or recreation. The child has few natural outlets for his energies and interests.

Personal Developmental History

The boy's early developmental history is not particularly significant. He learned to walk and talk at the usual age and there were no very serious illnesses in early childhood. He has always slept well at night, has never suffered from night terrors, convulsions, or the like. There have been no injuries.

Gabriel started to school at the usual age, but his attendance was discontinued very soon after entering, as we have said. When eight years o'd, he entered the parochial school, where he made little progress. Within the last year he was placed in the public school near his home, in the fifth grade, but before very long was suspended because of misconduct. His stepmother says that the school authorities wished to place him in a special school, but the father objected, saying that his boy was smart enough, and that he was not going to consent to his going to school "with those nuts." He was examined a year ago by the department of tests and measurements of the public schools, was rated at eight years mentally, and was recommended for a special class as a mental defective.

The boy's interests are very few. He is fond of pets, and has chickens on the place, to which he attends. He is extremely fond of music, and though he has taken no lessons, he is able to play a little on the piano. Although he is fond of baseball, his parents allow him to indulge in this recreation only on rare occasions. He hardly ever goes to the movies. He has no interest in books, and reads very little.

Gabriel has smoked cigarettes for a long time and is a confirmed masturbator. He has been a constant source of trouble to his parents, is disobedient, stubborn, and antagonistic. His violent temper outbursts and personality difficulties seem to be a small copy of his father's.

Companions

Gabriel associates with a group of boys in the neighborhood who have frequently got into various kinds of scrapes. It is with this gang that he has repeatedly run away from home, bumming around from place to place.

Behavior

From the age of fifteen months to four years, this boy was in a good foster home, and his conduct, so far as we have been able to learn, was not unusual. At the age of four his father took him back into his own home, where he was very badly neglected. After entering public school, he had to be sent home by the school officials because of bodily neglect. About this time he was brought into court as a neglected child. As stated above, he was then placed in an orphanage, where he remained until he was twelve. It has been impossible for us to secure much information about Gabriel's conduct while in this institution, other than the fact that the nuns state that he was unmanageable and that "his conduct was abominable." At the age of

twelve he again entered the public school and at once became a difficult problem, continually fighting with other boys, exhibiting bad sex practices, and being considered a source of moral contagion for the other children. Finally, after making an attempted sexual assault on a little girl, he was suspended by the school authorities. He has on occasions run away from home, remaining out for several days, "bumming" around with a gang, stealing, and getting into various kinds of mischief. He has been particularly antagonistic to his stepmother. He said that he was there before she was, and that he is the son of the boss of the house and therefore is next boss. It has been entirely impossible for her to handle him. Very recently, when his stepmother tried to punish him, he threw a sickle at her with such force that the blade, missing her, went through the screen door.

Physical Examination

Height $56\frac{1}{2}$ inches, weight $72\frac{1}{2}$ pounds (average height and weight for his age 56/82). The boy is fairly well developed, but is poorly nourished. He has a deflected nasal septum and enlarged tonsils. His teeth are in good condition, his chest and abdomen normal. Neurological examination negative; urinalysis negative; other special tests negative.

Mental Findings

His test age, as obtained by the psychologist of the clinic, is ten years, ten months, and his I. Q. 79, although he had previously been rated at eight years by the psycho-educational clinic of the public schools. Performance tests showed specialized abilities along mechanical lines superior to that expected for his mental age. By Healy Picture Completion II, he got a score of 41, rated at age 9-10; by Porteus Maze Tests he was rated at $11\frac{1}{2}$ years; by the Healy Puzzle A, he rated at 11 years; by the Stenquist Mechanical Series he was rated at 13. In educational ability he was rated by the Stanford as of fifth-grade ability; by the Monroe Silent Reading Tests as fifth-grade; by Curtis Arithmetic Tests No. 7 he rated at grade four; by the Trabue Language Scale E, at grade two; by the Healy-Bronner Learning Test "A," he rated (July 11, 1922) approximately at 13 years. In general he may be considered subnormal in intelligence.

The psychiatric examination disclosed no evidence of mental disease. Gabriel appeared to be a psychopathic boy, with considerable personality handicaps, showing character defects that must undoubtedly have been important factors in his conduct. He has very erotic and

vivid sexual imagery—secures sexual gratification through lifting girls' dresses. Both parents state that the boy has a "bulldog stubbornness," is restless, quick-tempered, very impulsive, highly emotional, has tantrums during which he will throw anything near at hand, is very selfish, inconsiderate, and difficult to manage. At times he is moody and sullen.

Own Story

Gabriel likes his father, but does not like his stepmother. She won't let him play outside of the yard and says he is always fighting. At times she will not give him anything to eat (when he does not work) and beats him with a big stick. He says that his mother and father won't let him play "baseball or nothing." He readily admits to bad sex practices, petty stealing, and other offenses with a group of boys. He gives an astonishing account of his sex life which has been filled with vivid imagery and bad personal habits and practices. This came to the surface very slowly and only after many interviews. (The bringing of it all to light resulted in a marked change in the boy, as will be seen later.) He frankly admits that he does not care for school, but does say that he like "to fix things." (He has considerable mechanical ability.) He wishes that the judge would let him go to live with an aunt; he likes her better than his father. She has two grown sons, both of whom have automobiles. They work and they are good boys. One is an actor, and the aunt would let him (Gabriel) go to the movies, and so forth. He likes to play out of doors, but his father and mother give him very little opportunity. He has an ambition to be a mechanic, and says he wants to be a good man and keep out of trouble.

Causative Factors

We will summarize here the most outstanding causative factors underlying this boy's behavior.

1. Distinctly unfavorable home conditions: early neglect, bad parental conditions, poor training and supervision, and the like.
2. Possible heredity.
3. The boy's own personality trends.
4. Bad associates.
5. Failure upon part of school system to grasp fully the educational problem presented by this boy.
6. Lack of healthy and wholesome outlets for natural interests.

Recommendations

Medical: Special attention should be given to a general constructive regime in building up this boy's strength and weight. His tonsils should be carefully watched.

Psychiatric: Repeated contact with the psychiatrist of the clinic is advised in order that a serious effort may be made to go more fully into the mental life of the child, and to secure this co-operation in the attempt to overcome his personality difficulties and to adjust himself to home and school. Careful consideration should be given to his sex life, and an effort should be made to supplant his present unhealthy mental imagery and activities with more wholesome interests.

Educational: While this boy should continue to receive academic training, we would advise that special stress be laid on manual and industrial work. He has abilities along these lines superior to his mental age, and special use should be made of them by the school authorities in fitting him for something in life. Aside from the effects purely in educational training, we believe that such a regime would go far toward adjusting his personality difficulties.

Social: Probationary supervision in his home is recommended, with very close and intensive contact. A special effort should be made by the probation officer to give to the parents a proper understanding of the child's difficulties, the dangers of a future career in crime, and what the right sort of co-operation from them along the lines of prevention should be. The father should be tactfully led to see the clinic's point of view and interested in providing some natural outlet for the boy's energies—mechanical work, Boy Scout troop, and other healthy recreational interests.

Follow-up Work

After the boy had been placed on probation, he was returned to the parochial school. In the meantime he was proving unco-operative with the probation officer. Backed up by his father, he became a difficult problem to handle. In school the sisters reported his conduct as very bad; he was always fighting, refused to obey the teachers, and was a constant source of mischief.

Within two months the social service department of the clinic had been requested to assist the probation department in the management of the case. At the first home visit of one of the psychiatric social workers, the father's attitude was that of a "bully." He frankly stated that he did not invite any member of the clinic staff into his home, and he did not want them "butting into his private business." He would

not have his boy taken to the clinic by anyone. If it was compulsory, he would take him himself, but a court order would be necessary before he would do this. Inasmuch as the clinic's representative could not furnish credentials, he would have her understand that he would answer no questions. How did he know who she was? He preferred to take Gabriel to his own physician. The boy was present at the interview and listened intently.

At the second visit of the psychiatric social worker to the parochial school, it was learned that Gabriel's delinquent conduct had continued unabated and finally the situation had become so disturbing that he had been expelled. When the home was visited again, the stepmother was found greatly distressed. She said that the boy was very antagonistic, continually talked back to her, and was impudent. The father would not co-operate when the mother tried to correct the child; he let her know very clearly that she had no authority to tell his boy to do anything. The stepmother said that the boy had proven a constant source of bickering and discord between them. At the time he was expelled from school, instead of blaming Gabriel, the father turned on the stepmother and accused her of being the source of all the trouble. The psychiatric social workers said that the father would not tolerate suggestions from anyone, announcing that he would not be told by anyone what he ought to do with his child. During this interview, the stepmother cried repeatedly, and stated that she was very unhappy. The social worker was impressed by the fact that the stepmother wished to co-operate with the court and the clinic, but on account of the father was afraid to do so.

It was impossible to get the father to discuss the expulsion of the boy from school. When requested to come to the clinic to talk with the psychiatrist in charge, he refused, but when it was explained that the chief probation officer of the court insisted on his doing so, he finally consented. At the same time he threatened: "If a continued effort is made to interview me or take my son to the clinic, I will take him out of the city. You people are bothering me."

On October 27, three months after the initial study of Gabriel's case, the father and stepmother, with the boy, came to the clinic. Now began a long series of interviews by the psychiatrist, aimed at changing the attitude of both father and son. With patience, tact, and insight it was possible to change a blustering, suspicious, antagonistic, and threatening man into an interested, co-operative, understanding, and helpful father. Plans were laid for interesting the boy in his home. A radio set was secured. A shop in the basement was provided where

the boy's mechanical interests found fullest expression. The father was very anxious that Gabriel should return to school, so the psychiatric social worker visited the principal of the Gardenville School (a public school). He showed great interest in the welfare of Gabriel and in properly placing him in school work, but stated that, since the boy had been tested last spring by the department of tests and measurements of the schools and rated for special school standing (subnormal class)—he showed a mental age of 8 years, and thus there was a suspicion of feeble-mindedness—he could not now be officially taken to the Gardenville School unless further arrangements were made; that proper placement would depend upon a conference between the clinic and the department of tests and measurements of the public schools.

On October 31, a conference was held between the psychologist of the clinic, Mr. E. K. Wickman, and the psychologist of the public schools. The difference between the mental ratings at the clinic (which was 10 years, 10 months at one rating and 11 years at another) and the rating of 8 years given by the department of tests and measurements of the schools was discussed, and it was decided that the boy had malingered in his first examination by the school psychologist. As a result of this conference, the public schools have agreed to find the best fifth-grade teacher available for this boy, and place him under her instruction. Since this conference, the co-operation of the parents with the clinic has been splendid. They have done everything possible to carry out the advice given them, and have practically put the entire matter of handling the boy into the hands of the clinic. The boy himself is now most co-operative, makes frequent visits to the psychiatrist and psychologist of the clinic, and his attitude is all that can be expected. At present he is presenting no behavior problems, is going to school, and shows considerable interest in manual work. The step-mother reports that the home is more harmonious and that she and her husband, now that they understand more clearly the real cause of their troubles, are happier. To be sure, only a beginning had been made in this boy's case; there will doubtless be many relapses. But there is a clearer understanding of the problem and a plan of procedure based on a knowledge of causes has been laid.

CASE II

Alfred Lebeaux, white boy, fourteen years, four months; American, born of American-born parents. Eighth grade in school.

Introductory Statement

Alfred was referred by a probation officer of the juvenile court. His mother says that he has been hard to manage all his life. He was disobedient when little and wholly unlike his brother. Even when very young, he would leave home whenever he wished and did not seem to heed the wishes of his father and mother or to mind punishment. If asked by his mother to go on an errand, "he says he will go when he gets ready, but he never gets ready." When punished, he would stir up the entire neighborhood by his loud yells, talking back to his mother and striking her. This has been so constant that the family have had to move several times on account of the boy. Finally it was necessary to take him to court and request that he be placed under the care of a probation officer, in order that he might be tolerated in the home. He continued after this to alarm the neighborhood, was constantly disobedient and stubborn, and at times actually struck both parents. Probation did not prove successful. There seemed to be no change in his conduct and an institution was considered, but the court wished an examination at the clinic before such a disposition was made.

Family Background

Paternal Antecedents: The grandfather died six months ago of pneumonia, at the age of seventy-eight years. "He was always a very nervous man and excited at the least thing. He was an inventor and a very eccentric man." The paternal grandmother had "fainting spells." One uncle, forty-two years of age, drinks to excess and is very nervous and irritable. Another paternal uncle has been treated "for nervousness in a hospital." Another uncle was in the army during the war, and is now being treated for "nervousness" in a government hospital. One paternal aunt has heart disease, and another has been treated in the City Sanitarium for mental trouble. The father died nine years ago from blood poisoning, due to a cut on the arm from a piece of glass. He was alcoholic and drank to excess and was very quarrelsome, particularly when drinking. By trade he was a glass bender.

Maternal Antecedents: The mother's family seem quite free from any particular hereditary defects. There is no history of mental disease, mental defect, delinquency, alcoholism or dependency in her family. She herself is in very good health and has been so all her life, except for an attack of rheumatism when she was very young. She is forty-three years old and has had a good education. She is somewhat unstable and lacking in force.

Brothers and Sisters: There is one brother, sixteen years old, who has always been in good health. He has had an eighth-grade education, and is now a clerk in a brokerage house. He lives at home, is a good and obedient boy, and has never caused any trouble.

Home Conditions

The father died when Alfred was five years old. Alfred was placed in the German Protestant Orphans' Home because his mother was unable to care for him. He was then about nine years old and he remained there until eleven years of age, when the mother remarried, and he returned home. The stepfather is a carpenter and has an income of from \$25 to \$30 a week. The older boy makes about \$50 a month. The income seems sufficient to provide well for the entire family, who occupy the top floor of an old-fashioned ten-room house. The two boys sleep together in the front room, where they have a wireless outfit. The family keep largely to themselves, having but few associates. They spend the evenings together, often playing cards, and sometimes they attend the theater. The boys attend the Methodist Sunday School.

The stepfather is said to be very easy-going, and he and the mother have no trouble except when they quarrel over Alfred. He willingly took the boys out of the orphans' home and says that he has tried his best to get along with them. The mother says that the stepfather has never been severe with the boys and rarely punishes them except at her request. He never has any trouble with the older boy. Alfred and his brother used to have very severe quarrels. The methods of disciplining employed have been whipping, putting to bed and denying privileges, but the parents are convinced that whippings are useless.

Developmental History

Birth normal, no instruments, full-term baby weighing 8½ pounds; breast fed; dentition at 9 months; walking and talking at usual time. The boy had spasms in early infancy, has had an attack of bronchitis that lasted several months, had scarlet fever at nine years and abscesses in the ear when eight years old. When in the orphans' home, he had an attack of unconsciousness. When he was seven years old, the doctor at Barnes Hospital told his mother that he had a weak heart. She had taken him there on the advice of his public school teacher, who complained of his great nervousness. He had chorea at this time. About six months ago he was in the hospital for blood poisoning, which resulted from cutting his foot with a hatchet. He has always been a

sound sleeper, has had no night terrors, and has never walked nor talked in his sleep. He is finicky about his food and eats between meals. He is very careful in his personal habits. He is not troubled with neurssis, does not smoke, has had no sex experiences, and does not masturbate, so far as the parents know. He entered kindergarten at the age of seven years and is now in the eighth grade. He has given no serious trouble at school, has been regular in attendance, and has not repeated any grades. He is both interested and talented in mechanical work. He makes wireless outfits for himself and others, and uses all of his spending money and sells his possessions to get electrical equipment. He formerly belonged to the Boy Scouts, but resigned. He likes swimming and baseball and is fond of music. He traded his bicycle for a violin and has played a trombone in the orphans' home band.

Companions

Alfred has no gang, but plays with the other boys in the neighborhood. One boy with whom he plays a great deal has advised defiance of the stepfather. Alfred is apparently not interested in girls.

Behavior

From early childhood, this boy has been very difficult to manage. He has always been disobedient, never willing to submit himself to authority. When very young, he would run away from home, and even in infancy it was impossible to manage him. He has never taken discipline satisfactorily. While in the orphanage he was difficult to manage and on one occasion ran away. A former landlady with whom the family lived last year said that he was a very bad boy, and that she thought that there was something the matter with his mind. She said that there was constant friction between the boy and his mother and stepfather, both of whom she thought were very fine people. She said that she saw Alfred throw a plate at his stepfather once, but it missed him and broke a window. She was forced to ask the family to move on account of the boy. The mother said that he would be all right if he could always have his own way, and always "do just as he pleased." In December, 1921, the mother and stepfather brought the boy to the probation office of the juvenile court and complained that it was impossible for them to manage him. In July, 1922, the parents again appeared with the boys at the probation office and said that he had been fighting his stepfather and had struck them both. The boy admitted that when he was mad and flew into a rage he did not know what he was doing. The stepfather had threatened to leave the family

if something were not done about the boy. When the question of having him examined at the clinic was broached, the parents were very much pleased.

Physical Findings

Height, 61 inches; weight, 100 pounds (average for his age 61/102). Fairly well developed and well nourished. Tonsils enlarged and should be removed. There is evidence of an endocrine disturbance (thyroid).

Mental Findings

A psychological examination gave Alfred a mental age of 12 10/12 years. His chronological age is fourteen years, four months. (The I. Q. was 89.) On supplementary tests, his score in Healy Picture Completion II was 89½, rated 100 per cent for age fourteen; in Porteus Maze he rated at fourteen years; in Stenquist Mechanical Series I, 66, rated at upper 98 per cent for age fourteen. In educational-ability tests, the Stanford rating indicated seventh-grade mental ability; the Monroe Silent Reading Tests rated him at the fifth grade; the Curtis Arithmetic Tests No. 6 at fifth to sixth grade; Healy-Bronner Test "A" between nine and ten years.

The boy is about average in general intelligence. Special educational tests showed lower attainment along educational lines than his mental ability warranted. He has unusual mechanical ability. A psychiatric examination disclosed no evidence of mental disease or mental defect. He has, however, marked personality difficulties. He is very impulsive, easily irritated, violent-tempered, and gives a history of attacks of unconsciousness in early childhood as well as spasms in infancy. He is an emotional, unstable, neurotic, self-centered, sensitive, moody boy. There is a suspicion of epileptic attacks.

Own Story

Much of Alfred's trouble started while he worked at a wholesale house as an office boy. He got \$30 a month, which he gave to his mother and stepfather to keep for him. After several months they decided to use the money for household expenses and told him that he could not have it any more. This seemed to bring on a complete change in him. He hated his stepfather and felt deeply the injustice of it all. This, of course, resulted in an argument and a serious quarrel. He had eagerly looked forward to going to summer school, but his parents argued incessantly about it. Everything had been

signed for him to go, but the father made him go to work and would not allow him to have his money. Alfred had already borrowed money from his brother to get some receivers for his wireless set, planning to pay for this out of his savings. In the meantime, as we have said, he had given his money to his parents and they would not return it to him; when the question was brought up, the father threatened to leave home. Finally, after repeated arguments over it, the father actually left and did not return for several days. Alfred said that he does not like this stepfather. "One minute he is all right, and the very next minute he does the opposite." He said that he was always willing to have his stepfather spank him when he was wrong, but the stepfather would never give in when he himself was in the wrong. From the boy's own story the money question has been a predominant one in the family.

From all that can be learned he has never been interested in girls. He never talks about girls when he is with boys, and he never hears bad things discussed. He is in the eighth grade in school and never refused to go to school, but does not like it. He would rather "do anything than go to school, but I certainly do like machinery and wireless." Most of the wireless set he made from reading the instructions in wireless magazines. He wants to do electrical work when he grows up. He does not belong to the Boy Scouts, "because I would rather listen on the wireless and take up radio." He plays with other boys, but does not belong to any gang. He does not care for movies and Wild West stories. He would rather stay at home and read about mechanical things. The reason he did not like the orphanage and ran away was that they had nothing to eat—"just bread and syrup." Everything would be all right "if I could get along with my stepfather."

Causative Factors

1. Bad heredity.
2. Home conditions—lack of proper understanding of the boy on the part of the stepfather (evidenced by his taking the boy's earnings), and lack of stability in the mother.
3. Endocrine disorder combined with personality difficulties.
4. History of unconscious attack and spasms indicates an unstable, nervous system and leads one to suspect epilepsy.

Recommendations

The boy should have medical treatment for a thyroid condition, his tonsils should be removed, and he should be circumcised.

He should be brought back to the clinic frequently for conference with the psychiatrist. We do not believe that pushing him in school along academic lines will prove of any great value. We should advise specialized technical training in mechanical fields, also employment. He should have a specified allowance from his wages. His parents should show a proper interest in his mechanical talents and he should be encouraged and helped in equipping himself as he wishes with apparatus. It should be remembered that such interests might very well be made a vocation and fit him for something particularly useful in life. Very close and intensive contact on the part of the social-service department of the clinic, as well as of the psychiatrist, with the parents and the child is advised.

Follow-up Work

An effort has been made to carry out the clinic's recommendations. Alfred has been placed under endocrine treatment, with particularly good results as to its effect on his nervous instability. Splendid cooperation has been shown by the boy, as well as by the mother and stepfather, and it has been possible to keep in very close touch with the situation. The boy's own side of the situation was gone into with great care. The justice of his claim for at least a part of his own earnings was discussed frankly. His viewpoint was impressed on the stepfather particularly, and suggestions were made for a more cooperative scheme. Careful explanations were made of his motives and attitudes and the best methods of dealing with them were considered. In our talks with the boy special emphasis was laid on the seriousness of his behavior and what the inevitable results must be if it was not corrected. Above all we tried to get the boy's own viewpoint and to secure from him a frank and free account of his difficulties and his own attitude toward them. Gradually we were able to get him to see his reactions in their true light and to strive for a more wholesome and healthy recognition of his duties and responsibilities.

The results have been most satisfactory. Alfred has been attending the Hogden School in the eighth grade and graduated this January. His school report shows that he has done particularly good work in all his studies. His mechanical interests and abilities have been given special attention. Employment has been secured for him and on Saturdays he works for the Stye Importing Company, putting up medicines. He makes \$1.25 per day. This is all given to him to use as he sees fit. His mother says that he is a different boy, more respectful, more obedient, and seems to have grown in a sense of responsibility and interest in his home.

CASE III

Preliminary Statement of Case

The following is a brief story of Rose, who for several years had been a ward of the court and was apparently making rapid progress toward a state institution for delinquent girls when referred to the clinic for study. With a better understanding of her problem and a change in the management of the case, her delinquencies cease and "a career" becomes apparently arrested.

Rose was an attractive seventeen-year-old white girl who had been a ward of the juvenile court since she was fourteen years old. She had had repeated court appearances for immorality, running the streets, shoplifting, stealing diamond rings and begging. She had proven to be a very difficult problem and it was thought she was an institutional case.

Her early childhood was spent in a home of poverty and filth, where she was neglected. Her mother was alcoholic and immoral; her father, a miner, was an industrious worker, but was unable to cope with his home situation. So when Rose was four years old, she was given to her present foster parents. They are very nice Polish people of the peasant type, and their home is pleasant, well-furnished and immaculately kept. The foster father was disabled in the mines, and as he has received no compensation for his injury, has resorted to selling shoe strings on the streets. This has taken Rose out into the streets with him and, inasmuch as the foster mother is a semi-invalid, the child has had practically no supervision. Not only this, but the foster parents have endeavored to shield her from the court and the probation department, making misstatements regarding her conduct and thus creating additional difficulties for Rose.

Upon her last appearance in court for immorality, she was referred to the clinic.

Rose was found to be a well-developed, well-nourished girl in good physical health. The examination of skin, eyes, ears, nose and throat, heart, lungs, abdomen, etc., was negative. The neurological examination was negative; so also were the special laboratory tests for urine, blood, etc.

Mentally she was found to be low average in general intelligence, but there was no evidence of mental deficiency. Nor was there any evidence of mental disease, mental conflicts, or serious personality difficulties. The child was open and frank, friendly, rather flippant, extremely suggestible, and quite emotional. She told a long story of associations with bad companions and, from her own account, was

very easily led by others into what seemed to her a more attractive and pleasant life than her foster home offered. Her fondness for companionship, which she did not find in her foster home, was easily satisfied through her friends and this opened the way to her following the life they lived.

The clinic felt that this was a case in which environmental influences were the predominant factors underlying the behavior problems. The outlook seemed particularly hopeful, providing a break with bad associates could be made, worth-while interests developed in the home, and a sense of responsibility for the child's future engendered in the foster parents. The girl herself seemed not to be innately vicious; on the contrary, she appeared to be quite amenable either to good or bad influences. No provision had ever been made for employment or special training with any objective in life. Her days were empty; from morning till night her time was her own, and she was allowed to choose companions who exercised the worst possible influence.

This entire situation was explained with great care by the psychiatrist, who talked at length with the probation officer and the foster parents. The clinic felt that Rose could be retained satisfactorily in the home, and arrangements were made for very close and intensive probationary and clinical supervision, suitable employment, and healthy interests. These all have been secured for her. She has reported regularly to the clinic since her examination five months ago. At each time she has had a heart-to-heart talk with the psychiatrist and constructive efforts have been made to help her to a better sense of values, a more serious attitude towards her own problems, and an appreciation of the inevitable end of a delinquent career. Her foster parents have cooperated splendidly in securing for her suitable employment and according to the probation officer's reports, she has now for several months presented no further problems. To be sure the supervision exercised by the probation officer has been far more intensive as well as more intelligent, while new companionships have been formed.

Rose's delinquencies have ceased, she is very helpful with the housework, she has a piano and a typewriter, and at night is learning to use them in order that she may fit herself, as she says, for something more worth while in life. Certainly the psychiatrist of the clinic has noted an unusual change in the girl. Both the foster parents and the probation officer report that she is happy, contented, and is giving no trouble.

It may be noted that when Rose's problems were approached from the aspect of her needs rather than her deeds, a different result was obtained.