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ABSTRACTS OF THESES

Abstracts of all the theses submitted to the Smith College School for Social Work will be published in the *Smith College Studies in Social Work*. The requirement of a thesis for the degree of Master of Social Science was first made in 1920, and to date something over three hundred theses have been submitted. The abstracts of these theses will appear in the first few numbers of the Studies, following the classification set forth below, which is intended merely to assist the reader and should not be considered as rigid.

In this number are published the abstracts of theses dealing with mental disease and deficiency. At the beginning of each abstract appears the name of the student, the institution at which she did her field work, the year of her graduation from the School for Social Work, and the title of her thesis. Each abstract contains a statement of the number of cases studied and of the method by which they were selected, in so far as it was possible to ascertain these facts.

The following is the classification of titles which will appear in this or in subsequent issues:

- I. Mental Disease and Mental Deficiency
 - A. Types of mental diseases
 - B. Social origins of mental disease.
 - C. Follow-up studies
 - D. Effects on the families of patients
 - E. Legislation
 - F. Social work practices in dealing with the mentally diseased or defective
- II. Physical Diseases and Defects
- III. The Practice of Social Work
- IV. Behavior Problems of Children; Juvenile Delinquents
- V. The Family
 - A. Emotional relationships within the family
 - B. Effect of the attitudes of various members of the family on the child
 - C. Broken homes; illegitimacy
 - D. Foster and step-children; children in institutions
 - E. Ordinal position, sex, and intelligence of children within a family

- VI. The School
- VII. Recreation
- VIII. Foreign Groups and Their Attitudes
- IX. Economic and Social Conditions

H. L. W.

A. TYPES OF MENTAL DISEASE OR DEFICIENCY

Dementia Præcox

Winn, Rosemary (Worcester, Mass., State Hospital, 1928). A Study of the Social Factors in the Cases of Thirty-five Catatonic Dementia Præcox Patients.

Material for this study was found in the Hospital Social Service records, supplemented, in the cases of ten patients, by intensive work on the part of the student.

It was found that the onset of the disease in those patients having desirable backgrounds, favorable social and home relationships, and out-going personalities was sudden and severe, preceded by a shock which acted as a precipitating factor. In others the psychosis developed gradually, no marked precipitating factor being present.

Fifty per cent of the first group recovered well, as contrasted with fourteen per cent of the latter group.

Three case histories are given in detail.

Walker, Dorothy (Boston State Hospital, 1921). A Study of Thirty-five Ex-service Men Treated at the Boston State Hospital.

All cases in the Hospital between January and June, 1921, that were diagnosed as having dementia præcox or manic depressive psychoses were studied in an attempt to discover the relation between the disease and their war services, and the question of compensation depending on that relationship.

Webster, Margaret (Michigan State Psychopathic Hospital, 1921). A Social Study of the Dementia Præcox Cases of Washtenaw County Discharged from the Michigan State Psychopathic Hospital over a Period of Fifteen Years.

Of the fifty cases selected for study, the histories of the sixteen who were discharged outside the institution, and of nine others committed to the institution, are discussed under the following headings: history before illness, length of illness, social and economic status after illness, recreation, and economic status after illness. Few conclusions are drawn.

Webster, Gladys (Boston State Hospital, 1928). A Study of the Personality Traits and Social Background Factors of Thirty Dementia Præcox Patients Admitted to the Boston State Hospital in 1925.

A study of thirty patients transferred from the Boston Psychopathic to Boston State Hospital in whose cases the diagnosis of dementia praecox was agreed upon by both hospitals.

Their personality showed a complicated mixture of schizoid and cyclothymic traits with a high degree of maladaptability in emotional, social, and occupational spheres. Their social background seemed fairly normal and could not account for their breakdown. Precipitating environmental situations were unknown in 65 per cent of the cases; but in 70 per cent of those whose personality was considered normal such a factor was known.

One case in given in detail.

Kempton, Edith (Worcester, Mass., State Hospital, 1930). A Comparison of the Social Adjustment of the Catatonic Before and After His Episode.

This study, based on 40 cases, represents an attempt to discover whether social maladjustment is an important element in catatonia and what the psychiatric social worker may be expected to contribute to the situation. Most of the discussion centers around a group of 20 that had been out of the Hospital from four to seven years, and with whom intensive psychotherapy or social service had been used.

In this latter group it was found that two had regressed to a childhood level of adjustment, three were living vegetatively happy lives, and that the rest were adjusting on the same or a higher level than before the onset of the psychosis.

The rôle of the psychiatric social worker in effecting such adjustments is discussed.

Kilpatrick, Mary (Boston State Hospital, 1922). A Study of Personality and Onset in Forty Cases of Dementia Praecox.

Twenty-six cases were studied through hospital records, and fourteen, selected at random, through home interviews. A history of personality traits before the onset of the disease showed a large proportion classified as "sensitive," "high strung." Most of them were rated high on emotional and low on social qualities.

Wilson, Anne (Manhattan, N.Y., State Hospital, 1923). Four Dementia Praecox Patients with Criminal Records.

Four detailed case studies. In all cases several crimes preceded the recognition of the psychosis. Hereditary findings were negative. Fathers were all autocratic; there was little supervision of the patients as children; physical conditions of the homes were poor. In personality traits, all were sensitive as children, but the basis for inferiority was obvious. All were excessively alcoholic, given to truancy, and illicit sex conduct.

Manic-depressive

Arrington, Winifred W. (Boston State Hospital, 1921). Study of 347 Cases of Manic-depressive Psychoses at the Boston State Hospital

between 1907 and 1916, 347 persons at the Hospital were diagnosed as manic-depressive, excluding those who died and those transferred to other institutions. In 1920, three hundred were outside the hospital jurisdiction. Questionnaires, sent to the relatives of these persons, were answered by sixty, of whom this study mainly deals, though the hospital records of all 347 were analyzed.

There were twice as many women as men. Duration of first attack averaged seven months; recurrent attacks, twelve months. Average interval between attacks, 3.4 years. Age at onset, 24-44, with the peak at 39.

Of those sixty for whom questionnaires were returned, eight had died and twenty were in mental hospitals, while forty showed no symptom of the disease and the rest showed mild symptoms.

Goodrich, Helen (Boston State Hospital, 1926). Social Problems Relating to Manic-depressive Psychoses.

A study of the fifty-two women diagnosed manic-depressive and admitted between 1924 and 1925. The possibility of suicide, economic stress—due to inability to continue work, to extravagance and destructiveness of the manic phase—maladjustment in the home situation, and the creation of public nuisances are the manic-depressive patient a social problem. Two case studies show complications that may result.

Petersen, Hilma (Danvers, Mass., State Hospital, 1930). A Study of Thirty-six Manic-depressive Cases in Whom the Economic Factor Appeared to Have a Bearing on the Psychosis.

Of the 84 cases diagnosed manic-depressive at the Hospital between June, 1929, and May, 1930, there were 36 in whom the economic factor seemed to be the cause of the psychosis. The heredity, life history, and personality of these patients were compared with those of the remaining 48.

Two-thirds of the "economic" group showed a positive heredity, a considerably larger proportion than was found in the "non-economic" group. Economic pressure, however, appeared to be an aggravating causal factor and, in some cases, the precipitating factor in the psychosis.

The two groups are compared statistically for various traits and brief case histories are given of all the "economic" group.

Wheeler, Arlene (Danvers, Mass., State Hospital, 1930). A Study of Twenty-eight Manic-depressive Cases Showing Suicidal Threats and Acts.

The cases in this study were selected from the same group of 84 as those studied by Petersen and included all those persons who attempted suicide. This group was contrasted with the remaining 56 who did not attempt suicide.

More of the suicidal group were found to have a positive heredity and more were under great emotional and environmental strain. Fewer precipitating causes of the psychoses were known in the suicidal group and what causes were known

seemed of a less intense character. The suicidal group thus appeared to be more generally unstable.

Brief case studies of all the suicidal patients are included.

Rodee, Evelyn (Danvers, Mass., State Hospital, 1929). A Study of the Social Aspects in the Recurrences of Fifty Depressive Patients.

Fifty patients suffering from manic-depressive psychoses who were returned to the Hospital between January 1, 1927, and January 1, 1929, were studied to see whether there were social factors that might help to account for the recurrence of the disease.

There was some evidence of fewer recurrences in those patients who came from homes in which both parents were living and in which the other members of the family were quite stable emotionally. These patients were better adjusted to their homes and to their work than were the others. Two-thirds of the group having fewest recurrences showed a definite environmental precipitating cause for the attacks, while but one-half of those with more recurrences showed such causes.

Trump, Elizabeth V. (Foxboro, Mass., State Hospital, 1922). The Cases of Manic-Depressive Psychosis: a Study of the Social Situations Discovered at the Onset of the Attacks.

Three studies illustrate types commonly found in state hospitals: a middle-aged person whose own interests are accomplishing the cure; one with whom the difficulty lies in a present situation and who must have the aid of a psychiatrist; one needing long-time supervision in whom the problem is solely social in nature.

Other Psychoses and Neuroses

Ehler, Ethel (Foxboro, Mass., State Hospital, 1927). A Study of the Records of Forty-three Male Alcoholic Patients Admitted to a State Hospital During a Five Year Period.

A study of all the male alcoholic patients (43) in the hospital January 1, 1927, or on visit during the years 1922-1927.

The percent of admissions showing alcoholic psychoses fell in 1921 (compared with the 1915-1920 period), rose in 1923 and 1924, and declined slightly after that.

Thirty-three patients showed purely alcoholic psychoses while in ten cases alcoholism complicated other psychoses. In the first group 75% were "solitary" drinkers, and one-half had "unsatisfactory" sex lives. Very few had undesirable personality traits. In the other group 70% drank in crowds but in other respects the groups were much alike. Findings for family backgrounds and environmental factors were largely negative, and it is concluded that the causal factors lie more in the make-up of the individual than in his environment.

Worrich, Lorraine (Worcester, Mass., State Hospital, 1930). A Study of the Various Types of Psychoses Associated with Pregnancy.

The study deals with thirty married women patients known to the Hospital between 1929-1930 who had suffered from post-partum psychoses. Eighteen had returned to their own homes. The twelve still in the Hospital were chosen on the basis of their ability to cooperate in the study. Material was secured from hospital records and from personal interviews with the patients.

Eleven women had had previous psychotic attacks, in seven of whom the attacks were also associated with child-birth. The psychoses were of the types frequently found in hospitals (16 dementia-praecox, 6 manic-depressive, and 8 largely organic psychoses) and there was nothing sufficiently distinctive to differentiate them from psychoses occurring at any other period in life.

The physical complications incidental to pregnancy were rarely precipitating factors. In those cases in which sexual relationships were satisfactory, pregnancy and child-birth were less frequently important as possible contributory factors in the psychosis than was the case with other patients. Following the removal of strain a great improvement was noticeable in all patients.

Worrich, Beth (Boston State Hospital, 1928). The Relation Between the Personality and the Environmental Factors in Ninety-three Cases of Involution Melancholia.

Ninety-three cases studied by Dr. J. O. May in forming his hypothesis that involution melancholia is a clinical entity with the climacterium as an etiological factor. 25 men and 70 women.

60% of the men and 35% of the women were single. All the married men had children but 16% of the married women had children. The first child was born to the women between 30-35 in 44% of the cases. Since they were almost entirely of skilled or unskilled worker status, this seems unusually late.

60% of women had the onset of the psychosis between 40-49; 60% of men, between 50-59.

90% of the women reported difficulty at menopause.

90% showed deviations from normal personality before the psychosis set in, even among the normal there was a tendency to sensitiveness and worry.

The study did not bear out the theory that involution melancholia is due to maladjustment.

Margaret (Connecticut Society for Mental Hygiene, 1927). The Anxiety Neuroses of Fifty Women Patients, and the Influence of the Mother's Neurosis on the Behavior Problems of Her Children.

One-half the cases studied were private patients and the other half came from the psychiatric clinic of the Connecticut Society for Mental Hygiene. The study was made on the basis of completeness of records, women with marked

physical or mental disabilities being excluded. Modal age, 30-40; all but nine were married. Clinic patients were largely of foreign extraction, marginal economic status, and had an average of two children. Private patients were American, of comfortable status, with one child, none of them having more than two.

84% were dissatisfied, largely on economic grounds and because of heavy responsibilities; 58% were emotionally retarded, due largely to the attitude of their parents or to sex traumas; 78% lacked affection for their husbands. Only 20% had physically normal intercourse with their husbands, and none secured satisfaction.

10% of the clinic and 46% of the private patients whose progress was known showed marked improvement under psychotherapy.

Eight case studies.

About half the mothers in both groups had "problem" children.

Mitchell, Betsey (Boston Psychopathic Hospital, 1921). Social Work with Traumatic Neuroses.

A description of the disease, a history of its legal implications, and a discussion of fourteen cases. Linked up as it is with the question of malingering, especially in industrial accident claims, the question of diagnosis is of real importance. The social worker can help in assembling the facts and in treatment.

Brown, Katherine (Boston Psychopathic Hospital, 1922). Possibilities of Social Work with Constitutional Psychopathic Inferior Patients.

The value of records in diagnosing, treating, and supervising such patients is discussed, and five case studies are given as illustrations.

Crouse, Dorothy (Manhattan, N.Y., State Hospital, 1922). Life Reaction Disorders of Psychopathic Personalities.

Three case studies showing the reactions of psychopaths with dull-normal intelligence. All showed a family history of emotional instability.

Olson, Elma Marie (Manhattan, N.Y., State Hospital, 1923). Study of the Emotions in Psychopathic Personalities, Based on the Pressey X-O Tests.

Twenty-four patients of psychopathic personality, but having no psychosis, were studied by means of Pressy X-O tests; twelve men, twelve women. Age range, 16-37; average 26. Mental age, 14-16.

Results obtained were compared with a tentative norm based on 114 college students. The norm was most nearly approached in anxiety tendency and departed from in richness of emotional association. In total affectivity the women were nearer the norm than the men. Men showed greatest affective response to the fear of hypochondriacal words and women to suspicion and hypochondriacal words. Five case studies show that the emotional score on the test compares favorably with emotional make-up revealed in the history.

Grill, Hilda (Foxboro, Mass., State Hospital, 1927). A Study of the Conduct Disorders of Thirty Psychopathic Personalities.

All the psychopathic personality cases (30) in the Hospital between 1914 and 1927 were studied. One-third of the group had no custodial care until age thirty. Half had I.Q.'s above 80; half below that point. Seventeen were married, nine separated and divorced, and four unhappy in their marriages. Twenty presented sexual irregularities; fifteen had been arrested for various offenses; and all showed conduct disorders of some type.

Woods, Marian (Worcester, Mass., State Hospital, 1929). A Study of Twenty-three Psychoneurotics Admitted to the Worcester State Hospital.

An analysis of the case records of the twenty-three psychoneurotic patients admitted to the Hospital between 1926 and 1929. Nine were between 20 and 30 years old; the rest were older. There was a large proportion of typical, borderline cases.

Two-thirds showed positive family histories of personality disorders but there were a few psychoses among their relatives. 43% were above the average of the population in intelligence. Home situations and sex life seemed to be important factors while physical defects played a minor rôle. Thirteen out of the twenty-three were responding well to hospital treatment.

Wolpin, Edith (Michael Reese Dispensary, Chicago, 1930). The Neurotic Child: a Study of Fifty Children Manifesting Functional Nervous Disorders.

Forty cases of children diagnosed as psycho-neurotic, emotionally unstable, emotionally infantile, or having marked feelings of inferiority were selected at random from the clinic files. Ages ranged from four to sixteen.

The group as a whole was found to be extremely restless and excitable, hypersensitive and irritable, showing personality rather than anti-social behavior problems. The mothers of 67% of the children were also neurotic; the fathers of half showed marked marital discord; discipline was faulty in 70% of the cases, and the parent-child relationship unwholesome in 75%.

The children themselves showed an undue proportion of external defects which marked them as conspicuous in the group, and they had had numerous debilitating diseases. The emotionally unstable group was differentiated from the other by inferiority feelings in that it showed more problems of an anti-social type and that its difficulties seemed traceable to environmental rather than to physical causes. The psychoneurotic group had few physical disabilities and a preponderance of neurotic mothers. The problems of the emotionally infantile group were also largely traceable to the mothers' attitudes.

Other Diseases or Defects

Wainford, Helen C. (Barnes Hospital, St. Louis, 1924). The Paretic Child in His Home: a Study of Seven Cases from the Tryparsamide Clinic of Barnes Hospital, St. Louis.

An intensive study of seven parietic male patients given tryparsamide therapy at the Barnes Hospital, St. Louis; to determine their adjustment in their homes during treatment. A clearing of the mental processes was found in some, while in others the progress of the deterioration was arrested.

Moffit, Margaret (Boston State Hospital, 1920). Social Problems Relating to Neurosyphilis.

Sixty cases of neurosyphilis were chosen at random. The character changes accompanying the disease creates special problems for the individual and his family. The social worker is useful in supervising the treatment of the disease and in aiding in adjustment.

Howgate, Mary (Boston Psychopathic and Munson State Hospitals, 1921). The Epileptic in Industry, a Study of the Industrial History of Twenty-eight Male Epileptics.

A description of the jobs held by epileptics before they became patients in the hospital. The need of training them in occupations suited to their diseases and their capacities is discussed.

Killam, Mary W. (Worcester, Mass., State Hospital, 1927). Some Aspects of the Relations between Crime and Psychiatry.

All known court cases sent to the Hospital from 1881 to 1926 (108; 78 men and 30 women) were studied to learn the disposition of cases by the Hospital and to gain a picture of the type needing long institutional treatment.

In the crimes which were committed those against "decency and good order" were most frequent (42) and those against persons (27) and property (26) next. Psychiatric diagnosis showed 26 without psychosis and three "defective delinquents." There was no correlation between the seriousness of the crime and the type of psychosis.

By 1927, 43 had been discharged from the hospital or some other institution.

Detailed discussion of many cases leads to the conclusion that individualization in investigation, diagnosis, and treatment is necessary.

Winslow, Dorothy (Boston State Hospital, 1926). A Study of Fifty Boston State Hospital Patients Charged with or Convicted of Crime.

A study of all the cases of this type that were referred to Social Service Department of the Hospital during 1924-26. Most frequent offense was drunkenness (22); then larceny (16), and assault and battery (10). These patients were found to be similar in psychosis, personal factors and background to the other patients at the hospital, their crimes being largely chance events, not really distinguishing them from others of their type.

Six case studies illustrate the different crimes they committed.

Dinsmore, Kate (Dallas, Texas, Child Guidance Clinic, 1924). A Study of Personality Differences in 150 Mentally Defective Children.

All the cases (150) of borderline or moron intelligence referred to the Clinic between February, 1923, and June, 1924, were studied. They made up 27.5% of the total referrals. 50% were of borderline intelligence; 33% were high-grade morons.

The analysis of the cases followed an outline suggested by Dr. Howard Potter and the analysis of personality traits. Illustrative cases are given.

Rampson, M. Louise (Foxboro, Mass., State Hospital, 1929). Types of Emotional Difficulty in Children and Their Treatment as Observed in Forty Cases at the Brockton Neuropsychiatric Clinic.

Forty cases selected by the Director of the Clinic to illustrate types of children being there as patients: 28 boys, 12 girls, 60% being between 8 to 11 years of age; 30% had I.Q.'s above 110; 20% were under 80 in intelligence.

Cases were grouped into five types recognized by the psychiatrist in charge as basic to their difficulties: inherent mental handicaps—22.5%; inherent physical handicap—25%; psychic trauma within the home—35%; psychic trauma from environment—10%; combinations of these—7.5%.

Case histories of children representing each type are given, and certain facts about the others are discussed. The case of a child who was successfully psychoanalyzed is included.

B. SOCIAL ORIGINS OF MENTAL DISEASES

Sackett, Helen May (Worcester, Mass., State Hospital, 1929). Religious Elements in the Psychosis as Related to the Social Background and Religious Training of Twenty-nine Women Patients.

All the psychotic women (29) entering the Hospital in February and between March 20—April 19, 1929, were interviewed on the subject of their attitude toward religion and their religious training. This material was supplemented by the case histories.

Twenty had some religious element in their psychosis. Comparison of these with the nine who had no religious element in the psychosis showed no relationship between this concern and age, education, economic status, and church membership. All cases of involution melancholia and dementia praecox showed religious concern. Single women, those having strict religious training in childhood, those attending church regularly, and those believing in a God of anger and retributive justice were more apt than others to have a religious element in their psychosis.

The form this religious element took seemed to depend on the type of psychosis and the character of the patient. Religious training seemed rather to be a symptom than to cause the psychosis. Numerous illustrative cases scattered throughout the text suggest that the church might profit by a knowledge of psychiatry.

Crutcher, Hester B. (St. Louis and Dallas Child Guidance Clinics, 1923). A Study of the Environment of One Hundred Psychopathic Personalities.

The cases of 27 girls and 73 boys diagnosed as being of psychopathic personality were studied. Age range, 4-18, with mode between 11 and 14.

Two-thirds showed no mental disturbances among parents or siblings. One-half came from homes characterized as quarrelsome; one-fourth had siblings who were delinquent. Only one-fourth lived in unbroken homes. These and other statistics suggest that environment is more important than heredity in the production of a psychopathic personality.

Two case studies.

Gorovitz, Martha (Boston Psychopathic Hospital, 1927). A Study of the Influence of Environment and Social Factors in Psychoneurosis.

A study of all the cases (71) known to the Social Service Department, 1922-1926; 26 men, 45 women. 32 were foreign born, and all but four of the others had foreign born parents. These facts of change of country or conflict between the generations due to the change are shown to be factors in the maladjustment process.

The Jewish (25) and non-Jewish (46) patients were then compared, and the conclusion drawn that Jews perhaps succumb to less intense situations than do non-Jews.

Illustrative cases throughout.

Hegner, Nancy (Public Health Service, American Red Cross, Cincinnati, 1921). Environment as an Etiological Factor in Psychoneurosis.

A study of 26 ex-service cases diagnosed as suffering from psychoneurosis. Causative factors and the effect of treatment carried on by a psychiatric social worker are discussed.

Henderson, Bernice (Boston Psychopathic Hospital, 1922). Environmental Factors in the Cases of Adolescent Girls Studied at the Boston Psychopathic Hospital.

Case studies of seven representative adolescent girls sent to the Hospital for observation: an analysis of the factors in their home backgrounds that might account for their condition and a description of the treatment for a year following discharge from the Hospital. Poor discipline and lack of suitable recreational facilities figured in all the cases, and all showed psychologically inadequate home backgrounds.

Johnston, Nancy (Foxboro, Mass., State Hospital, 1923). Juvenile Manifestations of Subsequent Mental Disease.

14 out of 869 hospital patients showed symptoms of mental disease in childhood. Twenty-five were chosen for intensive study. Their case records were supplemented by personal interviews with their relatives.

School difficulties (53) was the most frequent symptom, followed by sensitiveness (38) and economic inefficiency (32). Truancy, sex delinquency and drinking occurred seldom. Only nine showed court records. Forty-three cases showed mental disease or alcoholism in their family.

Twenty-five brief cases.

Michesky, Frederika (Foxboro, Mass., State Hospital, 1928). A Study of the Social Situations of Thirteen Families in Which Two or More Siblings Were Patients in a State Hospital.

All of the cases of this type (28 cases; 13 families) in the Hospital during the past ten years were studied. The incidence of mental disease in siblings, parents, uncles, aunts, and grandparents is shown on charts. Only one parent was psychotic, but there were five families with some history of mental disease. The psychoses of siblings tended to be similar—nine out of thirteen falling within the same classification. Age at onset tended to be similar within a family. All but two families were characterized by definite social tension. Histories of all cases are included.

McCreery, Mary Agnes (Danvers, Mass., State Hospital, 1929). A Study of the Early Life of Nine Patients with Manic-depressive Psychoses.

In February, 1929, there were 32 patients in the Hospital diagnosed as manic-depressive and under 40 years of age. In 17 cases the diagnosis was later changed. Of the other 15 only nine had reliable sources of information in regard to their childhood. These formed the basis for this study.

The cases were analyzed for physical and environmental factors in childhood that might have contributed to the disease. In four cases the disease seemed to be due to a combination of defective constitutional equipment and a bad environment. Two others showed questionable inheritance and poor environment, the latter being most defective in habit training and education to responsibilities. In the other three cases there was nothing in the history to indicate superior constitutional endowment or environment, but the patients were all differentiated from their siblings by some specially unfavorable elements. Nine cases are given in outline form.

Row, Louise (Worcester, Mass., State Hospital, 1928). A Study of the Early Home Situations of Fifty Patients Admitted to the Worcester State Hospital.

The histories of fifty psychotic patients are compared with those of fifty non-psychotic individuals.

The groups differed in economic status (twenty-two psychotic and eight non-psychotic being dependent) and education (fourteen psychotic as compared with

two non-psychotic being illiterate). A comparison by personality traits showed the psychotic patients much higher in those traits making for social maladjustment. (Grouping the traits another way, the psychotic patients greatly exceeded the non-psychotic persons in passivity and withdrawal and were exceeded by them in "excessive consciousness of self" and aggression.)

Definitely more of the psychotic patients had alcoholic, delinquent, or mentally abnormal parents, were markedly devoted to one or both parents, and were the favorite children, while the groups did not differ in the matter of broken homes, type of discipline, or ordinal position.

Six case studies of psychotic patients.

Perry, Clara Elizabeth (Boston Psychopathic Hospital, 1924).
Study of Early Histories of Dementia Praecox Patients Suggesting Possibilities of Prevention.

Five cases referred to the Social Service Department, selected for study on the basis of availability of material (three were carried by the writer, two by a fellow-worker), were studied in an effort to show the psychogenic basis of the disorder.

Shapiro, Sadie (Manhattan, N.Y., State Hospital, 1923). A Study of the Personality Traits of the Siblings of Ten Hebrew Dementia Praecox Patients.

Personality studies, according to plan formulated by Hoch and Amsden, were made of the siblings of ten dementia praecox patients. All belonged to Orthodox Jewish families and lived on the East Side of New York. Modal age was 25. None were found mentally diseased and only one sibling (out of 26) was feeble-minded, but nearly all showed shut-in, seclusive traits and many conflicts.

Veo, Louise (Boston Psychopathic Hospital, 1930). Personality Studies of Children Who Later Became Psychotic.

Among the patients of the Boston Psychopathic Hospital were found eight persons who, from two to ten years previously, had been studied by the Jung-Baker Foundation. The Foundation records are abstracted in this study as an attempt to discover whether mental disease can be predicted on the basis of certain personality traits.

In six of the eight cases the Foundation found serious maladjustments in the patients when they were children, but a prognosis of a mental breakdown was made in only two cases. Three of the four children who later developed dementia praecox showed a constellation of traits usually described as schizophrenic.

In those children who were first examined before the age of puberty there was no evidence looking toward a mental breakdown, but soon after puberty mental symptoms were noted. The treatment recommended by the Foundation was carried out in only a few cases, and those individuals were beyond the age of puberty when first examined. There is thus little evidence to show whether early treatment would have prevented the psychosis.

Margaret D. (Boston Psychopathic Hospital, 1927). Social and Environmental Factors in the Behavior Reactions of Nineteen Neurotic Children.

Nineteen cases were selected for study on the basis of their diagnosis, age (6 to 10), I.Q. (over 100), and the fact that they attended school. Physical findings were negative on the whole.

Seven were oldest, five youngest, and two only children. Three came from homes of luxury, and six from comfortable homes. Domestic friction was acknowledged in eleven cases, while in seven information on this subject was lacking. Thirteen out of seventeen mothers, and twelve out of fifteen fathers for whom information was available were described as neurotic. All the girls were separated from their mothers at from two to four years of age. Extensive treatment carried on in three cases was not of great assistance in overcoming the difficulty.

FOLLOW-UP STUDIES

Key, Eileen (Worcester, Mass., State Hospital, 1930). A Follow-up Study of Children Previously Attending Special Classes.

The after-careers of fifty children leaving a "special class" of the Worcester State Schools, between 1927 and 1929 were studied through personal interviews with their parents. There were 20 boys and 30 girls; I.Q.'s ranged from 58 to 79. According to standards of success outlined in the study, 13 were adjusting well, 16 satisfactorily, 12 poorly and 9 were considered failures. Intelligence was not found to differentiate these groups. The girls adjusted somewhat better than the boys. Favorable parental attitudes and desirable personality traits led to successful adjustment.

Annan, Margaret (Manhattan, N.Y., State Hospital, 1927). Some Factors in the Successful Social Adjustment of Six Cases of Dementia Praecox, Hebephrenic Type.

A follow-up study, five years afterward, of six men suffering from dementia praecox, discharged as recovered or improved and not returned to the Hospital. Five were found well-adjusted in their work, four using it as a means of emotional satisfaction. In five cases the families helped to make adjustment easy. A prognosis had been considered unfavorable in several cases. Six case studies.

Blanche E. (Illinois Institute for Juvenile Research, 1924). The Problem of Social Adjustment Following Epidemic Encephalitis in Children (Published in *Mental Hygiene*, Vol. VIII, pp. 977-1023).

The post-encephalitic condition with its periods of extreme irritability and emotional upsets demands careful adjustment of the home environment to the child. This study describes the situation and shows what the social worker is able to accomplish in the cases of ten children. Treatment consisted largely in directing the adult persons involved in establishing a strict but quiet régime

Scott, Dala (Boston State Hospital, 1925). A Study of One Hundred and Forty Unsuccessful Hospital Parolees.

Out of 346 patients released in 1923, the 140 who were returned within a year are the subject of this study. 55 were under 30 and 57 over 40 years of age; 78 were single. Dementia praecox (58) and manic depressive psychosis were the most frequent psychoses found.

In only 22 cases had the physicians definitely recommended parole. When on visit, only 47 were able to do useful work. 105 were returned due to definite recurrence of the mental symptoms.

18 brief illustrative cases.

Shope, Mary K. (Boston State Hospital, 1927). A Study of Boston State Hospital Cases Discharged Against Advice, July, 1925 to July, 1928.

All the cases (30) discharged from the Hospital against advice between the above dates were studied. 20 women, 10 men; ages 16 to 72.

16 returned to the Hospital, the average time out being ten months, while 14 were still out at the time of study. Various facts about the two groups are tabulated, and four case histories are included.

Sperry, Jeanette (Wrentham, Mass., State School, 1926). A Study of Forty-four Girls Maladjusted while on Parole from a School for the Feeble-minded.

This study is concerned with the 44 maladjusted girls out of the 217 on parole during 1921-1925. Their average I.Q. was 60. Family histories showed poor background.

16 were paroled to relatives, usually against the wishes of the School. On parole, bad traits which were exhibited before admission usually reappeared. 16 were returned to the School because of sex difficulties, 13 because of placement, and two for general inability.

Summaries of all cases are given.

Waterhouse, Eleanor Hale (Foxboro, Mass., State Hospital, 1925). Community Adjustments of Dementia Praecox Patients Released from the Hospital.

42 patients were "on visit" Sept. 1925—May 1926; 26 of these the Social Service Department was in contact with. Of these 26, 15 were found to be adjusted, seven partially, and four maladjusted. All who returned to environments in which the disease was understood and in which the patient was subjected to little strain were well adjusted, while two out of the five who returned to definitely unfavorable environments adjusted well. Three case studies.

West, Harriet (Foxboro, Mass., State Hospital, 1926). The Environmental Adjustment of Married Psychotic Patients on Release from a State Hospital.

15 married, separated or widowed patients officially "on visit" January to May 1926, were studied; 33 men and 55 women.

Twenty women and four men had manic depressive psychoses; thirteen men and six men, dementia praecox.

One-half of the women and one-third of the men adjusted to an outside environment of the same or a superior type to that they were engaged in before admission. Most of the women, however, returned to housework, and this may account for the difference. Half of both sexes adjusted well in their environments.

Three case studies show the rôle of the social worker in the adjustment of these patients.

Wheeler, Ruth (Boston State Hospital, 1928). A Study of Fifty "Criminal Insane" Patients Committed to the Boston State Hospital Under Sections 100 and 104, Chapter 123, General Laws.

This study is concerned with the 50 such cases in the Hospital from January, 1927 to October, 1927; 40 men, 10 women.

These sections provide that all persons showing mental symptoms before trial or while serving sentence shall be sent to a state hospital for treatment.

The age range, 18-60, with over half between 30-50. Alcoholic psychoses were the most frequent in occurrence (13), with manic depressive (10) and dementia praecox (6) being the only other type found in five or more of the patients. Twelve were without psychoses; two had psychopathic personalities; one was mentally deficient and two were without mental defect. Crimes against persons and violation of the drug and liquor law were most frequent offenses.

Twenty were returned to the court for disposition, of whom eight were sentenced to a penal institution and eight were put on probation, while the rest were on file or not prossecuted.

At the time this study was made, six had died, twenty-three were in hospitals, five mentally diseased, five were in penal institutions and sixteen were in the community.

D. EFFECTS ON THE FAMILIES

Mildred (Foxboro, Mass., State Hospital, 1925), Mental Health of Children of Psychotic Mothers.

The 33 psychotic mothers (33) admitted during 1924 who were under 60 and had at least one child under 21 were studied. Hospital records, other social records, and personal interviews with fathers and relatives served as sources of information.

Of the 33 mothers had dementia praecox; 28%, manic-depressive psychosis. This study shows practically same results as one made by Canavan: 72% of the children were normal; fourteen were "nervous," eight showed conduct disorder, three were feeble-minded, and five retarded. Two had dementia praecox. Numerous illustrative cases.

Rockwell, Olive (Foxboro, Mass., State Hospital, 1923). The Family's Attitude Toward a Psychopathic Member.

A study of 105 patients known to the writer. The various attitudes of the relatives toward them are described and the causes analyzed. A favorable attitude was found of great value in the treatment and adjustment of the patient. Unfavorable attitudes were found largely based on ignorance of the disease and a feeling of disgrace.

Wells, Ada (Worcester, Mass., State Hospital Child Guidance Clinic, 1927). A Study of Fifteen Maladjusted Children Each of Whose Parents Had a Parent in a State Hospital.

113 married patients under 60 years of age and having children were admitted to the Hospital in 1926. 42% had maladjusted children, the proportion being higher among those with functional psychoses.

In 15 families the children were patients at the Child Guidance Clinic. The studies and discussion of each of these are given and the conclusion drawn that the mental disability of the parent was a definite factor in the children's problems both directly, while he was in the home, and indirectly due to the economic and social losses occasioned by his removal. Several cases showed the possibility of inheritance of mental instability.

Williams, Prudence (Boston Psychopathic Hospital, 1925). A Study of Some Familial Influences Upon Children.

Four case histories of families in which one member was a patient of the Hospital but lived at home. All were of immigrant stock, rather low intelligence and of marginal financial status. The effect on the children (not easily summarized) is discussed.

E. LEGISLATION

Hamm, Florence G. (Boston State Hospital, 1927). The Three-Five Day Observation Commitment Law in Massachusetts and Its Relation to Social Service.

There were 96 cases in the Hospital under this law in 1926. Forty were discharged at the end of the observation period. Of these six reentered the Hospital within the year. The case histories of these patients are given and the conclusions drawn that the observation period should be lengthened and that there should be supervision of all discharged cases by the Social Service departments, as much preventive work could be done.

McCabe, Elinor Johnston (Boston State Hospital, 1920). Legislation on Commitment in Massachusetts With Particular Reference to Insanity, Epilepsy, Feeble-Mindedness and Contagious Diseases. A historical review of the laws.

F. SOCIAL WORK PRACTICES

Fernell (Manhattan, N.Y., State Hospital, 1924). The Place of Psychogenetic Material in Psychiatric Case Records.

A study of case records from a hospital for the mentally diseased to show what type of material should be included in the record in order to make possible a psychogenetic interpretation of the case. 150 records were analyzed on the basis of the concrete acts they portrayed, and the method of concrete acts shown helpful as illustration but useless in itself. Twenty-five records of cases closed successfully were studied to show what material in them had proved useful to the psychiatrist. It was concluded that records must contain material for dynamic psychology.

Dorothy Q. (Cornell University Clinic, 1921). Inadequate Social Examinations in Psychopathic Clinics.

A discussion of the value of the social worker in diagnosis and treatment of mental diseases.

Esther (Public Health Service, American Red Cross, New York, 1921). Developments in the Field of Mental Hygiene During the Past Eighty Years.

A survey of mental hygiene theory with special emphasis on the theories of Ray (1850), Hoch (1873), and recent physiological and psychological investigations.

Cornelia D. (Boston Psychopathic Hospital, 1920). Development of Social Trends in Mental Hygiene.

A historical review of the treatment of the mentally diseased in America as influenced by the development in one institution, the Northampton State Hospital, and a discussion of the social trends in the mental hygiene treatment of the groups.

Elizabeth O. (Boston State Hospital, 1924). Social Service Work with the Psychopathic Personality.

Case studies showing the treatment carried on by the social worker from the beginning to the end of the five years—usually without much success. The need for clearer psychiatric diagnosis and the underlying mechanisms is stressed.

Edith (Michael Reese Dispensary, Chicago, 1930). A Study of the Results of Occupational Therapy with Mental Patients.

A description of the occupational therapy shop connected with the out-patient department of the Michael Reese Hospital and an analysis of its results with 38 patients. The shop is about two years old and has treated 38 patients. 10 improved greatly during attendance at the shop; 14 improved somewhat, and 14 did not improve at all.

Improvement was found to have no relationship to sex, diagnosis, intelligence quotients, work adjustment or social adjustment before the onset of the disease, or to the attitude of the families. It was found to bear some relation to age, marital condition, financial status, personality, education, medical history, home adjustment, cooperation on the part of the patient, and the length of attendance at the shop.

McBee, Marian (Michael Reese Dispensary, Chicago, 1927).

Study of the Changes in Behavior of Three Cases of Psychopathic Personality Correlative to Social Treatment.

Three cases, a mother and her two daughters, carried from two to three and a half years are given in detail. In the mother fixed habits interfered with a good intelligence helped her adjustment. One daughter, dull-normal, was aided slightly, while for the other—younger and with a higher I.Q.—the program was considered good.

Porter, Annie C. (Boston State Hospital, 1925). A Study of

Results of Different Types of Social Therapy in Relation to Different Types of Mental Disease.

Fifty-three cases, selected to illustrate different mental diseases, with which intensive work had been done. Mental hygiene with the patient, arrangement of environment, and explanation to relatives were the types of treatment used by the social worker. Manic depressives and paranoids responded best to mental hygiene, dementia praecox to occupational therapy, while with the psychotics and psychopaths, success depended more on the personality and the social situation than on the type of treatment. Work with the mentally deficient was generally unsuccessful.

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THE SOCIAL ADJUSTMENT OF CHILDREN OF LOW INTELLIGENCE

A FOLLOW-UP STUDY OF TWENTY-SIX DULL-NORMAL
PROBLEM CHILDREN¹

IDA OLIN

In recent years child welfare programs have been greatly supplemented and enriched by the mental hygiene movement. The new psychiatry not only has given an interpretation of the social behavior of the individual but has suggested ways in which personality can be modified by early environmental experiences. Child guidance clinics have been perhaps the chief agencies to benefit from these new psychiatric principles, but, because they have so recent origin, there has been little opportunity to determine their success in the treatment of problem children. This study is a step in the direction of evaluating results. It attempts to describe and to account for the present adjustment of a group of children studied at the Minneapolis Child Guidance Clinic three to four years ago.

The clinic, established in the autumn of 1924, was the first complete mental hygiene unit to be operated entirely within an urban public school system. Its establishment followed directly from the termination of the Twin City Demonstration Clinic which had been organized and maintained for a year by the Commonwealth Fund of New York.

The aim of the Clinic, as stated in its annual report, is "to aid the ignorant, perplexed, or genuinely interested adults in their understanding and guidance of the disturbed child. In cooperation

This thesis submitted to The Smith College School for Social Work in August, 1930, is based on case records and material collected by the student during her period of work at the Minneapolis Child Guidance Clinic.

with parents, teachers, and agency workers, the Clinic endeavored to assist disturbed children to an improved physical and mental condition, to a more adequate and gratifying intellectual expression and achievement, and to a satisfactory emotional stability—fundamental factors which tend to facilitate academic progress, vocational selection, acceptable recreational satisfaction, and ultimate social adaptation.”²

Since this clinic is an integral part of the school system it seems to present definite advantages for a follow-up study of a group of cases which constitute a school problem—the dull-normal child. As schools are now organized, the dull-normal child has little opportunity to succeed. He is above the mental level of the “special class” group and below that of the regular graded public schools. He is almost forced to compete in a school program made for the average child, where he is constantly confronted with a sense of failure. Children in such a situation would seem to present an especially difficult problem to a child guidance clinic, and it seems worth while to inquire into how much a clinic had been able to accomplish with a group of them.

The group selected for follow-up study was composed of the children with I.Q.’s of 85 or less who had been patients of the Minneapolis Child Guidance Clinic three to five years ago. The aim was to discover how these children were progressing in school, how they were adjusting in their social relationships, and what part clinic treatment and other environmental forces had played in their adjustment.

In selecting the cases, only those problem children who had been given a complete study (psychological, physical, and psychiatric) by the Clinic were included. In order to control the personal factor in the psychiatric treatment, all Demonstration Clinic cases were eliminated, and only those cases seen at the Clinic between January, 1925, and January, 1927, were chosen. In other words, the children were all originally treated by only one psychiatrist. This selection of cases allowed a three to five year interval to elapse between the initial study and the follow-up study. Then, since the adjustment of the children in school was one point of interest, only those were chosen who were still in school; that is, children who were sixteen years of age or under.

² Chamberlain, Herbert E., “Child Guidance Clinic,” *Annual Report of the Minneapolis Public Schools, 1928-1929*, p. 1.

Thus out of all the cases given complete study by the Clinic between January, 1925 and 1927, those were selected for follow-up study who had shown problem behavior, had I.Q.’s of 85 or less, and were still under the compulsory school age. Forty-two children of this type were found. Their present home addresses and school placements were traced through the Board of Education Census Department. Sixteen cases had to be eliminated because the families had moved from the city, or because the children, upon reaching their sixteenth birthday during the fall semester, had dropped out of school.

METHODOLOGY

The clinic record of each child was read and analyzed, symptomatic behavior problems and all possible causal factors as indicated by the original study being noted. Two follow-up visits were made on each case—one to the mother or mother substitute, the other to the school.

Most helpful in the home interview were the suggestions for the observation of a child’s progress made by Healy and Bronner.³ However, because of the nature of the visit and lack of time it was impossible to follow their suggestions in detail. The interviews varied in length from fifteen minutes to two hours, most interviews lasting about half an hour. In each case an attempt was made to check on the presence or absence of problems noted at time of the original study and any home deviations which seemed to have been factors in producing those problems. A modified questionnaire was used in recording this information and in comparing it with data obtained from the original case record.

In order to facilitate the collection of necessary information from the school, a questionnaire for the teachers was devised. It was submitted to the child’s two most recent teachers, except in the case of children in “special classes.” In these cases the teacher had known the child at least more than one semester. The questionnaire was explained to each teacher before she filled it out.

“Achievement” was defined as meaning the child’s school work as understood in relation to his classmates, whether in special class or in the regular school. In checking the “behavior” traits, the teachers were instructed to rate each child on all of the eight traits. Those

³ Healy, Bronner, Baylor, Murphy, *Reconstructing Behavior in Youth*, Knopf, 1934, p. 146, f.

SCHOOL QUESTIONNAIRE

Permanent Record-Card Information

- a. Grades skipped or repeated _____
 b. Attendance _____
 c. Schools attended _____

Information to be given by Teacher

- a. Achievement (Check)
 Failing Fair Good Very good
- b. Special Abilities _____ Disabilities _____
- c. Class-room Behavior (If average in the trait, check the center column)
- | | | | |
|--------------------------------|-------|-------|----------------------------|
| 1. _____ Respect for authority | _____ | _____ | _____ Defiant of authority |
| 2. _____ Listless | _____ | _____ | _____ Attentive |
| 3. _____ Shows initiative | _____ | _____ | _____ Needs supervision |
| 4. _____ Trustworthy | _____ | _____ | _____ Irresponsible |
- d. Social Behavior
- | | | |
|--------------------|-------|--------------------|
| 5. _____ Unpopular | _____ | _____ Popular |
| 6. _____ Leader | _____ | _____ Follower |
| 7. _____ Sensitive | _____ | _____ Invulnerable |
| 8. _____ Confident | _____ | _____ Timid |

children who were not adequately described by either extreme of a given trait (for instance, neither markedly "respectful of authority" nor "defiant") were to be checked in the center of the column for average.

In securing the information, the purpose of the study was not disclosed. Mothers readily accepted the explanation that the Clinic was interested in "getting a report of children previously studied". The school for the most part was interested to know that the Clinic was "making a follow-up report on old cases". The retardation of the child at the time of the original study was not mentioned.

PRESENT ADJUSTMENT

The twenty-six children to be studied consisted of seventeen boys and nine girls. This sex distribution is in accord with the general clinic distribution, there being about twice as many boys as girls referred for study. Their age at referral to the Clinic ranged from five to eleven years and at the time of the follow-up study from nine to sixteen years, nineteen of the children being then thirteen years or older.

The I.Q. range was from 64 through 85. Twenty-four of the twenty-six children had I.Q.'s above 74. This lack of children with very low I.Q.'s was due to the fact that teachers who were sure that a child was deficient referred him to the Board of Education

psychological Clinic instead of to the Child Guidance Clinic unless outstanding behavior or emotional problems were also present.

In economic status, three children belonged to "dependent" families: they lacked the necessities of life and received aid from public funds or from persons outside the immediate family. Four were classed as "marginal": the families were living on earnings that had accumulated little or nothing and fell into the dependent class during short-time emergencies. Ten cases were classified as "adequate": they were under financial strain but had enough to meet short time emergencies and to maintain a fair standard of living. Six were "comfortable;" that is, they were ordinarily free from financial strain; and three were "affluent"—had large incomes and accumulated resources.

All the children, when first referred, were in the regular graded public school, ranging from kindergarten through the seventh grade. The problems for which they were referred to the Clinic are shown in Table V.

Any study that attempts to determine the relative degree of adjustment of a group of individuals meets the objection that success and failure are subjective terms, based on purely personal judgment. The criticism is largely valid, but even its most vigorous proponents will agree that there are differences between the social adjustment of various individuals and even that the extremes can be quite easily recognized and agreed upon. But if extremes can be recognized, certain crude gradations can be made between extremes and a semblance of a scale of adjustment arrived at.

Given a group of school children, what are some of the commonly accepted criteria by which their relative social adjustment is judged? It would seem that the following are some of the points which the man-on-the-street would look for. How do they get along with other children? Do they have companions of their own age and sex? Is their school work consistent with their intelligence? Do they stand out as problems in the school room, either because of aggressive or restless behavior or because of unusual quietness or shyness? Do their parents find them helpful and happy, or are they a constant source of irritation for one reason or another? What is their reputation in the neighborhood? All of these are questions upon which a certain amount of reliable information can be obtained by a social worker through visits to the home and school,

and, while the answers will be far from "scientific," the material secured should be of some value.

Such a method of judging adjustment was used in this study and the following were the points on which information was secured:

1. *The child's behavior in his home*—Did he fit in harmoniously with the other members of the family?
2. *His symptomatic behavior problems*—Had the problems for which he was referred to the Clinic disappeared? Had any new problems developed?
3. *Friends and interests*—Did the child make friends easily? Were his friends of his own age and sex? Were his interests those usual for his age and sex? Was he "social" or "solitary"?
4. *Home duties*—Was certain work assigned to him at home? What was his attitude toward it?
5. *School progress*—His grade in school and the quality of his work there.
6. *Attitude in the class-room and personality traits shown there*

On the basis of this information the children were placed in five adjustment groups, ranging from those three who seemed very well adjusted, to the six who were rated as poor on at least four of the above six criteria. The first group, to be known as A, seemed to be fulfilling favorably all of the above criteria of adjustment. Five cases fell in the B group. They were rated lower due either to the presence of a symptomatic problem or to their type of friends and interests; in other words, they did not satisfy all of the criteria. Four cases, rated as C, were below standard in at least two of the criteria. Eight cases, the D group, were failing in three of the requirements for a good adjustment. The six cases were noticeably lacking in four or in all of the criteria.

Allowance must be made for the unreliability of a single subjective judgment. However, the writer is fairly certain that Groups A and E are correctly placed, and it is believed that if the B, C, and D groups were rated by several persons they would not be changed on the scale more than one step up or down.

Table I gives, in summary, the data by which the adjustment of each child was judged.

The A, B, and C groups together contained just about half of all the children studied, so it would seem that three to five years after clinic study about fifty percent of this group of dull-normal children were at least fairly well adjusted at home and school.

The grades in school which these children of limited intelligence were able to reach and the quality of the work they did there

interest. If it is granted that a child of seven years should be at least in the first grade, of eight years in the second grade, and so on, it will be seen from Table I that five of these children were in grades in keeping with their chronological age and that seven others were not more than one year retarded. Twelve were in at least the seventh grade, the usual first class in the junior high school, three of these being in the senior high school. Fifteen, including those in special classes, were reported as doing at least "fair" work. All of this would seem to be quite out of keeping with their I.Q. ratings.

In personality traits, as noted by the teachers on the questionnaire (see page 110), there was a considerable range. Those ranked most adequately adjusted were largely described as being "average" in the traits, while the number of "negative traits" increased rather consistently with the decrease in degree of adjustment.

A rather striking difference in type of friends and interests is shown among the various adjustment groups. Those judged best adjusted had friends of their own age and were well liked by the group. Those in the C and D groups were generally solitary or mixed with younger children; but the delinquent children in the D group appeared to be quite as gregarious and popular as the children in the A group, the difference lying in the type of children with whom they associated.

Differences in family attitudes and organization are probably reflected in the category, "home duties," in which marked differences in type of tasks and children's attitudes toward them are to be seen.

FACTORS ASSOCIATED WITH ADJUSTMENT

The important question to be answered is—what can account for these differences in the children's adjustment? A group of other objective traits will be considered first—the age, sex, and grade of the children, their school history, the economic status of their parents, and the problems for which the children were referred to the Clinic.

There seemed to be little relationship between age and adjustment. Only one out of the eight children thirteen years of age or younger was in the A or B group, while a third of the thirteen children over that age were in those groups. But, on

TABLE I
Data on Which Adjustment Rating Was Based

Case Number	Sex, Age, I.Q., and Adjustment Rating	Mother's Estimate	Symptomatic Problems Noted by Mother	School Achievement	Teacher's Estimate of Traits (See key at end of table)	Friends and Interests	Home Duties
1	Boy, 16 yrs. I.Q.—84 Rating—A	Favorite of family; responsible, obedient, industrious	None	10A—fair or good. Repeated 1C, 2C. Skipped 3A by summer school	1.A 5.A 2.A 6.A 3.A 7.A 4.A 8.A	Four boys own age. Reads a great deal; foot-ball, track team, H.S. Orchestra, plays cards.	Mops floors, yard work, some cooking.
2	Boy 12 yrs. I.Q.—80 Rating—A	No trouble; happy-go-lucky.	Slight oral inactivity. Has to be told "time for school"; dirty in play.	5A—good. Repeated 1B; 4A at S.S.	1.? 5.A 2.+ 6.A 3.A 7.A 4.A 8.A	Three or four boys own age. Skiing, sliding; carpentry; dislikes reading.	Few, but willing. Errands to store, wipes dishes occasionally.
3	Boy 16 yrs. I.Q.—79 Rating—A	Helpful; no stealing for two yrs.; seldom lies.	None	9B—fair or good. Repeated 6B, 7A, 8B. Likes new school.	1.+ 5.+ 2.? 6.A 3.? 7.A 4.A 8.A	Three or four boys own age, shuns girls. Out-door activities; takes saxophone lessons.	Hauls ashes, delivers packages, yard work, drives car.
4	Boy 15 yrs. I.Q.—83 Rating—B	No trouble; average child, not obstinate.	Stutters less—only when excited.	Vocational H.S.—failing shop; good in academic. Repeated 1A, 2A, 3B, 5B.	1.? 5.? 2.+ 6.A 3.? 7.? 4.+ 8.A	Four boys own age. Reads excessively; hiking, foot-ball, Y.M.C.A. Club.	Yard work, paper route.

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Case Number	I.Q. and Adjustment Rating	Mother's Estimate	Symptomatic Problems Noted by Mother	School Achievement	Teacher's Estimate of Traits (See key at end of table)	Friends and Interests	Home Duties
5	Boy 15 yrs. I.Q.—83 Rating—B	Favorite boy of the family; pleasing personality.	Avoids physical combat or exposure.	10A—fair. Repeated 1B, 7B.	1.A 5.? 2.? 6.? 3.— 7.? 4.— 8.A	Popular with boys and girls own age. Teaches Sunday School class of little boys; dramatic club, golf; refuses to go to camp.	Few or none; eager to work.
6	Boy 16 yrs. I.Q.—80 Rating—B	No trouble.	No delinquency since excellent probation record two years ago.	Special Class—good or fair. Completed 6A; Repeated 4B, 5A.	1.— 5.A 2.+ 6.? 3.A 7.— 4.+ 8.—	Delinquent boys, younger brother. Attends Big Brother camp; plays in R. R. yards and market.	Few; brings home spoils of market.
7	Girl 14 yrs. I.Q.—79 Re-test—89 Rating—B	Companionable, kind.	Fearful of being taken from foster-mother. Complains of small ills.	7B—fair Repeated 2B; 2A at S.S.	1.+ 5.+ 2.+ 6.A 3.+ 7.— 4.+ 8.A	Sociable; Camp Fire Girls; leader with younger girls; swims; cares for small children.	None.
8	Boy 14 yrs. I.Q.—78 Rating—C	Kind, thoughtful, companionable.	No problems. (Possible over-attachment to mother.)	6A—good or fair. Repeated Kg. A, 1C (3), 2B (2), 3A, 4B.	1.+ 5.A 2.? 6.— 3.? 7.— 4.+ 8.—	Usually with mother at home, prefers this. Church activities; plays horn.	Helps when mother does day-work.

SOCIAL ADJUSTMENT OF CHILDREN

TABLE I
Data on Which Adjustment Rating Was Based

Case Number	Sex, Age, I.Q., and Adjustment Rating	Mother's Estimate	Symptomatic Problems Noted by Mother	School Achievement	Teacher's Estimate of Traits (See key at end of table)	Friends and Interests	Home Duties
9	Boy 12 yrs. I.Q.—76 Rating—C	Improving; kind, thoughtful.	Feels inferior to older brother; incoordination, sensitive.	4B—fair. Repeated Kg., 4B.	1.+ 5.A 2.+ 6.— 3.? 7.? 4.+ 8.?	Older or younger boys; easily teased by boys of own age. Base-ball, foot-ball; expert at bridge and checkers.	None; no handwork.
10	Boy 15 yrs. I.Q.—78 Rating—C	Thoughtful, eager to work; no trouble.	Untidy, temper at school; dislikes special class; ashamed of it.	Special Class—fair or good. Completed 5A; repeated 1C, 1B, 2A.	1.A 5.? 2.+ 6.? 3.? 7.? 4.? 8.	One or two boys own age; never in a gang. Works evenings in a barber shop; movies, Citizens Club for amusement.	None.
11	Girl 14 yrs. I.Q.—78 Rating—C	Improvement over previous nervousness; annoys mother.	Irritable, nervous; bites nails, puts hands on face.	7B—good. Repeated 1A, 2A, 4B, 6B.	1.+ 5.A 2.A 6.— 3.A 7.A 4.+ 8.A	One girl, 12 yrs. old. Plays ball; reads excessively.	Few; unwilling; cleans, wipes dishes.
12	Boy 12 yrs. I.Q.—85 Rating—C	Helpful; no stealing or lying.	Reading disability.	4B—failing. Repeated 1B, 2B, 2A, 3A.	1.? 5.A 2.— 6.? 3.? 7.A 4.— 8.A	Boys own age. Movies every Sunday with a friend; sold magazines until recently.	Carries ashes; lawn work.
Case Number	I.Q. and Adjustment Rating	Mother's Estimate	Problems Noted by Mother	School Achievement	Teacher's Estimate of Traits (See key at end of table)	Friends and Interests	Home Duties
13	Girl 16 yrs. I.Q.—82 Rating—D	Hard to handle; less nervous.	Irritable, magnifies ills, self-depreciatory. Feels school doesn't like her. Can't go down town alone.	9B—failing. Repeated 1C (2), 1A, 2C, 2B, 2A, 3B.	1.+ 5.A 2.— 6.— 3.— 7.— 4.+ 8.—	One or two girls; father forbids going with boys. Plays ball; cares for children.	Few; complains of these; sews a little.
14	Girl 15 yrs. I.Q.—74 Rating—D	Kind, good worker; mother worried over extreme shyness	Very sensitive, bashful, nervous	8A—fair. Repeated Kg., 1C, 1A(2), 3A.	1.+ 5.A 2.A 6.— 3.+ 7.— 4.+ 8.—	Unsocial, seclusive; likes to play with babies. Reads, writes stories, goes to movies	Helps in store; neat, shows initiative.
15	Boy 9 yrs. I.Q.—85 Rating—D	Irritates mother; happier since in special class; better arm coordination.	Very self-conscious; occasional temper outbursts at mother.	Special Class. Completed 3B; Fair or good. Repeated 1B, 2B	1.+ 5.+ 2.— 6.— 3.— 7.A 4.A 8.A	Solitary—few friends; in neighborhood of Jews. Skiing, skating, bicycling, carpentry.	Few; picks up clothes in the morning.
16	Girl 13 yrs. I.Q.—75 Rating—D	Humiliated over class transfer but happier since achieving. Sympathetic, lovable, dependable.	Nervous, bites nails; sensitive, cries; twists story when excited; needs prodding	Special Class—fair. Completed 4B; Repeated Kg, 1B, 2A, 4B	1.A 5.+ 2.A 6.A 3.— 7.— 4.— 8.+	Younger children and babies; friends own age take advantage; won't fight, runs away. Music lessons; teaches little sister to read; skating, skiing.	Washes dishes, cleans, errands to store, sews

TABLE I
Data on Which Adjustment Rating Was Based

Case Number	Sex, Age, I.Q., and Adjustment Rating	Mother's Estimate	Symptomatic Problems Noted by Mother	School Achievement	Teacher's Estimate of Traits (See key at end of table)	Friends and Interests	Home Duties
17	Girl 14 yrs. I.Q.—81 Rating—D	Helpful, obedient; takes responsibility.	Easily irritated; tired all the time; suggestible; conscious of home inferiority.	6B—failing. Repeated 1A(2), 1B, 3B, 4A, 6B.	1.+ 5.A 2.— 6.— 3.— 7.— 4.— 8.—	No friends brought home; accepted at school. Reads excessively	Wants to work outside home; cooks, sews; responsible for home when mother confined.
18	Girl 11 yrs. I.Q.—83 Rating—D	Beyond control; gets on her nerves	Cannot be held to any task; appears immature. Incoordination; sucks thumb since stopped masturbating; craves sweets.	5A—failing. No repetitions	1.? 5.A 2.? 6.A 3.— 7.? 4.— 8.?	One girl of own age; sociable. Bicycling, skating, tennis; music lessons until recently.	Hates to help; will pick up own clothes if prodded.
19	Boy 15 yrs. I.Q.—84 Rating—D	Improving; hard to handle.	Sensitive; wants own way, distractible. Day-dreams; conscious of brother's superiority.	7A—failing. Repeated 3A, 6B, 7B, 7A.	1.+ 5.— 2.? 6.A 3.— 7.— 4.— 8.A	One boy own age; easily teased, boys call "sissy"; liked by adults and children. Inventive; tinkers with old car; tennis, drives car.	Few

Case Number	I.Q. and Adjustment Rating	Mother's Estimate	Symptomatic Problems Noted by Mother	School Achievement	Teacher's Estimate of Traits (See key at end of table)	Friends and Interests	Home Duties
20	Boy 10 yrs. I.Q.—85 Rating—D	Hard to handle	Disobedient; cannot concentrate; Incoordination. Quarrelsome; slow to grasp ideas.	Special Class; Completed 2B; Repeated Kg., 1B, 1A	1.+ 5.+ 2.— 6.— 3.— 7.— 4.— 8.—	Boys own age. Reads, carpentry, boxing, sliding, hiking.	Few; own garden.
21	Boy 15 yrs. I.Q.—64 Rating—E	Uncontrollable	State Training School for "incorrigibility"; erratic behavior	4A—fair. Special Class after 3B in Mpls. Repeated 1C, 2C(2) 2B(2), 2A	1.A 5.? 2.— 6.— 3.— 7.A 4.— 8.A	Not known	Few
22	Boy 15 yrs. I.Q.—84 Rating—E	Uncontrollable	State Training School for stealing. Wants attention, flighty, hard to manage	9B—fair. Repeated 1C (2), 2C, 4B.	1.+ 5.+ 2.A 6.+ 3.— 7.— 4.— 8.+	Delinquent boys, popular, sociable; boxing	Few
23	Boy 15 yrs. I.Q.—80 Rating—E	Uncontrollable	State Training School for truancy. Disobedient, steals	8B—failing. Repeated 1C, 3A, 4A, 6A (2), 7A(2)	1.— 5.— 2.— 6.— 3.— 7.A 4.— 8.A	Delinquent boys, sociable. Part-time work in garage; likes mechanical things.	None
24	Boy 16 yrs. I.Q.—78 Rating—E	Uncontrollable	State Training School for stealing. No inhibitions; irresponsible.	8B—fair. Repeated Kg. A, 6A	1.A 5.+ 2.A 6.A 3.— 7.? 4.A 8.+	Delinquent boys, sociable. Out late nights; parties.	Few

TABLE I
Data on Which Adjustment Rating Was Based

Case Number	Sex, Age, I.Q., and Adjustment Rating	Mother's Estimate	Symptomatic Problems Noted by Mother	School Achievement	Teacher's Estimate of Traits (See key at end of table)	Friends and Interests	Home Duties
25	Girl 9 yrs. I.Q.—66 Rating—E	Uncontrollable	Temper tantrums, destructive, erratic, sensitive, nervous; fears physical injury, poor coordination	Special Class—good. Completed 1B; repeated Kg. A.	1.+ 5.+ 2.A 6.+ 3.— 7.+ 4.— 8.—	Children tease, called "dumb." Popular at school; plays in the street	Few—cleans shelves in the store
26	Girl 15 yrs. I.Q.—75 Rating—E	In an institution; feels sorry for her; "pathetic."	Stuttering, unattractive, careless; wants approval; over-demonstrative	Special Class—good or fair. Completed 5B. Repeated 1B, 1A, 4A.	1.+ 5.A 2.— 6.A 3.+ 7.— 4.+ 8.+	Eager to have friends; obscene notes to boy in another special class. Reads, movies, hiking, cares for children	Receives \$1 a week and maintenance for work in laundry at Home in which she is placed.

Key to Teacher's Estimate (see p. 110)

Trait Number	Extremes of the Trait		Trait Number	Extremes of the Trait	
	Positive	Negative		Positive	Negative
1	Respects authority	Defiant	5	Popular	Unpopular
2	Attentive	Listless	6	Leader	Follower
3	Shows initiative	Needs supervision	7	Invulnerable	Sensitive
4	Trustworthy	Irresponsible	8	Confident	Timid

other hand, the proportion of children in the E group was larger among the older than among the younger children.

TABLE II
Relation of Age to Adjustment

Age	A	B	C	D	E	Total
9	—	—	1	1	1	3
10	—	—	—	1	—	1
11	—	—	—	1	—	1
12	1	—	1	—	—	2
13	—	—	—	1	—	1
14	—	1	2	1	—	4
15	—	1	1	1	—	3
16	2	2	1	2	4	9
17	—	1	—	1	1	3
Total	3	4	5	8	6	26

boys seemed to be making a slightly better adjustment than girls. Seventy-seven percent of the girls were in the D and E

TABLE III
Relation of Sex to Adjustment

Sex	A	B	C	D	E	Total
Boys	—	1	1	5	2	9
Girls	3	3	4	3	4	17
Total	3	4	5	8	6	26

girls, while only forty-one percent of the boys were making an adjustment.

TABLE IV
Relation of I. Q. Rating to Adjustment

I. Q. Rating	A	B	C	D	E	Total
65	—	—	—	—	2	2
66	—	—	—	—	1	1
67	—	—	—	—	—	—
68	—	—	—	—	—	—
69	—	—	—	—	—	—
70	—	—	—	—	—	—
71	—	—	—	—	—	—
72	—	—	—	—	—	—
73	—	—	—	—	—	—
74	—	—	—	—	—	—
75	—	—	—	—	—	—
76	—	—	—	—	—	—
77	—	—	—	—	—	—
78	—	—	—	—	—	—
79	—	—	—	—	—	—
80	—	—	—	—	—	—
81	—	—	—	—	—	—
82	—	—	—	—	—	—
83	—	—	—	—	—	—
84	—	—	—	—	—	—
85	—	—	—	—	—	—
86	—	—	—	—	—	—
87	—	—	—	—	—	—
88	—	—	—	—	—	—
89	—	—	—	—	—	—
90	—	—	—	—	—	—
91	—	—	—	—	—	—
92	—	—	—	—	—	—
93	—	—	—	—	—	—
94	—	—	—	—	—	—
95	—	—	—	—	—	—
96	—	—	—	—	—	—
97	—	—	—	—	—	—
98	—	—	—	—	—	—
99	—	—	—	—	—	—
100	—	—	—	—	—	—
Total	3	4	5	8	6	26

These were based on the Stanford Binet scale.

There was a slight relationship between I. Q. and adjustment. All the children in the A and B groups had I.Q.'s of at least 82, while nearly forty percent of the children in the D and E groups had I.Q.'s under that point. On the other hand, the proportion with I.Q.'s of over 82 was about the same at both extremes. It may be concluded that the I.Q. rating in itself is not a good indication of future adjustment.

Knowing that most behavior problems are purely symptomatic, one would expect to find little relationship between the present adjustment and the problems for which the children were referred. Table V shows this situation.

Truancy occurred only in the E group, while sex delinquency, masturbation, and enuresis were restricted to the D and E groups. Aside from these problems, there seemed to be no significant relationship between referral problems and present adjustment.

TABLE V
Relation of Referral Problem to Adjustment

Behavior Problems	A	B	C	D	E	Total
Truancy	—	—	—	—	3	3
Stealing	1	1	2	1	2	7
Incorrigibility	2	1	1	1	3	8
Lying	2	—	2	1	2	7
Sexual delinquency	—	—	—	1	1	2
Temper tantrums	—	—	1	1	3	5
Fighting	1	—	—	—	—	1
No social judgment	1	—	—	—	1	2
Erratic behavior	1	—	—	—	2	3
Sensitiveness	—	1	1	3	1	6
Distractibility	1	1	1	2	1	6
Fear of physical injury	—	1	—	—	—	1
Sullen, resentful	—	—	1	1	—	2
Desire for attention	1	1	—	2	1	5
Lack of interest in school	1	1	1	—	1	4
Unpopularity	—	1	1	—	—	2
Hypochondria	—	—	1	1	—	2
Irritability	—	—	1	1	—	2
Inferiority feeling	—	1	—	2	—	3
Day dreaming	—	—	1	1	—	2
Incoordination	1	—	1	2	1	5
Speech defect	1	1	—	1	1	4
Masturbation	—	—	—	1	2	3
Enuresis	—	—	—	1	2	3
Nervousness	2	1	1	3	2	9
Feeding difficulties	1	1	—	—	—	2
Untidiness	1	1	1	—	2	5

In comparison with this, it is of interest to find which problems disappeared by the time of the follow-up study, which were still present, and what new problems were noted. Table VI shows the distribution.

Truancy, temper tantrums, and sensitiveness continued in all cases in which they had been present at time of referral. For the most part, untidiness remained. Sex misconduct, masturbation, enuresis, and feeding problems disappeared. Relatively few new problems were noted, but it is obvious that the information on these problems was less accurate than on the original problems. At the Clinic, frequent school transfer is often considered a factor in the child's behavior. The follow-up study showed that there was some relationship between the number of schools attended

TABLE VI
Status of Problems at Time of Follow-up Study

Problems	Cases showing problems on referral to Clinic		Cases showing new problems at time of follow-up study
	Now Present	Now Absent	
Truancy	3	—	—
Stealing	2	5	1
Incorrigibility	3	5	—
Lying	3	4	1
Sexual delinquency	—	2	—
Temper tantrums	5	—	1
Fighting	—	1	—
No social judgment	1	1	—
Erratic behavior	2	1	—
Sensitiveness	6	—	2
Distractibility	4	2	—
Fear of physical injury	1	—	1
Sullen, resentful	1	1	—
Desire for attention	2	3	—
Lack of interest in school	3	1	—
Unpopularity	1	1	—
Hypochondria	1	1	1
Irritability	1	1	1
Inferiority feeling	2	1	—
Day dreaming	1	1	1
Incoordination	3	2	—
Speech defect	3	1	—
Masturbation	—	3	—
Enuresis	1	2	—
Nervousness	6	3	—
Feeding difficulties	—	2	—
Untidiness	4	1	—

and adjustment. (Table VII.) Promotion from grade school to a junior or senior high school in the same school district was not considered as a school transfer, since it did not require a marked readjustment to another school group.

TABLE VII
Relation of Number of School Transfers to Adjustment

Number of School Transfers	A	B	C	D	E	Total
0	2	—	—	1	1	4
1	1	—	3	3	—	7
2	—	2	1	1	—	4
3	—	1	1	2	—	4
4	—	—	—	1	1	2
5	—	1	—	—	1	2
6	—	—	—	—	2	2
7	—	—	—	—	—	—
8	—	—	—	—	—	—
9	—	—	—	—	1	1
Total	3	4	5	8	6	26

On the whole, the children with the poorest adjustment have been transferred the most frequently, but which of these factors was cause and which effect it is impossible to say. The one child in the B group shown in Table VII. as having five school transfers suffered four of these before being brought to the Clinic, while the one child in the E group with no transfers was considered a possible post-encephalitic patient.

There has been much discussion as to the advantage and disadvantage of the "special class" as a means of training of abnormal children, and the Clinic has at times recommended placement there. Table VIII shows the relation between the type

TABLE VIII
Relation of Type of School Attended to Present Adjustment

Type of School	A	B	C	D	E	Total
High School	1	2	—	—	—	3
Junior High School	1	—	—	2	—	3
Grade School	1	1	3	2	—	7
Other Schools	—	—	1	1	—	2
Special Class	—	1	1	3	2	7
State Training School	—	—	—	—	4	4
Total	3	4	5	8	6	26

of school the child was attending and his degree of adjustment. All of the children in the A group were in the regular public schools, while those in the E group were in either a special class or the State Training School. The B, C, and D groups were found in all types of schools.

The proportion of children in a special class increased rather consistently with each decrease in adjustment. This may only mean, of course, that the less hopeful cases were transferred there, but it does at least throw a doubt on the efficacy of these classes in training dull-normal problem children.

The number of school grades repeated shows some relationship to later adjustment. (Table IX.)

TABLE IX
Relation of Grade Repetitions to Adjustment¹

Grade Repetitions Semesters	A	B	C	D	E	Total
0	—	—	—	1	—	1
1	2	1	—	—	1*	4
2	—	1*	1	1*	1	4
3	1	1	1	1	1*	5
4	—	—	1	2*	1	4
5	—	1	1	—	—	2
6	—	—	—	2	1	3
7	—	—	—	1	1	2
8	—	—	1*	—	—	1
Total	3	4	5	8	6	26

¹Stars indicate that the children were placed in special class after the number of repetitions noted.

No child in the A and only one in the B group had more than one semester repetitions, while only a third of the children in the other three groups combined had so few repetitions. Of course it must be remembered that the child's progress in school was used as one of the criteria of adjustment so that this correlation is probably spurious. While it may, therefore, not go far in accounting for adjustment, it does give weight to the validity of the adjustment grouping.

The regularity of school attendance was also somewhat associated with adjustment, as Table X shows. The A group attended both repeated and non-repeated grades regularly, while the E group was irregular at all times. In the other groups many more child-

ren attended their non-repeated grades than their repeated grades regularly.

In general, then, the children's school histories were reflected in their adjustment. Those who were considered best adjusted

TABLE X
Relation of School Attendance to Adjustment

Attendance in Repeated Grades	A	B	C	D	E	Total
Regular	3	2	2	4	1	12
Non-regular	—	2	3	4	5	14
Total	3	4	5	8	6	26
Attendance in Non-repeated Grades	A	B	C	D	E	Total
Regular	3	4	5	7	1	20
Non-regular	—	—	—	1	5	6
Total	3	4	5	8	6	26

were seldom transferred from school to school, attended the regular rather than the special classes, repeated relatively few grades, and were regular in attendance, while those who made the poorest adjustment were characterized by the reverse of these traits.

It has been already stated that the parents of most of the children were of at least middle-class economic status. Table X shows that economic status was not highly associated with adjustment.

Only one child in the A and B groups belonged to a family of less than "adequate" status, while half of the E group were

TABLE XI
Relation of Economic Status to Adjustment

Economic Status ¹	A	B	C	D	E	Total
Dependent	—	1	—	1	1	3
Marginal	—	—	2	—	2	4
Adequate	2	1	2	3	2	10
Comfortable	1	1	—	3	1	6
Affluent	—	1	1	1	—	3
Total	3	4	5	8	6	26

¹ See page 111 for definitions of economic classes.

such a situation, but the C and D groups showed a wide variation in financial standing. It would appear that adequate financial resources were almost necessary to a good adjustment, but that they did not insure it.

The preceding traits showed varying degrees of relationship to adjustment. The problems for which the children were referred, their age and sex, and the economic condition of their families seemed to be poor indicators of adjustment, while their I.Q.'s and their school histories were of somewhat greater value. But none of these traits offered a real explanation of differences in adjustment.

The next factors to be considered are less objective than these and cannot be treated in the same manner. They deal largely with the children's environment and with changes that took place in it between the time of clinic study and the follow-up visit, which might be thought to have a bearing on their adjustment. Table XII summarizes this material briefly, while the case abstracts in which the table was constructed are to be found on page 136f.

In Table XII, Column 1 shows changes in the children's health, "+" indicating a change for the better, "—" for the worse. Column 2 shows the "emotional tone" of their homes. Here "+" indicates either that there was a change for the better and the tone was now favorable to a good adjustment, or that it had always been favorable; "—" indicates the reverse of this situation. The attitudes of the mother and the father toward the child (Columns 3 and 4) are designated in the same manner. Column 5 shows the changes in which some person who influenced the child's adjustment had been removed from the home. In most of the cases the change was favorable (+), as when a bed-ridden grandmother who had been a disturbing element in a home died; but in some cases it was unfavorable (—), as when a father, companionable to his son, was kept away from home by a new job.

Column 6 shows the shifting of parents' attention to other siblings. Sometimes it was favorable to the patient (+), as when other siblings were considered "problems" instead of the patient; sometimes it was unfavorable (—), as when other siblings began to receive more praise. Column 7 shows whether or not the parents had some points on which they felt superior to their siblings, while the last two columns indicate whether there had been favor-

TABLE XII
Factors Possibly Accounting for Differences in the Children's Adjustment

Case numbers by adjustment groups	Attitude to patient		Emotional tone of home	Change in health	Removal of some person from contact with patient	Parents' attention shifted to other siblings	Patient has some points of superiority over other siblings	School transfer or treatment in school	Change in recreation
	Mother	Father							
A group									
1	+++	+++	+++	++	+	+	+++	+	+
2					+			+	
3									
B group									
4	++?	++	++	++		++	+++	++	++
5									
6									
7									
C group									
8	++++	+++	++++	++++	+			++	+
9					+				
10					+				
11					+				
12					+				
D group									
13	++++	+++	++++	+++	+			+	
14									
15									
16									
17									
18									
19									
20									
E group									
21									
22									
23									

... or unfavorable changes in school or in recreation, usually a result of clinic treatment.

The change in the proportion of "+s" and "-s" from Group A to Group E is most striking. The A group shows only positive changes; the E group very few changes for the better.

CHANGES IN HEALTH

Two of the children in the A group had formerly been ten per cent or more undernourished, and all three were now in good health.

In the B group the health of two of the four children had improved. One had practically overcome a marked speech defect, and his deafness had disappeared following a tonsillectomy; the other had recovered from malnutrition. Case 5, on the other hand, weighed over two hundred pounds and had diminutive genitalia. His pleasing personality and reputation for being a "good fellow" in those interests which did not demand physical combat or exposure seemed to be an effective compensation for this defect.

All five children in the C group, as in the A and B groups, were in good health at the time of the follow-up study. The epileptic attacks of Case 8 had disappeared. Case 9 had had convulsions and rickets in infancy, and frequent colds due to sinus trouble had caused absence from school. His teacher now claimed that a test would show that his I.Q. had raised. Case 10, previously fifteen per cent underweight, was now up to normal. Case 11, described originally as suffering from a choritic infection, was in good health.

In contrast, only two of the eight children in the D group had no physical handicap or defect, and one of these had been undernourished. Two children were obese; in one the endocrine system proved negative, but the feelings of difference shown by shyness and withdrawal from the group undoubtedly were partly due to this defect. The other was under treatment for thyroid deficiency and was gradually losing weight, but since this was a very recent change, the effect can only be conjectured. In Case 15 a deformed arm caused by injury at birth gave rise to a feeling of difference seen in his extreme self-consciousness. Case 16 had diminutive genitalia. Why this was a factor in his maladjustment as contrasted to the more adequate adjustment of Case

5, who had a similar defect, is better explained under sibling relationships, which will be discussed later.

Four of the six children rating E adjustment showed some physical handicap. Case 21, until an operation in 1926, was lame from infantile paralysis incurred at a year and a half. Extreme malnutrition was still present in Case 22. There was a question of encephalitis and starvation in infancy in Case 25. Case 26 had a premature birth. Her marked stutter was a handicap in making social contacts.

In general, then, the D and E groups both had poorer health records at the time of clinic study and improved less in this respect than the other groups.

CHANGES IN THE HOME SITUATION

Changes in the home situation were even more enlightening as an explanation of the children's present adjustment. In three cases in Group A there were changes in the home which counteracted the factors which seemed to cause maladjustment at the time of the initial clinic study. If considered in themselves some of these changes would lead one to assume they would have had a negative effect. However, when considered in the light of individual child's needs, it is apparent that they were decidedly constructive factors toward his adjustment. Two examples illustrate this situation.

In Case 1, the mother had a "nervous breakdown" which required care and attention at home, and the father worried over his financial obligations because of the doctor's bills. But, since much of this child's previous maladjustment seemed to be due to the pressure exerted by the parents in constantly demanding superior achievement both at school and home, their preoccupation with themselves was a timely and constructive factor for the boy.

In Case 3, one might suppose that the boy's extreme insecurity and unhappiness due to the presence of the uncle in the home might have been aggravated when the mother married the uncle. But as stepfather, the uncle was less harsh to the boy, and, more significantly, the mother still gave him much individual affection and defended him against the stepfather. The mother was not well, but this condition caused her to depend upon the boy for much assistance at home, thereby making him feel that he was needed in the family group and adding to his sense of security.

The siblings of all three children in the A group either evidenced a lack of desirable traits which the patient possessed, or they were not retarded in school. The general emotional tone of all these homes either continued to be harmonious or there was less tension than formerly.

In the B group, for the most part, the home situation seemed to show less improvement. There were destructive factors, such as over-ambition, nagging, drunkenness, and immorality. In Case 7, however, the foster home placement which had been made at the time of the initial clinic study was proving most satisfactory.

In this B group, sibling relationships seemed to be more important as factors making for the child's adjustment. Feelings of inferiority which seemed to have arisen because of a child's retardation in school were overcome in part because some or all of his siblings were now retarded as much or more than he was, and so because they had some personality traits which made them appear as "problems" to their parents.

For the most part, the general emotional tone of the homes in Group C continued to be harmonious or there was a lessening of tension.

In contrast to the siblings in Group A and B, most of the siblings in the C group presented no behavior problems and were either brighter or less retarded in school than the patients. An older brother used to call one patient "dumb," and now taunts him with being "sissy," while he himself is an A student in high school and a good athlete. In another case, a younger sister who is very bright had threatened to get ahead of the patient, who was recently transferred to special class.

Five of the eight children in Group D came from homes where there was a general emotional tone of tension. Most of the mothers seemed to be over-protective and either deprived the children of opportunities to develop self-reliance, or had too high standards of achievement for them. In this group there also seemed to be changes in the home since the time of the first clinic interview, but the changes tended to be destructive in effect. The only exception was Case 13, in which the previous strain due to the presence of a bed-ridden grandmother in the home was removed by her death two years ago.

The siblings, too, seemed to be a factor in the poor adjustment of the group of children. Three of the girls, for instance, had siblings who were more attractive and were not retarded in school. In the E group, four boys had been committed to the State Training School. In three of the four homes there was no change in the home attitude of constant nagging, friction and useless

threats. The homes of the two girls in Group E also showed factors which would tend to make for maladjustment. Sibling relationships in most of these cases were also destructive.

In general, Table XII shows that while in the A, B, and C cases the emotional tone of the homes was almost universally good and the attitudes of the parents had improved, just the reverse had taken place in the D and E groups. Then, too, all but one of the children in the A and B groups had come to possess some traits that made them feel superior to their siblings; in the C, D, and E groups only one child felt such an advantage. Thus changes in the situation within the home seemed to distinguish the adjustment groups from one another even more sharply than did changes in health.

CHANGES IN THE SCHOOL SITUATION

Although the home situation seemed to explain much of the children's adjustment or lack of it, there were factors outside the home which also greatly modified their behavior. Among these the school was important.

In at least two of the cases in Group A, a change in the school situation seemed to facilitate school progress.

For instance, in Case 1, the boy transferred to another grade school shortly after the original clinic study. His former teacher was said to have been very impulsive and nervous, and demanded high achievement. (His mother had the same traits.) There seemed to be a decided improvement under the new teacher, who was more unemotional and did not require as high standards of achievement.

In the B group, too, the school played a constructive part in the adjustment of three of the four children.

In two of the five cases in Group C the school helped by encouraging the children and providing opportunities for group activities. In two other cases, however, the school situation seemed to have a destructive influence.

CASE 6, for example, whose home life presented such gross factors as drunkenness and immorality, had been overgraded in school and was a class-room behavior problem. He was transferred to special class where he was found to have superior ability in doing detailed work with his hands. Opportunities were given by the teachers to demonstrate this, and he ceased to be a disciplinary problem.

CASE 10 presented no symptomatic behavior at home, but was a "problem" child at school. This boy resented his transfer to special class three years ago. At that time he said he lost all his friends by it. He still is resentful and defiant and

usually shows violent outbursts of temper. He especially dislikes the reed work, which hurts his hands, but in the academic subjects he is doing better than average.

In the D group the school appeared to be a definitely constructive factor in four out of eight cases, while in the E group its influence seemed somewhat questionable.

EFFECT OF CLINIC TREATMENT

To attempt to evaluate the part played by clinic treatment in the modification of each child's behavior, there are obvious difficulties. Many of the cases were carried cooperatively with the visiting teacher or other social agency. In some cases there was no report of the treatment given by them or else it was too general and not complete.

The treatment seemed to fall into certain general types: (1) those cases with no treatment; (2) those in which clinic treatment seemed to be instrumental in improving the family attitude, (3) in changing the school attitude or (4) in changing both school and family attitudes; (5) cases in which clinic treatment seemed to be detrimental or, for the most part, did not effect any change in the child; (6) cooperative cases in which information on treatment was not available; (7) cooperative cases in which the treatment seemed to be a positive factor in the child's adjustment, and (8) cooperative cases which seemed to be detrimental or for the most part did not effect any change in the child. Table XIII

TABLE XIII
The Relation of Treatment to Adjustment

Types of Treatment	Adjustment Groups					Total
	A	B	C	D	E	
No treatment	1	—	—	—	—	1
Cooperative cases						
Family attitude changed	1	—	2	3	1	7
School attitude changed	—	—	—	2	1	3
Family and school attitude changed	—	1	2	—	1	4
Detrimental or no change	—	—	—	3	—	3
Cooperative cases						
Information not available	1	—	—	—	—	1
Improvement	—	3	1	—	—	4
Detrimental or no change	—	—	—	—	3	3
Total	3	4	5	8	6	26

shows the distribution of these treatment types as related to present adjustment.

Only one of the three cases in Group A seemed to be affected by the clinic treatment.

In Case 3, the mother stated at the time of the follow-up study that she had gained much from the clinic study in how to manage the boy and understand him better. She believed the stepfather had tried to be less harsh since his mistreatment was pointed out to him. However, when it is seen that this change occurred after the uncle married the mother, it loses much in force.

In the B group both the school and home attitude was changed in one case, and three cases showed improvement when some of the clinic recommendations were carried out by cooperating agencies.

It was through the clinic recommendation that Case 5 was transferred to another school in order to repeat a grade. The school was given an understanding of the boy's home situation and his need for achievement. This probably accounted for the teacher's writing a note of praise concerning the boy to his over-ambitious mother. The parents refused to accept the clinic diagnosis of mental retardation but nevertheless they have not demanded so high an achievement and have encouraged his social interests.

In two cases in Group C clinic treatment seemed to effect a change in the family attitude toward the child, as by helping to relieve much of the mother's pressure in demanding high school achievement or changing the mother's attitude toward the child's illness. In two cases both school and home attitudes were affected.

In one of these cases, Case 12, through a close contact with the family during a period of particular stress, the Clinic was able to show the need of more satisfactory outlets for the boy and delinquency was apparently forestalled.

In Case 10 the visiting teacher, in carrying out the clinic recommendation helped the boy by interesting a neighborhood house leader in encouraging him to participate in group activity. After he stole candy and fruit from a nearby grocery store, she was able to persuade the store keeper to employ him as a delivery boy and the stealing ceased. However, it was through the clinic recommendation that this boy was transferred to a special class. At time of follow-up study this appeared to be the only factor tending toward his maladjustment.

In the D group there were three cases in which the family attitude was somewhat changed, two cases in which both home and school attitude were improved, and three cases in which the clinic treatment appeared to be detrimental or to have no effect.

Throughout the foregoing discussion it has been seen that in the E group there were more destructive environmental factors. The

seemed to be more deep-seated in origin or were not altered as much by circumstantial changes as was the case in the better adjusted groups. However, in one case, clinic treatment seemed to be helpful in changing the family attitude somewhat; in another, the school situation was affected favorably, and in another both school and home were helped. In the three cooperative cases treatment seemed to be either detrimental or of no effect.

In Case 21 the clinic recommendation for the boy's transfer to special class was carried out. It was also recommended that if delinquency continued, he should be sent to the State School for the Feebleminded. After two periods of probation and two commitments to the County Home School for Boys, an attempt was made to enter him there. There was no record to show whether an effort was made to change the home situation, and at the time of the follow-up study there appeared to be no change.

In Case 22 the Clinic kept close contact with the cooperative agencies working with the family, trying to make the family attitude more tolerant. In this case the school was very cooperative throughout, giving the boy individual attention, special room duties, and encouraging him to enter group activity at the neighborhood house.

The visiting teacher also tried to change the family attitude. In working with the boy she reprimanded him when necessary but in a friendly way and appealed to his reason, and he always responded. But when a very serious offense for stealing from school was discovered, all previous technique in handling the boy seemed to be forgotten, and she threatened him with telling his mother about it the next day. This directly preceded stealing a car and led to his commitment to the reform school.

In Case 23 the school carried out the clinic recommendation to demote the boy and provide him with opportunities for success in the group. After that there was apparently no further modification of the school program. The visiting teacher tried to change the attitude of the family, but felt it was hopeless, since there were many adults in the home who were constantly criticizing and two young brothers were the center of attention. Notwithstanding the emphasis in the clinic case on the inconsistent discipline in the home and the use of ineffectual punishments, each time the boy was brought into court the probation officer threatened punishment for further delinquency by commitment away from home.

At the time of the follow-up study, a chance remark made by the stepmother in Case 24, when speaking of the attempts of the family to carry out the clinic recommendations, seemed to be significant: "The boy has turned out just as the doctor predicted. He is absolutely irresponsible, and will steal whatever he wants regardless of training."

In Case 25 the school was most cooperative, but no treatment could be carried out with the family. The aunt felt her time in taking the child to the Clinic had been wasted and that she herself was too busy to attempt to carry out its recommendations.

The Clinic, in Case 26, was instrumental in keeping the girl in the present home, thus avoiding a placement in her own home where she was not wanted, or a com-

mitment to the State School for the Feebleminded. She was helpful about the Home and especially happy over recently being given a wage of a dollar a week in addition to her board and room.

In general, then, differences in the children's present adjustment seemed largely explainable on the basis of changes (or lack of changes) in their health or in their family and group relationships. Some of these changes were effected by means of clinical treatment, but many of them were the result of more or less accidental circumstances. A clearer picture of just what happened in each individual case is given by the following case summaries.

CASE SUMMARIES

CASE 1—Male, 16; I.Q., 84, grade, 10A. Adjustment—A

On referral—Age, 11; econ. status, adequate.

Problems: Excitable, nervous, stubborn; defiant of authority, lies; erratic; appears "unbalanced."

Psychiatric Summary: "A boy of low average intelligence, restless and overactive. He has been considered superior at home and school. This undue pressure, together with poor home hygiene and inferior physical make-up has accentuated his restlessness and general maladjustment."

Recommendations

1. Parents to be given report of findings, pointing out this boy's limited intelligence.
2. Mother should do the disciplining, and father should not threaten.
3. Sleep alone.
4. Diet and rest periods for malnutrition.
5. Younger brother should have his own companions.
6. Teacher to be given a report of findings, and to praise patient for his effort.
7. Summer camp.

Treatment: Cooperative case with Visiting Teacher; no treatment records.

Factors possibly accounting for adjustment.

In child

1. Up to weight. Good health.
2. Severe pneumonia during infancy may have caused early retardation in school.

In home

1. General emotional tone has been harmonious. Parents are congenial.
2. Maternal grandparents moved from home two years ago. Grandmother nervous, sickly, irritable. The home is less crowded.
3. Mother no longer presses the boy by demanding high achievement. She had a nervous breakdown two years ago which required rest care in the hospital for several months.
4. This boy, being the oldest child, had to assume the home responsibility

they could not afford to hire help. Mother believes "he could get all A's if he studied more," but, is more preoccupied with her own health.

5. Father is more companionable, but still expects a high standard of achievement. He is under some financial strain trying to pay mother's doctor bills.
6. Siblings are considered "problems" by the mother. Younger brother is "slow" in school, but studies hard. He attends another school where he has made his own friends.

Of the two younger sisters, one is "spoiled," and the other is repeating the 2B grade due to inability to learn to read.

In school

Shortly after the initial clinic study this boy was transferred to another grade school. Former teacher was said to be very impulsive. Mother noted a decided improvement with the new teacher who was more unemotional and did not require as high standards of achievement.

CASE 2—Male, 12, I.Q., 80; grade, 5A. Adjustment—A

On referral—Age, 7; econ. status, comfortable.

Problems: Awkward, slow, incoördination; food fads, nail-biting, stuttering; fights, dislikes school.

Psychiatric Summary: "Boy of very poor intelligence. Malnutrition may be a factor. He shows marked inactivity of his speech organs when he talks. This is a typical type of oral inactivity found in feeble-minded and retarded children. His behavior is to be expected from one with physical and mental handicaps."

Recommendations

1. Diet for malnutrition. Tonsillectomy.
2. Require only minimum essentials in school work.
3. Parents to be given a report of findings pointing out patient's limited mental ability.
4. Stress need for consistent training and discipline.
5. Father to take more interest.

Treatment: Clinic case

Letter was sent to mother asking her to come to the clinic for a report of findings. She did not keep appointment.

Factors possibly accounting for adjustment.

In child

1. Up to weight. Good health.
2. Very slight oral inactivity.

In home

1. General emotional tone is harmonious as always. Parents are congenial.
2. Father previously had worked away from home, being absent several months at a time. His work now enables him to live at home. He is companionable; has a rather "easy-going," happy disposition.
3. Mother previously was over-protective, evidenced by her marked affection for this boy and extreme apprehension for his welfare. She was nervous, fearful of noises, and insisted that he sleep with her. She now allows him more freedom and is less apprehensive, although very fond of him.
4. Older brother is very bright in school, and plans to enter the University next

fall. However, he is more shy and studious, and lacks the "happy-go-lucky" disposition and ability to make friends which characterize this boy. He is also less adept in mechanical lines.

CASE 3—Male, 16; I.Q., 79; grade, 9B. Adjustment—A

On referral—Age, 11; econ. status, adequate.

Problems: Stealing, lying, poor school work; poor social judgment.

Psychiatric Summary: "Boy of very inferior intelligence. He does not know why he steals, appears childish. He is very unhappy in school and home, tremendous feeling of insecurity. He has not been taught property rights, and lies. His inability to make proper social judgments is a significant factor in his behavior."

Recommendations

1. Simplify educational requirements so as to win success in school.
2. Give habit training he can understand.
3. Uncle to be less severe, and less partial to sister.
4. Allowance.
5. Later, to be encouraged to join the Boy Scouts, Y. M. C. A.

Treatment: Clinic case

1. Mother and uncle were given a report of findings at the clinic.
2. Social service contact at the school.
3. Mother had treatment interview with psychiatrist five months after report of findings.

Factors possibly accounting for adjustment

In home

1. Previous tension and friction has been lessened since uncle married mother four years ago.
2. As step-father, uncle is less harsh, although apt to criticize the boy.
3. Mother defends the boy and acts as a buffer between stepfather and boy. She is not well (menopause) and depends upon son for help, praising him for anything he accomplishes.
4. Sister is openly step-father's favorite. She, however, is "slow" in school.

In school

1. Boy transferred to another school second semester upon entering high school. He disliked the former school and felt that "the principal was against him." He is now happy in the present school and likes it.

Clinic treatment

1. Mother said she had gained much from the clinic study in how to manage the boy, and understood him better. She believed step-father had tried to be less harsh since his mistreatment was pointed out to him.

Other factors

1. Delinquent companion moved away from the neighborhood.

CASE 4—Male, 15; I.Q., 83; Boys' Vocational High School. Adjustment—B

On referral—Age, 10; econ. status, adequate.

Problems: Stuttering, poor school work, obstinate, food fads.

Psychiatric Summary: "A boy with a marked speech disorder, showing incoordination of the muscles of his lips, throat, and vocal cords, with letter substitution and guttural sounds. An inferiority feeling is present, based largely on this defect. Emotional blocking is indicated by his general restlessness and tendency to fidget."

Recommendations

1. Continued speech training.
2. Early vocational placement with reduction of educational requirements.
3. Let him feel success.
4. Group recreation as soon as possible.
5. Removal of tonsils and adenoids. Examination of hearing and if necessary advise lip reading, etc.

Treatment: Cooperative case with Bd. of Education Speech Department—no treatment record.

Factors possibly accounting for adjustment.

In child

1. Speech defect is much less marked.
2. Tonsillectomy; disappearance of deafness.

In home

1. General emotional tone of the home suggests tension. There seemed to be little change in this respect.
2. Father is companionable, but firm, and ambitious for the boy.
3. Mother is nervous and quick-tempered. (Recently she had an operation for "internal goitre.")
4. Siblings are more of a "problem": twin sister, lame from infantile paralysis, is shy and sensitive, humiliated over a transfer to special class. Younger brother is also dull in school. Older brother is a successful tailor.

In school

1. Speech training

Other factors

1. Special interest by the Y. M. C. A. secretary to encourage the boy in group activity; showed him individual attention.

CASE 5—Male, 15; I.Q., 83; grade, 10A. Adjustment—B

On referral—Age, 11; econ. status, affluent.

Problems: Lack of school adjustment, mischievous; called a "sissy"; physical coward.

Psychiatric Summary: "A boy who is retarded so that he is not able to do his work and is over-graded. The boy has a profound feeling of inferiority and discouragement about his school work. His lack of intelligence prevents him from making the social adjustments and from competing with the other children on equal grounds. Added to this difficulty, he is fat and has a feminine contour of the body and is not able to compete with the other boys in athletics. This has given rise to an even more profound discouragement than his school failures. He has a pleasant personality. He has been misplaced in school and is unable to compete with the other boys in their games because of his physical make-up."

Recommendations

1. That his mental capacity be recognized by the school and that he be allowed to do what he can do and be praised for it and remain in the same grade until he catches up. He should repeat his present grade next year.
2. That the mother cease worrying about his school work.
3. That he be given some training in athletics—tennis and boxing—so that there are some things in athletics in which he can excel.
4. Drop idea of summer school.
5. Transfer to Jefferson Junior High School, thus making less conspicuous the repetition.
6. Have patient go to a boys' camp for this summer if he is able to get anywhere with his athletics. If not a camp, the family should go out to the lake.

Treatment: Clinic case—Report of findings given to parents by the psychologist.

*Factors possibly accounting for adjustment**In child*

1. Obese—six feet tall and weighs over 200 pounds.
2. Diminutive genitalia.

In home

1. General emotional tone is harmonious as always. Parents have been "ideally happy."
2. Father, as formerly, refuses to consider the boy as having limited mental ability. He still hopes he will be a doctor like himself. He is companionable.
3. Mother gives little opportunity to develop independence at home. However, she is less exacting and does not expect as high standard of achievement. She praises the boy for any improvement and is very proud of his pleasing personality.
4. Two older brothers are both retarded, and are shy and seclusive. Due to pressure from parents they graduated from high school after six years. Family favorably compares his boy to older sister who is bright, graduated from the University, and is popular socially.

In school

1. Teachers in Jr. H. S. took a special interest in the boy, and reported to parents his splendid effort and pleasing personality.

Clinic Treatment

1. Parents refused to accept the clinic diagnosis of mental retardation.

CASE 6—Male, 16; I.Q., 80; special class. Adjustment—B

On referral—Age; 12; econ. status, dependent.

Problems: Continually annoying in school, distractible, defiant.

Psychiatric Summary: "A boy who has borderline intelligence. There are wretched home conditions with insufficient recreational outlets. He is not graded in school; the teachers sympathize with him because of his home conditions. They have given him credit for more intelligence than he has."

Recommendations

1. Transfer to special class.

2. To be given recreational outlets and training in habits of cleanliness.
3. Regular meals and cod-liver oil.
4. Family Welfare to continue case-work with the family and also send a visiting housekeeper.
5. Big Brother camp.

Treatment: Cooperative case with Visiting Teacher—No treatment record. One entry from the Juvenile Court stating patient had been committed to County Home School for Boys 11-25-27. Released 2-24-28.

*Factors possibly accounting for adjustment**In child*

1. Up to weight; formerly undernourished.

In home

1. Very low standards. Drunkenness and immorality. Parents speak only Polish. Intensive case-work by Family Welfare has made no apparent change. House is filthy and barren of any cheer.
2. Father is alcoholic, shiftless; had several work-house sentences. Encouraged boy to bring home spoils from the market and pick up coal from the railroad tracks.
3. Mother is also alcoholic and there are rumors of immorality. However, the children seem fond of her.
4. Eight older siblings in Poland. Next younger brother is a close companion of this boy. He is doing well in junior high school and is not a behavior problem. Two younger sisters are retarded and also in special class.

In school

1. This boy showed superior ability in doing detailed work with his hands. Teachers gave him opportunities to demonstrate it before the class.
2. A hot lunch was given free to the special class.

Other factors

1. Three months committment at County Home School for Boys two years ago. Head master reported a marked improvement under this changed environment. There has been no recurrence of delinquency (burglary and petty larceny) since that time.
2. Big Brother Camp.

7—Girl, 14; I.Q., 79 (Clinic re-test, 89); grade, 7B. Adjustment—B

On referral—Age, 9; econ. status, comfortable.

Problems: sensitive, conscious of mother's lack of interest; stealing; placement advice required.

Psychiatric Summary: "A girl who is definitely feeble-minded. Alert expression and pleasing personality give the impression that she is more intelligent. She is sensitive and conscious of mother's rejection."

Recommendations

To be placed in an easy-going home.

Treatment: Cooperative with Childrens' Protective Society—No treatment record until 2-5-30, when referred to clinic for complete study to determine the desirability of present foster home with elderly widow, no siblings.

*Factors possibly accounting for adjustment**In home*

1. General emotional tone is harmonious.
2. Foster-mother is easy-going and does not have a high standard of achievement. She is over-protective, anticipates the girl's needs and shields her from any duties which would "interfere with her school work."
3. They frequently visit in the homes of foster-mother's two married sons.

Clinic Treatment

1. Instrumental in placing the girl in present foster-home five years ago.
2. Recent study approved of foster-home; also encouraged more contacts outside the home.

Other factors

1. A year ago the neighborhood circulated a petition to have this girl removed from foster-home, complaining that she had played with younger children sexually; but this was never verified. Incident seemed to have left a deep impression on the girl and may account for her fearfulness of being separated from foster-mother.
2. Three previous boarding homes; the present home was the first permanent placement.

CASE 8—Male, 14; I.Q., 78; grade, 6A. Adjustment—C

On referral—Age, 9; econ. status, marginal.

Problems: irresponsible, no self-control, convulsions; jealous, obstinate, defiant.

Psychiatric Summary: "A boy of unknown heredity who since the age of one year has had attacks strongly resembling idiopathic epilepsy. The scattered tests on tests and poverty of emotion and thought suggests deterioration of an epileptic type and intellectual deterioration caused by epilepsy. If he is an epileptic, irritability will increase and there will be progressive mental deterioration." det

Recommendations

1. Foster-parents to be given a report of findings.
2. Transfer to special class.
3. School to be more tolerant.
4. Institution to be considered in light of the poor prognosis.

Treatment: Clinic case—9-25, mother given a report of findings at clinic; 7-28, mother and boy seen at clinic; two social service visits to school; 12-28, 10-29.

*Factors possibly accounting for adjustment.**In child*

1. No epileptiform attacks for four years.
2. Good health.

In home

1. Some tension over fear of being separated from foster-mother.
2. Foster-parents obtained a divorce four years ago and epileptic attacks ceased about that time.

3. Foster-father remarried. No interest in the foster-mother nor boy. Occasionally he bought clothes for the boy.
4. Foster-mother is over-demonstrative. She still loves her husband and did not seek the divorce.

In school

1. Principal and teacher showed the boy individual attention.
2. He was encouraged to enter sports and social activities.

Clinic Treatment

1. Encouraged foster-mother to give boy more outside interests.

Other Factors

1. Family Welfare refused relief during the winter when foster-mother was ill because the boy had no legal status in the family. Foster-mother and boy became more fearful of being separated.

CASE 9—Male, 12; I.Q., 76; grade, 4B. Adjustment—C

On referral—Age, 7; econ. status, affluent.

Problems: Poor school work and poor motor coordination.

Psychiatric Summary: "A boy of borderline intelligence, who is timid, sensitive, and complains of physical ailments. He is indifferent, apathetic and rather suggestible."

Recommendations

1. Better posture. Retest eyes. Sinuses watched.
2. Less supervision by mother; more by father.
3. Not to expect fine movements.
4. To remain in same grade with present teacher.
5. To consider a transfer to boarding school.

Treatment: Clinic case—Report of findings to mother; two social service contacts at school.

*Factors possibly accounting for adjustment**In child*

Premature birth may have been a factor in retardation.

This is the first winter boy has had good health and did not have to miss school.

In home

General emotional tone is harmonious, as always.

Father did not take more responsibility, but was lenient with the boy. He is twenty-five years older than mother.

Mother is inclined to be over-protective, allowing the boy little opportunity to develop independence. Occasionally she defends him in fights at school, although not as frequently as before. She worries less about his school-work, and praises him for any improvement; also discourages any unfavorable comparison with brothers.

Older brother is very bright in school and a good athlete. He used to call the boy "dumb," and now taunts him with being "sissy."

In school

Teachers have not expected as high standard of work, and have praised him. School principal believes his I.Q. has raised.

Clinic Treatment

1. Helped to relieve much of mother's pressure in demanding school achievement.
2. School more understanding.

CASE 10—Male, 15; I.Q., 78; special class. Adjustment—C

On referral—Age, 11; econ. status, marginal.

Problems: no progress in school, untidy, occasionally steals; considered "peculiar."

Psychiatric Summary: "A boy of borderline intelligence, who is doing poor school work and is over-graded. Home discipline is wretched. Very poor physical conditions."

Recommendations

1. Transfer to special class.
2. Visiting Teacher to work with the family in regard to diet and sanitation. If necessary enlist Family Welfare.
3. To be given clothing, and play equipment—skates and foot-ball.
4. Enlist the interest of Mr. ——— at the Citizens Club.
5. Cod liver oil; regular meals; bath at school if needed.

Treatment: Cooperative case with Visiting Teacher.

*Factors possibly accounting for adjustment**In child*

1. Up to weight (fourteen percent underweight on referral).

In home

1. Much less friction than formerly. Less crowded and better hygiene in home.
2. Father has long working hours which now keep him away from home. His irritable disposition and violent temper has been a chief factor in causing the home friction.
3. Mother has a calm, unemotional attitude. Children are all very fond of her.
4. Four older brothers and two older sisters have married and moved away from home. They used to annoy this boy by constant nagging and criticism.
5. Next older brother left junior high school at sixteen (retarded). At present he is out of work, irritable at home, and considered a "problem." Younger brother is also dull, but a leader and sociable.

In school

1. This boy resents special class transfer. He said he lost all his friends by being placed in special class.
2. Dislikes hand-work and prefers the academic subjects in which he achieves more than the average pupil in special class.
3. He is eager to work full-time, and resents being compelled to remain in school until sixteen years of age.

Clinic Treatment

1. Upon recommendation of the clinic Visiting Teacher arranged for a weekly bath at school.
2. After an episode of stealing candy and fruit from a near-by grocery store three years ago, it was arranged for him to be employed as delivery boy. The stealing ceased.
3. Man at the Citizens Club encouraged boy to participate in their club activities, and gave him individual attention.

CASE 11—Female, 14; I.Q., 78; grade 7B. Adjustment—C

On referral—Age, 10; econ. status, adequate.

Problems: motor incoördination; irritable.

Psychiatric Summary: "A girl of borderline intelligence, who is over-graded in school and is therefore under a great strain, who is in wretched physical condition, apparently has a choretic infection at the present time which affects the right side of the body. It interferes with her writing and to some extent her walking. Under emotional stress, this condition grows worse. This seems to be a case due primarily to physical causes."

Recommendations

1. Refer to the University Hospital for more careful examination and perhaps treatment. Examination for tuberculosis also to be made.

Treatment: Clinic case—two social service contacts at home, and one social service contact at the school.

*Factors possibly accounting for adjustment**In child*

1. Good health.

In home

1. General emotional tone is harmonious, as formerly.
2. Father takes less interest in family. He lost his former position and had to accept a more menial one. Tired at night.
3. Mother is frail-looking, nervous, and tires easily. She tries to discourage girl's recalling of previous illness, and is not as concerned over small complaints as formerly.
4. Siblings are all of average ability and hold fairly successful positions. Two older sisters live away from home. Next older sister recently graduated from high school and works as messenger in a bank. She is fond of the patient.

Clinic treatment

1. Helped to change mother's attitude toward girl's illness.

CASE 12—Male, 12; I.Q., 85; grade, 4B. Adjustment—C

On referral—Age, 8; econ. status, adequate.

Problems: Stealing, lying, poor school work.

Psychiatric Summary: "A boy of dull-normal intelligence, with a broken home. There are no playthings and few recreational outlets. He has had inadequate training in honesty."

Recommendations.

1. Care of teeth.
2. More toys and recreation.
3. To be encouraged in mechanical work; later to learn a trade.
4. School to be given a report of findings.

Treatment: Clinic case—Report of findings by social worker to family. Five social service contacts with family during 1927. Grandmother seen at the clinic.

*Factors possibly accounting for adjustment**In child*

1. Reading disability.

In home

1. Previous friction has been alleviated. General emotional tone is harmonious.
2. Paternal grandmother who aggravated children has moved to another neighborhood.
3. Father married young house-keeper two years ago.
4. As step-mother, house-keeper gives the boy more attention and discipline; also more sympathy.
5. Family has discontinued exploiting the boy's singing by performance on stage. Singing lessons discontinued until he can learn to read.
6. Father is sympathetic, and companionable; depressed during the winter because of unemployment.
7. Siblings present no problems—older sister is more companionable than step-mother; younger sister is bright in school.

In school

1. He was passed on because of size.
2. No attempt made to give remedial instruction in reading.

Clinical Treatment

1. Through close contact with family during a period of particular stress of the mother was able to show need of more satisfying outlets for the boy and delinquency was probably forestalled.

CASE 13—Female, 16; I.Q., 82; grade, 9B. Adjustment—D

On referral—Age, 12; econ. status, adequate.

Problems: severe nervous condition with phobias, crying, insomnia, fear of dying.

Psychiatric Summary: "Patient has had a severe nervous condition with phobias, crying spells, insomnia and inability to do her work since she saw a child whom she had known. She has been out of school most of the time. When in school she has sobbed all day, has refused to go to school or home alone. Her mother has had to sleep with her. She complains of pains in various parts of her body and is afraid she is going to die."

Recommendations

1. Report findings to parents.
2. Report findings to school.

Treatment: Clinic case—Report of findings to school; one social service contact with school and home; mother and girl seen by psychiatrist at clinic.

*Factors possibly accounting for adjustment**In child*

1. Good health.

In home

1. General emotional tone suggests tension.
2. Maternal grandmother who was bedridden and acted as a restraint on children's activities died three years ago.

Father is overambitious and expects high achievement. He closely supervises the girl's recreation.

Mother also is over-protective. She continues to be apprehensive, has little confidence that the girl can depend upon herself and tends to cheat her of any opportunity to develop self-reliance.

Older brother is also nervous; disappointed father by not graduating from high school, and worked as a delivery boy.

Younger brother is retarded in school and nervous; younger sister is not nervous and is succeeding in school.

In school

Teachers helped to overcome severe nervous state by reassuring, providing opportunities to succeed, and taking a friendly attitude.

Tried to persuade family to send the girl to Vocational High School.

Clinic Treatment

Instrumental in changing the attitude of the school.

14—Female, 15; I.Q., 74; grade, 8A. Adjustment—D

On referral—Age, 10; econ. status, adequate.

Problems: stuttering; nervous and bashful; enuresis; retarded in school.

Psychiatric Summary: "A girl of very inferior intelligence showing a marked feeling of insecurity and inferiority resulting in speech defect due to her feeling of anxiety. Low mentality explains low school rating."

Recommendations

Tonsillectomy and adenectomy; endocrine study.

School not to expect high achievement.

Parents to be told her mental ability and relieve pressure.

Continue speech training to build up self-confidence.

Environment to be simplified wherever possible and the girl given a chance for success and praise.

Treatment: Clinic case—Report of findings to mother at clinic.

*Factors possibly accounting for adjustment.**In child*

Obesity; endocrine study proved negative.

In home

General emotional tone of the home is harmonious; parents are congenial.

Mother has a confectionery store in conjunction with the home. Little opportunity for home-life.

Father is good-natured and fond of the girl.

Mother, as formerly, tends to baby the girl, and anticipates her wants. Encouraged her to be more sociable, but showed a lack of confidence in her ability to make social contacts.

Older sister is very attractive in appearance; had no difficulty in school. She is married and now lives at home with her baby while husband travels.

Clinic treatment

Mother no longer expects high standard of achievement, but appears more realistic since she understands the limitations.

CASE 15—Male, 9; I.Q., 85; special class. Adjustment—D

On referral—Age, 5; econ. status, comfortable.

Problems: poor school progress; self-conscious; desire for attention.

Psychiatric Summary: "A boy who was injured at birth and shows borderline intelligence. He appears more immature than his mental age. Dependence is due to mother who is anxious, worrying, over-aggressive, and on the defensive for him. She is not happy with father, and very attached and solicitous of the boy."

Recommendations

1. Promote to first grade. Teacher to be told his limited mental ability. To be given freedom in movement, and work with concrete material.
2. Reeducation of mother to make the boy more independent. Satisfy mother's ambition in the achievement of the other two children, and do not expect her not expect high achievement from the boy.
3. Father to handle the boy more frequently.
4. Speech class for relaxation.

Treatment: Clinic case—Mother and school given a report of findings at clinic; one social service contact at school and home.

*Factors possibly explaining adjustment.**In child*

1. Deformed arm much improved through mother's daily massage and occupational therapy.
2. Left-handed, but mother insisted that he use the deformed right hand in order to strengthen it.

In home

1. General emotional tone is one of tension. Parents are separated.
2. Father's work now takes him out of the city, causing him to be away several months at a time. There is an unusual bond of understanding between mother and the boy.
3. Mother is less solicitous, has discontinued during the past year the daily massage of the deformed arm. Although deformity is not noticeable, mother uses this to explain the boy's transfer to special class, and insists that she tutor him nightly so as to keep up to regular grade standard. She is over-protective, aggressive, and appears to identify the boy with father, saying "I never like boys"; favors the two sisters. Becomes easily irritated and impatient with the boy.
4. Older sister is bright, resents mother's impatience with the boy, and is sympathetic toward him.
Younger sister is very bright, threatens to get ahead of the boy in school, and is favorite of the mother.

In school

1. Transferred recently to a special class in school for crippled children. In the great majority of the children are very deformed. Bus ride to and from school because of the distance leaves less time at home.
2. Shows superior ability in weaving rugs.

Clinic Treatment

Encouraged father to be more companionable. Mother allowed boy more freedom.

CASE 16—Female, 13; I.Q., 75; special class. Adjustment—D

On referral—Age, 8; econ. status, adequate.

Problems: distractible, suggestible; inferiority feelings; disobedient.

Psychiatric Summary: "The girl is a retiring, quiet child with a dull facial expression. It is difficult to hold her attention; very suggestible, and definitely shallow intelligence. There is a justified feeling of inferiority. No indications of conflicts or fixations. The girl's low mental age explains her low school rating and lack of interest in social matters. Constant home pressure increases her inhibitions and inefficiency."

Recommendations

1. Transfer to special class.
2. Family to understand her inferiority and to accept it.
3. Timidity to be stressed as an asset.

Treatment: Clinic case—Report of findings to mother and school at clinic.

Factors possibly accounting for adjustment.

In home

1. General emotional tone suggests tension. Family is deeply humiliated over the girl's transfer to special class and tries to keep it a secret, avoiding explanations to relatives and friends. Parents are congenial.
2. Father, as formerly, is indulgent, quiet, and fond of the girl; felt special class was a disgrace.
3. Mother fought special class transfer; continued to be over-ambitious. Concerned over future vocational training. Beginning to see the girl's need for praise and opportunities to succeed in the home.
4. Younger sister is very bright in school, will not let friends know that the patient is in special class. Youngest sister, not yet in school, is very bright.
5. Patient gained considerable satisfaction in teaching her reading as taught in special class.

In school

1. Friction between mother and school over special class transfer. Tried to make mother accept the girl's mental retardation.
2. Special class teacher gave the girl individual attention and praise.

Clinic treatment

Mother refused to accept the clinic diagnosis of mental retardation.

CASE 17—Female, 14; I.Q., 81; grade, 6B. Adjustment—D

On referral—Age, 10; econ. status, dependent.

Problems: suspected of stealing; sullen, refused to talk, cried; no interest in school.

Psychiatric Summary: "A girl who is conscious of inferiority of home and school, is on the defensive through sullenness, refusal to talk and defensive lying. Defective if she did not steal and lie in that home."

Recommendations

1. Continue in present grade. Teachers to praise good work and express confidence in her.
2. Provide recreation and association with acceptable children; Sunday School.
3. Consider boarding out.

Treatment: Clinic case—Report of findings to the school.

*Factors possibly explaining adjustment.**In child*

1. Up to weight; previously undernourished.

In home

1. No change in home situation. Overcrowded living conditions with no facilities for hygiene. Strong family solidarity, on defensive against neighbors and social agencies.
2. Father shiftless, braggadocio, indifferent. Is believed to encourage child to steal.
3. Mother weak, vacillating, unstable. Tends to restrict the girl's outside interests because fears the dangers of the city for one as suggestible as this.
4. Older brother, since transferral to another school, is doing average work and is well-liked by the school.
5. Five younger siblings attend grade school nearest home. They are shut out by the other children; steal and lie, and are retarded in school.

Four other siblings not yet in school, and mother is pregnant with twelfth child.

In school

Present school takes an interest in the girl. She is only one of the girls in the school. Lapse of stealing and lying in the new school situation.

Clinic Treatment

Aroused sympathy of the school for girl because of her home situation and encouraged opportunities for her to be accepted favorably.

CASE 18—Female, 11; I.Q., 83; grade 5A. Adjustment—D

On referral—Age, 6; econ. status, comfortable.

Problems: masturbation, very nervous, boisterous, distractible.

Psychiatric Summary: "The girl is restless, uncontrolled, very inquisitive, asks her questions and answers. Shows flight of ideas. The mother's undue concern may be a causative factor. Mother is annoyed and exasperated. Her intelligence plus poor discipline account for her uncontrolled habits."

Recommendations

1. School work to be simplified and emphasis to be placed upon fundamentals.
2. Mother to accept child's limitations.
3. Mother to set up one habit at a time, praise her, and show affection.
4. More opportunities to play with girls her age or younger.
5. Boarding school to be considered.
6. Dispel worries of mental disorder from masturbation.
7. Regulation of diet.

Treatment: Clinic case—Report of findings to parents at clinic; five service contacts with mother.

*Factors possibly accounting for adjustment**In child*

Obese. Endocrine study showed thyroid deficiency.

In home

General emotional tone of the home is one of great tension.

Father took law course at night and has less time to devote to family.

Easily irritated by this girl; more companionable with brothers.

Mother is still extremely nervous, and easily irritated; tendency to be "psychotic" (attempted suicide; very suspicious.) Has taken many courses in child training and is convinced that she is unable to manage this girl. Constantly nags.

Older brother is a close companion of father; average intelligence; in trouble at school for breaking rules. Younger brother is average, no problem.

Clinic treatment

School recommendations not carried out.

Changed mother's attitude in regard to the girl's masturbation, which is no longer a problem.

Boarding school was arranged for, but parents took the girl home when she complained of being lonely. Mother still expects a high standard of achievement.

Q—Male, 15; I.Q., 84; grade, 7A. Adjustment—D

Personal—Age, 10; econ. status, affluent.

Problems: delicate health, sensitive, petulant; poor motor coordination; temper tantrums.

Psychiatric Summary: "A boy of inferior intelligence from a very superior family. Domineering, worrying, anxious mother and aunts. They expect too much of him, and as a result there is nervousness, marked feeling of unhappiness, inferiority with occasional temper tantrums."

Recommendations

Report findings to father.

Encourage an interest in sports.

Encourage mechanical interests; he should have a shop of his own.

Other not to interfere with the school.

Consider boarding school.

Treatment: Clinic case—Father given a report of findings at clinic; social service contacts with mother.

*Factors possibly accounting for adjustment**In child*

Physically immature, slight build with diminutive genitalia.

In home

General emotional tone is one of tension. Parents are congenial.

Two maiden elderly aunts live with family. One is depressed, the other nervous and irritable.

Father, a successful doctor, of happy disposition, is a companion to the boy. Mother, intelligent, but emotional, sentimental, and over-ambitious. She is over-protective, evidenced by too close supervision of the boy's play;

defends him in any school fight, and gives him little opportunity to develop self-reliance.

5. Siblings are very superior, intellectually and physically. Older brother recently won scholastic honors at Harvard Prep school; good athlete. Another brother, although three years younger, is one-half year behind the first at school; has won several athletic honors at school.

Clinic Treatment

1. Family encouraged mechanical interests.

CASE 20—Male, 10; I.Q., 85 (re-test, 75); special class. Adjustment—D

On referral—Age, 6; econ. status, comfortable.

Problems: school retardation, "peculiar," motor incoördination, disobedient speech defect.

Psychiatric Summary: "A boy of dull-normal intelligence showing muscular coordination and oral defect. Mother needs to be more firm in discipline."

Recommendations

1. Mother to know the boy's retardation, so as to train him according to capacity.
2. Speech class.
3. Firmer discipline; spankings to be given occasionally.

Treatment: Clinic case—Mother was given a report of findings at the clinic; was referred back for complete study four years later.

Factors possibly accounting for adjustment

In child

1. Speech defect no longer present.
2. Muscular incoördination

In home

1. General emotional tone of the home is harmonious as always. Parents congenial.
2. Father, as formerly, is easy-going and indulgent.
3. Mother expresses doubt in the boy's ability. She tends to cheat him of opportunity to develop self-reliance.
4. Older brother, in junior high school, has average mentality. He interferes with the patient and is apt to nag.

Other Factors

1. The boy was given a psychological test at the University and a discographical written report of his retardation was given to the patients, stating the rating.

CASE 21—Male, 15; I.Q., 64; grade, 4A. Adjustment—E

On referral—Age, 10; econ. status, marginal.

Problems: truancy, stealing, masturbation, violent temper, poor school record, erratic behavior.

Psychiatric Summary: "A boy having the mental level of a moron. The strain may have caused him to test lower. His behavior is due to being

in impossible situations in school. Delinquencies seem to be of a minor nature that any child in his situation may have. He needs habit and occupational training for the retarded. Temper outburst should be checked and taught to control."

Recommendations

- Transfer to special class.
- Dietary for the family.
- Sleep in other room from sisters.
- Encourage recreation. Give him sled and skates.
- Send to Faribault (State School for Feeble-minded) if he continues to be delinquent.

Treatment: Cooperative with Juvenile Court—transfer to special class was made.

Factors possibly accounting for adjustment

In child

Operation for deformity of foot caused by infantile paralysis when one year old.

In home

General emotional tone of the home is one of friction; overcrowded living conditions.

Father, fond of the children, but too tired after work to take much interest in the home.

Mother lacks force; useless threats; weak, ineffectual sort of person.

Two older siblings had a juvenile court record; five younger children received more attention than the boy.

Other Factors

On probation from juvenile court three times for stealing and incorrigibility. Two commitments for three months each at the County Home School for boys.

There was no opening at the State School for the Feeble-minded; therefore he was committed to the State Training School on charge of incorrigibility.

CASE 22—Male, 15; I.Q., 84; grade 9B. Adjustment—E

On referral—Age, 10; econ. status, marginal.

Problems: unmanageable at home and school; slovenly, restless, excitable; temper tantrums.

Psychiatric Summary: "A boy from a home where there is continual nagging and correcting. No consistent discipline. The boy has been spoiled by the mother. Hyperactivity shows lack of inhibition and irritability of the nervous system. This has been accentuated by malnutrition and poor physical hygiene. Inability to inhibit. Mother is forceless and dependent. She should not expect high achievement of the boy."

Recommendations

- Mother to give firm, consistent discipline.
- Sisters to refrain from nagging.
- Sleep alone; regular meals; diet, tonsillectomy.
- Teachers not to expect high achievement; to be given more freedom in the classroom.

4. Trade training; part-time job.

Treatment: Cooperative case with Visiting Teacher—No treatment record in 4-28. The boy was seen at the clinic for treatment twice; two social service contacts with cooperative agencies—Jewish Family Welfare and Visiting Teacher.

*Factors possibly accounting for adjustment**In child*

1. Extreme malnutrition has not been changed by attendance at school for 4 months; undernourished.

In home

1. General emotional tone of the home is still one of friction, constant nagging and useless threats.
2. Father is dead.
3. Mother, older sister, and boy have light housekeeping rooms with another family. This family is also impatient and critical of the boy.
4. Mother is now tubercular, sickly. She is inconsistent: sometimes nagging and critical; threatened reform school; sometimes defensive; cried over boy.
5. One older sister married and lived away from home. She also is critical of the boy when with him. Older sister at home nagged him.

In school

1. Attempt was made during the fall to enter the boy at Vocational H. S. but they had a full quota, and knowing that he was a behavior problem refused to accept him.
2. Visiting Teacher arranged for a double industrial program, gave him books free, and also free hot lunch.
3. Visiting Teacher tried to modify the family's attitude.
4. A threat by the Visiting Teacher to inform mother of a stealing episode in school preceded stealing of a car which led to commitment to State Training School.

Clinic Treatment

1. The clinic advised attempts at special school program.
2. Placement was made in home of a printer as an apprentice.
3. Advised Jewish Family Welfare worker in her contacts with the family.

CASE 23—Male, 15; I.Q., 80; grade, 8B. Adjustment—E

On referral—Age, 10; econ. status, comfortable.

Problems: truancy, no interest in school, hard to manage at home.

Psychiatric Summary: "A boy who is definitely borderline in intelligence. Very poor home and little consistent discipline. Solidarity of the home is an asset. They expect the boy to have high achievement in school. He truancies and escape."

Recommendations

1. Demote to 5B if he is not sensitive over it; give some manual training.
2. Teacher to know the boy's intellectual limitations; praise him, make school pleasant.

Treatment: Cooperative with Visiting Teacher—Demoted to 5B; given special duties and attention.

*Factors possibly accounting for adjustment**In home*

1. General emotional tone is one of tension. Parents are congenial. In better financial state; moved to comfortable home.
2. Father is anxious; grieved over the boy's commitment to State Training School.
3. Mother, as formerly, was over-protective; allowed the boy little freedom; Useless threats of reform school; compared him unfavorably to other siblings. Is deeply humiliated over commitment to State Training School.
4. Three older brothers and one older sister live at home. Each tried to discipline the boy; criticized him. Two younger twins, now in school, are very bright, and are the center of attention in the home.

In school

1. School program only slightly modified.

Other Factors

When put on probation in juvenile court, probation officer threatened commitment to County Home School for Boys if he continued to steal. Threatened that if he ran away from there, he would be sent to State Training School.

CASE 24—Male, 16; I.Q., 78; grade, 8B. Adjustment—E

On referral—Age, 12; econ. status, adequate.

Problems: truancy, stealing, poor school work, lying.

Psychiatric Summary: "A boy of borderline intelligence. After mother's death he was boarded three years and learned to steal from a boy in the boarding home. There is consistent stealing; he takes anything he wants. Poor training and intelligence, and immaturity prevent inhibitions. Home situation is very difficult. The step-mother does not understand how to discipline the boy, and the grandmother interferes. Lack of interest in school due to over-grading."

Recommendations

1. School to understand his mental capacity. To be given more manual training.
2. Transfer to special class.
3. Mother and father to be given a report of findings. Discipline by step-mother to be more consistent and have more rewards.
4. Worker to talk with sister so as to cooperate with step-mother.
5. More recreational outlets.

Treatment: Clinic case

Step-mother and grandmother given a report of findings at the clinic. Report of two commitments to County Home School for Boys; on probation in juvenile court twice for petty larceny; sentenced to State Training School.

*Factors possibly accounting for adjustment**In home*

1. General emotional tone is harmonious. Step-mother and father are congenial. Less economic strain.
2. Paternal grandmother moved from city two years ago.
3. Father concerned over the boy; grieved over his commitment to State Training School; kind.

4. Step-mother is sympathetic, but felt she was at a disadvantage in trying to discipline him because of being a step-mother.
5. Older sister, attractive, bright, graduated from H. S., now works and lives at home. Sorry for the boy.

In school

1. Expected to keep up to average standard; no special program.

Clinic Treatment

1. Helped to make family more tolerant and understanding.

CASE 25—Female, 9; I.Q., 66; special class. Adjustment—E

On referral—Age, 5; econ. status, adequate.

Problems: erratic, uncontrolled behavior; "peculiar."

Psychiatric Summary: "A borderline mental defective. Conduct explained by mental age and erratic, vascillating training. Doubtful if she will respond to average level. With firm, kindly treatment may get better results."

Recommendations

1. Teeth, tonsillectomy, psychological re-test in six months.
2. Inform aunt concerning her mental ability; she is not to be the center of attention; requests and demands to be carried out.
3. Good food habits
4. Continue with present teacher.

Treatment: Cooperative with Speech Department, Board of Education—Speech Teacher reported findings to aunt.

Factors possibly explaining adjustment

In child

1. Question of encephalitis in infancy.
2. Starved in infancy.

In home

1. General emotional tone of the home suggests tension. Management of grocery store in conjunction with the home prevents family life; very noisy.
2. Father remarried and no longer lives with child in home of uncle and aunt. Does not want the child. Own mother remarried and also does not want child. Father occasionally visits the child; she is fond of him. Child dislikes father and is sensitive over rejection.
3. Uncle is easy-going, defends the girl, and believes she is bright.
4. Aunt is generous, erratic, very much on the defensive. Blames the mother and clinic for the girl's behavior, ashamed to have the girl in special class.
5. No siblings.
6. Child spends most of her play-time in the store or on the street; gains attention by tantrums.

In school

1. Child responded to firm, consistent discipline.

Clinic Treatment

1. Changed the school attitude toward the child.

CASE 26—Female, 15; I.Q., 75; special class. Adjustment—E

On referral—Age, 10; econ. status, dependent.

Problems: school retardation, stuttering, masturbation, exhibitionism; very demonstrative.

Psychiatric Summary: "A girl who is childish in appearance and behavior. No marked scatter on psychological test, no morbid emotions; rather a dead-level of simple-mindedness. Typically retarded child. Stutter is an emotional affect due to her inferiority. She cannot win success, and the stutter shields her. She needs the supervision of an understanding and sympathetic environment and proper inhibitions developed."

Recommendations

To remain in the Institution for the Aged and Children.

Special class.

Treatment: Cooperative case with Children's Protective Society—Not transferred to special class until 1928; school simplified academic work; attended speech class.

Factors possibly accounting for adjustment

In child

1. Premature birth (7 mo.).
2. Marked stutter.
3. Unattractive appearance.

In home

Likes the routine of the Home. Matron kind and sympathetic. Illegitimate child; paternity unknown. Mother indifferent; stepfather occasionally visits her.

Clinic Treatment

Instrumental in keeping girl in the Home. Encouraged matron to give her opportunities for achievement.

CONCLUSIONS

A follow-up study of twenty-six dull-normal problem children was made at the Minneapolis Child Guidance Clinic. Those children were selected for study who had I.Q.'s. of 85 or less, were referred by the Clinic three to five years ago, and were still in school. In order to determine their status at the time of the follow-up study, certain criteria for adjustment were selected: (1) the child's adjustment in the home, (2) symptomatic behavior problems, (3) interests and interests, (4) home duties, (5) school progress, and (6) adjustment in the classroom.

On the basis of these criteria an estimate of the children's adjustment was made. They were rated A, B, C, D, or E, according as they fulfilled this standard. Three children seemed to satisfy the highest qualifications of the criteria and were rated A. Four children were in the B group, five in the C group, eight in the D group, and eight in the E group. Allowance must be made for the unreliability of a single subjective judgment, but it is believed that A and E

groups were correctly placed and that if B, C, and D groups were re-rated by several persons, they would not be changed more than one step up or down on the scale.

An attempt was made to determine what factors were related to adjustment. It showed little relation to either I.Q. or age. Seventy-seven percent of the girls were found to be poorly adjusted as contrasted to forty-one percent of the boys.

Number of school transfers seemed to show a moderate relationship to adjustment. Of special interest was the fact that no one in the A group changed schools more than once, while in the B group, with one exception which was explainable by other counteracting forces, the number of school transfers ranged from four to nine. Regularity of school attendance showed only a slight relationship. Of the seven children in a special class, only one was making a B adjustment, and the rest were in the C, D and E groups. How much of this was actually due to placement in special class it is hard to say, but several reports from homes and schools showed detrimental attitudes concerning it.

Economic status showed a large scatter, indicating little relationship to adjustment.

For the most part there was no relationship between original problems and adjustment. Truancy, however, occurred only in the E group, and sex delinquency, masturbation, and enuresis were restricted to the D and E groups. A check on the presence or absence of original problems showed that truancy, temper, sensitivity, and untidiness continued. Sex misconduct, enuresis, and feeding problems disappeared.

A more detailed analysis of the individual histories showed a close relationship between type of adjustment and certain changes in the child himself or in his home or school relationships. There seemed to be a close relationship between health or physical defects and adjustment.

The fact that these twenty-six dull-normal children had "problems" when first examined indicated their emotional condition. When studied in connection with home and school relationships, it was found that the periods of disturbance were associated with specific and observable factors in that environment. Removal or improving of the situation was directly associated with improvement in the adjustment of the children.

An attempt was made to evaluate the effect of clinic treatment, to see whether it was a factor in aiding adjustment. The incompleteness of the records, due to the fact that much of the treatment was cooperatively carried, greatly hampered this attempt. The use which cooperating agencies made of the clinic findings was of special interest. Although in several cases cooperative treatment seemed to be helpful, there were cases in which the cooperative worker disregarded the clues to treatment revealed by the clinic findings and dealt with the patient in such a way apparently to recall the old, unacceptable behavior response. The proportion of successfully adjusted cases was, however, somewhat higher among the cooperative than among the clinic cases.

In view of the limitations of the study, no conclusions can be reached which are more than tentative, partial, and suggestive. The results seem to indicate that no one factor explains adjustment, but that it is due to the cumulative effect of many factors, some of which are accidental and not traceable to social treatment. The high correlation that was found to exist between beneficial changes in the home and school environment and the children's adjustment would seem to suggest that further research of this nature would be fruitful.

II. THE SOCIAL AND ECONOMIC ADJUSTMENT OF A GROUP OF SPECIAL CLASS GRADUATES¹

EILEEN BLACKKEY

In 1919 Massachusetts passed an act² "to determine the number of children retarded in mental development and to provide for their instruction." The school committees of those cities in which ten or more children were found to be retarded three or more years were required to establish "special classes to give such children instruction adapted to their mental attainments." It is the purpose of this paper to inquire briefly into the after-school careers of a group of children who attended a special class of this type in a Massachusetts city, and to attempt to find some clue as to what factors make for the successful social adjustment of such feeble-minded children.

The special class which is the subject of this study was in existence long before the passage of the state law. In 1898 the school committee of the city singled out a group of sub-normal and foreign children for special instruction, and in 1900 the subnormal group was placed in the school which is the subject of this paper. In subsequent years ungraded classes were formed in other school buildings, but this school has been consistently more experimental than the others. In 1913 it inaugurated a plan for special training. Each child was given work best suited to his mental level regardless of his chronological age. Such fundamental academic subjects as reading, spelling, writing, and arithmetic were retained in the school program, but part of each day was given over to manual work. Girls were taught knitting, weaving, basketry, and housekeeping; boys were instructed in toy-making, weaving, and basketry.

From this beginning there has emerged an organization which is looking forward to the time when its program can be included in the public schools enough to give every mentally handicapped child a special training and can supervise and guide his activities in the community after the completion of his school career.

¹ A thesis submitted to the Smith College School for Social Work in 1930. The material was collected during the period of the student's field work at the Worcester (Mass.) State Hospital and Child Guidance Clinic.

² This act was amended and materially changed by Chapter 231 of the Acts of 1922.

The school has greatly enlarged its enrollment and its staff. In addition to the work previously mentioned, the boys are now taught sand-papering, brush-making, chair-caning, painting, and wood-work. The girls are instructed by the school nurse in home nursing, hygiene, and first aid. Housekeeping is carried on in a model home-making department where the girls prepare and serve meals, emphasis being placed as much on their social success as on their ability in cooking. Both boys and girls are taught physical exercises.

The children in this school thus presumably receive the best instruction which the city offers to their type. It would be interesting to know whether they get along more satisfactorily after leaving school than do children from the special classes of other schools, but this paper will be concerned only with the question of how well they do adjust, leaving the other question for later study.

Graduation from the school takes place automatically on the child's sixteenth birthday. In the spring of 1930, when this study was made, thirty-one graduates who had been out of school two years could be located. To these were added five who had been out three years, and fourteen out one year. Most of the school records of children graduating three years ago contained inadequate material, and one year seemed a rather short period on which to base an estimate of after-school adjustment. Hence the one-year group was added to only after it was found that its numbers were too small for an adequate study. In all, sixty-two children were chosen for study, only fifty of whom could be located.

The material on which the estimate of adjustment was based was secured from the school records and from an interview with the child and his parents in his home. It was impossible in one visit to go deeply into the numerous factors which make up family attitudes and responses, but sufficient impressions were secured to give a picture, favorable or otherwise, of the individual in his environment. The findings of these interviews and the conclusions drawn from them form the subject matter of this paper.

The group chosen for study contained twenty boys and thirty girls who ranged in I.Q. from 59 to 79. The mean I.Q. was 66. Placement in the school does not occur until a child is three years retarded, and graduation takes place automatically on his

sixteenth birthday, there was no uniform period during which the group attended the class. Table I shows the distribution in this respect.

TABLE I
Distribution according to Number of Years in the Special Class

Number of Years	Number of Children		
	Boys	Girls	Total
1	3	10	13
2	4	5	9
3	9	7	16
4	3	4	7
5	—	3	3
6	1	1	2
Total	20	30	50

Though there was a scattering over a six-year period, the majority of the children were in the class three years or less. A third of the girls were in attendance only one year, which means that they did not enter the class until they were fifteen, while almost half of the boys were enrolled for a period of three years, entering at thirteen.

In most cases the children had been in special classes before their transfer to the school which is the subject of this study. In the following table the age at entering that school is given, not necessarily the age at which the child was found to be deficient.

TABLE II
Age at Entering the Class as Related to Mental Ratings

Age at Entrance	Intelligence Quotients ¹				
	58-59	60-64	65-69	70-74	75-79
10	1	1	—	—	—
11	—	—	1	2	—
12	—	1	1	3	2
13	3	5	5	2	—
14	1	—	4	3	—
15	—	3	9	—	—
Total	5	10	20	10	2

¹ Intelligence quotients of three children were unknown.

The table does show, however, that there was little correlation between the I.Q.'s. of these pupils and the age at which they

to the school, and it suggests that intelligence was not the determining factor in their school careers.

The school does not limit its enrollment to any particular section of the city but draws its students from the entire school district. Table III shows the group of children distributed according to their fathers' nationality and economic status. Any conclusions concerning these factors must be made with caution, since the distribution in the population of the city as a whole is unknown.

TABLE III
Nativity of the Fathers of the Students and Their Economic Status

Nativity	Economic Status ¹				
	Dependent	Marginal	Adequate	Comfortable	Total
Irish	7	7	1	2	17
Polish	2	5	1	—	8
English	—	3	—	1	4
Scottish	1	2	1	—	4
French	—	1	1	2	4
German	1	3	—	—	4
Italian	—	2	1	—	3
Portuguese	2	—	1	—	3
Spanish	—	—	2	—	2
Other	—	1	—	—	1
Total	13	24	8	5	50

Economic status was defined as follows: dependent—in receipt of aid from public or private sources; marginal—in need of outside aid in emergencies; likely to become dependent; adequate—sufficient money for maintenance of health but little for education; comfortable—sufficient money for supplying unusual facilities for their children; comfortable—all of the above. The class designated "adequate."

Seventy-seven (seventy-four percent) of the cases fell within the first two economic classifications—dependent and marginal—while only thirteen of the group (twenty-six percent) came from homes offering adequate or comfortable conditions. The natural conclusion here is that mental defectives are being produced largely among those in the lower economic strata, but this may well be a general conclusion.

In the first place, although the proportion of "dependent" and "marginal" homes in the city is unknown, it is obvious that the poor far outnumber the rich. Perhaps the ratio of five "comfortable" to "thirteen" dependent is what should be expected in a random sample. Then, too, many "comfortable" families

make use of private schools for the training of their feeble-minded children. Whether this is the case or not, it is clear that the children from the special class that was investigated were not only handicapped by low intelligence, but they lived under economic conditions which may have intensely aggravated their difficulties.

In this connection it is interesting to notice the tendency toward and association between the families' economic status and the attitude they assumed toward their sub-normal children. The letters A, B, C, and D have been used to designate four types of homes which differed in their degree of understanding of the problem of feeble-mindedness and their sympathy for the child. The following extracts from the case records illustrate the types.

Type A

CASE 1—Mother and father intelligent. Mother uneducated but accepted the child's deficiency and did not try to urge him beyond his capacity. Home was pleasant and offered adequate recreational outlet. Siblings were encouraged to help the patient.

Type B

CASE 2—Parents were illiterate, but sympathetic and intelligent to a fair degree. Methods of approach to the child were not always the best but they were made in good faith. There was a spirit of good-will in the home.

Type C

CASE 3—Mother was good-natured and pleasant but not very intelligent. Child was well-treated but no problem was recognized and nothing was done to help him.

Type D

CASE 4—Father was alcoholic and a deserter; mother was mentally deficient, promiscuous, and alcoholic; home was a boot-legging establishment. Grandmother expected to do all the work and to support mother and small brothers.

TABLE IV
Parental Attitudes as Related to Economic Status

Economic Status	Parental Attitudes				Total
	A	B	C	D	
Comfortable	4	1	—	—	5
Adequate	1	3	4	—	8
Marginal	—	4	13	7	24
Dependent	—	—	4	9	13
Total	5	8	21	16	50

The table shows a high positive correlation between the economic status of the families and their attitudes. Thirty-seven of the families were rated as C and D in their attitudes while only thirteen measured up to the A and B standard. None of the dependent group had in any way dealt with the problem of mental deficiency, and only four out of the twenty-four in the marginal group had any understanding of the situation. Of the eight families in the adequate group four were rated as being cognizant of the problem and making some attempt to solve it, while four of the families in the comfortable group handled the situation in an understanding and intelligent fashion.

Parental attitudes were also found to be somewhat related to the size of family. As might be expected, the A and B attitudes were found only in relatively small families, though most of the families surveyed considerably more children born than would probably be expected in a random sample of the population.

TABLE V
Parental Attitudes as Related to Number of Children Born

Number of Children Born	Parental Attitudes				Total
	A	B	C	D	
1-5	5	3	6	2	16
6-10	—	5	10	11	26
11-15	—	—	4	3	7
Over 15	—	—	1	—	1
Total	5	8	21	16	50

Three hundred and fifty-six children were born to these fifty families of parents. Forty-nine died under one year of age, and the remainder were between two and ten years. When interviewed, eighteen of the families contained from one to five children, and the remaining thirty-two, from six to eighteen children.

In summary, then, this study deals with fifty children sub-normal in intelligence—twenty boys and thirty girls—who had been pupils in a special class. The mean I.Q. of the group was 66; the period of enrollment in the class averaged about three years. The children belonged, for the most part, to large, foreign-born families of low economic status, most of whom had little appreciation of the problem of mental deficiency. The question to be

answered is, with such handicaps, how were these children adjusting in the community from one to three years after leaving school?

An investigation of the work histories of the children shows that since leaving school they have been employed at forty-two different kinds of jobs, not one of which could be classified as skilled labor. The jobs they held have been arranged into the classes shown in Table VI.

TABLE VI
Distribution of Children according to Types of Jobs

Type of Job	Number Holding the Job
Factory work—Sorting and trimming in: Valentine shop Garter shop Corset shop Shoe factory Envelope factory Wall-paper factory Book bindery	18
Mill work—Spinning, specking, sewing and packing in: Woolen mills Silk mills	17
Manual labor— Mixing cement Road work Farm work Truck driver	9
Restaurant work— Lunch counter Bus boy Kitchen girl Waitress	8
Peddlers— Fruit Milk Handbills Groceries Ice	8
Machine shop	7
Miscellaneous Nurse-maid Errand girl Caretaker	5
Housework	4

Seventy percent, at one time or another, were employed in factories and mills doing very routine work, such as sorting, labelling, trimming and packing. Manual labor and peddling recruited a large percentage of boys. Only a few of the girls were engaged in domestic service.

As a whole, the boys and girls said they were satisfied with their work. In discussing their jobs, the majority of them stated that their work gives them a rather high degree of satisfaction. As has been pointed out in several studies, the mentally defective child may be at an advantage in industry, in that he is unmindful of its monotony and seems to enjoy the routine and sociability of the factory. Pound puts this very aptly when he says:

Just as deafness is an advantage in certain industrial occupations—our shops employ many mutes with satisfaction both ways—so mental lacks may become assets for certain industrial purposes. Given enough sense to master simple routine occupations and appreciation of duty, or fear of relatives, to come to the shop regularly, the below average person can soon be found to be adjusted industrially. And when adjusted, the moron will be found immune to many of the pricks which create the normal man into seeing red, less fretted by monotony, less worn by rhythmic clatter. There is less in his soul striving to release itself; he has brought to the shop comparatively little that the shop cannot use; and so he accepts humbly his appointed place in the scheme of things industrial, remains unambitious, and reacts not at all against subordination. The less mind one has, the less it resents that invasion of personality which is inseparable from large-scale mechanized enterprises. I have heard industrial engineers and welfare workers say that industrial efficiency, as working out in our day, puts a premium on mental deficiency.³

There is a point here, however, which is often overlooked. Perhaps these children are satisfied with their work because they have never known anything better. This may be due in part to the fact that they have not been trained for anything but unskilled jobs. Their lack of specialized training is shown by the wide variety of jobs they have held and the frequent changes made, a situation which cannot be attributed entirely to economic conditions. The boys in the school under discussion participate in such manual training activities as brush-making, chair-caning, and rug-weaving, while the girls are instructed chiefly in domestic duties. If the future adjustment of these children is the ultimate goal, it would seem that their training might be along more practical lines. Davies' comments on this point are of particular interest:

Pound, Arthur, *The Iron Man in Industry*, New York, 1924, pp. 53, 54.

"In special class work with the younger children, basket-weaving, clay-modeling, rug-weaving, chair-caning, and various forms of woodwork do well enough as educational projects. Activities of that type do not serve so well for the later years when the special classes should devote themselves to more definite vocational training. This is especially true of the boys' training. It has been found that very few boys gain employment at wood-working, chair-caning, broom- and brush-making, or other types of activity carried on in the usual special classes. They are more likely to find opportunities for employment, if at all skilled, as plumbers' helpers, machinists' helpers, bakers, barbers, machine tenders in factories, chauffeurs, garage men, and the like. *The fact that most of the boys and girls graduating from special classes today are compelled to accept wholly unskilled work does not necessarily indicate that many of them are not capable of doing skilled or semi-skilled work, but simply that they have not been the recipients in school of genuine occupational training.*"

A comparison of the industrial careers of the two sexes suggests that the girls were somewhat more stable. This may mean only that they had less opportunity of shifting jobs.

TABLE VII

Comparison of Boys and Girls with Reference to Intelligence, Time out of School, Number of Jobs Held, Number Holding One Job, Unemployment, and Wages

Employment History	Boys	Girls
Average I. Q.	66	66
Average months out of school	23	19
Average number of jobs held	2.5	1.5
Percent holding one job	13	46
Average months out of work	9.4	7.2
Average weekly wage	\$12.80	\$8.94

The average intelligence ratings of the boys and girls were identical. In the matter of work, however, the boys changed jobs at a rate almost double that of the girls. Only thirteen percent of the boys as compared with forty-six percent of the girls were holding the same job they took on leaving school. On the average, the boys were unemployed forty-one percent of the time after they left school; the girls, thirty-eight percent. In judging the significance of this fact, however, it must be remembered that the population studied was one of severe unemployment in New England, manufacturing in the city in question being especially depressed.

The preceding discussion has given some indication of the adjustment of the group as a whole, as measured by the work history.

⁴ Davies, Stanley Powell, *Social Control of the Mentally Deficient*, New York, 1930, pp. 309, 310.

there was, of course, considerable variation within the group. This variation and the causes for it that are the chief interest of this study.

We have been impressed with the fact that those elements that go to make up the failure or success of mental defectives in life are in no sense different from the elements that affect the lives of normal persons. Those same elements of character and personality make-up, those same conditions in the home, and those same factors in training that speak for the successful career of a normal child, bear with equal force on the career of the feebleminded child.⁵

These conclusions, which came as a result of a mental hygiene survey of Cincinnati, are equally applicable here. Investigation on this point, however, means dealing with rather intangible, but probably important social factors—personality traits and mental attitudes.

An effort has been made to classify the personalities and attitudes of the children studied as one basis for determining the degree of their social adjustment. Accompanying each classification is a description, which may aid in definition. The alphabetical arrangement, is somewhat indicative of the estimated ability of each group.

Group A—These cases were the most promising. They were intelligent and anxious to try, were likeable, social, and had "good common-sense." They were leaders in their own groups and were well behaved.

Case 5—Tony (18; I.Q. 65) came from an excellent home in which the parents were thoroughly Americanized. The boy was a leader at school, was intelligent, and willing to learn. He was somewhat bashful, but when the occasion demanded could speak well and exercised a good choice of words. Tony's disposition was pleasant and his sense of humor quite mature. He was skilled in skating and swimming.

Group B—This group was fairly responsive and had some qualities of leadership. Many of them were quarrelsome and emotionally unstable, but under sympathetic supervision they did well and made rapid progress.

Case 6—Hilma (18; I.Q. 58) came from an unusual Swedish home in which there was a great deal of understanding and patience. She was neat and very capable of doing handwork or housework. She was easily discouraged, however,

⁵ Anderson, V. V. and Fearing, Flora May, *Report of the Mental Hygiene Survey of Cincinnati*, The National Committee for Mental Hygiene, May 1922.

and cried frequently. Her inability to read was a severe handicap to her enjoyment of music, in which she was rather talented.

Group C—The children in this group showed an active resentment to their handicap by pronounced egotism and conceit. They were domineering, resentful of authority, and often unpopular. Beneath the exterior of bravado, however, there was usually a very workable basis for training and treatment.

CASE 7—Harry (18; I.Q. 63) belonged to a family in which there was much tension. His father was alcoholic and his mother on the verge of a mental collapse. Harry was egotistical, suggestible, stubborn, easily angered. He was well-dressed and good-looking, talked incessantly and appeared to be thoroughly satisfied with himself. He was a bully and a coward, but when this defense was broken down he was fairly responsive.

Group D—These cases were the least troublesome from the point of view of discipline, although this lack of response may not have been a healthy indication. The group was made up of dreamers who were, in most cases, reserved, well-liked, and cooperative. They needed helpful and constant supervision.

CASE 8—Margery (19; I.Q. 67) belonged to a family in which there was a history of insanity and alcoholism. Her mother was the dominant factor at home and sheltered Margery to the extent of finding jobs for her. The girl was seclusive and shy, had few friends, but was well-liked by those she did have. She was very capable around the house, liked to cook and sew, and gave no trouble.

Group E—In this classification was placed the impulsive, giggling type of girl who was otherwise well-behaved and liked. She seemed particularly well fitted for the routine of industry.

CASE 9—Ora (18; I.Q. 62) had a mother who was mentally deficient and a father who deserted. The girl was very slow, inattentive, and somewhat erratic. She was unusually pretty and capitalized this as a compensation for her mental deficiency. She was rather difficult to handle because of her "flightiness," but was capable of doing neat work if supervised.

Group F—These children were sullen, irresponsible, and resentful of authority. They were extremely hard to handle because of their aversion to supervision and their quarrelsome nature. In this group fell those who were either delinquent or were tending toward delinquency.

CASE 10—Eunice (17; I.Q. 67) had one of the worst backgrounds in the group. Her father was serving a prison sentence for abusive treatment of his family. Her mother was a chronic deserter. Eunice had gonorrhea at 13 and made

an attempt to commit suicide. She was ill-tempered, had no inclination to learn, and needed constant and close supervision because of her mental retardation and delinquency.

These personality groupings are, of course, not clear-cut. Personality under any circumstances is an elusive term, and when an attempt is made to interpret the personality traits of subnormal individuals, definition becomes even more difficult. Nevertheless, these groupings may serve as a rough classification of personality. The children were distributed among the groups as Table VIII shows. In Table IX they are compared on various points.

TABLE VIII
Distribution of Cases According to Personality Group

Personality Group	Number of Cases
A	7
B	13
C	6
D	11
E	5
F	8
Total	50

TABLE IX
Comparison of Personality Groups in Sex and Average Intelligence, Time out of School, Unemployment, Number of Jobs Held, and Wages Received

Personality Groups	Sex		I.Q.	Months out of School	Number of Jobs	Months out of Work	Weekly Wage
	M	F					
A	4	3	65	19	2.0	9	\$13.19
B	6	7	67	25	1.9	10	11.16
C	4	2	67	19	2.3	4	10.68
D	2	9	65	19	2.5	6	8.49
E	—	5	66	24	1.7	5	9.30
F	4	4	67	19	1.8	9	10.90

Intelligence ratings—In the distribution of I.Q. averages, the A group was found to have the lowest, 65, while the average of the F group was 67. The variation among the six groups was so slight, however, as to lead to the conclusion that differences in personality could not be accounted for on the basis of I.Q.

Group E, by definition, was composed wholly of girls of the "impulsive, giggling" type) and Group D (the shy but cooperative type which needs much supervision) contained a high pro-

portion of girls. In the other personality groups, the proportion of boys exceeded that of girls. These facts influence, to some extent, the other figures in the table. (See Table VII.)

Months since leaving school—Groups B and E were out of school two years; the other groups nineteen months. While this may have some slight bearing in accounting for the personality of the “impulsive, giggling” group, it seems of more significance in indicating that time out of school bore little relation to personality.

Number of jobs held—The average number of jobs held by the boys and girls after they left school calls for some explanation. In general, it was greatly affected by the prevalence of unemployment. As work became scarce in one industry, many of the children were laid off and then found work where they could, whether it was temporary or permanent. One boy, for instance, formed a partnership with an older man and both of them sold bananas from a peddler's card; another boy mowed lawns; and another worked night on a milk wagon. Despite this abnormal situation, however, there is some basis for considering these figures an index to various personality ratings. Groups A and B changed jobs less frequently than did C and D. These groups met with a comparatively high degree of success and consequently had an incentive to remain with one employer longer. Those in C and D, on the other hand, proved less satisfactory—Group C perhaps because of their egotistical, domineering nature, and Group D because of their need of constant direction and supervision. This is reflected in the short unemployment periods of these two groups. They were laid off more frequently, but they had sufficient desirable personality traits to secure other jobs and hold them until the less desirable traits became evident.

The low average of 1.70 for Group E can be accounted for in several ways. The group was made up entirely of girls who, Table VII showed, had few changes of jobs. Then, too, their domesticity probably enabled them more easily than any other group to fit into the monotonous routine of the factory. They were usually satisfied as factory workers because of their willingness to comply with requests, and they may have stayed because they lacked the initiative to quit one job and look for another.

It is equally necessary to explain the low job turnover in Group F. Two of the boys were in reform schools and another boy refused to work. At the time of the visit to his home, this boy had

working for two weeks in a dairy at \$15.00 a week, but he was already dissatisfied with the idea of work. Had he made any previous attempts to secure work, his record would without doubt have made a difference in the average number of jobs held by his group.

Unemployment averages—In reference to the unemployment averages, it must be pointed out that because of the period in which this study was made, these figures are probably not truly representative. The children were studied after the industrial depression had been in progress for at least a year, and with few exceptions, they had been out of work for months. However, fourteen of the fifty children were able to stay at one job after completing their school training.

The personality groups varied considerably in their average amount of unemployment. The C group (egotistical and domineering) was out of work the least amount of time, and the two groups composed largely of girls came next in frequency. The A and B groups, presumably the most promising, were unemployed for considerably longer periods, but they had a smaller job turn-over and earned higher wages.

Average wage—The wages earned by Groups A, B, and C seem quite consistent with their various traits and attitudes. As might be expected, the A's earned considerably more per week than any other group. This group can be illustrated by a boy who was out of school only one year, out of work only one month, and was earning \$20.00 a week consistently. A girl in the same group earned \$14.00 a week for the past year with a loss of only three months work.

If we exclude from Group F the boy last discussed, the wage average of \$10.90 falls to \$9.38, thus making the last three groups quite uniform. In considering these wage groups, it is important to remember that none of them represents the highest earning capacity of the children in them. Because of the scarcity of work, these earnings have been smoothed out over slack periods so that a boy who usually earned \$12.00 a week might be forced for months to work only three or four days a week, and thus her wage would be brought down to seven or eight dollars a week.

Dividing these children into groups according to their personality thus gives some indication of their vocational adjust-

ment. Another way of looking at the problem is to divide them into groups according to success on the job and to attempt to find points on which such groups differ.

In measuring the success of these boys and girls, groups were defined as follows:

Class A—This group consisted of those who had unquestionably adjusted well, as evidenced by such qualities as responsiveness, industry, reliability, pleasant disposition, attractive personal appearance, and ability to profit by criticism. Their work histories were indicative of stability.

Class B—This group was divided into two sections. B1 included those who more closely resembled Class A, while B2 consisted of those who leaned toward Class C. In B1 were found such characteristics as obedience, friendliness, reserve, a certain amount of egotism, and a rather high degree of dependability. The children in B2 had most of these qualities also, but to a smaller degree. They were apt to project the blame for their failures on others and, as a consequence, were not able to remain long at one job.

Class C—This group contained the failures—those who, for one reason or another, became delinquent or gave evidence of becoming delinquent. They were lazy and shiftless, easily led, sullen, and in need of constant supervision.

Thirteen children were judged to belong to Class A, sixteen to Class B1, twelve to Class B2, and nine to Class C. Grouping those in A and B1 together, twenty-nine children (fifty-eight percent) were found to have attained a satisfactory degree of success while twenty-one (forty-two percent) were poorly or rather poorly adjusted. The Federal Children's Bureau,⁶ in a study of a thousand special class children out of school for several years, classified seventy-eight percent of the boys and eighty percent of the girls as doing satisfactory work. Practically similar percentages were found in our group if Classes A, B1, and B2 are grouped together.

The question next is what has contributed to the success or failure of these children? The following tables attempt to answer this question by showing the relation of the degree of success to intelligence, sex, economic status, parental attitudes, and personal stability.

TABLE X
Distribution of Success Groups According to Intelligence

Intelligence Quotient	Success Groups				
	A	B1	B2	C	Total
58-59	2	—	3	1	6
60-64	2	3	2	1	8
65-69	7	7	3	3	20
70-74	2	5	2	3	12
75-79	—	1	—	—	1
Total	13	16	10	8	47

TABLE XI
Distribution of Success Groups according to Sex

Sex	Success Groups				
	A	B1	B2	C	Total
Male	5	3	6	6	20
Female	8	13	6	3	30
Total	13	16	12	9	50

TABLE XII
Distribution of Success Groups according to Economic Status

Economic Status	Success Groups				
	A	B1	B2	C	Total
Dependent	1	4	4	4	13
Marginal	6	9	6	3	24
Adequate	2	2	2	2	8
Comfortable	4	1	—	—	5
Total	13	16	12	9	50

TABLE XIII
Distribution of Success Groups according to Parental Attitudes

Parental Attitudes	Success Groups				
	A	B1	B2	C	Total
A	4	1	—	—	5
B	4	4	—	—	8
C	3	7	8	3	21
D	2	4	4	6	16
Total	13	16	12	9	50

⁶ *Fourteenth Annual Report of the Chief of the Children's Bureau*, pp. 12-15.

TABLE XIV
Distribution of Success Groups according to Personality

Personality Groups ²	Success Groups				Total
	A	B1	B2	C	
A	5	1	1	—	6
B	5	3	4	1	13
C	1	5	4	1	11
D	1	2	1	2	6
E	—	4	1	—	5
F	1	1	1	5	8
Total	13	16	12	9	50

¹ See page 164.

² See page 169.

It is very clear that success was not dependent on intelligence. An I.Q. range of 58 to 74 is found in the very successful group and an identical range among those who were ranked as failures.

The girls apparently were somewhat more successful than the boys, as evidenced by the fact that twenty-one of the thirty girls were placed in the two upper groups while only eight of the twenty boys were so classified.

Economic status seemed to play an important part in the successful adjustment of these children. None of those from "comfortable" homes were classed as failures, while the proportion of children from "dependent" homes increased with each decrease in amount of success.

Favorable parental attitudes were also closely associated with success, as would be expected from Table IV, which shows economic status and parental attitudes highly correlated. Eight of the thirteen children in the most successful group belonged to homes in which the parents were cognizant of their difficulty and sympathetic understanding in their handling of it. Three came from homes with a fair attitude, and two succeeded in spite of ignorance and discouragement at home. The B1 group showed a smaller proportion of children from homes of sympathetic understanding. In the B2 group and in the C group there were no homes of this type.

Personality appeared to be a factor in success, due partly to the fact that in judging success personality traits were used as one of the criteria. The various types of personality, however, were scattered among the various adjustment groups, the A personality

being concentrated in the A adjustment group. This finding is in agreement with Davies, who says:

"When one comes to the so-called moron group, with mental ages ranging from eight years up, one cannot be sure, by knowing the mental age alone, whether that individual can or cannot get along successfully in the community. All the elements of personality . . . enter as determining factors for success or failure. The individual with a nine-year mind, who has socially agreeable characteristics and other personal qualities which enable him to make the most of his limited intelligence, is doubtless a fitter citizen and a better workman than the one with an eleven-year mind, whose personal characteristics are such that he cannot get along with people, has little or no judgment as to moral standards, is unwilling to apply himself in acquiring the means of livelihood, and thus becomes a community burden or menace. Finally determined by the social test, the former individual with a mental age of nine years appears not to be feeble-minded, while the latter with a mental age of eleven would be classified as feeble-minded."⁷

A low I.Q. did not prevent a considerable group of these children from attaining success on the job and an adequate social adjustment. In such an adjustment, economic sufficiency and sympathetic understanding on the part of their parents played an important part. The extent to which the training in the special class was of assistance to these children can be judged only by a comparative study of children similarly handicapped and lacking the training which such a class gives; but it seems highly probable that training also was a definite factor in their adjustment. In summary, then, our findings are in strict agreement with Davies', who writes:

"These studies of the after-school careers of the mentally deficient indicate definitely that the large majority of special class graduates are able to take their place in community life as ordinary, decent, working citizens, who mind their own business and make their way in such a manner as to be in no sense social burdens or expenses. Many of these graduates may be regarded as social and industrial assets. In other words, though deficient according to the usual grading of intelligence, they do not properly be called feeble-minded."⁸

CONCLUSIONS

This study is concerned with the after-school careers of fifty children who attended a special class in a Massachusetts city in 1927, 1928, and 1929. Those children were chosen for study who

⁷ Davies, Stanley Powell, op. cit., p. 8.
⁸ Ibid., p. 323.

had been out of school from one to three years. The average time out was two years, but a few children were out three years and others out but one year. There were twenty boys and thirty girls in the group; their I.Q.'s. ranged from 58 to 79.

According to the standards for success adopted for the study thirteen children made an unquestionably acceptable adjustment; sixteen attained a satisfactory degree of success; twelve were rated as making a poor adjustment; and nine were considered failures.

The study of this group of cases showed the relation of the following factors to success:

1. Intelligence was not a factor in social adjustment.
2. The girls were somewhat more successful than the boys.
3. Economic sufficiency of the home, although not an absolute determinant of success, was undoubtedly an aid to it.
4. Parental attitudes were an extremely important factor in the degree of adjustment attained by the children.
5. Desirable personality traits very definitely contributed to success; and, since economic sufficiency and favorable parental attitudes determine personality to a large extent, all three of these were judged to be vital factors in adjustment.

What can the school do to make for more successful adjustment of such children?

The fact that desirable attitudes were so essential to success suggests that through social service in the home, the school could become a constructive force in the community.

Because personality was an important determinant in success those children who possess undesirable personality traits might be helped considerably in the modification of them while still in school.

The following plan outlined by Taft⁹ suggests a most desirable way of accomplishing the aims just discussed:

1. Adequate mental clinics under a psychiatrist and psychologist—

To pass on the mentality of every child entering school so that assignment of a child to special class will not be delayed several years.

⁹ Jessie Taft, "Supervision of the Feebleminded in the Community," *Conference of Social Work Proceedings*, 1918.

2. Social service—

From the time the child enters the special class, the visiting teacher should keep in touch with his home and school adjustment, carrying on education in the home and deciding what is to be done with the child when he leaves school. She would know his abilities and chances of success and his tendency toward anti-social behavior.

3. A vocational and employment bureau—

- a. Should aim to place the child in an occupation for which he is best fitted.
- b. Should give careful supervision at the time of a crisis in the life of the child.
- c. Should give explanation to the employer of the child's abilities and limitations.

THE ROLE OF THE PSYCHIATRIC SOCIAL WORKER IN THE TREATMENT OF POST-ENCEPHALITIS:

A STUDY OF RESULTS WITH THIRTY-FIVE PATIENTS¹

LULU M. SCOTT

Marked changes of personality and the onset of behavior difficulties in children are sometimes traceable to an illness which parents describe as "flu" or sleeping sickness but which has been recognized for about twelve years under the name of epidemic encephalitis or encephalitis lethargica. A few cases of this type are known to each child guidance clinic, and the question of how best to treat them is one that concerns social workers as well as physicians. It is the purpose of this paper to review the literature on the subject, to show the present status of thirty-five cases that were examined and treated by the staff of the Illinois Institute for Juvenile Research between 1921 and 1929, and to describe the social case work carried on with nine typical patients.

I

ETIOLOGY AND SYMPTOMS

Epidemic encephalitis is an infectious disease of unknown etiology but of well-established pathology. The cerebro-spinal nervous system, especially the brain, bears the brunt of the infection. Several theories as to its etiology have been advanced. O'Connell states that it is a toxic disturbance of the central nervous system due either to toxins produced by organisms located probably in the respiratory or gastro-intestinal tract or to toxins elaborated as a result of metabolic disturbances; another, that it is caused by a cultivable bacteria, and a third that it is caused by a filterable virus.²

Symptoms may persist without intermission from the acute illness or may develop weeks or months after the patient has apparently made a good recovery.³ Though the interval is usually

¹ A thesis presented to the Smith College School for Social Work, August 1929, Series C, No. 166, Institute for Juvenile Research publications.

² Neal, Josephine, "The Present Status of Epidemic Encephalitis," *The Journal of Mental Science*, Vol. 214 (June 30, 1928), p. 1328.

³ Editorial, "Encephalitis Lethargica," *The Lancet*, Vol. 214 (October 22, 1927), p. 873.

than twelve months, a Parkinsonian syndrome (physical disturbance) is known to have developed as long as five years after the original attack.⁴

The clinical pictures presented after encephalitis are exceedingly varied, the majority of cases falling into one of three groups distinguished by their principal symptoms: motor, respiratory, or mental⁵ (personality changes).⁶ The latter appear most frequently in children while adults usually show physical disturbances. Mackenzie states that it is a remarkable fact that in this disease which pronounced aberrations of conduct are found there should be practically nothing in the nature of a dementia, as that term is understood by the alienist.⁷

Motor Disturbances.

These disorders are shown most frequently by the rigidity of the muscles and a consequent loss of automatic movements. The result is a general stiffness of the body, slowness of movement, and a masklike, staring expression. In some cases the difficulty of movement may become so great that the patients are unable to eat and dress themselves and even have difficulty in chewing. Owing to the stiffness of the muscles some patients' mouths are usually held open, and excessive salivation causes drooling. In the true Parkinsonian disease there may be a loss of equilibrium, a tendency to run forward or backward, or, when sitting, to let the body sink slowly forwards or sideways.⁸ Tremors of different parts of the body occur chiefly as a complication of the Parkinsonian syndrome. This is found in the shaking of the head and hands, clicking of the teeth, to and from movements of the tongue, and a rhythmical sucking action of the tongue.⁹ Speech defects in the form of stumbling, stammering, and lolling are seen. In many

⁴ *Ibid.*, p. 214.

⁵ *Ibid.*, p. 873.

⁶ *The Lancet*, an English journal, uses the term "mental" where an American psychiatrist would say "personality change."

⁷ Mackenzie, Ivy, "Epidemic Encephalitis," *The Journal of Mental Science*, Vol. 214 (October, 1927), p. 574.

⁸ Editorial, "Encephalitis Lethargica," *The Lancet*, Vol. 214, (October 22, 1927), p. 874.

⁹ Riddock, George, "The Acute Psychiatric Type of Epidemic Encephalitis," *Journal of Mental Science*, Vol. 7, (May, 1928), p. 504.

patients speech is slow and painfully thought out, and the voice has a monotonous tone.

A rapid increase or decrease of weight may take place after encephalitis. Parsons¹⁰ finds that patients suffering from pathological obesity have not improved under treatment but have definitely deteriorated and in all cases have developed unmistakable signs of an early Parkinsonism.

The appearance of Parkinsonism is regarded by some observers as of ominous import, as in the majority of cases the patient becomes hopeless and unfitted for his work. Physical and often mental deterioration is evident in the helpless cases, and severe asthenia may characterize the closing stages.¹¹

Abnormal drowsiness often persists and may merge into a Parkinsonian syndrome. On the other hand, patients may be troubled by a peculiar insomnia in which night is turned into day and day into night, the so-called "inverted sleep rhythm."

Respiratory Disturbances.

Respiratory disturbances are often shown by behavior which reminds one of hysteria. Wimmer¹³ describes a girl who developed episodic giddiness, headaches, and fainting spells soon after her encephalitis. About three years later she was seized with a series of quick, clonic jerkings of the muscles of the neck so that her head was thrown back. At the same time her mouth opened widely and marked gasping for breath was noted. Frequently during these attacks there were myoclonic jerks around the mouth and in the left shoulder. These seizures occurred as frequently as one hundred and thirty times a day. A second type of rigid seizure developed later, which accompanied the polypnea.

Wimmer¹⁴ concludes that the same anatomic-physiological apparatus is disturbed in hysteria patients as in encephalitis patients.

¹⁰ Parsons, Allan, "Report of an Inquiry into the after Histories of Patients Attacked by Encephalitis," *Reports of Public Health and Medical Subjects*, p. 65. H. M. S. Stationery Shop, London.

¹¹ *Ibid.*, p. 54.

¹² *Ibid.*, p. 61.

¹³ Wimmer, August, "Hysteriform Respiratory Seizures in Chronic Encephalitis," *International Clinics Quarterly*, Vol. IV, December, 1927, p. 100.

¹⁴ *Ibid.*, p. 92.

Mental Disturbances (Personality Changes).

Children who were docile and tractable before the attack may become aggressive, untruthful, quarrelsome, untidy, and uninterested in sex interests. Parents and teachers irritated by this behavior generally attempt to break the will of the child. The result is the appearance of hyperactivity and violence.

Beverly and Sherman¹⁵ find the following traits most frequent: change in disposition, inability to sleep at night, violent outbursts of temper, irresponsibility, incorrigibility, changes in school behavior, cruelty to animals, emotional shallowness, childish mannerisms, impulsive delinquencies, poor insight, appearance of deterioration, hyperactivity, irritability, alertness, emotional instability, explosive reactions, and marked indifference."

Sometimes the children realize the atrociousness of their actions, showing spontaneous regret and evidence of trying to control themselves, weeping or giving signs of the most genuine repentance and complaining that they could not help it. Advice, admonition, punishment, though the patient receives them with genuine repentance and promises amendment, are without effect, for primitive tendencies cannot be influenced and as soon as these arise again, the patient relapses.¹⁶

Such behavior, whether immediately following the acute attack or appearing only after some months, develops to a maximum rapidly, and then runs a steady course for years, not progressing or regressing, except that in some cases Parkinsonism supervenes and, when pronounced, abolishes it. The cases may continue in a mixed state but behavior disorders do not occur in the same degree and are not usually lessened by mild Parkinsonism."¹⁷

Bond and Partridge¹⁸ find that true psychoses are rare, but when occurring they "have usually taken the form of some phase of manic depressive insanity, a profound hebephrenic, praecox-like psychosis." The patients preserve, as a rule, sufficient mental keen-

¹⁵ Beverly, Bert I., and Mandel Sherman, "The Factor of Deterioration in Children Showing Behavior Disorders Following Epidemic Encephalitis," *Archives of Neurology and Psychiatry*, Vol. 10 (September, 1923), p. 335.

¹⁶ *Ibid.*, T. R., op. cit., p. 4.

¹⁷ *Ibid.*, p. 2.

¹⁸ Bond, Earl and G. E. Partridge, "Post-Encephalitic Behavior Disorders in Children and Their Management in a Hospital," *American Journal of Psychiatry*, Vol. 52 (1926), p. 93.

ness to compare their attainments with those prior to the illness. They appreciate the fact that they have changed and feel less able to cope with mental problems. In consequence they frequently withdraw from society and become seclusive.

It is sometimes stated that the catatonic stupor of dementia praecox closely resembles encephalitic Parkinsonism. This is true in the outward appearance of the two diseases, but there is a profound difference in mentality. If the encephalitic is aroused, he is accessible, his answers are rational, and he will not express any delusional ideas.¹⁹

FORMS OF TREATMENT PRESCRIBED

At the present time no form of treatment has proved universally helpful for post-encephalitic patients.²⁰ Good hygiene and a simplified life, with educative and especially occupational programs, seem to have brought improvement in some cases. Bond and Partridge²¹ developed a routine life for eighteen post-encephalitic boys whom they had under observation in the Pennsylvania Hospital. Marked eccentricities of conduct were noticed in nearly all of these patients during the first period of their admission. After eighteen months of good physical care and routine life the children responded well to simple methods of discipline. A good spirit could be aroused in spite of the patients' strong individualistic behavior before their entrance. The boys progressed in school work; they gained physically, were more easily managed, and remained happy with no wish to leave the hospital. On the other hand, there was little evidence that the predominant cause of these patients' difficulties had been done away with, and it seemed highly probable that their bad behavior, which was confirmed by years of practice at home, would again be resorted to if they were discharged.

Certain drugs, such as belladonna, hyoscine, parathyroid extract, and iodines, have made some patients more comfortable, particularly by reducing the constant flow of saliva, which is such an unpleasant feature of the Parkinsonian state. Most of these measures, however,

¹⁹ McCowan, P. K. and L. C. Cook, "The Mental Aspects of Chronic Epidemic Encephalitis," *The Lancet*, Vol. 215 (June 30, 1928), p. 1318.

²⁰ Parsons, Allan, op. cit. p. 118.

²¹ Bond and Partridge, op. cit., p. 25.

ever, are only palliative and do not in any way arrest the progress of the disease.²²

Hill²³ has found some encouraging results in the use of bulbocapnine. Though its pharmacological action is quite different, it has a chemical structure closely related to that of apomorphine. Hill found that some of the patients taking bulbocapnine improved to such an extent that they were no more troublesome than normal boys. The Parkinsonian patients, however, became rigid by the use of the drug, and their behavior disorders were little affected. The beneficial effect which was operative on the patients having behavior disorders disappeared at once on omitting the drug. He concludes that bulbocapnine exerts a specific depressive action on the thalamostriated level of the brain and has little or no action in the cerebral cortex.

As only temporary improvement followed the use of drugs and as chronic encephalitis has a resemblance to general paresis, the inducing of malaria has been used as a means of treatment by some English specialists. Craig²⁴ reports upon eight Parkinsonian cases in which mosquitoes infected with malaria were allowed to inoculate the patients. Nine rigors were aimed at, and quinine was given to check the malaria. He concludes that some temporary degree of improvement was apparent in all the cases. There was a decrease of salivation, quicker cerebration and improved facial expression. Some degree of improvement in the mental condition seemed to have taken place. On the other hand, McCowan and Cook,²⁵ who have had years of experience in treating general paresis with malaria, conclude that the malarial treatment which they tried on fifteen post-encephalitics was in no way beneficial. They found that it had a debilitating effect owing to the poor recuperating powers of the encephalitic.

²² Craig, Roy, "The Treatment of the Parkinsonian Syndrome Following Encephalitis by Malaria," *The Lancet*, Vol. 214, (October 22, 1927) p. 860.

²³ Hill, T. R., "Juvenile Behavior Disorders in Epidemic Encephalitis and Their Treatment by Bulbocapnine," *The Lancet*, Vol. 216 (May 11, 1929), p. 968.

²⁴ Craig, Roy, op. cit., p. 860.

²⁵ McCowan, P. K. and L. C. Cook, "Chronic Epidemic Encephalitis Treated by Induced Malaria." *Lancet*, Vol. 214, (October 22, 1927), p. 863.

II

DESCRIPTION OF THIRTY-FIVE PATIENTS STUDIED
BY THE INSTITUTE FOR JUVENILE RESEARCH

Between 1921 and 1929 thirty-five post-encephalitic patients were examined and treated under the supervision of the staff of the Illinois Institute for Juvenile Research.²⁶ They came from varied social backgrounds and ranged from three to twenty-four years of age and from 51 to 126 in intelligence quotients. They showed wide variation in personality types and were referred to the Institute because of diverse behavior problems. The only characteristic which the group had in common was the diagnosis of post-encephalitis.

Sources and Causes of Referral.

The thirty-five cases studied became known to the Institute for Juvenile Research in the following ways: nine were referred by hospitals, six by social service agencies, eight by school authorities, four by court workers, seven by some member of the family and one by a family physician.

The problems for which they were referred were varied. Twenty-six came because of some aggressive behavior (truancy, stealing, sex interest, lying, and quarrelsomeness). Phantasy²⁷ (regressive behavior) was mentioned as a reason in thirteen of the cases, of which seven also showed some form of aggressive behavior. The difference to surroundings was given a reason in five cases; four of these patients were definitely diagnosed as having the Parkinson syndrome. Incurability and temper tantrums were listed for twenty-six patients. This indicates the encephalitic child's desire to have his own way and shows why teachers and parents find him so difficult. Lack of concentration and emotional instability were mentioned in referring twenty-eight of these children. Some had a physical disorder (inverted sleep rhythm, respiratory disorder,

²⁶ Ten of these thirty-five cases have been described in former papers. Blanton and E. Cole, "The Problem of Social Adjustment Following Epidemic Encephalitis in Children," *Mental Hygiene*, Vol. VIII, pp. 977-1023, Haathi, Helvi, "The Possibility of Re-education for Post-encephalitic Children Following Methods Used for Crippled Children," *Welfare Magazine*, March, 1926.

²⁷ "Phantasy" is here used to include mild hallucinatory experiences, daydreaming, and the weaving of stories, such as "my father killed my mother one morning and then he ran away, so I no longer have a home."

or hyperactivity) were given by twenty-eight of the referring agents as one reason for asking to have the patients examined.

Age and Sex

Seventeen of the cases studied were girls, and eighteen were boys. In age at the time of referral the patients varied from three to twenty-four years, about half being from nine to twelve years old. (Table I). Special arrangements were made to have the three patients over eighteen studied, as the Institute for Juvenile Research seldom accepts those over that age. Two of them were referred primarily because of apathy, while the other was manifesting serious antisocial behavior.

Intelligence

Table I shows the age and sex of the thirty-five patients and their intelligence quotients as measured at various times by Stanford Binet tests.

The group as a whole showed a range in I.Q. which suggests that there is no relation between intelligence and the post-encephalitic condition. Two children were found to have superior intelligence, ten on retests, and ten had I.Q.'s. under 80, leaving twenty-two with I.Q.'s. between 80 and 110.

While case number ten was found in two successive years to have an intelligence quotient of ninety-seven, the other cases fluctuated somewhat on the retesting. Twenty-nine out of the thirty-five patients were retested. In seventeen of these cases the variation between the first and second test was less than ten points. In the other twelve cases, four improved from ten to fifteen points, and one declined from fifteen to twenty-four points. The examiners noted emotional instability and distractibility, traits which are, of course, characteristic of the disease and which may account for some of the changes in I.Q. ratings. Taking the test results at their face value, however, it would appear that somewhat more than a fourth of the patients who were retested showed a real increase in intelligence while about an eighth showed decided improvement. This finding is not strictly in line with that of Bond and Partridge,²⁸ who conclude that if there are any changes in intelligence they are very slight in comparison with the emotional and

²⁸ Bond and Partridge, op. cit., p. 100.

TABLE I
Sex, Age, and Intelligence Ratings of Thirty-five Post-encephalitic Patients

Case Number	Sex	Age at first test	Intelligence Ratings in Various Years											Change in I.Q. between first and last test			
			1919	1920	1921	1922	1923	1924	1925	1926	1927	1928	1929				
1	M	3															+12
2	F	6															-24
3	F	6															+4
4	F	7															+7
5	M	7															-17
6	M	8															+7
7	F	8															-8
8	F	9															+19
9	M	10															0
10	M	10															-18
11	M	10															+3
12	M	10															+15
13	F	10															-2
14	M	10															+10
15	F	11			71												+15
16	M	11			121												+6
17	M	11			86												+4
18	M	11															-
19	M	11															-
20	F	11															+10
21	F	12															3
22	F	12															-
23	F	12															2
24	M	12															2
25	F	14															+10
26	F	14															-15
27	F	15															+3
28	F	15															4
29	F	16															+7
30	M	17															+13
31	M	17															-

instinctive reaction changes. They believe that low intelligence is a serious handicap in the treatment of the patients, since the reconstruction of the behavior depends so largely on reeducation.

Habitat and Occupations of the Parents.

One child studied had the onset of encephalitis in New Orleans, one in Detroit, another in a small town in southern Illinois, while the others had the disease while residing in Chicago.

Seventeen of the fathers were unskilled laborers, fourteen were skilled or clerical workers, and two were in the professional group. These data bear out the findings of others that encephalitis is not peculiar to any one locality or economic group.

Type of Family.

Of the thirty-five cases studied, twenty-four came from families in which both parents were in the home. In all other cases there was, added to the disease problem, the additional problem of a broken home situation.

Nationality.

The parents of seventeen children were born in America; three of these children were negroes. The foreign-born parents came from Sweden, Holland, Hungary, Ireland, Poland, Russia, Czechoslovakia, and Germany.

Family Attitudes.

Twenty-seven of the patients came from homes in which the attitudes of the parents and other siblings were unfavorable to recovery. Some of the parents were at times over-protective while other times they complained of the patients' behavior. In other cases, the parents considered the patients "subnormal," criticized their drooling, their table manners, and their impulsive behavior. Others clearly showed that they no longer wished the children in the home. The other siblings were ashamed of the patients and would not allow them to accompany them on recreation trips. In only one case were the family attitudes found to be really helpful. This is the case which is believed to have made the best adjustment.

Table II shows that of the thirty-five cases, nineteen had the onset of the disease between five and eleven years of age. Three

TABLE II
Age of Patients at the Onset of the Disease

Age	Number of Children		
	Male	Female	Total
2-4	2	1	3
5-7	5	3	8
8-10	3	10	13
11-13	0	2	2
14-16	5	0	5
17-19	0	1	1
Unknown	2	1	3
Total	17	18	35

of the patients and their families could not recall any symptoms such as a high fever, seeing double, pains, weakness or abnormal drowsiness, which are usually found in encephalitis. The diagnosis of these cases were based on the neurological signs, such as immobility of the facies, abnormalities of the pupils, tremors, and changes in reflexes, gait, and speech.

Time between Onset of Disease and Later Disorder.

The length of time elapsing between the disease and the onset of behavior disorders was not noted in all of the social histories. However, sixteen of the thirty-two informants who described the onset stated that changes were noted immediately after the period of stupor and weakness had passed.

School Problems.

Thirty of the thirty-five patients studied were in school some period during the time they were known to the Institute, and each of the thirty presented some type of school problem. Incompetibility, quarrelsomeness, demand for attention, and lack of concentration were the major complaints.

Present Status.

Table III shows the status of the cases in the spring of 1931 when a follow-up study was made.

Nine patients were at home unable to work or to attend school and eleven were in some form of institution. Three of the patients were in special boarding schools, and one patient was attending a crippled children's school. Two of the four patients attending

TABLE III
Date of Onset of the Disease as Related to Present Status

Present Status	Date of Onset												Total			
	1918-19		1920-21		1922-23		1924-25		1926-27		Unknown		Number	Percent		
	M	F	M	F	M	F	M	F	M	F	M	F				
Adequate Adjustment working full time married and well adjusted	1				1								1	1	6	
Partial Adjustment attending grammar school attending special school working part time married	1		1		1		1	1		1		1	4	4	1	28
Unimproved or Deteriorated convalescent home at home unoccupied parochial training school correctional institution feebleminded institution state hospital penitentiary	1		1	2	1		1	1		2		1	1	9	2	60
Dead																1
Not located	1															1
Total	6	3	3	6	3	2	4	3	0	2	1	2	35			100

lic grammar schools were repeatedly in difficulty and on the border of expulsion, while the other two were progressing fairly well. One patient could not be traced; in June, 1928, he was in the county infirmary, deteriorating physically and mentally. Another boy died in 1928 in an institution for the feebleminded. He was bedridden with progressive paralysis before his death. One girl was in a convalescent home, as her hyperactive condition and choreiform movements had increased. Previously, she had been considered a behavior problem in the foster home in which she was placed. One boy was working full time; another, who was handicapped physically, was working part time. Two girls were married, and each had gone through one pregnancy successfully. One of these was obviously better adjusted than the other.

Summing up the present status of the thirty-five patients, it will be seen that twenty-one have not been able to make an adequate adjustment to the usual demands of school or work. Nine of these were at home unoccupied, while twelve were in some form of institution. One could not be traced, and one had died. Of the remaining twelve, two were making fairly adequate adjustments, being married or at work, while ten were partially adjusted, being able to attend school or to do some work.

It is interesting to compare these findings with those of other studies. In 1927 MacKenzie²⁹ of Glasgow said that he knew of only one recovery among fifty post-encephalitic cases. Parsons³⁰ cites two studies made in England. In one study of three hundred and thirty-four patients who had the onset in 1924, twenty-three could not be traced, thirty-eight had died, and of the remaining two hundred and seventy-three who were examined fifteen months later fifty-six percent were unfit for work or school. The total incapacity rate was estimated at forty-two percent.

Date of Onset in Relation to Present Status.

Table III also correlates the date of onset of encephalitis with the present status of the patients. This correlation is of interest because the theory has been advanced that the earlier epidemics were more severe. It will be seen that three men having the onset in the 1918-19 epidemic were in correctional institutions, one woman having the onset in 1921 was in the state penitentiary, and

²⁹ MacKenzie, Ivy, op. cit., p. 570

³⁰ Parsons, Allan, op. cit.

two women having the onset in 1918 were in state hospitals. On the other hand, the two patients making the most adequate adjustment had the onset of their disease in 1919 and in 1922; while of the twelve who had the disease in 1924 or later, none were adequately and only four partially adjusted. It would therefore seem that the date of onset bears little relation to subsequent adjustment.

III

NINE CASES ILLUSTRATIVE OF TYPES³¹

The following cases were selected for illustration of the different maladjustments found in post-encephalitic children and of the social service treatment which was used with them.

CASE 2³²

This case shows some of the conduct disorders found in post-encephalitic children and indicates the importance of getting an adequate and accurate social history.

Carrie, aged six, was referred to the Institute of Juvenile Research in 1921 by the pediatrics department of a general hospital because of incorrigibility, temper tantrums and suspected retardation.

Personality changes were noted by the family several months before Carrie was examined. She had formerly been considered a good child by her parents and the kindergarten teacher. At the time of referral the mother complained that she pulled the furniture around the house, was destructive in her play, and had temper tantrums.

In the psychological test given in 1921, she had an intelligence quotient of 114; in 1923 she made a score of 99 on the Stanford Binet Test and 103 on the Seguin. A year later, she had difficulty on some of the tests as she could not read them and made a score of 97.

A diagnosis of "psychopathic personality" was made, and it was advised that consistent discipline be used in the home. The social worker visited the home every afternoon for a month to observe the patient and compelled her to lie down to rest for half an hour. The patient fought and swore at the worker and showed little improvement. Her behavior at times improved and at times became worse. Attempts to regulate the home routine met with little success.

In 1923, Carrie persisted in standing or sitting on the street car tracks. When moved by the street car motorman, she would return again before he could start

Several of these cases have been described in the studies mentioned above. MacKenzie, op. cit., described the cases here named Donald, Edith, Larry, and Henry with the initials I. D., E. S., L., B., and H. H., and Haasti, op. cit., described Larry with the initials L. B. A.

The case numbers correspond to those given in preceding tables.

the motor. She used to throw herself on the floor, scream, kick, bite, scratch and swear voluminously. She initiated quarrels with other children by thumbing her nose and teasing them. Court action was taken to place her in a foster home, as her mother appeared to have no control over her. She was refused placement by the children's agency interested, as she caused such an uproar in the receiving home. Since there were no other sources available, she was returned to her home.

Information about an illness was not elicited from Carrie's mother until 1924. Finally, after going over the patient's past history with the mother very carefully, she recalled that the family had been asked to move from a certain flat because of the patient's behavior following the "flu." Carrie's older brother then recalled that her eyes had been crossed and that she complained of seeing double. Upon the basis of the neurological findings and this history of the illness, a diagnosis of post-encephalitis was made. Twelve hours of sleep each night, warm baths, and activities at a near-by settlement house were recommended.

Carrie was so unmanageable at a summer camp which she attended in 1926 that it was necessary to return her after the second day. She masturbated and had precocious sex interests. She was ingenious in eluding adults and constantly ran away from home. The family could not be persuaded to move to a less congested part of the city, and they failed to understand that her behavior was due to her former illness.

Her anti-social behavior continued. Purses, costumes, hats, and other finery were brought home, with the statement that people gave them to her. She was expelled from the parochial, public and crippled children's schools because she fought with the children and was incorrigible. On one occasion when refused a pair of scissors in the school office, she grabbed the scissors and dashed through the halls threatening everyone she met. Sex curiosity and uninhibited play continued, resulting in intercourse with several boys.

Social service treatment consisted in urging the parents to use more consistent supervision, interpreting her illness to the family and her teachers, and in supervising her recreation. She became so unmanageable in 1927 that it was advised that she be placed in a parochial training school. Institutional life seems to have had a calming influence. Carrie was a great problem at first but adjusted gradually so that in a year and a half's time she was able to return home. She has now attended public school for a year without any outstanding problems occurring.

A washing compulsion was present for several months after her return home. This was interpreted by the psychiatrist as being a transfer of the "cleansing" and "washing" beliefs taught at the parochial institution. Hyperactivity, excessive fatigue, demand for attention, and emotional instability are some of the characteristics still present. However, it has been possible for her to adjust to some degree in the home and school. Parental supervision has been more consistent, and she has been threatened with returning to the parochial institution if she is not obedient. It is questionable how long this control will prove effective.

CASE 30

This case is presented as an example of a Parkinsonian syndrome.

Martin, a Jewish boy seventeen years of age, was referred by the Psychopathic Hospital in 1927. The complaints were that the patient sat around all day and

no interest in what was going on about him. He did not get up until noon, and all his movements were slowed up. The mother reported that in 1925 Martin's arms began to jerk, his hands twitched, and he complained of being very tired and sleepy. He slept a great deal at this time.

The physical examination in 1927 indicated that he was of normal height and weight. The right shoulder drooped and his right leg dragged. Mask facies and rigidity common to the Parkinsonian syndrome were described. Brisk reflexes and tremors of the lids and tongue were present. He had an enlargement of the thyroid. A diagnosis of post-encephalitis was made.

In 1927 Martin showed an intelligence quotient of 88 on the Stanford Binet test. A year afterward he made a score of 101 on the same test. At this time a good vocabulary and excellent definitions were noted. He confided to the psychologist that he could do much better if he were not so self-conscious.

In the psychiatric interviews the patient talked about suffering for the world. It was his philosophy that each day he was to save someone from an accident. A voice told him the way in which he should work. He found this voice rather disturbing but continued to obey it. Sex interests were also troublesome. Martin wondered if he would not be justified in going to a prostitute.

He lost interest in the recreational activities and club he formerly belonged to in his neighborhood. A great deal of time was required for him to dress. He lathered and re-lathered his hands many times. He walked with a shuffling gait. He complained of dizziness in school and inability to concentrate, so that he was advised to leave school. His inability to move fast and coordinate his movements more successfully suggested that he would adjust better in a crippled children's school where he would be treated as a sick child. Martin was opposed to this suggestion, and the family did not urge his attendance.

For a year he has worked part time for a druggist and is discouraged because he is unable to do more. His mother has given him several kinds of patent drugs. The family are satisfied that one kind of medicine is "pepping" him up some. He gets up in the morning more readily, as he is not so troubled by insomnia as formerly.

There appears to be a harmonious family spirit, although the mother is ambitious and talks at length about one son who has been unusually successful. There is undoubtedly a great deal of plodding of the patient and his lassitude is discussed with everyone the mother meets. Martin is made to feel dependent on the family. The mother nags at him about his slowness.

The psychiatrist believes that if the foci of infection are removed, and he is given medication his condition will greatly improve. His behavior so far has not included any anti-social acts, but a psychosis might be expected from the hallucinations he describes.

CASE 34

The third case illustrates the severe social consequences that may result from the disease. A patient, unable to control her tendency to steal, although recognized as a "sick" person, was nevertheless sent to the penitentiary, where her behavior disorders were aggravated.

Mary is a white woman now twenty-seven years of age. She was referred by the county social service department in 1924 because of stealing. The social history revealed that she had always been a "highstrung" girl and received "poor" in deportment at school. In 1920, following an attack of influenza, she became more quarrelsome, unstable, and was found stealing. She was depressed, said that every one was against her, and talked about jumping in the river. She cried and struck at people in her anger. Many of her reactions were childish. She stole wearing apparel and some property which was of little worth to her. While in the county jail she was violent, used profane language, and was insubordinate.

In 1924, the examiner noted that her pupils were sluggish and that she had tremors of the hands. She was suffering from gonorrhoea. She showed an intelligence quotient of 96 on the Army Alpha Test given in 1924.

In the psychiatric interview the patient resented the questions asked, and her attention was sustained with difficulty. She made the following statements: "I am not insane. There is nothing the matter with my head. I just take things I want when I see them. It has been this way ever since the sleeping sickness. Somehow I can't stop."

The following report was sent to the county social worker. "The ordinary legal test of responsibility in my opinion is not applicable here within the definition of the law, which requires merely consciousness and intelligence sufficient to guarantee awareness. This girl is responsible. In view, however, of the marked degree of involvement on the part of the midbrain as a result of the encephalitis, it is not likely that she could at present control her behavior sufficiently to give any guarantee of the future. It seems also obvious that punishment would be of little avail in such a condition, but on the contrary might aggravate the situation by arousing resentment and other inferiority reactions.

The only hope in a case of this sort is a carefully planned and strictly supervised system of re-education by which it may be possible to train latent brain centers to take over the functions of those destroyed. How effectual this would be it is impossible to state in advance. In order to carry it out it would be desirable to have some legal authority over the girl, since she is twenty-two years of age."

Intensive social work was carried on from December 24, 1924, to March 1925. Mary was asked to report to the Institute daily by telephone. She was offered suggestions as to working and sleeping arrangements. In March, 1925, the patient stole a diamond ring and swallowed it when she was suspected. It was recovered and returned to the jewelry shop. As they did not prosecute, Mary was again placed on probation.

During the following year, she had twenty-five different jobs. Unable to inhibit she again stole a diamond ring, and this time was sentenced to the penitentiary for one to ten years. As the psychiatrist's earlier report to the judge indicated, Mary was believed incapable of governing her actions. However, as she was not insane she was held responsible in the eyes of the law.

The mental health officer at the penitentiary reports that during the three years she has been imprisoned, Mary has been in repeated difficulty for violation of the disciplinary rules of the institution. She has shown great emotional instability, impulsiveness, and incorrigibility. At one time, as a result of trying to escape, she was placed in a solitary cell and handcuffed to the bars. This punishment was continued on a diet of bread and water for about a week. Mary once

demanded for sympathy, claimed that she was pregnant, refused to touch the bread offered her, and drank only water throughout the period of her punishment. She continued to insist that she was pregnant until a full nine months had passed when she had to abandon the claim because no child was born. When not employed she protests her desire to work, but when given employment she finds fault with the work, the matron in charge, and the behavior of the other inmates working with her. The neurological examination made in March, 1929, revealed very acute trophopathic and epicretic sensation. Her sense of motion and position was normal. Coordination tests were fairly well done but there was some overlapping in the finger test. Her station and gait were normal but there was a slight swaying noticed in the rhombic position. Eye movements were normal, but there was a slight ptosis of the eyelids. The reaction to light and accommodation was very sluggish. A slight asymmetry of the face with a flattening of the left side was noted. The tremors of the eyelids, mouth and tongue were very marked. No evidence of atrophy or hypertrophy was found anywhere about the body. The deep reflexes were active and equal.

The patient's sleep has been much disturbed. At times she showed almost a panic flight in her conversation. Her content of thought is distinctly tinged with paranoid ideas. Her desire for sympathy because of her nervous disorder has caused her to exaggerate her symptoms and to make less effort to succeed.

The plan is place her in one of the state hospitals upon her release from the penitentiary, as she cannot adjust in the community and is in need of custodial care. Her behavior will be understood on the basis of her illness.

CASE 9

In treating case nine, schools of many types were used. His family, like many others in such circumstances, was unable to understand the child's behavior or to cope with his problems.

Henry, a white boy now sixteen years of age, was referred by the school principal in 1922 because he was "nervous" and a behavior problem.

His mother reported that he had a slight attack of the "flu" in 1918. A year after this time he complained of being hot and refused to be dressed. His arms and legs were twitched, and his eyes had an "odd look." The twitching was soon alternated by periods of breathing spells. This condition was thought by the family physician to be epilepsy.

The physical examiner in 1922 noted tremors of the hands and tongue, rigidity of the muscles, mask expression, an undernourished condition, heavy breathing and

The psychological test given in 1922 showed that he had an intelligence quotient of 94. He became angry during the test, threw the papers on the floor and had an attack of polypnea. In 1925 his score was 83 and in 1928, 75.

The psychiatric examination revealed that he had a number of fears. There was marked resistance during the interview and considerable restlessness.

The patient is the youngest of four children. Before his illness he was considered a pure, obedient child. After the illness he was impertinent to his mother and often resorted to force in gaining his ends. He learned to relieve

the twitching of his legs and arms by breathing deeply. These attacks were noticeable in the morning and at night. Enuresis occurred several times a week.

After being expelled from the public school in 1922 for ringing the fire alarm he was placed in a boarding school where he made fair progress. His mother was asked to remove him because of incendiary tendencies. In 1923 he was placed in a private school where special attention was given his physical condition. He was expelled after a year's fair work because he was a nuisance and teased other children. Following this he attended a private school where there were many retarded children. The boy felt superior to the other children and hated it there. He returned home and attended classes at another special school where he was asked to leave several months later because of exhibitionism.

In 1928, when he was expelled from the school last mentioned, the re-examination revealed slow speech, stuttering, hyperkinesia, explosive reactions, sex interests, desire for excitement, and Parkinsonian syndrome. The family reports cruelty to animals and mischievous behavior as evidenced by his ringing doorbells and fire alarms. On several occasions he tried to snatch purses.

Although from 1922 on, repeated explanations concerning Henry's illness were given the family and suggestions were made relative to discipline, he continued to act like a spoiled child. He quarreled with his brothers who were attending university. They found him troublesome and in the way. He blackened his mother's eyes and threw things at her on several occasions. He was placed in a detention home for observation where he was caught attempting homosexual relations and was committed to the older boys training school in 1928. The psychiatrist at the training school reports that Henry's reactions are childish. It is believed that he is showing the effects of inconsistent discipline. His physical condition greatly improved through medication, and the infantile behavior is being attacked through psychotherapy.

CASE 6

This case was chosen because it illustrates what little effect continued social service treatment and placement in correctional institutions may have on an encephalitic patient.

Larry, a white boy of Dutch descent, now fourteen years of age, was referred by a children's hospital in October, 1922, because of stealing, truancy, and other behavior disorders.

He is reported to have had diphtheria in February, 1922. He was removed to a hospital where he slept for two weeks. The hospital record shows that he was weak, lethargic, and that he urinated frequently. His temperature was 99.0. The diagnosis was post-diphtheria nephritis. During convalescence and the period following he slept most of the time.

On the psychological tests Larry proved to have adequate intelligence. In February 1922, his intelligence quotient as measured by the Stanford-Binet test was 93; no irregularities were observed. In March 1923 he made a score of 100. The examiner notes that he moved about in his chair considerably. His score in December, 1923. Poor effort, restlessness, and unsustained attention were observed.

The physical examination showed that he was suffering from post-encephalitis. There was a left convergent strabismus; the left pupil was irregular and reacted sluggishly to the light. He attended the nutrition clinic for a year, in 1922-23. Rorschach and Messmer Tests were negative. In 1928, there was a pituitary disturbance. X-rays showed the sella unusually small, but there was no other apparent pathology. In the psychiatric interview in 1922 he admitted all his delinquencies and sex experiences freely. There was a moderate flight of ideas. He was physically and mentally restless. After changing the subject several times he invariably came back to his sex experiences of which he was proud. When given one wish, he said he would like to have intercourse with a certain girl he knew. In February, 1923, he talked about seeing boys and girls having intercourse in barns and sheds. He admitted masturbating several times a day in the bathroom. He appeared shocked in detecting any laxity on the part of those who supervised him. Although he was docile during psychiatric interviews, closer observation revealed that he was evasive, sly, and lied readily and cleverly.

The mother described him as a good child before his illness, affectionate and obedient.

Following his illness Larry became uninhibited about sex. He was instructed in sex practices by his older sister, who had learned them in the neighborhood. From that time on he has been predominantly homosexual but has attempted relations with his sister and other girls and has masturbated. Enuresis and fecal incontinence have occurred regularly.

His mother worried greatly over the change in her son. The other children were neglected and behavior problems began appearing in them. The younger brother was truant from home and school with the patient. The father resorted to severe punishment, and Larry showed some remorse but forgot easily. In 1923 the family was so emotional over the patient's behavior that the psychiatrist advised that he be placed in a foster home where there would be a minimum of excitement, he would not receive severe punishment and would lead a routine life.

As the family could not afford to pay for the patient's care, numerous agencies and boarding schools were consulted in an attempt to place him, but there was nothing available. As a slight measure, Larry and his brother were transferred from the parochial to the public school, where the teachers showed unusual patience. Larry did not truant for four months, but he stole things from the other children and was a general annoyance. Larry said the "other kids got him crazy," and then stole. After tampering with the fire extinguisher he was expelled from school. In recreation, less severe punishment and better habits were arranged by continued social service treatment. Improvement was shown for a time until the mother had to undergo a serious operation, when Larry became so unruly that the mother could not control him. He was placed in the parental school, as there were no other available resources. Although his parents wept bitterly at his departure, Larry took hands gayly and showed no concern. He was unimpressed by anything that was said to him at parental school. Stealing and truancy ceased but other difficulties remained. Enuresis began again and caused the other boys and his teacher to punish him. He was demonstrative to the social worker and to the cottage matron. On several occasions he was placed in this parental school because of inability to control the impulse to steal and because of truancy. Teachers at the parental school considered him "subnormal" and never felt that he was a sick boy.

Upon his return home in 1925 sex practices increased. The mother could not leave him alone with the other children, as he persistently played with their genitalia. The mother took him to a practical psychologist whom she thought helped him for a time. When a sudden outburst of stealing occurred he was taken to the Detention Home. The Institute recommended foster home placement near the crippled children's school, whose principal was interested in post-encephalitic children. Placement could not be brought about, and the court ordered him to a boys' training school. From June until August, 1925, Larry made thirteen attempts to escape. He was successful upon two occasions, returning home one time and to the former neighborhood on another occasion.

As his parole was not kept, he was ordered to an older boy's training school. The crowded conditions and restricted program caused the boys to sit idle several hours a day. During this inactivity the patient attempted to kill flies and eat them. It was observed that he showed a voracious appetite, and his fly-catching habits were given up when his diet was increased. Close supervision has been observed at the training school as they knew of Larry's homosexual interests. A few such attempts have been made by him, and he appears very remorseful when punished.

This boy and his family were under the supervision of social service department continually from 1922 to 1925. During the entire time practically no changes were made in the boy himself, and it was felt in reviewing the case that the only thing accomplished was the separation of the patient from the other members of the family. Larry needed twenty-four hours of supervision in an institution where the program could be varied. He reacted best when under frequent change of program, constant activity, occupations which furnished some physical fatigue, and in which his hyperactivity would not form a problem.

At the present time he is not receiving a varied program, and the enforced dullness appears detrimental. He is in custody, but nothing is being done to relieve his disorders. It seems apparent that state training schools are too crowded and do not have facilities for caring for post-encephalitic patients.

CASE 31

This case showed decided improvement. The family attitude toward the patient were modified through social service contact. An attack of malaria may have accounted for some of the improvement.

Donald, a Jewish boy now twenty-three years of age, was referred by a family welfare agency in 1922 because of personality changes following sleeping sickness. He had been in bed for five weeks and for two weeks received treatment in a hospital where the diagnosis of encephalitis was made. Before this illness he was ambitious and devoted to his family. After it he was irritable, drowsy, had no reasonable desires, and lost interest in everything.

During the psychological test in September, 1922, he was talkative and even remarking about knowing more than the teacher and boasting of his vocabulary. He made a score of 101 on the Stanford Binet Test. Six months later he made a score of 109. He continued to show poor judgment.

In the physical examination old residuals of encephalitis were found. The right pupil was somewhat larger than the left and reacted sluggishly to light. During the psychiatric examinations he appeared emotionally shallow and boasted about reading psychology. He interrupted the examiners to tell jokes and apparently wished to be the center of activity.

The patient is the second of seven children. Prior to the encephalitis he accepted responsibility and got along well with others. At the age of thirteen he graduated from the eighth grade where his teachers reported good work. For two and a half years before his illness, Donald worked as a file clerk earning seventy-five dollars a month. He left this position at the time he had encephalitis. He was interested in reading books and writing reviews for newspapers. This was the one interest which continued after his illness. Numerous attempts were made to find him employment, but he refused to take work which did not pay well or did not appeal to him. Although he was urged at home to find employment, he did not take his obligations seriously. He was discharged from several reporting jobs, as he was slow and inefficient. He did considerable writing during this time and had several reviews accepted by newspapers.

The mother talked with the psychiatrist and social worker on several occasions. She was so anxious to help Donald in every way that she carried out their suggestions of warding off irritating situations in the home and did not permit the father and other siblings to react emotionally to the patient's behavior.

In the spring of 1923 some improvement was noted, although he continued to show poor judgment in relation to his work. In August, 1923, he had malaria, following a "bumming" to New Orleans. He was delirious during this time and had a very high fever. The mother reports a gradual improvement since that time. Donald has been able to keep work over periods of time. For two years he drove a cab for the Checker Cab Company. He has been regular in payments made to the family welfare association. He stays home in the evenings, spending his time reading and enjoying the radio.

Donald is not cured yet, but he has been able to adjust in the family group and to keep positions over a period of time. He realizes that he is not able to meet sudden emergencies or unusual strain but he has assumed an attitude of acquiescence. The family has been unusual in its tolerance toward him and does not nag or irritate him excessively.

CASE 21

This girl made the best adjustment of the thirty-five patients studied.

Edith, a white girl now twenty years of age, was referred in July, 1921, by a child hospital because of breathing attacks during which she trembled, groaned, and acted as if she did not know where she was, and often fell. She did not become violent and the attacks lasted only a minute or two. At other times she mutilated herself whenever her mother was near her. She tore her nightgowns into shreds, swore, spit, and bit. During the psychological tests she worked well for a time. As the tests became more difficult her breathing difficulty began. She ran about the room in a jerky manner and out to see her mother. After wetting her handkerchief, throwing it against the wall and putting her arm about the examiner, she quieted down and

completed the examination. She made a score of 83. This rating was held to be unreliable because of her distractibility. She had been out of school for two years previous to the test.

Physical examination showed that she was fifteen pounds underweight. Pupils were irregular, reflexes were exaggerated, and vasomotor instability was present. The special fluid and Wasserman tests were negative. An attack was witnessed by the physical examiner. Edith had previously been smiling and cooperating well, when suddenly she had panting and respiratory movements with rigidity of the neck, open mouth and dilated pupils. She moved about constantly in the room, fingering the various objects while going from one to another, tearing paper, attempting to scratch the examiner, and spitting at him. Her muscles were tense. When spoken to she did not respond. The entire duration of the attack lasted four minutes. Increased respiration was the only symptom noted afterward.

The child was in a convent when the disease started. The sister in charge reported irritability, restlessness, and loss of interest in her school work in the fall of 1919. She was ill at home for two or three weeks at that time. The physician made a diagnosis of influenza. Breathing spells were noticed immediately after she recovered but were not as violent as those witnessed at the Institute. Before her illness Edith was described by her family and teachers as being obedient, her interests were well directed, and she was well liked by the other children.

The deep breathing attacks increased to ten or twelve times a day. It was impossible to prevent destruction of whatever was near her during these attacks. Falling spells occurred about twice a day when she would suddenly grasp whatever was near, holding on rigidly, staring, and not responding to her name. She was greatly exhausted after these attacks. She was a restless sleeper. There were periods when she would get in and out of bed at frequent intervals. Fecal incontinence occurred and was a matter of interest to her.

She was kept away from other children and not allowed to go to school regularly until 1922, as the children irritated her and caused her to have temper tantrums. After coming to the Institute the mother and step-father discontinued punishment and were consistent in requiring a routine life. No friends were allowed to come to the home, the family spoke in low tones, and every effort was made to eliminate excitement. She was taken to the country nearly every day where she was allowed complete freedom.

Her step-father discovered that if she were held tightly as soon as a breathing spell began and told firmly to control herself the attack lasted for a less time.

Recovery went on rapidly. Upon her return to school in the fall of 1922 there were two attacks the first week. The teacher told her to control herself and gave her no special attention. The patient had only one more attack at school and progressed fairly rapidly.

She completed the eighth grade in the public schools and attended a convent girls' school for two years. At present she is making a good adjustment as a married housewife caring for her small child. She talks about her illness and her frequent behavior in an objective manner. The breathing and falling attacks have completely disappeared.

It is difficult to assume that any one method brought about this girl's recovery. As she was an only child, the mother and step-father devoted their entire time

to her recovery. They made it possible to allow her freedom in the country and they kept her away from all exciting influences and had confidence that these methods would bring her back to normal. When she was stronger, they arranged that outside activities should come only gradually.

CASE 29

This is another illustration of the failure of psychotherapy and occupational service treatment.

Marie, a white girl, was referred in 1925 because of change in personality, nervousness, and "nervousness." She was sixteen years of age at the time of the first examination.

She had been severely ill in 1918, a diagnosis of influenza being made at that time. During the illness the family had to waken her to feed her. As she was in bed for several months, she became so weak that she had to be carried for several months afterward. She was drowsy and sleepy for some time after her illness. Decided personality changes were observed by her family. At the time she was referred, the family wished placement, as they were afraid that she would become "more nervous." A psychometric test given in 1924 at the Juvenile Court, Marie made a score of 73. In April, 1926, she showed an intelligence quotient of 73, and in August, 1926, she made a score of 80 on the same test.

In the physical examination she was found to be undernourished, to have a visual field defect, exaggerated reflexes, fine tremor of the hands and tongue, and facial and muscular twitching. She refused to have a Wasserman test made. A diagnosis of post-encephalitis was made in view of the clearcut history of the illness and the personality changes.

During the psychiatric interviews Marie was apprehensive and resistant. However, she talked quite freely at times about the way people looked at her (because of her choreiform movements) and she seemed depressed over her inability to work. She knew that she would not work among well people, and she refused to do occupational therapy work "because of the sick people." She appeared dull and inattentive. There was a lack of continuity in her thought processes. She would "don't know" to many questions, and then there would be a rush of words. Her behavior now shows a lack of control and great instability. She is easily excited and has temper displays but she has overcome the habit of striking her hands and screaming. She stays away from home much of the day and lies about the things she does during that period. Other children do not like her because she intimidates them and makes rude remarks. Her sleep is disturbed, especially if she has seen an exciting movie. The family complain that she wrings her hands, jerks her head, and shrugs her shoulders.

In 1928, while in a general hospital for observation, she twice tried to commit suicide. These attempts followed quarrels with a nurse and internes when she was allowed her own way. She now complains that she does not receive enough vegetables at home and that the family nag at her about going to work. Her inability to partake in activities as her two younger sisters do adds to her depression. She feels that she would recover if allowed to live on a farm where she could be away from the noise and crowds of a city. Her occupational service treatment has consisted of trying to interest the girl with occu-

pational therapy and physical activity, such as tennis, roller skating, and swimming. She could not be persuaded to attend occupational therapy classes because that "other nervous and crippled people made her worse." Their presence to remind her of her own handicaps. She attended the physical activities regularly, her excuses being that she forgot.

Removal from the home seems advisable since her unemployment is a source of irritation to her parents but it has been impossible to place her anywhere because of lack of financial resources. The family does not wish her removed at present, saying that she is improving since her attack of influenza a few months ago.

CASE 10

This is a patient who was unwanted in the home after his behavior and personality disorders were recognized. It also illustrates the difficulty of adjustment in a large public school system.

Edwin, a white boy now fourteen years of age, was referred to the Institute of Juvenile Research in 1925 by his maternal grandmother. The complete history includes sleep disturbances, quarreling with other children, and swearing.

On the mental tests given he was found to have an average intelligence.

The physician examining the child in 1926 noted the following: "asymmetric facies, mouth breathing, mild right convergent strabismus, visual defects, tremor of hands and tongue, vasomotor disturbance, over-developed genitalia." A positive diagnosis of encephalitis lethargica progressive was made several months afterward.

Psychiatric study revealed that the boy was the unwanted child in the home. Neither parent would tolerate his misconduct, and they threatened to remove him away. They beat him and deprived him of privileges continuously.

Edwin admitted masturbation and visualizing heterosexual relations. His mother was angered by his continued interest in playing with the genitalia of other siblings and neighborhood children. The grand-parents report that they found exhibiting himself on several occasions. He annoyed girls in the neighborhood at school.

After some treatment his "inverted sleep rhythm" improved so that he slept almost as soundly as the other children. Formerly he prowled about the house, rustled papers, and caused so much disturbance that the family could not sleep.

It is believed that the parents' lack of insight and severe punishment have aggravated the patient's conduct disorders. While helping in his grandfather's business, his behavior problems were noticed, probably because he was occupied and his grand-parents were interested in him.

It was recommended that the boy be removed from the home and placed in a foster home where he would receive considerable attention and where the control would not be too severe. Although the mother admitted wishing to place Edwin, she and the father would not consent to foster home placement. They did not like one home recommended. They refused to cooperate with the hospital and other interested agencies so observation of the boy was carried on through the school.

His teachers were surprised to learn that Edwin had average intelligence but that he showed no interest or progress in school. He spent his time day-dreaming

and to perform errands. When called to the office because of some misdemeanor he invariably had a smile on his face and appeared honored that some attention was given to him. At times when individual assistance was given he worked and showed good ability, but these efforts were not long sustained. He forgot to bring his books to classes and went to the library during class hours, saying that his teacher had excused him for that period. These conditions have continued until the teachers were thoroughly disgusted with him. Arrangements are being made for him to attend the Spaulding Crippled Children's School.

His inability to work independently and lack of concentrated effort have made it impossible for him to adjust in the public school system as it is administered. He needs to be in a school where the teachers understand his behavior and where he will have a certain amount of recognition intermingled with duties which he is able to perform.

These cases show that one of the most outstanding handicaps of the post-encephalitic child is the failure of those about him to recognize that he is ill and to attribute all his behavior to "mean-ness." Case 2 illustrates this point: although Carrie's mother was repeatedly told that her behavior deviations were due to illness, she did not fully grasp the situation. This same lack of understanding is illustrated in case 34: the attendants in the penitentiary believe Mary is a "bad actor," since she causes them trouble and is constantly under discipline. Because of this failure to recognize the full significance of behavior disorders and personality traits the methods of control used only aggravate the post-encephalitic to further delinquency. In case 10, Edwin's behavior deviations became the more pronounced as his parents punished him the more severely.

The average home is often the most harmful environment for the post-encephalitic patient. It was found that twenty-seven of the patients were living in homes in which the parents' and attendants' attitudes were unfavorable. Ambitious parents fail to recognize the seriousness of their actions when they nag the patients to find work and make the patients feel unwanted. Case 29 illustrates a girl whose feeling of hopelessness was increased through the realization that her two sisters were carrying on their usual school activities while her own lack of concentration and her disability prevented her from competing with them. On the other hand, as shown in case 6, the patient's delinquencies may be due to the environmental influence on the other siblings and may keep the family in a continued uproar. It thus seems often unfair to require the patient and to the other members of the family to keep the patient in his home.

The average public school is as unequipped to meet these problems as is the average family. Competition and conformity are such major factors in the public school system that the encephalitic child is looked upon as queer. Case 10 is an example of this: the teachers did not understand the child's behavior and, with a large number of pupils in the classroom, did not have the time to give him individual assistance and encouragement even when his difficulties were explained. Many post-encephalitic patients whose anti-social behavior on the playground or in the halls brings them into conflict with the school regime, as was seen in cases 2 and 6. When an individual becomes too much of a nuisance in the public school classroom he is sent to a room for incorrigibles. From there he may proceed to parental school, and then he often comes under the jurisdiction of the Juvenile Court and may be sent to a correctional institution. Larry (case 6) is an example of a post-encephalitic child following this course.

A few post-encephalitic children have been placed in one of the Chicago schools for physically handicapped children, the Spaulding School. Here the children's disorders are understood and dealt with patiently. Methods such as hydrotherapy, rest periods, and muscular exercises are employed.³³ Possibly, case 2 would have improved if she had been placed at the Spaulding School several years before her aggressive behavior became so well established. However, this school cannot keep patients whose actions might endanger the other crippled children.

Recreation resources have been utilized by the Institute of Juvenile Research workers in the hope of substituting constructive and socially acceptable behavior for anti-social conduct. In cases 2 and 6, recreational recommendations were carried out to some degree, and improvements were observed in the patients during those periods. The difficulty often goes back to the parents who do not understand the significant role which recreation may play. In Case 10 for instance, when the parents deprived Edwin of his recreation they accentuated his misdeeds. Case 29 shows that an older girl, although desirous of outside interests, did not join in a recreational group because she was apprehensive about the other girls' not liking her.

Regular employment is almost out of the question for the post-encephalitic patient, since he is distractible, is fatigued readily,

³³ Haahti, Helvi, op. cit., p. 9.

and exhibits personality difficulties which bring him into conflict with employers and fellow workers. Choreiform movements and poor motor coordination are other obstacles in the way of his employment. Yet he is eager to work, and it is not an unusual experience for him to go from job to job, as is shown in the case of Mary (case 34), who had twenty-five jobs in one year. It would be surprising to find that Martin (case 30) will have difficulty adjusting to any work situation, since he spends twice as long on a job as the usual person does.

The mental hygiene clinic has a definite place in the interpretation of the behavior disorders to the patient's family. The psychiatrist and social worker become the medium for modifying the patient's environment by removing as many as possible of the aggravating factors. Cases 21 and 31 showed definite improvement as soon as the families became less emotional and more objective in their treatment. If, however, encephalitis includes an organic lesion which causes a chronic excitation of the thalamus, psychotherapy would appear to have little value. Case 29 is an illustration of an eleven year old girl who was unable to benefit from the therapeutic plans.

Beside from interpreting and educating the family and teachers with respect to the patient's illness, the social worker can do much toward establishing a regimen of life for the patient, while collaborating with other organizations which can aid in treatment and which are not antagonized by her. Social treatment, then, consists in padding the patient's environment until it becomes adapted to his needs. It is necessary for the social worker to repeat to the family again and again that the patient is sick and that he requires a shifting, sympathetic environment.

When comparing the present methods of treatment with those used in 1923 and 1925, we find that little progress has been made. A study made in 1923,³⁴ showed that social treatment for post-encephalitic patients then consisted in educational work with parents, teachers, and other adults involved, in establishing for the patient a regimen of life that would aid in convalescence, and in protecting the mental life of other members of the family by removing the conflicts that were almost sure to arise. Special conditions for post-encephalitic patients were thought to be the mode of treatment. However, as there were no such re-

³⁴ Cole, Blanche, op. cit., p. 46.

sources, treatment of the individual in the home was the only resort. A study made in 1925³⁵ emphasized the improvement made by post-encephalitic children in the Crippled Children School. Treatment then consisted in eliminating all irritating factors in the child's environment or protecting the patient from the environment as far as possible. This form of treatment was called the negative or protective type.

The cases used for illustrative material show that treatment at the present time consists of the same methods in the home that were used formerly and that the Spaulding Crippled Children School is often recommended to meet the school problem.

However, we are faced with the question of what recommendations to offer after the above methods have been tried and have failed. It is known that correctional institutions do not offer proper treatment in caring for these behavior problems. As shown in cases 6 and 9, the inmates receive the minimum of individual attention. They remain unoccupied for hours and very little done to them to improve their physical condition. Illinois has recently adopted the plan of admitting post-encephalitic patients to two state institutions for the feebleminded in which a specialist from the Mayo Clinic is supervising experimental work with serums and vaccines. Post-encephalitic patients are admitted irrespective of age or intelligence. Two of the patients studied have been placed there. The treatment, however, has not been carried on long enough to examine the results.

A national committee, the William Mattheson Commission on Epidemic Encephalitis, has been appointed to study the problem throughout the country. Their findings will undoubtedly throw more light on the etiology of the disease and with this knowledge it is believed that special institutions for post-encephalitics should be created by the different states.

CONCLUSIONS

1. Epidemic encephalitis is an organic disease of unknown etiology but well known pathology. For this reason, it is possible to treat the causative factors.

2. Conduct disorders, personality changes, and physical handicaps are the sequelae of encephalitis. The uninhibited behavior of the post-encephalitic causes him to become a social problem.

³⁵ Hahti, Helvi, op. cit., p. 23.

3. The community in general fails to realize that post-encephalitic patients are ill and this misunderstanding aggravates the patients' behavior.

4. From the thirty-five cases analyzed in this study, one patient's good adjustment is attributed at least in part to the family's intelligent care. Another patient's partial recovery may be based on the mother's untiring efforts in removing all irritating factors from the home.

5. The forms of treatment attempted have been (1) educational work with the family and teachers, (2) setting up a routine life for the patient with recreational outlets suited to his needs, (3) placement, particularly in the Spaulding School for Crippled Children.

6. In spite of such treatment, however, (and it must be remembered, of course, that the cooperation of the parents was not always secured nor were the conditions always changed to accord with the Institute's recommendations) but two of the thirty-five post-encephalitic patients have made satisfactory adjustments. It would appear that the solution for these patients' permanent recovery lies in the field of medical science.

7. Social service treatment is of value in interpreting the patient to his family and other individuals involved and in "padding" the environment so that irritating factors do not prevent the individual from making the maximum adjustment of which he is capable.

ABSTRACTS OF THESES, 1920-1930

Abstracts of all theses submitted to the Smith College School for Social Work in partial fulfillment of the requirements for the degree of Master of Social Science will be published in this journal. The September, 1930, number contained abstracts of theses dealing with mental disease and deficiency. The following are abstracts of theses on physical diseases and defects and of those concerned with social work practices. The name of the student, the institution in which she received her field work training, and the year of her graduation from the Smith College School for Social Work head each abstract.

II. THESES DEALING WITH PHYSICAL DISEASES
AND DEFECTS

Buncher, Miriam (Massachusetts General Hospital, 1925).
Place of the Child in the General Hospital.

991 children were admitted to the Hospital in 1923. The study gives the statistics on age, diagnoses, and financial status of these children and discusses the special equipment needed for their treatment.

Brigham, Helen (Massachusetts General Hospital, 1921).
Social Problems Involved in a Group of Patients with Chronic Orthopedic Condition.

A description of the usefulness of a social worker in treating the patient and maintaining the family unit. Eight cases illustrate the type of problems that

Draper, Merle (Allegheny General Hospital, Pittsburgh, Pa., 1924).
Social Work with Diabetics.

A description of the disease and its treatment, showing the value of the social worker in securing the needed cooperation of the patient.
Five case studies.

Duncan, Mildred (Allegheny General Hospital, Pittsburgh, Pa., 1924).
A Study of the Medical, Educational, and Social Conditions in Sixteen Children Suffering from Bone Tuberculosis.

All cases referred to Social Service Department in one year (16) are discussed from the angle of what a hospital and social worker can do in aiding them. The need for more specialized institutions where hopeless cases can be isolated, the hopeful cases better treated, for more nurses and social workers in rural areas and for more open air classes is pointed out.

Sixteen case studies.

Ge, Corinda (Massachusetts General Hospital, 1925).
A Study of Under-nutrition in Children; Based on 247 Cases so Diagnosed at the Massachusetts General Hospital during the Years 1923 and 1924.

Medical records of the 247 children diagnosed in 1923 and 1924 as under-nourished are given. Intensive investigation was made of the fifty-two known to Social Service and sixty-six others chosen at random as a control group. The group followed up by the Social Service Department showed much greater improvement in health than did the other group, 44% of which never returned to the clinic for further treatment.

Gold, Mabel (Massachusetts General Hospital, 1923).
The Medical-Social Aspects of Pre-natal Work as Related to Syphilis.

Twenty patients, selected because they presented potential medical and social problems, were studied. The value of the social worker in educating the mother as to the significance of the disease and in securing her cooperation in treatment is shown.

Goodenough, Frances (Illinois Institute for Juvenile Research, 1929).
A Study of the Behavior Reactions of Forty Physically Handicapped Children.

From 154 cases of long-standing physical disease (defined as a condition affecting the activity of the child over a long period of time) forty were selected for study, those showing intelligence quotients under 80, inadequate information, stammering, or a disease not crippling in competition being omitted.

The handicap itself was found to produce certain problems with a physical basis, such as restlessness and distractibility. Normal group competition and adjustment were prevented, producing feelings of inferiority and insecurity. Only 20% were able to play with other children.

Fourteen children were over-protected and fifteen rejected by their parents. Parental attitudes, often based on the disease, seemed more important than the disease itself in determining the child's behavior.

Graves, Estella (Kalamazoo State Hospital, Michigan, 1923).
The Social Significance of Huntington's Chorea (published in *American Journal of Psychiatry*, Vol. IV, Pages 537-574).

All choreotic cases (46) in the Hospital between 1871-1923 were studied by means of hospital records and interviews with the families. They gave a history of 22 cases of the disease in their families, three-fourths of which were traced through the 5th and 6th generations. A study of these 218 cases shows:

The disease is directly inherited and does not seem to develop in the children who escape it.

Potential choreotics do not differ from their siblings in early personality traits.

3. Two-thirds of the choretics showed behavior difficulties, often of an extreme nature.

4. Most of the families were in the United States prior to 1800, and fifteen of them were traced to N. Y.

Lewis, Ruth (Massachusetts General Hospital, 1920). Social Aspects of Mitral Stenosis.

A discussion of the value of a social worker in the supervision of persons suffering from heart diseases. Illustrative cases.

Lincoln, Miriam (Massachusetts General Hospital, 1923). Industrial Aspects of Heart Disease.

Eighty industrial workers chosen at random from industrial patients attending the heart clinic were interviewed: fourteen women, sixty-six men; modal ages, forty to sixty.

Those with rheumatic heart disease with only structural damage were able to carry on work better than any other group. Suggested classifications for use in judging a patient's capacity for various types of work were made. Five case studies show that under proper care persons suffering from heart disease can be self-sustaining and satisfied.

McCullister, Crystal (Boston Habit Clinics, 1926). A Study of Habit Clinic Children Having Convulsions.

Out of the 1600 total referrals, the 124 children who had convulsions prior to the fourth year, not associated with an acute or chronic condition, were studied. 25% had first convulsions associated with acute infection, 15% with reflex-irritation and 34% with gastro-intestinal upsets. 44% were either "mentally deficient or retarded." 84% had the first convulsions under thirty months of age. Short histories of fourteen cases.

Maxwell, Mary (Massachusetts General Hospital, 1926). A Study of Seventy-one Surgical Hip Cases.

All the hip cases operated on in a sixteen month period were studied by a follow-up interview eighteen months later when twenty-nine were still under treatment. A description of the types of cases, the social cost involved, and the importance of social service in such cases is given. At least forty out of the group were found to have a handicapping mental attitudes toward their disease.

Potter, Kathryn T. (Essex County, N. J., Juvenile Clinic, 1924). Some Aspects of Reactionary and Endogamous Disturbances in Adolescent Girls.

Six cases studies, three illustrating adolescent disturbances due largely to environmental circumstances and three due largely to physical make-up of the individual. The first group tended to respond well to treatment, while with the second group little was accomplished.

Werman, Mary (St. Louis, Mo., Hospital, 1924). Straightening the Child: a Study of Ten Orthopedic Cases Treated Over a Period of More Than Ten Years.

Seven case histories of child patients, showing the contribution of the medical social worker in treatment. She aided by securing uninterrupted medical treatment, interpreting the needs of the child to his parents, and the home to the physician by providing adequate home care, transportation, outdoor summer vacations, and placement in employment.

Winnon, Hilda (Massachusetts General Hospital, 1925). Social Factors Present in Fifteen Cases of Exophthalmic Goiter.

Fifteen case studies of goiter patients showing that all were subjected to various degrees of strain in the period preceding the onset of the symptoms.

Wright, Mary (Out-patient Department, University of Penn. Hospital, 1920). Social Case Work in the Campaign against Syphilis.

Brief summaries of 29 syphilis patients show in what ways social work may aid in treatment.

Wright, Marian (Sloane Hospital for Women, N. Y., 1921). A Survey of Sloane Hospital for Women.

An elaborate analysis of a maternity hospital in which all the facts shown in the records of 1578 patients are tabulated and brief case summaries of 176 patients from broken or irregular marital relations created special problems are given.

Wright, Carol (American Red Cross, Cincinnati, 1921). The Employment of Seventy-four Neurocirculatory Asthenia Patients.

This disease, whose subjective symptoms are out of proportion to the physical debility involved, calls for careful supervision by the social worker. Of the 74 patients studied—ex-service men diagnosed by a government clinic—less than half were employed and those usually at light work.

Wright, Frances I. (Massachusetts General Hospital 1924). The Importance of Individual Social Treatment of Children Crippled by Infantile Paralysis.

One hundred cases—nearly all of patients attending the clinic for infantile paralysis in 1924—were analyzed. Ages, seven to sixteen. Eighty-five were visited at homes and fifteen in institutions.

Three-fourths were found of foreign parentage, living in crowded districts, and had insufficient incomes. The attitude of the parents toward the patient was wholesome in 56% of the cases. 30% of the children had made satisfactory adjustments in the family and neighborhood groups, while 60% showed behavior difficulties. Over half adjusted normally in school.

The need for special schools and careful case work is discussed.

III. THESES DEALING WITH THE PRACTICE OF SOCIAL WORK
Alsberg, Pauline R. (General Medical Clinic, Washington University Dispensary, 1924). The Social and Medical Significance of Social Service in the Asthma Clinic (Published in *Hospital Social Service*, XIII, 317).

Successful treatment of bronchial asthma necessitates a thorough knowledge of the patient's environment, and also supervision to see that the proteins to which the patient is sensitive are removed from the environment. This implies attention to the most minute details of food, clothing, to household furnishing. To this must be added the re-educating of the patient himself. Several case studies make it clear that in both diagnosis and treatment the physician must be aided by a well-trained social worker.

Beals, Katharine (Philadelphia Family Society, 1930). A Study of the Effect of Long-time Relief upon Children of Working Age.

Seventy-five children belonging to families who were in receipt of relief for at least four years were studied with a view to ascertaining the effect of such relief upon the child's attitude toward work and toward relief. An equal proportion of boys and girls were found to be continuing in school after they became fourteen years old as were going to work. Only a few were found to be "drifting" or to be developing anti-social behavior. There seemed to be little evidence that long-time relief tended to make the children dependent.

Bemmels, Violet (Institute for Child Guidance, New York, 1928). A Study of Methods Used in the Treatment of Three Over-protective Mothers.

The study attempted to evolve a method for analyzing the treatment of over-protective mothers and to discover just how three such mothers were treated. The method evolved was an analysis of only that part of the treatment that had been verbalized and recorded: what the social worker said and what the mother's immediate reaction was noted. Discussion centered around *what* was done, *how* it was done, and *when* it was done.

The objective in all the cases was found to be the freeing of the mother from the child; it was an education in independence for the mother. In the first case "specific suggestion" therapy was frequently and unsuccessfully used. In the second case the greatest amount of time was spent on preparing the mother to release the child by means of what is termed "superficial treatment." The mother's own fundamental problems were not broached until near the end of the treatment and then unsuccessfully. The mother did, however, release the child. In the third case the same methods were used as in the second case but not so intensively.

Blakestee, Lydia M. (Illinois Institute for Juvenile Research, 1929). A Revised Form of the "Process Interview" Record Form.

Discusses the advantages and disadvantages of the "process interview" form, formulated by Mrs. Sheffield and Miss Myrick of the Committee on Interviewing, and of other older types of recording in which the subjective element was omitted. A "revised form" which omits much of the quoting of conversation which is characteristic of the "process interview" type and yet retains the description of the process is proposed, and examples are given of similar interviews written up according to both methods.

Wolken, Rose (Philadelphia Family Society, 1929). Interviews: The Effects of the Case Worker's Attitude in Seven Situations Involving Problems of Family Relationships.

This thesis might have been called an analysis of a psychiatric social worker's conscious technique. Extracts from interviews are given showing how the case worker definitely attempted to influence her client by her attitude. In one group of cases, direct interpretation of one person to another was used; in another an attempt was made to break down emotional attachments; while in a third the worker tried to influence the client through underlying mechanisms rather than through overt behavior.

Wolfer, Margery (Opportunity Room, Longfellow School, Oak Park, Ill., 1927). Social Case Work as Applied to Problem Children in a School in Which There is No Visiting Teacher. A review of the work done by a social worker in helping to adjust a group of problem children, educationally backward.

Wolgan, Catherine I. (Boston State Hospital, 1921). A Study of the Development of Social Work at the Boston State Hospital. A description of the work between 1913 and 1920, showing the set-up of the social service departments and the type of cases handled.

Wolcott, Annette (Institute for Child Guidance N. Y., 1928). The Treatment of the Shut-in Type of Adolescent.

Three intensive studies which show the use of the mechanism of identification and transfer in the treatment of shut-in problem adolescents. Shut-in personalities are shown to be best approached through an understanding of their underlying identifications, and the role that the psychiatrist or the social worker should play in treatment should depend upon those identifications. Both should guard against involvement of their own identification processes.

Wolcott, Rose (Boston Psychopathic Hospital, 1930). A Study of the Relationship between a Psychopathic Hospital Out-patient Department and the Family Case-Work Agencies in the Community.

All cases referred to the Clinic by the Family Welfare Society and the Jewish United Charities of Boston during 1929 were studied in order to see what services such agencies desired and what were given to them. 61 cases were covered.

The Clinic seemed to be meeting the community needs in the diagnosis and treatment of mental disorders and in the recognition of mental deficiency, but seemed to be failing to get at the underlying motivating forces in the behavioral difficulties of less severe cases of social maladjustment.

The social agencies appeared to be unskilled in the recognition of mental hygiene problems and to lack training needed to interpret and treat the factors involved in such maladjustments. The Appendix contains charts showing the types of services requested from the Clinic, the recommendations made by it, and the extent to which the recommendations were carried out.

Graham, Margaret E. (Foxboro Mass., State Hospital, 1924). *Is There a Need for Psychiatric Social Work in Industry?*

Twenty-two short case histories of industrial or store employees who came to the Clinic because of mental disorders or were committed to the Hospital. The value of mental hygiene and the need for a psychiatrist or factory medical staff is discussed.

Hayes, Elizabeth C. (American Red Cross, Minneapolis, 1924). *Case Correspondence: a Method of Psychiatric Social Work* (Published in *Mental Hygiene*, VI, 125.)

A discussion of the technique of carrying on psychiatric social work with service men by correspondence. Several general principles were evolved by the writer, illustrations of which are given in this study.

Healy, Elizabeth (Department of Child Guidance, Board of Education, Newark, New Jersey). *The Feasibility of Using the Psycho-analytic Approach in Case Work Interpretation and Treatment.*

Three very detailed case studies showing how the ego-libido type of analysis as worked out by Kenworthy may be used by a social worker in interpretation and treatment of personality problems. It is briefer than other methods of analysis and makes the social worker emphasize the emotional factors in the situation, and bases treatment on the actual experiences of the patient.

Howland, Katherine E. (Boston State Hospital, 1923). *Social Service in Relation to Those Patients in the Boston State Hospital Not Over Twenty-five Years of Age at First Admission* (Published in *Mental Hygiene*, VII, p. 804-830).

Hospital records of all cases (385) active on November 20, 1922, coming under the above description were analyzed and tables of the outstanding facts drawn up. There is a discussion of the value of social work in prevention and cure.

Jones, Ellen Bodley (Boston State Hospital, 1921). *Occupational Therapy: Educational Requirements and Relation to Social Work.*

A discussion of the principles of occupational therapy, its field of value, its relation to social work, and the institutions offering courses of training.

Reeve, Ada (Boston Psychopathic Hospital 1925). *Social Treatment of Problem Children as an Aid to the Teacher.*

A description of the difficulties in the social treatment of eight problem boys from well-to-do homes. Ages, 7-13; I.Q.'s normal. Three were removed from clinic supervision, four were improved by treatment, and with one little was accomplished.

Reeve, Margaret (Massachusetts General Hospital, 1924). *A Study of the Relation of the Social Service Department at the Massachusetts General Hospital to the Community Agencies in the City of Cambridge.*

One hundred fifty-seven cases, the total referred to the Social Service Department of the Hospital from Cambridge in 1922-1923, were studied. Hospital social service retained responsibility in one-half the cases and transferred it to another agency in the other half. Sixty-four social and medical agencies were used but there was great concentration on a few. In general, medical social workers did not use themselves of the community resources.

Reeve, Lila (U. S. Public Health Service, Minneapolis 1921). *The Personal Psychiatric History* (Published in *Mental Hygiene*, VI, 93).

A discussion of the methods of history-taking in twenty out-patient clinics of the U. S. Public Health Service. Numerous examples are given, as well as the history outline and one complete history from the Minneapolis Clinic.

Suzuki, Matsu (Lincoln House Association, Boston, 1921). *Home Health Lessons for Tokio Based on Observations in Boston.*

A description of recent changes in Tokio making for its ability to adopt new methods of preventive medical work and a suggestion that it should institute immediately a Baby Hygiene Association and an Instructive District Nursing Association and later should introduce nurses into the public schools and start a new form of medical social work.

Wright, Margaret R. (Illinois Institute for Juvenile Research, Chicago, 1930). *A Study of the Relationship between a Preschool Child Guidance Clinic and an Infant Welfare Society.*

A description of the working arrangements between the Preschool Branch of the Illinois Institute for Juvenile Research and the Infant Welfare Society of Chicago and an analysis of the mechanics of the treatment of their cooperative cases. The cases referred to the Clinic over a four-year period and treated cooperatively or separately form the basis of the study.

It was found that the Institute gives little more care to its intensive than its cooperative cases of this type. The chief advantage of intensive service seems to lie in the work of the psychiatric social worker who, through her training in mental hygiene, is perhaps more alert in detecting incipient problems.

Twenty-eight out of the 81 cases were closed at the time the study was made. Seven of the 15 intensive cases were considered satisfactorily adjusted, as were 4 of the 13 cooperative cases.

Lyday, June F. (Boston State Hospital, 1920). *The Nature of Social Treatment.*

An analysis of twenty cases along the lines suggested by *The Kingdom of Evils* and a discussion of the treatment given them.

McNutt, Lila E. (Boston Psychopathic Hospital, 1924). *Advantages of Psychiatric Training for the Visiting Teacher.*

A description of the eight school-children cases handled by the writer over a six-months period shows that a visiting teacher with psychiatric training could have been helpful in prevention and treatment.

Moore, Katherine (Boston Psychopathic Hospital, 1920). *The Relation of the Social Worker and the Patient.*

Questionnaires on this subject, sent to 60 representative social workers, were answered completely by twenty-one and partially by three others. Their answers cannot be summarized briefly.

Neumann, Frederika (Los Angeles Child Guidance Clinic, 1924). *Adjustment of Problem Children under Eight, from the Point of View of the Social Factors Involved.*

Five cases selected to illustrate different problems of young children and the possibilities of adjustment from a social point of view. Parental understanding and cooperation with the social worker seemed to be the chief factors making for success.

Post, Katherine (Illinois Institute for Juvenile Research, 1927). *A Discussion of the Need for Psychiatric Work in the Schools.*

The principals of private schools in Chicago and Cleveland were interviewed on the question of the need for psychiatric workers there. Maladjusted children were found to be as numerous, proportionally, in these as in public schools. Financial limitations, the attitude of the patrons and of the administrators were the chief blocks to psychiatric work being introduced.

Rabinowitz, Lee (Institute for Child Guidance, New York, 1928). *Reactions of Children to Administered Relief.*

Twenty-one cases carried in cooperation with other social agencies by the Institute for Child Guidance, New York, in Baltimore, Maryland, in the Clinic, the total case load of that type in December 1, 1928, were studied in an attempt to ascertain the reaction of the child to the fact that his family received relief.

A study of the first eleven cases showed this point to be largely neglected in the case records, so in the other ten cases the psychiatrist in charge of the case was asked to attempt to discover the child's feelings on the subject.

The ten children's attitudes varied from extreme resentment to definite pleasure, a few children being able to accept the fact with little emotion and to consider it a necessity not a disgrace, but a situation which they would remedy when grown. This latter attitude was not confined to any one age or level of intelligence. It is suggested that attitude social workers should strive to develop in children.

Twenty-one case summaries.

Shannon, Marion E. (Illinois Institute for Juvenile Research, 1926). *Resistance to the Psychiatric Social Worker's Technique in Meeting Resistance.*

The causes of resistance are analyzed and examples of technique used in overcoming typical resistances are described. The contribution of the psycho-analytic method to methods of interviewing is discussed.

Ullman, Barbara (Illinois Institute for Juvenile Research, 1927). *The Importance of Obtaining the Child's Own Story in Relation to the Treatment and Adjustment of his Difficulties.*

In twenty-three cases in which the child's story was secured and twenty-three in which it was not secured, all involving stealing, truancy, or sex problems were studied. Those showing physical factors as causative were omitted. I.Q.'s were all above 75.

One-half of those whose stories were secured and one-sixth of the other group responded well on treatment. The first group had an average of 5.47 psychiatric interviews, 6.73 social service contacts, and treatment lasted 5.65 months, while in the second group the corresponding averages were 3.43, 7.77, 7.21. Illustrations of different methods of securing the autobiography are given.

Ward, Margaret (Massachusetts General Hospital, Boston, 1921). *The Need for Mental Hygiene for Children as Illustrated by the Experience of Medical Social Workers.*

A description of some cases handled in the out-patient department of the Massachusetts General Hospital shows the need for training parents and teachers.

Wickhamer, Gladys (Children's Aid Society, Philadelphia, 1923). *The Advantages of Cooperation between Justices of the Peace and a Social Agency.*

A discussion of the agency with justices of the peace in Baltimore, Maryland, in the cases of eleven children.

Sytz, Florence (Illinois Institute for Juvenile Research, 1927). The Contribution of Psychiatric Social Work to Social Work.

Four cases carried jointly by the United Charities and the Institute are presented to illustrate the difference in use of facts and methods of treatment by the two types of agencies. The contribution of the psychiatric point of view to family social work is discussed.

Worch, Margaret (Amer. Service Section, Red Cross, St. Paul, 1921). Psychiatric Social Work in a Red Cross Chapter (Published in *Mental Hygiene*, VI, 312).

A description of the psychiatric social work carried on by one Red Cross chapter

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STUDY OF TRAITS PREDICTIVE OF ECONOMIC SUCCESS¹

NORA Y. HAWES and WINIFRED A. MURFIN

A rather unusual opportunity to study the relation between success on the job and various other traits of a group of high school graduates was presented by the records of the Chicago Scholarship Association for Jewish Children. This Association was founded in 1913 to give financial assistance to boys and girls of working age who would otherwise have to leave school. To be eligible for a scholarship, a child must be fourteen and in good health, and the economic status of his family must be such as to necessitate aid of this type. Until the fall of 1925, a school record above the average was also one of the requirements. That year a small group of children who were doing only average work were granted scholarships. Since then a large number of scholarships have been awarded to children who, according to intelligence tests, belong to the groups designated as "dull and backward" and "borderline defective."

Before a scholarship is granted, the child is given a complete routine examination at the Illinois Institute for Juvenile Research. This consists of a physical examination, an individual psychometric test, and an interview with a psychiatrist. Special vocational tests and an interview to determine the child's recreational needs have also been given in some cases.

During the period that the child is in school and receiving a scholarship, he is seen at regular monthly intervals by a case worker.

This paper combines the theses submitted by two students to the Smith College School for Social Work in August, 1930: Hawes, *Factors Influencing Success on the Job: a Study of Thirty-Three Adolescent Jewish Boys*, and Murfin, *Factors Influencing Success on the Job: a Study of Thirty-Two Adolescent Jewish Girls*. The material was secured from the records of the Scholarship Association for Jewish Children and of the Illinois Institute for Juvenile Research. Institute for Juvenile Research Publication, Series C, Number 170.

age of patients from such families more nearly approached the average age of all patients referred for stealing and truancy. It therefore seemed that the relatively greater frequency of stealing and truancy among large families could be explained at least partially on the basis of the age and sex of the patients referred from such families. Intelligence quotients also varied with size of family, larger families referring a greater proportion of dull children. The relation between I.Q. and type of problem was unknown. This investigation thus seems to suggest that the size of family to which a patient belongs bears little relation to the problem for which she is brought to a child guidance clinic, such differences as are found to exist being explainable on the basis of age and sex.

ABSTRACTS OF THESES

Abstracts of all the theses submitted to the Smith College School for Social Work will be published in the *Smith College Studies in Social Work*. In the September, 1930, number were published the abstracts of theses dealing with mental disease and mental deficiency while in the December, 1930, number appeared those dealing with physical disease and with the practice of social work.

In this number the theses which describe the different types of behavior problems for which children are referred to child guidance clinics are abstracted. At the beginning of each abstract appears the name of the student, the institution at which she did her field work, the year of her graduation from the School for Social Work, and the title of her thesis. Each abstract contains a statement of the number of cases studied and of the method by which they were selected, in so far as it was possible to ascertain these facts.

IV. BEHAVIOR PROBLEMS OF CLINIC PATIENTS

Classification of Problems

Gaff, Edith (Cleveland Child Guidance Clinic, 1928). An Interpretation of Adolescent Revolt Based on a Study of Fifty Cases Manifesting Problem Behavior

64 cases were selected at random from the clinic cases of children over 12, 14 being discarded that showed mental illness or an I.Q. below 80. There were 26 boys and 24 girls, 12 to 17 years old. 60 percent had foreign-born parents; only 10 percent were dependent; 64 percent came from unbroken homes. Correlations between the type of problem and factors in the child's background were sought, without any striking results. Case histories illustrate the conflict situations.

Morel, Elfrieda (Michael Reese Dispensary, Chicago, 1928). The Conduct Disorders of Adolescent Girls

A study of 20 cases referred to the Advisory Council of Lake View High School, January 1, 1927, to May, 1928. Ages, 14 to 18; I.Q.'s all above 90; good economic status. These are compared with four girls referred to the Mental Hygiene Clinic of the Dispensary, ages 15 to 18; I.Q. over 90; poor economic status. The relation of the girls' problems to their parents' attitude is discussed.

Four case studies.

Safley, Henrietta (Michael Reese Dispensary, Chicago, 1929). The Behavior Problems of Clinic Patients: a Classification and an Analysis

A classification of the problems for which children were referred to two mental hygiene clinics was worked out. The types correlated quite highly with age, and an attempt was made to discover the underlying causes.

Attention-getting Behavior

Leonard, Shirley (Institute for Child Guidance, New York, 1929).

A Study of Twenty-five Cases of Attention-getting Behavior Based on Feelings of Inferiority

25 cases were chosen for study in which marked feelings of inferiority were combined with "show-off" or attention-getting behavior, children with I.Q.'s under 90 being excluded.

80 percent were boys. Ages ranged from 6 to 16 with 40 percent being between six and eight. In both of these respects the group differed from the rest of clinic cases. 12 were only children and 9 were oldest. 19 showed some organic inferiority, but other factors seemed equally important in the production of feelings of inferiority.

Sillman, Marguerite (Philadelphia Child Guidance Clinic, 1927).

The Rôle of Imitation in Creating Behavior Problems in Children

Case studies of 10 children, I.Q.'s 90 to 102, whose behavior was found due largely to imitation. They all imitated conduct which they observed was used to others in securing attention.

Day-dreaming

Ladenburger, Alma (Illinois Institute for Juvenile Research, Chicago, 1929). A Study of the Social Factors in the Lives of Solitary Children Who Withdrew into an Imaginary World

A description of 35 white children with I.Q.'s above 79 who had few friends and who built up an imaginary world through books and day-dreams. The child's "three wishes," his "interests" as expressed to the psychiatrist, and the psychiatrist's comments were used as the means of judging the content of day-dreams.

Only half were found correctly placed in school, as judged by their mental age. The economic situation of the families frequently made the children feel inadequate in comparison with their companions, but poverty in itself did not seem a factor of importance in producing withdrawal from society. Religion caused conflict in one case.

22 were only, oldest, or youngest children, and these positions seemed of importance in many cases in producing withdrawal. Only half lived in their own homes with both parents, and in most cases the parent-child relationship was not constructive.

Egocentricity

Hopper, Leilia E. (Cleveland Child Guidance Clinic, 1927). *Causal Factors behind Egocentric Behavior in Problem Children*

Among the hundred cases selected by Lowrey to illustrate general types of behavior problems, 18 cases of egocentric behavior were found. There were 10 girls and 13 boys; ages ranged from 6 to 16, with the median at 10; 70 percent had I.Q.'s between 80 and 110. In these respects they were similar to the rest of the hundred problem children.

10 children showed inferiority feelings and 10 felt insecure in their homes—a somewhat larger proportion than was found in the less-detailed study of the hundred cases. In undesirable home factors the two groups were very similar except that the egocentric group exceeded the other by at least 20 percent in lack of affection on the part of the parent, parental maladjustment, and over-attention. 30 percent of the egocentric and 17 percent of the control group had a history of poor health. In school the total group showed a larger percentage of unfavorable placements and of unfavorable relations with the authorities. In other problems the egocentric group showed at least 20 percent more cases of lying and misconduct or disobedience at home, while the control group exceeded in truancy.

McClenaghan, Jean V. (Illinois Institute for Juvenile Research, 1926).

An Inquiry into the Processes of Social Treatment in Two Cases of Egocentricity

Detailed studies and a criticism of the methods of treatment used in the cases of two adolescent egocentrics.

Smith, F. Leslie (Illinois Institute for Juvenile Research, 1923). A Study of Egocentric Behavior

Of the 314 behavior problem cases referred to the Institute during one year, 83 were classified as egocentric. 79 of these came from homes in which an abnormal social situation existed. All showed behavior problems in addition to egocentricity.

Social treatment was carried on for a year with ten of the patients. At the end of that time one was adjusted; four were slightly improved; two showed no improvement, while three were adjusting well in institutions.

Six case studies illustrate the treatment methods that were used.

Emotional Immaturity

Richards, Winifred (Essex County, N.J., Juvenile Clinic, 1927). A Study of Emotional Immaturity in Sixteen Adolescents of Average Physical and Mental Endowment

16 adolescents, 12 to 17 years of age, were studied and diagnosed emotionally immature. Bad attitudes on the part of the parents—ranging from excessive protection to severe punishments—were present in all cases. Intensive psychiatric work over long periods produced little change in the children.

Enuresis

Wentworth, Miriam (Illinois Institute for Juvenile Research, 1924). The Social Problem of Nocturnal Enuresis in Children

18 percent of the 1008 patients studied at the Institute for Juvenile Research between January, 1923, and March, 1924, were found to have been enuretic after four years of age. In 135 cases enuresis was present at the time of referral to the clinic, but in only 22 was it cited as a reason for referral.

A slightly larger proportion of boys than of girls were enuretic. Little relation between enuresis and intelligence was found.

The social backgrounds of 90 unselected cases are described briefly, and five case histories illustrate types.

Deniston, Audrey (Illinois Institute for Juvenile Research, 1930).
Enuresis: A Study of Factors Influencing Response to Treatment

A study of 42 enuretic children, over nine years of age, having I.Q.'s over 80, treated individually, and in whose cases the treatment recommendations were followed. Routine habit training, psychotherapy, and suggestion were used. 17 were successfully treated (i.e., the enuresis ceased for a period of at least six months); 17 improved, and 8 showed no improvement.

Economic status and education of parents showed a slight positive correlation with success in treatment, but, on the whole, no significant correlations were discovered. It was concluded that the mode of treatment must vary with the needs of the individual case.

Hyperactivity

Blackman, Bernice (Institute for Child Guidance, New York, 1930).
A Descriptive Study of Fifty Hyperactive Children

50 hyperactive children referred to the clinic were compared with 100 non-hyperactive selected at random from the files and with 50 non-hyperactive identical with the hyperactive group in age. Hyperactivity was defined as constant activity, out of proportion to the stimulus or the results obtained, tense and compulsive, with frequent shifting of goal.

In national background and sex the hyperactive children proved to be similar to other clinic patients. Their average age at referral (6.5) was four years younger than that of the control group. Half were of average height; the rest were equally divided between over- and under-weight, not differing in any respect from the control group. In I.Q. they were also not markedly different from the control group.

Weight and intelligence were negatively correlated. Eliminating cases of positive physical findings, this negative correlation was raised to a point of significance. Hyperactive children seemed to be either dull and over-weighted, bright and under-weight.

In developmental history, the hyperactive group was similar to the control in age of walking and talking and in the number of illnesses, but more showed feeding problems, more were weaned early, and more had toilet habits established early. In behavior problems they exceeded the control group in all types except those of personality adjustment.

A questionnaire for a more adequate descriptive study is appended.

Shorn, Pearl (Child Guidance Clinic, St. Paul, 1928). A Study
of Factors Underlying Hyperactivity in Problem Children

33 cases were definitely diagnosed as hyperactive by a psychologist or psychiatrist. There were 30 boys and 3 girls with age range from three to eleven, 29 being between five and nine. 14 had a subnormal I.Q.; 20 were of average, and 7 were superior in intelligence. 9 were found to be undernourished; 14 had unstable parents, and nearly all came from homes of emotional conflict. The study shows the unfavorable conditions from which each child suffered.

Most of the children were handicapped by several types of adverse factors, suggesting that hyperactivity cannot be explained by any one cause.

Jealousy

Blakeslee, Ruth (Institute for Child Guidance, New York, 1930).
Sibling Jealousy: A Comparison of Older Children Jealous of Younger Siblings and Younger Children Jealous of Older Siblings

39 cases were selected for study in which the diagnosis of sibling jealousy was made by the time of the first staff conference. Subject to the requirements that the children should be in school and that there should be adequate information in the records, the cases were chosen at random, an equal number (34) of older and of younger children being selected. 39 were boys, 29, girls; ages ranged from 5 to 18; I.Q.'s from 73 to 154.

Real differences between the older children jealous of younger siblings and the younger jealous of older siblings were found. Jealousy seemed to be more frequent among girls and to be related to size of family and to an age difference of two years or less. In a large proportion of the cases the mother favored the child of the jealousy; less frequently than the mother, the father too favored the child.

The jealous-child was frequently surpassed by his sibling in health, appearance, intelligence, school success, social adjustment, parents' affection, and was usually compared unfavorably with the sibling of whom he was jealous. An average of 4.5 of these items were found in each case.

Sybil (Boston Habit Clinics, 1924). A Study of the Personality Make-up and Social Setting of Fifty Jealous Children

50 cases were selected which showed jealousy as one symptom and were compared with 100 non-jealous children chosen chronologically from the files of the clinic. Ages ranged up to 12.

Two-thirds of the jealous children were girls as compared with one-half of the non-jealous. Jealousy appeared most frequently between three and four years. In the jealous group 70 percent of the children were oldest or only children; 46 percent in the non-jealous group. Significant differences in personality traits were found, pugnaciousness, sleep disturbances, and hyperactivity predominating in the jealous group. A larger proportion of the jealous children were ruled out by punishment.

Three case studies show the interaction of personalities in the homes of jealous children.

Ross, Bertha M. (Institute for Child Guidance, New York, 1928).
A Statistical Study of Sibling Jealousy among Problem Children

The study was based on the records of the child guidance clinics held for demonstration purposes under the Commonwealth Fund and of the Institute for Child Guidance, New York. Its 1275 cases include all the children living at home with one or both parents, "only children" being, of course, omitted. 13 per cent were checked as jealous on the Findex cards.

Jealousy was found to be somewhat more frequent among girls, among first-born children, among children with I.Q.'s above normal, in small families, and among the first-born. Negativism and fears were associated with jealousy, as were "mother nagging" and "unfavorable comparisons." Maternal over-protection showed no relationship with jealousy.

Sewall, Mabel (Illinois Institute for Juvenile Research, 1929).
Causes of Jealousy in Young Children

Published in *Smith College Studies in Social Work*, September, 1929

Smalley, Ruth (Institute for Child Guidance, New York, 1929).
Influence of Differences in Age, Sex, and Intelligence in Determining the Attitude of Siblings toward Each Other

Published in *Smith College Studies in Social Work*, September, 1929

Laziness

Sproul, Dorothy G. (Child Guidance Clinic, St. Paul, 1926).
Lazy Child

The records of 43 children described as lazy were chosen from the clinic files and the underlying factors in the child's lack of desire to exert himself were traced to disturbances in physical, mental, and emotional spheres. Sixteen seemed to be due to extreme physical disorder, nine to emotional conflict, three to sense of social inferiority, three to mental defect, five to a pre-psychotic condition, and twenty to maladjustment at home or school.

Left-handedness

Dexter, Margaret (St. Paul Child Guidance Clinic, 1927).
of Left-handedness in Twenty-six Children

All cases (26) of left-handedness referred to the clinic over a four-year period were studied. 26 right-handed cases showing the same age range and other group were selected for comparison.

Ages at learning to walk and talk were slightly later in the left-handed group. It also contained more stutterers (9) than the other group, but in only one case was that habit traced to a forced change to using the right hand.

Attempts to change to righthandedness were made in 11 cases. A comparison of these with 11 unchanged left-handed children and 11 right-handed showed the predominance of introversion in the unchanged group. There were, however, no mental defects and speech disorders that might account for the introversion of the left-handed children.

A questionnaire for the study of left-handedness is appended.

Wright, Daisy (Boston Habit Clinic, 1928). A Study of the Social Maladjustment of Twenty-five Left-handed Children

Records of 25 right and 25 left-handed children between the ages of two and ten were studied on the basis of fullness of case histories. The groups were fairly similar in age, I.Q., and economic status, and differed somewhat in sex and ordinal position, nearly all the left-handed children being only, oldest, or youngest children. Disturbances of sleep and speech, and habit spasms occurred more frequently in the left-handed group, but there were so many other factors that might account for these habits that it is doubtful whether left-handedness was the primary cause.

Masturbation

Worcester, Margaret (Worcester, Mass., State Hospital and Child Guidance Clinic, 1929). A Study of Thirty-four Masturbation Cases

The records of 18 clinic boys and 16 men in the State Hospital, the total number of cases showing masturbation as a serious problem, were studied to determine the relation of this habit to other behavior problems or mental disturbances. There was little to show what the habit meant to the boys, but it seemed to play a prominent part in the psychoses of the adults. Parental attitudes toward masturbation were almost wholly destructive.

Worcester, Louisa (Boston Habit Clinics, 1925). The Relationship between Enuresis and Masturbation in Children

Enuresis and masturbation occurred together in seven percent of a thousand cases, while 26 percent of the rest showed masturbation and six percent, enuresis.

Of the 266 cases of enuretics, 85 percent had never received proper training. In others, seven of the relapses followed an illness, three followed accidents, and four changes in the emotional situation of the home. 75 percent of the cases showed improvement under treatment.

Of the 58 cases of masturbation were under six years of age. The cause of 26 cases was attributed to lack of training and discipline. 85 percent improved under treatment.

Of the 68 cases showing a combination of the habits, 92 percent were under six years, 75 percent under six. Temper tantrums, food capriciousness, other bad habits were the most frequently associated problems. The cause was again largely to lack of training and ignorance (58 cases). 75 percent improved under treatment.

Negativism

Gale, Hilda (Institute for Child Guidance, New York, 1929). *Negativistic Tendencies in Children from Two-child Families*

50 cases of problem children who came from two-child families and showed negativistic tendencies were studied. Negativism was slightly more frequent among first children. 70 percent were boys. In average age children studied were somewhat younger than the usual clinic child.

The median age of the first children was 8.5, of the second children 7.5. 50 percent had an I.Q. of more than 110. The first children came from homes that were superior to those of the second children in economic status and emotional tone.

Poor discipline was more frequent among the first children than among the second, while lack of security and sibling antagonism characterized over 50 percent of the latter.

Personality Changes

Ruddiman, Helen (Boston Habit Clinics, 1925). *Environment as a Factor in Acute Personality Changes in Children*

The 37 children who, out of 975 patients, were found to have undergone acute personality changes unaccounted for on an organic basis were chosen for study. There were 22 girls and 15 boys. The age at which change occurred varied from one to eleven, half of the children being three or four at the time (Most Habit Clinic children are of pre-school age.) I.Q.'s were all above 100.

Indulgence, unwise discipline, inadequate play opportunities, oversolicitude, and unstable parents characterized the home situation of many of the children. In many cases the change followed an illness or accident, but the effects were aggravated by their home situation.

Reading Disability

Anderson, Margaret (Illinois Institute for Juvenile Research, 1926). *A Study of Possible Factors Leading to Reading Disability in Children of Normal Intelligence*

50 children referred to the Institute for problem behavior and found to have a marked reading disability were compared with 50 other problem children of the same age, sex, race, and I.Q. This study was made at the same time as Kelley's (below) and is similar to hers except that the children in this group had I.Q.'s of at least 90. There were 40 boys and 10 girls in each group. Ages ranged from 6 to 15, with the median at 8; I.Q.'s from 90 to 140, with the median at 100. The median age in Kelley's group was 11, suggesting that children with reading disabilities do not get into difficulty as early as other children.

Term of pregnancy, type of delivery, presence of birth injuries, and history of masturbation, accidents and illnesses, and auditory or visual defects showed no relation to reading disability. There were a few more children with speech

with left-handedness in the reading disability group. Fewer children in the reading disability group than in the control group lived in homes in which a foreign language was spoken. Otherwise the two groups seemed to be similar in physical make-up and environmental setting.

Kelley, Mae E. (Illinois Institute for Juvenile Research, 1930). *A Study of Possible Factors Leading to Reading Disability in Children of Sub-normal Intelligence*

50 children showing reading-disability and having I.Q.'s under 90 were compared with 50 of the same I.Q., age, and sex who did not have a reading disability. All were "problem" children studied by the Illinois Institute for Juvenile Research. I.Q.'s ranged from 40 to 89, only six being under 60. Ages ranged from 6 to 15, all but 9 children between 8 and 13 years of age. There were 44 boys and 6 girls in each group.

This proportion of boys far exceeds that generally referred to the Institute and suggests that boys more frequently than girls have a reading disability. The reading-disability group and the control group were similar to each other in number of visual and auditory defects, in number of changes in school, in grade most frequently repeated, in ordinal position, in home background, in attitude of parents, and in personality traits and behavior problems. The reading-disability group differed from the control group in containing a few children with speech defects, and more who had infectious diseases and convulsions before the ninth year. Fewer children in the reading-disability group had foreign-born parents or parents who spoke a foreign language, and the economic status of this group was slightly higher than that of the control group. Only five of the reading-disability cases were referred to the Institute because of that problem.

Sex Problems

Mildred (Illinois Institute for Juvenile Research, 1926). *A Study of Sexual Delinquency*

The 213 cases referred in 1926 for some sex delinquency or in which the psychiatrist considered sex disturbances a problem were studied to show the relation between such delinquency and other problems. 120 boys, 93 girls. 77 percent of the boys were between 9 and 15; 60 percent of the girls were between 13 and 17. Half the cases were between 70 and 90 in I.Q., the distribution being definitely lower than usual among school children.

With the girls there was found a tendency for hetero-sexual activity to be associated with home truancy, lying, and stealing, and for sex interest and masturbation to be associated with stealing. With the boys the associations were masturbation with stealing, lying, and truancy; and homo-sexual activity with stealing.

Werner, Paula (Illinois Institute for Juvenile Research, 1928). *A Comparison of the Results of Institutional and Home Treatment of Thirty Delinquent Adolescent Girls*

30 cases of sexually delinquent girls, ages 12 to 18, were selected on the basis of completeness of records. 15 had been placed by the court in the Illinois School for Girls and 15 were put on probation.

In I.Q., grade placement, and offenses committed, the groups were similar. The institutional group showed a longer period of time over which the offenses had been committed.

Ten of the probationed girls and seven of those committed to the State made satisfactory adjustments in the community afterwards, while three of the former and seven of the latter were later unsatisfactory.

Sears, Florence (Illinois Institute for Juvenile Research, Chicago, 1930). A Study of Fifty-seven Children Referred to a Child Guidance Clinic because of Alleged Sexual Delinquency

This study deals with all the white children having I.Q.'s above 85 who were referred to the Institute because of sexual delinquency between January and May, 1930—57 cases. Seven were found to be falsely accused and were excluded from further study. There were 33 boys and 17 girls; age range 12 to 20 with the median at 13 for the boys and 15 for the girls; I.Q.'s from 85 to 140, with the median at 92.

Masturbation and enuresis were found frequently among the boys and the girls exceeded the usual clinic frequency in lying, stealing, and truancy. A larger proportion of both sexes had American-born parents of adequate economic status than was usual among clinic patients. The boys were found to be solitary, seclusive children having much repression and guilt in regard to sexual activity. The girls were aggressive, and gregarious, and seemed well-informed on the subject of sex. They viewed their sexual activities less seriously than did the boys and showed little emotion in discussing it.

Shyness

Nicholson, Jean (Minneapolis Child Guidance Clinic, 1928). A Study of Forty Shy and Timid Children

The study deals with all the cases referred between September, 1926, and January, 1928, in which shyness and timidity were found to be predominant factors—40 cases out of 529 clinic patients. 82 percent were over ten years of age but in most of these cases it was found that they had always had difficulty in making social contacts. Only two were only children; eight were young children, eighteen were oldest. Fourteen had I.Q.'s above 110. Emotional factors in the home seemed linked with the child's shyness.

Speech Defects

Swain, Clara (Institute for Child Guidance, New York, 1930). A Statistical Study of Speech Defects among Child Guidance Clinic Patients

This is a study of the relationship between speech defects and their associated behavior problems, sibling jealousy, mother nags, unfavorable comparison

with masturbation, enuresis, nervousness, sleep disturbance, negativism, temper, inferiority complex, and school failure. The material was taken from the index cards of four child guidance clinics and is limited by the statistical definition of the above traits.

The percentages of the above traits found among speech defect cases as compared with all other cases were strikingly similar. Nervousness and fears were the greatest difference between the two groups. The number of boys referred for stuttering was greatly out of proportion to the total number referred to the clinics, particularly between the ages of eight and twelve. Nervousness and fears were also most highly associated with speech defects in the same age group. The I.Q.'s of speech defect patients were found to be generally lower than those of other patients.

Stealing

Barbara (Institute for Child Guidance, New York, 1930). A Study of Fifty Children Referred to a Clinic because of Stealing

Forty-five cases were selected at random from those referred for stealing between 1926 and 1929. The sex distribution was similar to that of other Institute patients—24 boys and 16 girls. Ages ranged from 6 to 18; I.Q.'s from 75 to 128, with the mean at 100. Only 16 came from families that were dependent or marginal in economic status, while 14 came from definitely "comfortable" homes. The home situations are described, and an attempt is made to relate the stealing to emotional deprivations in the children's lives.

Brook, Pauline (Worcester, Mass., Child Guidance Clinic, 1929). A Study of Forty-four Children Referred to a Clinic because of Stealing

In the cases in the clinic between 1926 and 1929, 13 percent were referred for stealing. The ages ranged from 8 to 22, with the mean at 11 years. I.Q.'s varied from 65 to 113, with the majority being between 80 and 100. There were four and a half times as many boys as girls in the group. The cases were discussed under what were considered to be the under-lying mechanisms related to the stealing: self-maximization, acquisition, conflicts, and pathological reactions. Home influences and family attitudes were shown to be of importance in the genesis of each child's problem behavior.

Mary (Cleveland Child Guidance Clinic, 1927). An Analysis of Thirty-nine Cases of Theft with Emphasis on Factors in Causation

Forty cases were selected at random from the 1,015 given full clinic service between 1925 and 1926. From these were chosen for study the 39 in which stealing was the problem of importance. There were 33 boys and 6 girls; age range, 6 to 18, with the mode between 11 and 14; I.Q.'s, 57 to 126, with the mode between 80 and 95.

In the stealing was most frequently associated lying (29 cases), truancy

(18), and misconduct and disinterest at home and school (14). Only 18 children came from unbroken homes.

Causes for theft were divided into the following groups: stealing a custom in the child's group, influence of gangs, wish-fulfillment, organic defects, emotional conflict; and illustrations are given of each type.

Sanders, Helen (Illinois Institute for Juvenile Research, 1928). *Some Factors in Twenty Cases of Stealing*

All cases (20) seen during an eighteen-month period were studied which satisfied these conditions: stealing a major problem; not in an institution; referred to clinic for treatment; I.Q. above 69; no mental disease or physical defects. 17 were boys; ages ranged from 7 to 16 with all but one being between 9 and 14.

The most frequent reason for stealing was connected with truancy (10); eight stole in order to buy friends, five to feel grown-up, and five as a means of annoying their parents. In 17 cases there was overt conflict with the parent and the children felt insecure.

With the stealing were associated the following problems: truancy at home (19), "nervous" habits (18), protective lying (18), masturbation (18), and other less frequent problems. 13 children had difficulty in making friends.

17 families were financially unable to satisfy the child's desires. A list of factors which influenced the child to steal reveals from 9 to 13 in each case.

Sippy, Maude (Illinois Institute for Juvenile Research, 1927). *Diagnostic Value of Histories in Determining the Causes of Juvenile Theft*

100 consecutive cases, starting August, 1925, in which stealing was a major problem were analyzed. There were 26 girls and 74 boys; average age, 11.5; average I.Q., 79. Among associated problems, lying was the most frequent, being found in 98 percent of the cases. Truancy was found in 67 percent, mental retardation and dullness in 40 percent.

Causes of stealing were found to be the following: gratification of normal childish desires, spirit of adventure, influence of bad companions, establishment of social equality, reaction against home conditions, faulty training, lack of recreation. The number of cases in which each of these appeared as the cause and as a contributing factor is noted.

The case records are analyzed to see whether they contain information useful in diagnosis, and many suggestions for improvement are made.

Stuttering

Perlowski, Frances (Minneapolis Child Guidance Clinic, 1927). *Psychiatric Significance of Stuttering*

400 cases of stutters were gathered through questionnaires compiled by the author and sent to speech teachers in Minnesota, Michigan, and Wisconsin. Age range, 3 to 30, with median at 12; 302 boys and 96 girls.

Age of onset ranged from two to twenty with 40 percent being under three. There were peaks at six and eleven. 43 percent had a family history of speech defects other than stuttering and 54 percent showed other stutters in the family. 45 percent showed some member of the family emotionally unstable. The cause of stuttering was attributed to emotional disturbances, 42 percent; physical causes, 19 percent; adverse home conditions, 15 percent. 11 percent of the cases were left-handed.

100 stutters studied through Blanton Behavior Charts, filled in by the speech teachers in Minneapolis, were compared with 100 non-stutters matched with the others for age, I.Q., school grades, and class-room teacher.

Both groups curved on the negative side of the ideal norm, as shown in their personality profiles, but the stuttering group, in most traits, was farther from the norm. The stutterer was found to be more socially maladjusted and inadequate, more suggestible and demonstrative than the non-stutterer.

Temper Tantrums

Bennett, Lillian V. (Michael Reese Dispensary, Chicago, 1927). *A Study of Temper Tantrums in Children between the Ages of One and Sixteen*

All the cases between 1922 and 1927 showing temper tantrums as one behavior difficulty, excluding 20 with insufficient data and five with I.Q.'s below 41 or above 110, were studied.

The most frequent age was between eight and eleven. I.Q.'s ranged from 41 to 110, the largest number being normal. The principal exciting causes of the tantrums were the refusal of a request, interference with activity, antagonism toward a sibling, and teasing.

25 percent of the cases were diagnosed as emotionally unstable. This group was compared with the other 75 percent, and there was found a larger extent of malnutrition in the unstable group (59 percent as compared with 28 percent). Lying, stealing, and crying were found more frequent there, while enuresis and stubbornness were higher in the stable group. Parental and filial difficulties occurred twice as frequently in the unstable group.

Truancy

Laughhead, Mary B. (Minneapolis Child Guidance Clinic, 1924). *A Study of a Truant from Home and School*

The home background and treatment of one truant is discussed in detail.

Baum, Frances (Illinois Institute for Juvenile Research, 1924). *A Study in Truancy from Home in Children and Adolescents*

The case histories of eleven children showing recurrent, over-night truancy from home were selected to illustrate a diversity of diagnoses and various experiments in social treatment. The cases were complex, and treatment proved successful in only a small proportion of them. This was due, in the opinion

of the writer, to the lack of necessary information about the truant. She suggests fuller histories covering all factors having a bearing on the truancy and giving specific information about the truancy itself: its first manifestation, the stimuli to it, frequency, duration, and a description of what occurred during it. From the information thus collected it could be seen whether the truancy is a "normal reaction to an abnormal environment" or vice versa, and treatment could be planned accordingly. Concrete suggestions for treatment of various types of truants are given.

Greene, Louise (Boston Habit Clinics, 1927). A Study of Twenty-four Children Who Ran Away from Home

24 truants were found among about 2500 children studied by the clinics between 1921 and 1927. 21 were boys; the modal age lay between five and nine.

Six truanted because of love of adventure, one was mentally defective, while the others left because of some unpleasantness in home or school. At least half of them had definitely pleasurable experiences while away.

Two-thirds came from homes of poverty; two-thirds had foreign-born parents; 17 showed definitely antagonistic relationships with their parents. There was a piling up of undesirable home factors in every case.

Gangs did not seem to be a factor in the truancy. School appeared to contribute directly to it in only two cases.

Six children improved under treatment by the clinics, while the others were transferred to other agencies or refused to co-operate.

Milliken, Irene (Illinois Institute for Juvenile Research, 1926). A Study of Hypotheses in Explanation of Truancy

A review of the theories of truancy and an application of them to four cases. All are shown to be helpful in explanation, and recommendations for school and home in the treatment of the truant are suggested.

Nash, Helen (Illinois Institute for Juvenile Research, 1928). A Study of One Hundred Truants from Home

A study of 50 girls and 50 boys selected from a total of 726 cases who showed recurrent over-night truancy.

With the truancy from home was associated, in the case of boys, truancy from school and stealing; to a less degree, lying. In the case of girls, truancy from school and stealing were not so frequent, but sex delinquencies were very frequent.

35 girls and 34 boys came from homes that were definitely unfavorable—cruelty, over-crowding, and excessive quarreling characterizing 50 percent of them. 60 percent of both groups came from homes of low economic status.

The children's stories of their reason for truancy showed a high proportion of girls feeling that they were discriminated against or that their parents' attitudes were antagonistic. Fear of punishment was a frequent reason among boys. Many girls and few boys gave "dislike of home" as a reason.

Wallace, Dorothy (Dallas, Texas, Child Guidance Clinic, 1924). Problem of the Quasi-delinquent in School (published in *Mental Hygiene*, Volume VIII, pages 115 to 165.)

Questionnaires were sent to thirty-two school principals in Dallas, asking for a record of the truant children over an eight-month period. 17 replies reported 107 truants out of a school population of 9000, only eight of them being girls. Median age was 12. 38 percent were retarded; 61 percent were failing in school; 68 percent showed other problems in addition to truancy. The principals reported 25 additional cases of behavior problems not involving truancy.

Ten case studies—five of them of boys about to be committed to the reform school—illustrated the different types of maladjustment.

Juvenile Delinquents

Driemeyer, Adele (Municipal Psychiatric Clinic, St. Louis, 1924). A Study of Forty Neglected Children Who Became Delinquents

The study covers all the cases (40) in the clinic judged neglected by the Juvenile Court who later became delinquent, omitting four negro children. There were 21 boys and 19 girls; ages, 10 to 18, with two-thirds 14 or more years old; 33 were native born of native parents. The I.Q. distribution was definitely lower than that found in the clinic as a whole.

67 percent of the fathers, 52 percent of the mothers, and 35 percent of the siblings were delinquent. Only 12 were found to have shown improvement under treatment carried out by the Juvenile Court.

Halliday, Anne (Essex County, N.J., Juvenile Clinic, 1928). A Study of Thirty Delinquent Negro Children

See pages 238-259 of this number of *Smith College Studies in Social Work*.

Hayward, Grace (Essex County, N.J., Juvenile Clinic, 1927). The Emotional Factors Found in Recidivists at the Essex County Juvenile Court

The cases of boys between the ages of eight and thirteen who had been in court more than once were selected from the 1600 clinic records. Those cases in which adolescence or gross feeble-mindedness seemed to be causal factors were excluded, and 50 cases were chosen from the remainder in which there was evidence of conflict in the home.

The average age was 13 years. Four-fifths were below average in intelligence, although only three were feeble-minded. Their fathers were largely unskilled laborers earning low wages. The marital relations of the parents, conflicts with siblings, poor discipline, and poor economic status were the chief disturbing factors found.

ABSTRACTS OF THESES

Abstracts of all the theses submitted to the Smith College School for Social Work will be published in the *Smith College Studies in Social Work*. The September, 1930, number contained those dealing with mental diseases and mental deficiency; the December number, those concerned with physical disease and those treating of social work practices; and the March, 1931, number contained those dealing with the specific behavior problems of child guidance clinic patients.

In this number the theses classified under the general heading, the family, are abstracted. At the beginning of each abstract appears the name of the student, the institution at which she did her field work, the year of her graduation from the School for Social Work, and the title of her thesis. Each abstract contains a statement of the number of cases studied and of the method by which they were selected, so far as it was possible to ascertain those facts.

V. THE FAMILY

A. *Emotional Relationships within the Family*

Fuller, Alfreda P. (Institute for Child Guidance, New York, 1929)
The Origin of Parental Attitudes Toward Discipline

A study of fifty cases in which disagreement between the parents over the discipline of the child was clearly marked. All the children lived at home with both parents. There were 41 boys and nine girls, two-thirds of them being between six and eleven years old. In I.Q. they formed a random sample of the Institute patients, 80 per cent being above 90.

Punishment was mainly repressive. Fathers were more apt to be objective and mothers to make the children dependent. Fathers tended to rule by fear, while mothers were, on the whole, lenient.

The parents tended either to repeat or to reverse the home situation of their childhood in their attitude toward discipline, but a factor of greater importance seemed to be their attitude toward the other parent. Every case showed clear evidences of discord between the parents on matters other than the discipline of their children.

Grossman, Grace (Michael Reese Dispensary, Chicago, 1926) Family Conflict in Relation to Types of Behavior Manifestations in Children

125 cases were analyzed to ascertain the presence or absence of family conflict; 37 were positive and 88, negative. 3.24 problems were found per child in

the conflict group, 2.18 in the other. About half of both groups showed personality defects, nor were there any differences in the type of defect.

Children from conflict families were definitely younger than the other group, 32 per cent being under six and 27 per cent over eleven as compared with 15 per cent and 50 per cent of the other group; and they were of somewhat higher I.Q. and contained a larger proportion of girls. No significant differences in the type of behavior problems were discovered. Two case studies.

Hall, Dorothy E. (Boston Habit Clinics, 1925) Domestic Conflict and Its Effect on Children

50 cases of most severe discord and 50 of greatest domestic harmony were selected from a thousand records of preschool children. No mentally defective child was included, and the groups were evenly matched for age and sex, slightly more in non-conflict group having I.Q.'s over 110.

The problems for which the children were referred showed a marked difference between the groups. 92 per cent of those from homes of friction and 48 per cent of the other group were referred for personality difficulties, while 94 per cent of the non-friction group and 76 per cent of the other group were referred for problems having to do with habit formation. More problems per child were found in the group from homes with friction.

Five case histories show the relation of the child's disorder to its parents' attitudes toward one another. All responded well to care in a nursery school or foster home.

Holloway, Edith (Worcester, Mass., Child Guidance Clinic, 1928)
A Study of Fifty-eight Problem Children, with Emphasis upon the Home Situation as a Causative Factor in Producing Conflict.

All cases at the clinic in 1926-28, excluding those with I.Q.'s below 80 and those with gross physical handicaps were studied. Ages ranged from five to fourteen, with three-fourths between seven and twelve. There were 51 boys and seven girls.

The children were divided into two groups on basis of their adjustment to children of their own age, 64 per cent being in the isolated group. Over-solicitous parents, inconsistent discipline, and poverty were found most frequently in the adjusted group, but the isolated exceeded in all other emotional disturbances in the home.

Problems for which the children were referred to the clinic were classified into six types. In all types the isolated children were shown to have more than their proportionate share.

Two illustrative cases are given.

Lewis, Margaret (Illinois Institute for Juvenile Research, 1928)
How Parental Attitudes Affect the Problem of Lying in Children

30 mothers who accompanied their children to the clinic were interviewed on the subject of lying. In ten cases the mothers reported that their children did not lie; this was used as a control group.

Eight lying children stole; none of the non-liars stole. The average I.Q. of first group was 99, of second, 90. 90 per cent of the non-liars came from stable harmonious homes as contrasted with 25 per cent of the other group. All the non-liars were "wanted" children while of the 20 liars, eight were definitely unwanted and seven others believed they were unwanted. 30 per cent of the non-liars and 75 per cent of the liars suffered from inconsistent discipline at home. 60 per cent of the mothers of lying children reported that they themselves lied frequently as children; 30 per cent of the other group reported lying.

Levey, Beatrice (Illinois Institute for Juvenile Research, 1926) Familial Inter-relationships as Causative Factors in the Behavior Disorders of Children

Three case studies of children, two diagnosed psychoneurotic and one as having "psychoneurotic manifestations," who responded well to social treatment. Psycho-analysis as an additional aid in treatment is discussed.

Madsen, Frances Hauss (Institute for Child Guidance, New York, 1928) Marital Conflict as a Causative Factor in the Conduct Disorders of Children

32 cases (28 families) in which there was marital discord, ranging from dissatisfaction by both parents to violent quarreling, but in which the parents lived together at the time the child was referred were analyzed. 57 per cent had adequate incomes, and 11 per cent were dependent. The age range of the children was one to 19 with the mode at 10-11; there were 19 boys and 13 girls; I.Q.'s ranged from 60-130, 62 per cent being above 90. 70 per cent were only, oldest, or youngest children.

Personality problems, as compared with an unselected group of cases, showed a preponderance of the inferior, inadequate, and shut-in types.

Treatment as of two types: those in which marital adjustment was attempted (16) and those in which it was not (16). Of the 10 cases in the first group in which marital friction was lessened, 5 children improved; in the 16 in which adjustment was not attempted, 9 children improved.

Middleton, Elizabeth (Family Society of Philadelphia, 1927) Environmental Handicaps of Children in Families in Which One or Both Parents Use Alcohol Habitually

34 dependent families were studied to ascertain the effect of excessive drinking on the person drinking and on his children. Physical disability of the father was found due directly to alcohol in four cases, partially due to alcohol in four others. 17 showed no disability. In three-fourths of the cases the man's drinking was associated with tension in the family. In 30 cases there was loss of work. The effect on the children was seen in the lowered economic status and in emotional maladjustments associated with the disturbance of family relationships.

Totten, Helen (Illinois Institute for Juvenile Research, 1928) The Emotional Setting of the Home as a Causative Factor in the Behavior Problems of Children

Fifty cases were chosen at random, omitting only those of insufficient detail. The children were grouped as to the type of problem they presented, and correlations between problems and personal histories were sought. Home atmosphere was shown to be important in producing the conflict, resulting in the problem. Eight case abstracts illustrate different types of problems.

Barnes, Delaphine (Institute for Child Guidance, New York, 1929) A Study of Twenty Cases in Which There Was a Marked Identification of Parent with Child

20 cases (14 boys and 6 girls) in which the psychiatric interpretation of marked identification of parent with child was made were chosen on the basis of degree of information in the records. In 18 cases both parents lived at home with their children. The group did not vary in age and sex from the total group of clinic children but was of slightly higher average intelligence. In problems for which they were referred the group showed a markedly undue proportion of inability to get along with other children, disobedience, hyperactivity, show-off behavior, day-dreaming, sibling jealousy, and school failure.

The identification was of mother with son, 9 cases; mother with daughter, 6; father with sons, 5. 18 of the parents were over-protective and two rejected their children. The children divided evenly in submitting or rebelling. The girls were somewhat more submissive than the boys, and the boys submitted more frequently to their fathers than to their mothers.

Possible causes for identification were found in deprivations in the early life of the parents (15 cases), marital disharmony (20 cases), lack of social contacts (15 cases), physical or mental resemblances between parent and child (5 cases) and guilt feelings (2 cases).

Three case studies illustrate identification types.

Clare, Minnie-Brown (Philadelphia Child Guidance Clinic, 1926) Parental Domination as a Factor in the Behavior Problems of Twenty Children

All cases in which parental domination seemed an important factor were chosen for study. In the cases of foreign-born parents their old-world ideas of discipline seemed definitely related to their children's stealing and defensive lying. Too great ambition for their children (3), over-solicitude (3), and the carry-over from the grandparent of an attitude of severity (4) characterized the other types of dominating parents.

Crissey, Eleanor (Philadelphia Child Guidance Clinic, 1928) A Study of the Effect of Parental Attitude on Behavior Difficulties of Fifty-two Physically-handicapped Children

52 children were chosen to present a fair sampling of cases in which a gross physical handicap occurred. Age range, 4 to 17; I.Q. range, 60 to 132; economic status range from four "affluent" to eight dependent. The children's behavior mechanisms showed high correlation with the type of discipline used by their parents, suggesting that their difficulties were due more to the parental attitudes than to the physical defect itself. Exceptions to this rule (six cases) were found in children suffering from certain degenerative diseases, glandular unbalance, or physical stigmata which made them very conspicuous. Eleven case studies illustrate the type of correlations found.

Rinaldo, Harriett (Institute for Child Guidance, New York, 1929)

The Altering of Family Attitudes toward the Child during a Prolonged Illness as a Causative Factor in Behavior Problems

The cases of 50 children who had suffered from illnesses lasting at least six weeks were studied to see in what ways they differed from other problem children. In problems for which they were referred they were found similar to other patients of the clinic except that more had school difficulties and fewer lied or stole.

50 per cent were found to be over-protected by their mothers. 57 per cent of those who were only children were found to be rejected. Their illness tended to induce their parents to compare them unfavorably with their siblings, an action which seemed to be productive of jealousy.

Smith, Helen (Institute for Child Guidance, New York, 1928) Families with Ambitions Unsuitable for Their Children

The study deals with all the cases (40) in which parental drives for success seemed to account in part for the child's difficulty. 47 per cent of the children were 10 to 14 years old, and 32 per cent were between 15 and 19. There were 30 boys and 10 girls.

Parental ambitions were for educational success in 22 cases; for social success, 12; for financial success, 6. The children were somewhat older and of higher I.Q. (average 101) than other problem children in the clinic. 36 per cent of the group whose parents were educationally ambitious, however, were under 90 in I.Q. There was a slightly larger proportion of Jews and smaller proportion of Catholics than in the clinic as a whole. Many came from comfortable or rich homes.

Quarrelling, disobedience, irresponsibility were the most frequent conduct disorders. 52 per cent were failing in school; 32 per cent showed phantasy and day-dreaming.

Zimmermann, Anna Cecelia (Philadelphia Child Guidance Clinic 1930) Parental Adjustments and Attitudes in Relation to the Problems of Five- and Six-Year-Old Children

In order to determine the relationship between the family configuration, the child's personality, and his school adjustment, the case records of all the children referred to the clinic when five or six years old and accepted for full study were

examined. Between September, 1927 and March, 1930, 25 such cases were referred. I.Q.'s ranged from 93 to 139; there were 20 boys and 5 girls.

Seven were found to show no school problem; seven were timid in school and eleven were aggressive. The aggressive children tended to have over-protecting or rejecting mothers; the timid children to have over-solicitous or over-anxious mothers. The rejecting mothers were found, on the whole, to be insecure, immature, and dependent; they were frequently dominated by their husbands and showed little compensation on the ego level. The oversolicitous mothers tended to feel insecure and inferior and had compensatory ego drives, frequently dominating both children and husbands.

Detailed descriptions of all cases are included in the study.

Maternal Rejection

Figge, Margaret (Institute for Child Guidance, New York, 1930)

The Etiology of Maternal Rejection: a Study of Certain Aspects of the Mother's Life

The purpose of the study was to test part of the hypothesis set forth by Dr. David Levy in explanation of maternal rejection by a comparison of the case histories of a group of rejecting and non-rejecting mothers. Thirty-five cases of rejection were chosen in which the staff members unanimously agreed to that diagnosis. Thirty-five non-rejecting cases were chosen at random from the files, cases showing over-protection being omitted.

The two groups of children were found to be similar in sex, age, ordinal position, size of family, intelligence quotients, and physical disabilities and disease history. The problems for which the rejected child was referred were more frequently of the aggressive, rebellious type.

The following differences between the rejecting and non-rejecting mothers were found: "unhappy childhood," rejecting, 26, non-rejecting, 7; "social frustrations through marriage," 26 and 5; "thwarted professional ambitions," 18 and 10; "social incompatibility," 28 and 13; "sexual incompatibility," 25 and 11; "social change through marriage," 17 and 3; "mother plays dominant rôle in marriage," 16 and 12; "child unwanted," 33 and 6.

Detailed abstracts of all the cases show the evidence on which these conclusions were based.

Gleason, Mary C. (Institute for Child Guidance, New York, 1929)

A Study of Attitudes Leading to the Rejection of the Child by the Mother

Case histories are presented showing the attitude toward their parents, siblings, husbands, and children of twelve mothers who rejected their children. Following the histories there is analysis of the evidence of rejection: the mothers' statements of attitude, the care they gave the children as babies, their treatment of them at the time of study.

Only two of the marriages were "love matches." Sexual relationship was definitely unsatisfactory in at least half the cases. Most were dissatisfied with

marriage because of the responsibilities and the clash of personalities it entailed. Eight of the women were antagonistic to their fathers at the time of their marriage and six felt that they were not loved by their mothers.

Maternal Over-protection

Brunk, Christine (Institute for Child Guidance, New York, 1930) A Study of the Developmental History of the Over-protected and the Non-overprotected Child

A group of 30 children over-protected by their mothers in infancy was compared with a group of 200 that were not over-protected in order to discover the effect of over-protection on early development and the establishment of certain habits. The children were considered over-protected if the case record showed that at least three persons made the observation that the mother was over-anxious, over-solicitous, or over-protective. Non-overprotected cases were chosen at random from the files.

The distribution by nationality was similar for the two groups of mothers, but the over-protective were of slightly higher economic status. The over-protected children showed somewhat higher I.Q.'s. One-half of the over-protected and one-fourth of the other group of children were "only children."

The two groups of children were similar in incidence of illness and operations and in age of walking and talking. The non-overprotected group contained more restless sleepers and more children with food fads. 72 per cent of the over-protected children were breast-fed for more than six months as compared with 43 per cent of the non-overprotected children. 41 per cent of the over-protected and but seven per cent of the others were breast-fed more than twelve months. The difference could not be accounted for on the basis of nationality or economic status.

Irvine, Olive (Institute for Child Guidance, New York, 1930) A Study of Sibling Relationships among Over-protected and Non-overprotected Children

24 over-protected children chosen for study by Dr. David Levy were compared with 20 non-over-protected selected at random from the files, cases of over-protection and rejection being omitted. The over-protected child was slightly less likely to be jealous than the non-overprotected child, but his sibling was more likely to be jealous. Jealous children were found to have slightly higher I.Q.'s. Jealousy was associated with a difference in sex.

Nixon, Mary (Institute for Child Guidance, New York, 1928) The Rôle of Maternal Influence in the Over-dependency of Children

20 boys, healthy, legitimate, of sound intelligence, living in normal, economically independent homes in which no marital conflict was admitted by the parents, but who showed marked dependence on their mothers were studied. 14 of the 20 were the only boy in the family, 9 were only children, 7 the

oldest, and 3 the youngest. Ages ranged from 6 to 14, 12 of them being 10 or older. Their problems showed a predominance of food fads (12), "nervousness" (10), sleep disturbances (9), difficulties in social contacts and lack of initiative (14), and poor school work (16). 16 of the mothers themselves were only, oldest, or especially favored children; 12 were excitable and tense; 10 had few outside contacts, and 10 with little education were desirous of more.

Blomquist, Emma (Institute for Child Guidance, New York, 1930) The Etiology of Maternal Over-protection, Part I: Manifestations of Maternal Over-protection

This study, the first of a series of three which were undertaken to test out Dr. David Levy's hypothesis as to the origin of maternal over-protection, serves to define over-protection. Concrete evidence of the parent-child relationship in 30 cases is classified under headings suggested by Levy: prolonged infantile care, excessive contact between mother and child, prevention of the development of independent behavior, the granting of excessive privileges, excessive mollifications, domination of the mother by the child. These traits occurred to a marked degree in the following number of cases, which correspond to the above categories—19, 12, 17, 13, 7, and 19.

Those cases were chosen for study in which both the Institute staff members and several outside persons agreed that the child was over-protected. 28 of the 30 children thus chosen were boys. I.Q.'s ranged from 85 to 147, with the median at 117; ages from 4 to 17, with the median at 9.

Hough, Elizabeth Bradford (Institute for Child Guidance, New York, 1930) The Etiology of Maternal Over-protection, Part II: a Study of Certain Factors in the Life of the Mother

32 over-protective mothers were compared with 32 non-overprotective mothers for certain traits which Dr. David Levy suggested as being related to maternal over-protection. Cases were selected as in Blomquist's study.

The over-protective mothers were found to be three years older on the average than the other group. The groups were similar in nationality distribution. Their children were similar in age but differed in that the over-protected were more frequently boys and "only children" and had higher I.Q.'s.

The mothers were compared in regard to libidinal satisfaction in childhood, ambitions thwarted by marriage, rôle in the marriage relationship, sexual adjustment, social relationships, desire for and hazards associated with the birth of the children.

The over-protective mothers were found to exceed the others in number showing an unhappy childhood, satisfaction from earning a living, sexual incompatibility, and extra hazards making the child a special risk for survival. Significantly more of the non-overprotective mothers played the dominant rôle in marriage. In other traits investigated the groups were quite similarly distributed.

Lewenberg, Martha Paula (Institute for Child Guidance, New York, 1930) The Etiology of Maternal Over-protection, Part III: A Study of the Marital Relationships of Over-protecting and Non-overprotecting Mothers

This study is a continuation of Blomquist's and Hough's above, and many of the same cases are used in it. 45 over-protective mothers were compared with 45 non-overprotective, the first being chosen by Levy and the latter by random selection from the files.

In the over-protective group there were more boys, the I.Q.'s were higher on the average, there were more "only children" and slightly more Jewish families. The groups were similar in age of children and in the education of the parents. Factors, suggested by Levy as related to over-protection, were consistently more frequent in the over-protective group and differences of at least 25 per cent were found in the following traits: social maladjustment, sexual maladjustment, disagreement over discipline, disagreement over desire for children, interfering relatives, and economic dissatisfaction.

Rosenblum, Deborah (Cleveland Child Guidance Clinic, 1925) A Study of the Causes and Effects of Exaggerated Maternal Solicitude

All the cases (17) in which maternal over-solicitude was judged an important causative factor were studied. Ages ranged from 3 to 15, with thirteen being between 8 and 13. There were fifteen boys and two girls.

Two were "only," three youngest, and twelve oldest children. A description of the personality traits of the children is given.

Shane, Aileen (Institute for Child Guidance, New York, 1929) A Study of Fifty-four Adolescent Problem Children Showing the Effects of Over-protection

54 children between the ages of 12 and 18 who were judged by the psychiatrist to have been over-protected in childhood were compared with 54 others of the same age, selected at random, who were not considered over-protected.

The over-protected group showed significantly more boys than did the other group. Only 28 per cent of that group as compared with 52 per cent of the control group were found to be in good physical condition. 31 per cent of the over-protected and 15 per cent of the control group were only children. The over-protected children showed a predominance of personality problems while the control group showed largely anti-social behavior. In I.Q. the groups were similar, but many more over-protected children were failing in school.

Young, Martha (Institute for Child Guidance, New York, 1929) A Study of the Treatment of Thirty-five Over-protective Mothers Whose Children Were Referred to a Child Guidance Clinic

The cases of 35 problem children whose mothers were found to be over-protective were compared with 35 others selected at random from the files. The two groups were fairly similar in age and intelligence but there were slightly more boys in the over-protected group. There were 17 Jewish children in the study group as compared with eight in the control group.

The over-protected group differed from the control group in economic status, considerably more of them coming from the "adequate" or "comfortable" classes; in number of siblings, 27 of the over-protected and 14 of the control group having no or only one sibling; in the number of "weak" fathers, and in mothers having no outside contacts. 32 of the over-protected group as compared with 16 of the control group showed a withdrawal type of behavior.

The results of treatment showed: successful, 7 over-protected, 12 control; partially successful, 9 over-protected, 15 control; unsuccessful, 19 over-protected, 8 control. Treatment recommendations aimed at modifying the behavior of the over-protective mother toward her child were largely unsuccessful, while those which directly concerned the activity of the child were generally carried out.

Weir, Helen (Institute for Child Guidance, New York, 1928) A Study of Parent-child Dependency

One hundred cases in which the difficulties were diagnosed as due partly to parental protectiveness and one hundred cases not showing this trait were studied. Age, sex, ordinal position, type of home (broken or not) were found to be similarly distributed in the two groups. The problems for which they were referred were similar with the exception of a slight preponderance of lying in the control group and school failure in the protected group. Four case studies of over-protected children.

(To be continued)